Swindon Safeguarding Partnership

ANNUAL REPORT

2025–2026

Foreword from Clare Deards, Partnership Chair

I am pleased to introduce the Swindon Safeguarding Partnership Annual Report for 2025–2026, covering the period from 1 April 2025 to 31 March 2026.

Before reflecting on the year, I want to begin by acknowledging the dedication and leadership of Gill May, Chief Nurse for the Integrated Care Board and former Chair of the Partnership. Gill's commitment to safeguarding, her ability to bring partners together, and her unwavering focus on improving outcomes for children, young people and adults with care and support needs has left a strong and lasting legacy.

The progress made under her chairship has provided a solid platform on which the Partnership continues to build. I took on the role of Chair in October 2025, and I am grateful for the warm welcome and support shown to me by partners across the system. Over the past months, my focus has been on continuing and strengthening our collective improvement journey, ensuring that our priorities are *purposeful, intentional and impactful*.

As a Partnership, we have not been afraid to be curious and, at times, deliberately disruptive, challenging ourselves to think differently about how we evidence impact and how we know that learning is truly embedded within practice.

Swindon Safeguarding Partnership

Foreword from Clare Deards Partnership Chair

A key area of development this year has been our increased focus on assurance and impact. The introduction of clearer performance indicators, a developing performance dashboard, and the invaluable contribution of our newly appointed Data Performance Analyst have significantly strengthened our ability to understand what difference safeguarding activity is making on the ground.

This work is helping us move beyond activity-based reporting towards a more meaningful understanding of outcomes for people in Swindon.

Looking ahead, I am genuinely excited about the opportunity to fully embed these new ways of working over the coming year and to build on ways of ensuring the voices and experiences of both Children and Adults are held at the centre of all we do. The Partnership is well placed to continue building a robust learning culture, improving consistency across agencies, and ensuring that safeguarding remains everyone's responsibility.

Finally, I would like to extend my sincere thanks to the Strategic Business Unit and all partners, both statutory and non-statutory for their continued commitment and dedication. Safeguarding work is complex, demanding and often challenging, but it is also vitally important. The collective efforts of colleagues across Swindon continue to make a positive difference to the lives of children, young people and adults with care and support needs. This report reflects that commitment and the shared determination to keep improving what we do together.

Swindon Safeguarding Partnership

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 2026. 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.

The Safeguarding Partners provide through financial or in-kind contributions the resources required to deliver effective multi-agency safeguarding arrangements. This includes funding of the Strategic Support Unit, independent scrutiny, multi-agency training and case reviews.

The Safeguarding Partners funding contributions for 2025-26 are as follows:

Swindon Borough Council	£128,000.00
Wiltshire Police	£49,800.00
BSW ICB	£82,000.00
Great Western Hospital	£17,700.00
Probation	£2000.00
Avon and Wiltshire Mental Health Partnership	£2000.00
Total	**£281,500.00**

Swindon Safeguarding Partnership will act with clear intent and shared purpose to achieve measurable, meaningful improvements in outcomes for children and adults with care and support needs. We will do this by:

- **Building a shared safeguarding culture**

Creating a strong culture of collective responsibility, where safeguarding children and adults is everyone's business.

- **Turning learning into improvement**

Acting on learning so we continuously strengthen how we support children and adults with care and support needs.

- **Empowering communities**

Activating and enabling our local communities to be active safeguarding partners.

- **Increasing lived-experience influence**

Strengthening the involvement of children and adults so their voices shape the Partnership's work.

- **Developing a confident workforce**

Building a confident, skilled and knowledgeable workforce, using expertise to drive high-quality practice.

- **Using data to tell a shared story**

Using data and insight to develop a shared narrative about safeguarding needs in Swindon and guide our priorities.

Lead Safeguarding Partners

As defined in the Working Together to Safeguard Children 2026 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.

Chief Executive for the Integrated Care Board (ICB) for an area, any part of which falls within the local authority area:
Jonathan Higman has taken over the Chief Executive role for BaNES, Swindon, Wiltshire, Dorset & Somerset ICB from Sue Harriman.

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

Delegated Safeguarding Partners

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

Swindon Borough Council
Clare Deards, Corporate Director People, DASS & Partnership Chair from October 2025.

Wiltshire Police
Liz Coles, Assistant Chief Constable, Crime, Justice and Vulnerability.

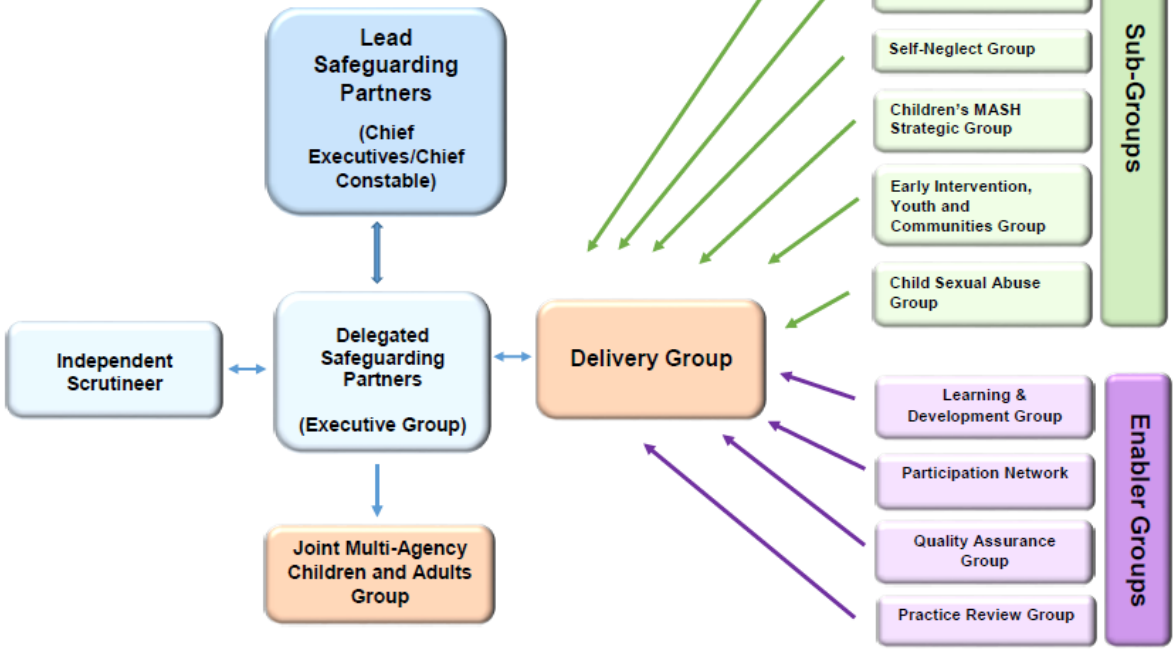
Swindon Borough Council Director of Children's Services (DCS)
There has been a change of DCS role with **Brenda McInerney** taking over from Lisa Arthey.

BaNES, SWINDON and Wiltshire Integrated Care Board
Gill May, Chief Nurse Officer who stepped down from the Chair role in October 2025.

Jackie Fieldwick has stepped down as education representative on the Executive Group and **Kashif Nawaz**, SBC Service Director of Education has stepped into this space to support and influence strategic decision making.

Swindon Safeguarding Partnership

Governance Structure 2025-26



Swindon Safeguarding Partnership

KEY ACHIEVEMENTS 2025–26

Working together to keep people in Swindon safe, supported and thriving.

STRONGER PARTNERSHIP GOVERNANCE

- Independent Scrutineer appointed
- New Quality Assurance Framework implemented
- Partnership Performance Dashboard introduced
- Outcome-focused assurance and accountability strengthened

SAFEGUARDING ADULTS

- CQC rating improved to **GOOD**
- Adult Safeguarding Dashboard launched
- Adult Safeguarding Service redesigned to improve oversight and responsiveness
- Enhanced multi-agency safeguarding arrangements recognised by CQC

SAFEGUARDING CHILDREN

- Ofsted recognised improved stability and permanence for children in care
- Reduced delays in securing permanent arrangements
- Families First Partnership Programme moved from mobilisation into delivery
- Continued improvement journey recognised through Ofsted monitoring activity

CHILD FIRST SWINDON

26
organisations signed up to the Child First approach

- Increased influence of children and young people's voices in strategic development

WORKFORCE DEVELOPMENT & LEARNING

1,451
multi-agency learning bookings

271
practitioners trained in exploitation awareness training

106
practitioners attended Child Sexual Abuse training

- SSP Learning Hub launched to improve access to learning

ROUGH SLEEPING & VULNERABLE ADULTS

50%
Rough sleeping reduced by almost 50%

6 of 9
priority entrenched rough sleepers moved into accommodation

- Stronger partnership working across housing, health, probation and support services

STRATEGIC SAFEGUARDING PRIORITIES DELIVERED

- Child Sexual Abuse Strategy (2026–2029) published
- Neglect Strategy refreshed and relaunched
- Self-Neglect policy and guidance strengthened
- Exploitation and transition pathways improved through multi-agency assurance and audit activity

Building a stronger safeguarding culture, improving outcomes through partnership working, and placing the voices of children, young people and adults at the centre of everything we do.

Independent Scrutiny

For 2025-26, the Delegated Safeguarding Partners contracted an Independent Scrutineer to work across the Partnership as a whole. This was a change in strategic focus for the Partnership as previously there were individual scrutiny tasks that were undertaken by a range of people. Independent Scrutiny sits outside day-to-day management, providing an external, objective, 'critical friend' assessment of whether arrangements are robust and compliant with statutory requirements.

Kevin Gibbs joined the Partnership in April 2025 and has undertaken focused work with the Delegated Safeguarding Partners and members of the Strategic Support Unit to develop clearer lines of accountability, improve evidence of outcomes for children, young people, and adults with care and support needs, and move the Partnership forward towards demonstrating impact rather than activity.

Alongside other activities such as regular timetabled meetings with safeguarding colleague and the individual Designated Safeguarding Partners, there was specific work by the Independent Scrutineer with the Delegated Safeguarding Partners on resetting the strategic priorities of the Partnership using available quantitative and qualitative data. This work led to a renewed focus on the impact of neglect on children in Swindon with a clear action plan in relation to multi-agency training, multi-agency quality assurance of the interventions with children, an agreement to review and refresh the set of professional tools for identifying and working with neglect and a thematic review linked to children impacted by neglect in Swindon.

Other work completed this year included scrutiny of the training and practice models used by all agencies in assessing and intervening in harmful sexual behaviour by young people leading to a consistent practice model being confirmed across the Partnership.

Alongside participation in multi-agency auditing activity undertaken by the Partnership there was active engagement with each of the priority groups for children as well as adults with care and support needs. This provided insight on the strengths within these groups and a focus on developing impact measures across this work.

Independent Scrutiny

The development of increased challenge within the Partnership based on multi-agency data, audit evidence and performance analysis has been supported by the addition of a data analyst role within the Partnership. The insights from this work are now being used with both the Quality Assurance and Delivery Groups in the Partnership to drive practice forward.

There is a need to develop plans for the specific participation of children and young people in the planning, practice and review of the effectiveness of the Partnership during the next twelve months.

There was scrutiny of the multi-agency learning and development processes in the Partnership to assess the application of learning across the range of agencies in Swindon. Learning from formal reviews in both adult and children's safeguarding was overseen in collaboration with the Strategic Support Unit to develop a thematic approach to learning and measure progress in completing actions linked to these reviews. This work will continue to be monitored for progress over the next year.

There has been consistent commitment and good levels of attendance from the statutory partners at Executive level throughout the year despite some changes in membership. Delegated Safeguarding Partners are appropriately senior, hold decision-making authority, and there had been evidence of shared ownership of priorities rather than any single agency leading by default. The involvement of the Education sector as a Delegated Safeguarding Partner through Swindon Borough Council has positively widened the perspective in the Partnership.

The commitment to make the experience of the children and adults with care and support needs in the Swindon Safeguarding Partnership as positive as possible has been demonstrated through observation, audit, data analysis and participation over the last twelve months. These strengths alongside those mentioned in the other sections of this report should form the basis of robust plans by the Partnership going forward as it manages the challenges of significant multi-agency structural changes including the Families First Partnership Programme, high levels of demand for all services, and a need for continuing improvement across Swindon.

Safeguarding Adults

(Safeguarding Adults Collection Snapshot 2024–25)

Adults (Aged 18–64) make up approximately **61.5%** of the population in Swindon, which equates to roughly 150,000 adults in this age range.

Older Adults (65+): make up about **16.3%** of the population, roughly 39,700 people.

Location of risk

Swindon: Most abuse or neglect occurs in the adult's own home, followed by care homes and supported living.

England: 51.9% of risks occur in the adult's own home, with care homes the second most common setting.

Safeguarding activity

Safeguarding concerns and Section 42 enquiries continue to increase year on year, reflecting improved identification and reporting.

Outcomes

Swindon: In the majority of concluded Section 42 enquiries, risk was removed or reduced.

England: 91.2% of enquiries resulted in risk being reduced or removed.

Most common types of abuse / neglect

Swindon:

- Neglect and acts of omission (most common)
- Physical abuse
- Emotional / psychological abuse
- Financial / material abuse

England:

- Neglect and acts of omission (40.8% of concluded Section 42 enquiries)
- Physical, emotional, and financial abuse follow similar patterns.

Learning & improvement themes

Swindon: Self-neglect, mental capacity and executive functioning, professional curiosity, and multi-agency information sharing.

England: National learning reflects the same themes, particularly neglect and self-neglect.

Adult safeguarding activity in Swindon continues to show an upward trend in concerns and enquiries, consistent with national patterns, with complete 2025–26 data to be confirmed through the **Safeguarding Adults Collection later in 2026.**

Safeguarding Adults

The Care Quality Commission (CQC) undertook its on-site inspection of Swindon Borough Council's Adult Social Care services in March 2025. This was Swindon's first inspection under the CQC's new local authority assessment framework.

Following a formal review and independent reassessment, the Care Quality Commission upgraded Swindon's rating from "Requires Improvement" to "Good".

The original assessment, published in October 2025, placed the council one point below the "Good" threshold; however, strengthened evidence in relation to governance and leadership led to an improved score and an overall "Good" rating. The assessment considered performance across nine quality statements within four themes under the CQC's new local authority assessment framework.

Swindon rated "Good" in most areas, including:

- Care provision, integration and continuity
- Partnerships and communities
- Safeguarding
- Learning, improvement and innovation
- Governance, management and sustainability

CQC identified co-production and the involvement of people with lived experience as a developing strength and highlighted that people with lived experience were being given an active voice in strategy and service development across the local authority and within the Safeguarding Partnership. CQC noted examples of working with experts by experience to improve accessibility and inclusive decision-making.

Safeguarding Adults

Care Quality Commission

Key strengths identified by CQC

- **Strong safeguarding arrangements**, with effective multi-agency working and appropriate responses to risk.
- **Improved governance and leadership**, demonstrating clearer oversight, accountability and strategic grip following review.
- **Effective partnership working**, including positive engagement with health, community and voluntary sector partners.
- **Good care provision, integration and continuity**, supporting people to live independently and maintain wellbeing.
- **Culture of learning and improvement**, with evidence of service reflection and innovation

Areas for improvement

- **Consistency and timeliness of needs assessments**, ensuring all people receive a strength-based, person-centred experience.
- **Equity of experience and outcomes**, with variation reported in how individuals experience access to care and support.
- **Timely access to services**, including reducing waiting times for assessments and reviews.
- **Care planning and review activity**, increasing the proportion of plans reviewed within expected timescales.
- **Backlogs in statutory processes**, including Deprivation of Liberty Safeguards (DoLS) assessments, with mitigating actions in place

Safeguarding Adults

Care Quality Commission

During 2025-2026, the Adult Safeguarding Service introduced a safeguarding dashboard, providing significantly improved oversight for managers. This has enhanced the ability to monitor team performance, identify trends, and recognise both areas of strength and those requiring further focus.

The Adult Safeguarding Service has also undergone a consultation and redesign, including the introduction of new Information Officer roles. These posts are enabling quicker and more consistent decision-making around safeguarding criteria, allowing Enquiry Managers to focus their time and expertise on those enquiries where Swindon residents are most at risk.

In addition, roles have been realigned within the team, increasing the number of Enquiry Officers and reducing the number of Enquiry Managers.

This has strengthened capacity to take a more proactive approach, including undertaking visits to our most vulnerable residents. It has also enabled Enquiry Managers to improve oversight of safeguarding activity, allowing them to use their time in a more strategic and supportive way.

Following the introduction of new roles, a new way of working has been implemented. Although still in its early stages, this approach focuses on reviewing safeguarding concerns in real time as they are received, rather than within the previous timeframe of one working day. This shift is supporting more timely decision-making and enabling a more responsive approach to safeguarding.

WHAT WE NEED TO DO NEXT

Safeguarding Adults

Looking forward to 2026-2027, the focus will be on fully embedding the redesigned safeguarding structure, including the new roles, increased number of Enquiry Officers and live duty. Once embedded, this will support to effectively utilise the safeguarding dashboard to assess the impact of these changes, identify trends, and drive continued improvement.

We will also continue to refine and enhance the safeguarding dashboard. While it has already improved oversight, we recognise there are still some gaps in the data. Addressing these will require further development of processes within our adult social care system. Our aim is to create a more streamlined and efficient approach, ensuring that colleague time is better spent supporting Swindon residents through clear and user-friendly processes. This will also support more accurate and meaningful data extraction.

In addition, safeguarding portals are planned to go live during 2026-2027. These will provide improved oversight of safeguarding concerns, further strengthening our ability to respond effectively and proactively.

We will also undertake a safeguarding audit to provide assurance around how effectively we are supporting our most vulnerable residents. This will enable us to identify key learning and development opportunities, while also recognising and building on areas of strength within the service. The findings from this audit will inform continuous improvement and support the ongoing development of high-quality safeguarding practice.

Over the past 12 months, the Rough Sleeping Service has strengthened partnership working across internal and external agencies, improving outcomes for individuals experiencing rough sleeping and enhancing the effectiveness of outreach activity. Closer collaboration with Adult Social Care, Safeguarding Enquiry Managers, CGL, Probation, and AWP has resulted in more coordinated interventions, increased engagement opportunities, and reduced duplication of effort.

The service has maintained a strong focus on its priority cohort of nine individuals experiencing entrenched rough sleeping. At the start of the year, all nine individuals were rough sleeping. As of year end, six have secured accommodation, one is in prison, and two remain rough sleeping, both of whom continue to receive intensive multi-agency support.

The service has also successfully managed several highly complex cases. One notable dual diagnosis case involved more than ten professionals and was supported through the escalation process. Through coordinated intervention, including mental health treatment and detox support, the individual secured accommodation and continues to receive ongoing support.

Performance has continued to improve, with the number of individuals seen rough sleeping during the month reducing by almost 50% compared to April of the previous year. Nightly rough sleeping figures have remained consistently low, averaging fewer than ten individuals per night, and Swindon's annual rough sleeping snapshot has also reduced.

Looking ahead, the service will continue to focus on preventing and reducing long-term rough sleeping through strong partnership working, earlier identification of risk, strengthened prevention pathways, and timely interventions to ensure rough sleeping is rare, brief, and non-recurring.

Safeguarding Children
2025–26 Snapshot

Children and young people age (0–17) living in Swindon account for 1 in 3 residents, one of the highest proportions in the Southwest.

Referrals, assessments and thresholds (Children's Social Care)

Swindon has seen an increase in social care referrals during 25/26, following a focus on thresholds at the front door. Swindon is now slightly above comparators.

Re-referral rates (within 12 months) have decreased in 25/26, and are below statistical and national averages.

Assessment volumes remain high, with increasing complexity, particularly linked to neglect, domestic abuse and parental vulnerability.

Children in Need (CIN)

Swindon's CIN rate is above the national average and has continued to rise year-on-year in line with national trends, driven by neglect and family stressors. Primary need type:

- Neglect – the most common reason for CIN plans
- Abuse or neglect combined with domestic abuse
- Family dysfunction and parental mental health/substance misuse

Child Protection Plans (CPP)

Swindon has a higher-than-average rate of CPPs per 10,000 children compared with England

Category of abuse:

- Neglect is the dominant category for both initial and repeat plans
- Emotional abuse (often linked to domestic abuse) is also significant

Repeat CPPs: A notable proportion of plans are second or subsequent plans, highlighting difficulties in achieving sustained change

Children Looked After (CLA)

Swindon's CLA rate is broadly in line with or slightly above national averages but has shown increasing placement pressure. Placement profile:

- High use of independent fostering agencies
- Out-of-borough placements remain too high
- Improvement noted in timeliness of permanence decisions
- More children settled in long-term or permanent homes

Safeguarding Children

Safeguarding demand in Swindon remains high, reflecting the complexity of need across the borough and the effectiveness of partners in identifying and responding to children and families who require support. Neglect remains the most common factor driving statutory intervention, reinforcing the importance of strong partnership working, early intervention and whole-family approaches.
Positive improvements have been achieved for children in care, particularly in relation to permanence and stability, with continued focus on strengthening early help, workforce capacity and placement sufficiency to sustain outcomes.
Children's Social Care has continued its improvement journey throughout 2025–26. Progress has been recognised through Ofsted monitoring visits in 2025, with further visits scheduled in 2026 as the service and its partners continue to build on this trajectory.

Key strengths were noted by Ofsted

- Improved stability for children in care, with more children living in long-term or settled placements.
- Reduced delays to permanence, meaning children are waiting less time for long-term plans to be secured.
- Stronger corporate and political commitment to children's services, including investment in leadership and management capacity.
- Many children in care are seen regularly, have positive relationships with social workers, and feel their views are listened to.

Ongoing areas for improvement:

- Quality of practice is inconsistent – some children receive good-quality support, while others do not.
- Management oversight and supervision happen regularly but vary in quality, limiting the impact on frontline practice.
- Placement sufficiency remains a major pressure, with too many children placed out of borough, far from family and networks.
- Children's voices are not yet embedded strongly enough in service design and strategic decision-making.

Families First Partnership Programme

The Families First Partnership programme is a national reform programme transforming how children, young people and families receive help, support and protection in England. It is a central part of the government's children's social care reforms, building on ***Stable Homes, Built on Love.***

The programme aims to rebalance the system away from crisis-driven responses towards earlier, more joined-up, family-centred support, ensuring children receive the **right help at the right time.**

The programme establishes a single, coherent system of help and protection built around **three core elements**:

1

Family Help

Integrating early help and Child in Need services into multi-disciplinary teams with one lead practitioner, one assessment and one plan.

2

Multi-Agency Child Protection

Creating Multi-Agency Child Protection Teams (MACPTs) with shared responsibility for safeguarding children at risk of significant harm.

3

Supporting Family Networks

Embedding Family Group Decision Making (FGDM) and strengthening practical support through Family Network Support Packages.

Stronger together for children and families | Earlier help. Joined-up support. Better outcomes.

Families First Partnership Programme

What does this mean for Swindon?

Swindon Borough Council, Wiltshire Police and ICB are expected to:

- **Provide shared leadership and accountability** for designing and delivering the reforms through multi-agency safeguarding arrangements.
- **Deliver an integrated Family Help system**, with meaningful involvement from all agencies, including education.
- **Establish and resource MACPTs**, ensuring joint decision-making, information sharing and shared ownership of risk.
- **Embed Family Group Decision Making**, including at pre-proceedings, and support family-led plans through Family Network Support Packages.
- **Strengthen system enablers**, including workforce development, data sharing, performance oversight and evidence-based practice.

Progress made so far.

Swindon has moved from mobilisation into early delivery, with foundations now in place.

- **Governance**: A multi-agency FFPP Strategic Governance Board has been established, with agreed terms of reference, regular reporting to DfE, and a draft Programme Initiation Document in development.
- **Leadership and Workforce**: Key programme roles are being recruited, workforce planning has started, and alignment with Prevention and Early Intervention and wider corporate transformation is underway.
- **Family Help**: A dedicated workstream is in place, with agreed design principles, alignment to Swindon's community hub model, and a phased, test-and-learn approach agreed.
- **Family-Led Decision Making**: A workstream has been set up, readiness activity completed, and early work underway to strengthen participation, co-design and the voice of children and families.
- **Multi-Agency Child Protection Teams (MACPTs)**: Design work is progressing, supported by partner workshops, agreed principles, and alignment with existing MASH arrangements and regional learning.
- **Engagement and Communications**: Multi-agency engagement has begun, shared direction agreed, and communications aligned with corporate priorities.
- Swindon has established the necessary governance, partnerships and design activity to support phased implementation of the Families First Partnership model through to March 2027.

Safeguarding Partnership Strategic Priorities

The Delegated Safeguarding Partners agreed the strategic priorities for the year. There has been one change for 2025–26, with **Child Sexual Abuse** replacing **Levels of Need** as a standalone priority. The Partnership recognises, however, that Levels of Need for children remains a fundamental principle that underpins all other children's priority areas. We also acknowledge the importance of maintaining an ongoing local strategic response to the remaining priorities, which are unchanged.

Child Sexual Abuse

Preventing, identifying and responding effectively to child sexual abuse. Protecting children and young people from harm.

Self-Neglect

Supporting individuals to stay safe, well and connected, and reducing the risks associated with self-neglect.

Neglect

Preventing and addressing neglect to improve outcomes for children, young people and their families.

All Age Exploitation

Protecting children, young people and adults from all forms of exploitation and reducing vulnerability and harm.

Child Sexual Abuse

Overview of Progress Against the 2025–26 Child Sexual Abuse Work Programme

The Safeguarding Partnership Child Sexual Abuse Group was established and has met bi-monthly during 2025–26. The Group has focused on the issue of Child Sexual Abuse by helping to improve awareness, identification and assessment of Child Sexual Abuse across Swindon.

The Group have progressed the 2025–26 work programme, which has made some meaningful progress in strengthening the Partnership's strategic, operational and learning response to Child Sexual Abuse.

A new Child Sexual Abuse Strategy has been developed and published, robust audit and assurance arrangements are in place, and practitioner awareness and confidence have been prioritised through learning activity.

However, audit findings continue to highlight the need to translate increased awareness into consistently improved practice for children.

Key priorities for 2026–27 will include embedding the Child Sexual Abuse Strategy, strengthening supervision and oversight, implementing the Harmful Sexual Behaviour Protocol through training, and enhancing practitioner support to ensure children's experiences and outcomes remain central to all responses.

Working together to prevent, identify and respond to Child Sexual Abuse and keep children safe.

Child Sexual Abuse

What We Have Achieved

Strategic Leadership and Governance

- Developed, ratified and published the Swindon Child Sexual Abuse Strategy (2026-2029), underpinned by national guidance from the Centre of Expertise on Child Sexual Abuse.
- The strategy was formally agreed by partners and published in January 2026, providing a clear framework for multi-agency working.
- National and local recommendations (including NSPCC CSA Snapshot and *I Wanted Them All to Notice*) were reviewed and embedded within the Child Sexual Abuse work programme.

Impact:

A shared strategic direction for Child Sexual Abuse across Swindon is now in place, with alignment to national best practice.

Audit, Learning and Quality Assurance

- Completed single-agency and multi-agency audits examining responses to children reporting sexual abuse.
- Undertook a face-to-face multi-agency Child Sexual Abuse audit in March 2026.
- Embedded Child Sexual Abuse audit actions within the Partnership audit and assurance tracker, with regular monitoring and escalation arrangements.
- Reviewed learning from rapid reviews, local audits, with actions progressed through the Child Sexual Abuse Group.

Impact:

Clear themes have been identified (including drift, insufficient focus on children's lived experience, and management oversight), allowing the partnership to target improvement activity.

Child Sexual Abuse

What We Have Achieved

Building Practitioner Knowledge, Confidence and Skills

- Delivered a Child Sexual Abuse focused partnership theme month (October 2025), including:
    - Webinar on medical examinations and Child Sexual Abuse
    - Impact of sexual abuse and recovery
    - Child Sexual Abuse practitioner forum
- Maintained and promoted a comprehensive Child Sexual Abuse toolkit and dedicated webpage.
- Continued delivery of Developing an Understanding of Child Sexual Abuse (DUCSA) training, with wide partner access.
- Incorporated Child Sexual Abuse into generic Levels of Need training across the partnership.

Impact:

Awareness of Child Sexual Abuse has increased in agencies, where there has been positive engagement in learning events and training.

Practitioner Voice and Practice Challenges

- Held a Child Sexual Abuse practitioner forum, providing direct insight into professional challenges, dilemmas and learning needs.
- Developed and issued a Child Sexual Abuse practitioner questionnaire, with findings informing future work programme priorities.
- Considered learning related to specific practice challenges, including work with electively home educated children.

Impact:

Practitioner feedback is now directly influencing Partnership discussions and priorities.

Assurance from Key Agencies

- Received assurance reports from:
    - Probation (management of people presenting a risk of sexual harm)
    - Wiltshire Police (risk management and disruption activity)
    - Fostering services
    - Health services, including CLA nurses, paediatricians and therapy services
- Child Sexual Abuse medical referral pathways were confirmed and promoted, including The Bridge and local non-recent medical provision.

Impact:

The partnership has clarified cross-agency arrangements to assess, manage and respond to Child Sexual Abuse.

Child Sexual Abuse

WHAT WE NEED TO DO NEXT

While progress has been positive, several areas require continued focus in 2026-27:

Embedding Strategy into Practice

- The newly published Child Sexual Abuse Strategy needs to be formally launched and socialised with practitioners and managers.
- Child and family friendly materials and a "strategy on a page" will support wider understanding.

Improving the Translation of Learning into Practice

- Despite increased visits to the Child Sexual Abuse toolkit, audit findings show practice has not consistently improved, particularly in:
  - Child-centred responses
  - Timely decision-making
  - Professional confidence following disclosure
- Further multi-agency learning and assurance activity is planned.

Harmful Sexual Behaviour (HSB)

- The HSB Protocol has been published, but:
  - Training to support its implementation has not yet been delivered.
  - Practitioner confidence and consistent application are not yet assured.

Practitioner Support and Supervision

- Consideration of a further Child Sexual Abuse practitioner survey to support evidence of increased confidence in practice.
- Audit evidence shows a need to strengthen supervision and management oversight, particularly around challenge, analysis and escalation in Child Sexual Abuse cases.

PROTECTING CHILDREN FROM SEXUAL HARM

Neglect

Overview of Progress Against the 2025–26 Neglect Work Programme

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 have made some progress with the 2025–26 Neglect Work Programme. Advances have been made in establishing strategic clarity through refreshed guidance, strengthening workforce development and learning, and making more effective use of audit and review findings to inform practice improvement.

While this progress is encouraging, important areas require continued focus, particularly the development of a fit-for-purpose neglect assessment tool, strengthened management oversight and supervision, and improved direct engagement with children and young people.

Our continued focus

By working together, we can better identify neglect, take timely action and improve outcomes for children and their families.

Neglect

What We Have Achieved

Neglect Strategy and Practice Guidance

- A Task and Finish Group met regularly to review the 2024-27 Neglect Strategy and Practice Guidance.
- Minor amendments were identified and incorporated following Neglect Group feedback.
- Updated Neglect Strategy (2026-2029) and Practice Guidance were published and shared with partners.

Impact: 🎯

The Partnership now has refreshed, evidence-informed strategy and guidance that reflect learning from audits, reviews and practitioner feedback.

Thresholds and "Right Help, Right Time"

- Safeguarding Partnership Levels of Need training continued on a bi-monthly basis from May 2025, with case studies presented that linked to priority areas, this supported good multi-agency discussions and decision making.
- A Task and Finish Group reviewed the Right Help Right Time guidance in January 2026, agreeing light-touch amendments aligned to national and local reforms.
- The Early Intervention and Youth Commissioning (EIYC) Strategy moved into a wider Prevention and Early Intervention agenda, including neglect as a priority in the strategy.

Impact: 🎯

Practitioners are better supported to make proportionate, child-centred decisions and access the right help earlier.

Neglect

What We Have Achieved

Embedding Learning from Audits and Reviews

- A multi-agency neglect audit and MASH dip-sample audit were completed and shared with the Neglect Group.
- Learning themes (e.g. home conditions, repeat referrals, anonymous referrals) aligned with findings from reviews.
- Learning actions were tracked via the Safeguarding Partnership audit tracker, with agencies held to account for dissemination.
- Learning from audits and reviews was shared through learning resources and sessions.

Impact: 🎯
A stronger, more consistent feedback loop between learning and practice improvement.

Workforce Confidence and Learning

- A management resource pack was developed and shared across agencies.
- A practitioner forum (June 2025) and practitioner survey informed learning priorities.
- A motivated multi-agency Community of Practice (CoP) was established to support practice development.

Impact: 🎯
Support in place to improve confidence among practitioners and managers in recognising, naming and responding to neglect.

Education and Early Years Engagement

- The neglect learning tool has been:
  - Delivered to DSL networks
  - Shared across Early Years settings
  - Presented to childminders
- Resources are hosted on the Education Hub and promoted through SSP communications.

Impact: 🎯
Improved awareness and shared language around neglect in universal and early-help services.

Neglect

Partnership Neglect Reset

In January 2026, Partnership Executives led an appreciative enquiry with key partners to review how services are responding to children experiencing neglect in Swindon. This strategic discussion provided valuable insight into current practice and enabled the Partnership to develop a clearer understanding of the systemic barriers and challenges associated with addressing neglect as an abuse type.

We identified:

- Inconsistent identification of neglect across agencies, with cumulative harm, particularly adolescent neglect, often minimised or poorly understood.
- Audits and reviews are not driving improvement, with recurring themes, limited impact on practice, and insufficient feedback to frontline colleague.
- Current tools and frameworks are ineffective, including low use of the neglect screening tool, lack of a shared definition, and poor capture of cumulative harm.
- Workforce pressures and culture challenges affect practice, including high workloads, desensitisation to neglect, downward threshold drift, and anxiety about addressing neglect with parents.
- Training provision is fragmented and low impact, with inconsistent attendance and limited evidence of practice change, despite some pockets of good practice.
- Lack of strategic grip and accountability, with neglect not consistently treated as serious harm and leadership activity perceived as compliance-driven rather than outcome-focused.

Neglect

WHAT WE NEED TO DO NEXT

1. Strengthening Essential Foundations

- Develop a shared multi-agency definition and thresholds for neglect.
- Redesign neglect tools into clear, separate screening and assessment tools, co-produced with practitioners.
- Introduce a continuous audit and learning cycle with frontline involvement and clear “You Said, We Did” feedback mechanisms.
- Strengthen supervision and managerial accountability, including mandatory neglect prompts and bite-sized learning.

2. Culture Change and System Leadership

- Launch a multi-agency neglect communication and culture strategy.
- Promote a shared understanding of neglect as serious harm.
- Embed neglect as a core strategic priority across all partner agencies.
- Ensure executive leadership ownership of neglect improvement.
- Align neglect work with early intervention, prevention, and neighbourhood delivery models.

3. Workforce Development and Sustainability

- Review and redesign multi-agency learning and training, focusing on reflective and analytical practice.
- Shift towards strength-based, practice-informed learning models.
- Improve neglect guidance to be clear, visual, and example-rich, covering adolescent neglect and confident communication with parents.
- Celebrate and share good practice to create an asset-based learning culture.

A Partnership Executive will be formally appointed as the Senior Responsible Officer for Neglect, providing strategic leadership, clear accountability, and oversight of the Partnership’s neglect improvement agenda.

Self-Neglect

Overview of Progress Against the 2025–26 Self-Neglect Work Programme

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 progressed the 2025–26 self-neglect work programme, which has successfully delivered the majority of planned actions and strengthened the Partnership's learning, assurance and governance foundations.

At a system level, the Partnership has improved shared understanding, multi-agency collaboration and access to learning. However, evidence of consistent impact on frontline practice and measurable improvements in outcomes for adults experiencing Self-Neglect remains variable.

Embedding learning into day-to-day practice, strengthening reflective supervision and improving the use of data will be critical to demonstrating sustained impact. These priorities are carried forward into the 2026–27 work programme, with a clear shift from development to embedding and outcomes.

> *"Don't judge me by the chapter you have walked in on. I have a past and a future and not defined by my current situation"*

Why a person may self-neglect

Working together to understand, respond and support people experiencing self-neglect.

Self-Neglect

What We Have Achieved

Governance, policy and assurance

- Multi-agency assurance reports on the Self-Neglect Strategy were completed by most partner agencies.
- Learning from Safeguarding Adult Reviews (SARs) and audits was consolidated into a self-neglect learning summary and published on the Partnership website.
- The Self-Neglect Policy was updated to include new multi-agency meeting guidance, ensuring alignment with learning and practice expectations.
- Audit recommendations and SAR learning were actively tracked through the Self-Neglect Group and Practice Review Group.

Impact 🎯

- Increased consistency in how self-neglect is understood and governed across partner agencies.
- Clearer expectations for multi-agency working have been set.
- Improved assurance that SAR learning and audit findings are actively monitored rather than held in isolation, strengthening system oversight.

Learning and workforce development

- Two multi-agency self-neglect training courses were delivered.
- Five Mental Capacity Act (MCA) mini-learning sessions from 2024–25 continued to be promoted, with recordings available to support induction and refresher learning.
- An annual self-neglect practitioners' forum took place in November 2025, providing updates, case examples and shared learning.
- Practitioner surveys were completed to gather feedback on confidence and practice issues.

Impact 🎯

- Some practitioners report increased confidence in working with self-neglect, particularly in balancing risk, autonomy and safeguarding duties.
- Some increased awareness of MCA, proportionality and human rights considerations in complex self-neglect cases.
- Improved access to learning across organisations, supporting induction, continuity and a shared partnership approach.

Self-Neglect

What We Have Achieved

Audit, data and performance

- A themed multi-agency audit on alcohol and self-neglect was completed.
- Website usage data began to be monitored, showing engagement with the Self-Neglect Strategy.
- Initial work started to improve use of dashboard data within the Self-Neglect Group.

Impact

- Identification of recurring practice themes and risks, enabling more targeted partnership discussion and improvement activity.
- Early insight into how practitioners access guidance and learning, supporting future communication and engagement planning.
- Foundations established for stronger, evidence-informed assurance, although data quality and routine use remain inconsistent.

Partnership activity and prevention

- Clarification was provided on changes to Team Around Me, with transition to community hubs following commissioning changes.
- Partner-specific learning and prevention activity took place, including fire safety messaging and internal learning hubs.

Impact

- Improved clarity for practitioners on referral pathways and support options, reducing uncertainty at the front door.
- Increased visibility of prevention activity, particularly around fire safety and home risk, although application remains variable.

Self-Neglect

WHAT WE NEED TO DO NEXT

While there has been some progress, key gaps remain that limit the Partnership's ability to evidence impact on frontline practice and outcomes.

- **Embedding into practice**
  - There is still insufficient evidence that the Self-Neglect Strategy and Welfare and Safety Plan are being used consistently or effectively in day-to-day practice.
  - Further work is required to demonstrate how learning, policies and tools are improving engagement and outcomes for adults who self-neglect.
- **Supervision and management oversight**
  - Audit and SAR learning highlight the need to strengthen reflective supervision and management oversight in complex self-neglect cases.
  - Legal literacy (Mental Capacity Act, Human Rights Act and proportionality) remains a development area for practitioners and managers.
- **Learning and reflective spaces**
  - While training delivery is strong, reflective learning opportunities need to be improved, as virtual forums alone have not supported reflective discussion effectively.
- **Data and assurance**
  - Use of self-neglect dashboard data requires further development, including improved data quality, consistency and routine discussion.
  - Dashboard data needs to be triangulated with audits, SAR learning and lived-experience feedback to better inform partnership decision-making.
- **Prevention and early intervention**
  - Use of the Welfare and Safety Plan needs to be actively re-promoted across the partnership, with clearer guidance on its role in prevention and engagement.
  - Consideration of fire risk and home safety remains inconsistent across agencies, so this also need to be strengthened.

All Age Exploitation

Overview of Progress Against the 2025–26 All Age Exploitation Work Programme

The Safeguarding Partnership All Age Exploitation Group has continued to meet bi-monthly and has focused on the issue of children and adults' exploitation by helping to improve awareness, identification and assessment of exploitation.

During 2025–26, the Partnership maintained strategic oversight of exploitation despite significant organisational change. Improvements were made in awareness and the availability and use of tools. Audit and assurance activity strengthened insight into practice and highlighted where further improvement is required.

We have identified further key areas for development, including the need for clearer adult exploitation pathways and contextual safeguarding arrangements, more consistent translations of audit findings into measurable impact, and stronger use of lived experience and performance data to inform decision-making. These learning point will shape the 2026–27 work programme.

Working together to prevent exploitation, support victims and strengthen our collective response for everyone, at every age.

Our commitment is to continue learning, improving and working together to keep people safe from exploitation.

All Age Exploitation

What We Have Achieved

Strategy and Governance

- Reviewed and refreshed the All-Age Exploitation Strategy (2024-27) in response to policing restructure and changing partnership arrangements.
- Received and discussed updates from Wiltshire Police on the Missing and Exploitation Unit (MEU) and wider exploitation response.
- Reviewed the purpose and effectiveness of the All-Age Exploitation Group, with proposals for revised governance and reporting lines developed for executive consideration.

Impact

- Improved shared understanding across partners of how structural and resourcing changes affect exploitation responses.
- Provided leadership with assurance that exploitation remains a priority area despite system change.
- Identified the need for clearer governance and accountability, shaping a more focused and streamlined structure for 2026-27.

Learning from Audits and Reviews

- Continued to embed learning from the multi-agency All-Age Exploitation audit and subsequent child and adult exploitation benchmarking audits.
- Completed a transitions audit, supported by reflective learning sessions with practitioners across children's and adult services.
- Used audit findings to inform discussions at the All-Age Exploitation Group and wider partnership.

Impact

- Strengthened oversight of practice quality and consistency across agencies.
- Improved understanding of where exploitation is not being recognised early enough, particularly for adults and those at transition points.
- Created a clearer evidence base to inform future priorities, including transitions, adult pathways and early identification.

All Age Exploitation

What We Have Achieved

Practice Tools, Training and Awareness

- Launched and promoted the Adult Exploitation Screening Tool through the Exploitation Conference, practitioner forums and partnership communications.
- Continued promotion and embedding of the Child Exploitation Risk Assessment Framework (CERAF) across statutory and voluntary sector partners.

Impact

- Some evidence of increased practitioner confidence and consistency in identifying indicators of exploitation, particularly in adult services where tools were previously limited.
- Supported a shared language and approach to exploitation risk across partners.
- Contributed to earlier conversations about vulnerability, even where statutory thresholds are not yet met.

Transitions and Assurance

- Received assurance reports from Children's Social Care and the Transitions Team on how exploitation risks are identified and managed for young people approaching adulthood.
- Used audit and assurance findings to examine strengths and weaknesses in current transition arrangements.

Impact

- Greater Partnership visibility of exploitation risks during transition to adulthood.
- Improved understanding of where responsibility can become unclear, increasing the focus on earlier planning and clearer handovers.

Data, Performance and Quality Assurance

- Continued development of exploitation dashboards and information sharing across agencies.
- Reviewed audit action plans and progress updates at the All-Age Exploitation Group.

Impact

- Reinforced the importance of data-led oversight of exploitation trends and service responses.
- Highlighted gaps in data quality and timeliness, strengthening the partnership's commitment to improved performance intelligence.
- Supported more informed discussion and challenge within partnership meetings.

All Age Exploitation

WHAT WE NEED TO DO NEXT

While we have made some progress, key gaps remain that limit the partnership's ability to evidence impact on frontline practice and outcomes for children and adults.

Strategic Direction and Contextual Safeguarding

- Update the All-Age Exploitation Strategy and agree a shared contextual safeguarding framework. This will provide clarity on roles, thresholds and expectations, and ensure exploitation responses reflect harm occurring beyond the family home.

Audit Actions and Practice Impact

- Review and rationalise overdue audit actions, with clearer ownership and measurable outcomes. Ensures audit activity leads to tangible improvements rather than procedural compliance.

Data and Performance

- Improve consistency and use of exploitation data to drive improvement. Stronger data will enable earlier identification of emerging risks and more effective targeting of partnership resources.

Adult Exploitation Pathways

- Establish clear adult exploitation pathways, early-help options and the proposed Adult Risk Forum. Without clear routes, adult exploitation risks remain under-identified and responses can be delayed or fragmented.
- Develop and implement an agreed all-age exploitation transition pathway. This will help reduce the risk of young people "falling through the gap" at 18 and improves continuity of safeguarding responses.

Lived Experience and Co-production

- Strengthen mechanisms for capturing lived experience of exploitation among children and adults. Ensures policies and tools reflect experiences and improve engagement and effectiveness.

PARTICIPATION AND CO-PRODUCTION

The Safeguarding Partnership understands how important meaningful engagement with children and adults is. We recognise that involving those with lived experience is essential to developing systems that are more effective, inclusive, and responsive to need.

Children and adults who contribute to the Partnership's work provide vital insight into what has worked well for them, where responses have fallen short, and how practice can be improved. Their perspectives ensure that learning is grounded in real experiences and help us shape policies, services, and interventions that respond to genuine need rather than assumption.

The Partnership has continued to strengthen its approach to participation and co-production.

Mapping activity has commenced across partner organisations to identify existing participation work, build on good practice, and maximise opportunities for meaningful involvement across the system.

> Working together, listening to lived experience and acting on what matters most creates better outcomes for everyone.

ADULT SCRUTINEERS

Over the past year the scrutineer's group has met quarterly and have discussed raising awareness of abuse through some posters for public and professional spaces, worked on the participation pledge and worked with senior leaders in the council on the impact of how front doors to the local authority can impact on those experiencing mental health needs, those with physical disabilities and autism and neurodivergence to improve access to services.

One group member has highlighted that:

"Working with the scrutineer's group has been absolutely brilliant. We are all in the same mix, coming up with ideas together. We operate as a collective, we can laugh together and respect each other, giving each other time to express our needs and wishes. Working alongside SSP to make change and make things better access Swindon has been great for me to see how we make change".

Our Focus

We are passionate about making services more accessible, inclusive and responsive to the needs of adults across Swindon.

Your voice shapes our work. Together, we can make meaningful change.

Over the coming year the group aim to:

Look at exploitation
and see how we support services when working with those who have experienced exploitation.

Continue to look at mental health awareness
and how we can improve services for experts by experience.

Thank you

to all our scrutineers for your time, insight and commitment.

You make a difference.

Swindon Safeguarding Partnership

What is Safeguarding?

Safeguarding means protecting an adult's right to live in safety, where people and organisations work together to prevent and stop abuse.

What is Abuse?

Abuse is when someone does or says something which harms you or makes you upset and scared.

Examples of Abuse

- Physical Abuse
- Domestic Abuse
- Sexual Abuse
- Financial Abuse
- Psychological or Emotional Abuse
- Modern Slavery
- Discriminatory Abuse
- Organisational Abuse
- Self Neglect
- Neglect

Who to Contact

If you are worried about someone you can call Adult Social care on **01793 463555**

In an emergency call the police on 999

For more information on safeguarding can be found on https://tinyurl.com/SBCReportaconcern

#SafeguardingIsEveryonesBusiness

ChildFirst SWINDON

Throughout 2025-26 we have continued to promote ‘Child First’ Swindon with 26 organisations signing up to being ‘Child First’ committed.

Two WAY Changemakers told us why the ‘Child First’ Approach is important to them and why organisations across Swindon should commit.

Hi, want to talk about the Child First approach. I'm excited about the Child First approach, and I think it's really important. It's important that children have a say and that what we say is really listened to, and that adults understand that what we think is important and use what we have said to make changes. As an adult, you wouldn't want someone else making all the decisions for your life without you, and nor do we. We want to be involved in decisions and plan about us as much as possible. We're all different, so we don't want the same solutions. We each need different approaches and support to help us grow and reach our own amazing potential as equal members of the community.

ChildFirst COMMITTED

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

Why is a child-first approach important? For me, there are three main reasons.

Reason number one is I believe it'll help to break down the stigma that young people who show symptoms of neurodivergence or mental illness are just bad kids who don't want to learn or don't want to engage, when in reality, they might not be able to learn because they can't learn with the way a subject is being taught, or they're unable to engage because they're struggling with their mental health.

Number two is, of course, safety. It will help keep more young people safe because it's about working together with them to make the best course of action and get them the help that they need.

Third of all, and possibly the most important to myself, is making sure that each individual person gets unique individual help. We can't all just be put into a box. Yes, we may struggle with the same things, or yes, we may have the same conditions, but each experience is unique, and we need to be treated as such.

So why should you sign up? It'd be great to have people in services like you to help us thrive and build positive relationships that will help us be meaningfully included in our community. It would be good to help to find better ways to cope before we end up in trouble or feeling isolated. Please commit to seeing us as individuals with unique ideas and needs, an important part of our community, and give us the encouragement and support we each need, rather than what adults might think is best for us.

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

The WAY Changemakers will support the Partnership to further promote and embed the 'Child First' approach across Swindon. They will also lead a programme of 'walk the floor' assurance visits during 2026–27, providing direct insight into how effectively organisations are implementing and embedding this approach in practice.

ChildFirst SWINDON

THE CHILD FIRST APPROACH IS MADE UP BY 4 CORE PRINCIPLES:

A

AS CHILDREN

Putting children's needs, rights, and potential first. Everything focuses on the child, understanding how they grow, acknowledging any barriers, and making sure responsibilities to children are met.

B

BUILDING AN IDENTITY OF BELONGING

Promoting children's strengths to help them build and identity of belonging, leading to safer communities. All work is about building strong relationships, helping children reach their potential, and encouraging them to make good choices for the future.

C

COLLABORATING WITH CHILDREN

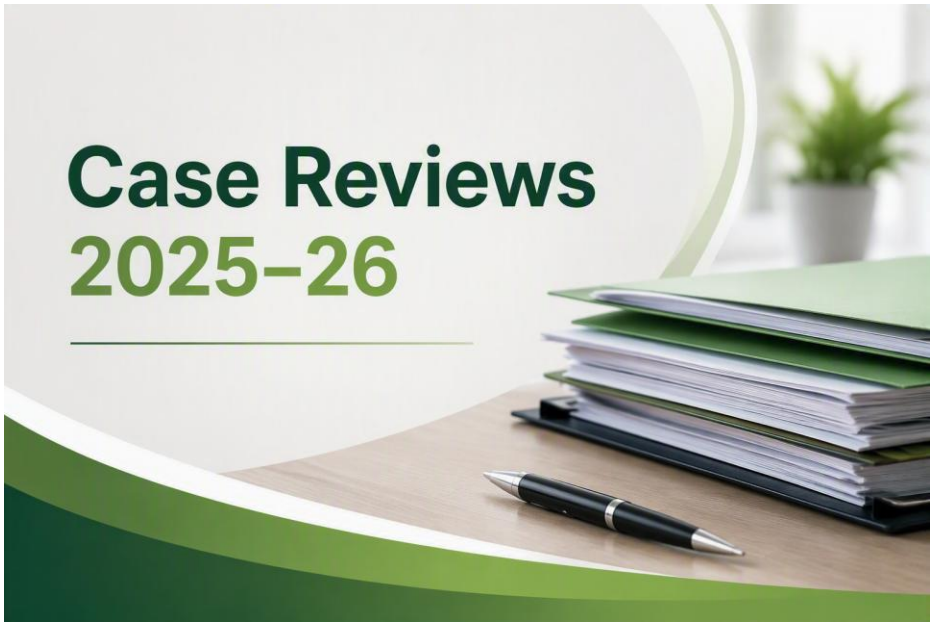
Encouraging children to get involved, engage with others, and be part of their community. All work is about meaningfully working together with children and their families.

D

DIVERTING FROM STIGMA

Focussing on preventing problems before they happen, finding alternatives to formal discipline, and stepping in only when absolutely necessary. The goal is to avoid labelling young people or making them feel like negative behaviour or actions are part of their identity.

These principles guide how the Child First Approach works across different types of services, from education to health care, social work, and beyond. The goal is to always put children first, creating a supportive environment where they can grow, learn, and succeed without being judged or held back by their circumstances.



During 2025-26 the Safeguarding Partnership considered several safeguarding case review referrals across both children's and adults. The period was characterised by complex need, repeated self-neglect, neglect-related harm, and challenges in escalation and multi-agency coordination.

Most adult referrals did not meet statutory thresholds for a mandatory Safeguarding Adults Review; and several cases progressed to Local Child Safeguarding Practice Reviews (LCSPR).

The Partnership has robust safeguarding review processes in place, has had positive engagement with the Child Safeguarding Practice Review Panel, and positive feedback on the quality of Rapid Review reports. The Partnership has maintained a strong focus on embedding learning, workforce development, and system improvement.

Cross Cutting Learning

Across both children's and adults' reviews, consistent themes emerged:

- Early indicators of harm were often present but escalated late
- High reliance on engagement and self-determination in cases of self-neglect
- Threshold decision-making and professional challenge remain areas for development
- Complexity at the intersection of mental health, housing, substance misuse, and safeguarding

Children's Safeguarding Case Reviews

Six Child Safeguarding Practice Review (CSPR) referrals were received and considered during 2025-26.

Of these, two cases did not meet the statutory criteria for a Serious Incident Notification. One additional case met the criteria, and a rapid review was undertaken; however, the National Panel determined that a full Local Child Safeguarding Practice Review (LCSPR) was not required, as the key learning had already been sufficiently identified.

Across these three cases, multi-agency learning was identified. The reviews highlighted recurring themes including children's and parental mental health needs, domestic abuse, parental mental ill-health, placement instability, and the impact of professional decision-making.

Learning and resulting actions were disseminated through established Partnership governance arrangements, including the Practice Review Group, to support continuous improvement in safeguarding practice across agencies.

Three Local Child Safeguarding Practice Reviews were progressed during the reporting period. These reviews were commissioned following either challenge from, or agreement with, the National Panel.

All three cases involved long-term neglect and identified missed opportunities for earlier, more effective intervention. Given the number of neglect-related cases, Safeguarding Partners agreed a coordinated and proportionate approach to maximise learning and impact.

This included commissioning a single independent reviewer to undertake all three reviews and the development of an overarching thematic review to draw together cross-cutting learning and systemic findings.

Publication of the individual reviews and the thematic report is scheduled for May 2026.

Key children's safeguarding themes

- Chronic neglect (including parental self-neglect)
- Threshold and escalation challenges
- Professional curiosity and reliance on parental self-reporting
- Adultification and young carers
- Parental mental health

Safeguarding Adult Reviews

A total of twelve Safeguarding Adult Review (SAR) referrals were received and considered during 2025-26.

Of these, two cases met the statutory criteria for a SAR:

- SAR authors were commissioned for the reviews with publication expected in July/August 2026.

In addition, one discretionary SAR was commissioned:

- This review is focused on multi-disciplinary team (MDT) working and the management of deteriorating health.

The remaining referrals did not meet the SAR threshold. However, all cases contributed to meaningful learning, including:

- Identification of single-agency and partnership-wide learning
- Improvements to guidance, training, and escalation processes
- Ongoing oversight and assurance through established Partnership governance groups

This approach ensures that learning is captured and embedded across the system, even where statutory review criteria are not met.

Key adult safeguarding themes

- Self-neglect (dominant theme across almost all cases)
- Substance misuse and alcohol dependency
- Mental and physical health deterioration
- Homelessness and housing instability
- Domestic abuse and exploitation
- MDT collaboration and discharge planning
- Use of legal frameworks and capacity assessments

Published Safeguarding Adult Reviews

Arlo and Paddy

This Safeguarding Adults Homeless Fatality Rapid Review was undertaken by Gloucester Safeguarding Adults Board and published in February 2026. The review examined the lives and deaths of two men, Arlo and Paddy, who were rough sleeping at the time of their deaths. Arlo was known to Swindon services. Both experienced severe and multiple disadvantage, including long-term trauma, substance misuse (particularly alcohol), mental ill health, housing instability, and repeated contact with criminal justice, health, and homeless services. Despite periods of engagement and examples of compassionate, trauma-informed practice, neither man was able to access sustained, coordinated support that met the complexity of their needs. Both deaths were alcohol-related and occurred in the context of chronic exclusion from suitable accommodation and consistent multi-agency care.

Key recommendations for Swindon include:

- Enhanced information sharing, including consideration of a multi-agency "passport" to reduce repetition and improve continuity of care.
- Investment in specialist accommodation and dedicated resources for people facing multiple disadvantage.
- Training and awareness to embed trauma-informed, person-centred practice and reduce stigma around substance use and mental ill health.

The review highlighted examples of good practice, including trauma-informed approaches, effective voluntary sector involvement, and multi-agency. However, it identified significant barriers: inconsistent information-sharing, lack of a clear lead agency to coordinate responses, resource constraints, rigid service thresholds, and a shortage of specialist accommodation with skilled colleague. Engagement often faltered at critical "windows of opportunity" (such as crises or willingness to accept help), with insufficient contingency planning when initial interventions failed.

Overall, the report emphasises the need for flexible, coordinated, and sustained responses that recognise complexity, act at critical moments, and avoid individuals "falling through the gaps" when services are fragmented or time-limited

SAR Ferdynand

SAR Ferdynand was published in August 2025. The review examined the multi-agency response to the circumstances leading up to the death of *Ferdynand*, a 61-year-old man with complex physical health, mental health, and homelessness-related needs. The review was conducted using an in-rapid-time methodology to enable early systemic learning.

Ferdynand was intermittently homeless, moving between Swindon, Oxfordshire and occasionally London. He had significant physical illnesses (including cardiac and renal disease) and bipolar affective disorder, with concerns about declining capacity and high levels of self-neglect. He was well known to multiple agencies across health, housing and social care, but disputes about ordinary residence, fragmented information sharing, and a lack of coordinated, cross-border multi-agency planning meant his needs were not met consistently or effectively.

Ferdynand died in October 2024 of natural causes while an inpatient in hospital. The review identified systemic weaknesses rather than individual failings, particularly where professional focus on responsibility and funding overshadowed timely needs-led responses. It also highlighted examples of good practice, showing that supportive systems do exist but were often activated too late.

Key Recommendations

The report sets out a series of recommendations for the Partnership, structured around six key system findings. Partner agencies have collectively identified and agreed actions to address these findings and strengthen safeguarding practice. The Partnership Practice Review Group will provide ongoing oversight, monitor implementation and assess evidence of impact to ensure that learning is embedded and leads to sustained improvement.

1. Prioritise needs over ordinary residence

- Reinforce understanding that uncertainty or dispute about ordinary residence must *not* delay meeting an individual's care and support needs.
- Develop cross-border agreements or memoranda of understanding to empower practitioners to act ethically and decisively.
- Deliver multi-agency training and awareness on ordinary residence principles.

2. Improve discharge planning from health services

- Strengthen systems to support Emergency Department and mental health colleague with time, processes and multi-agency involvement in complex discharges.
- Introduce earlier identification of people requiring coordinated, cross-border discharge planning, including Section 117 aftercare.
- Promote early, multi-agency discharge meetings for high-risk individuals.

3. Strengthen multi-agency and cross-border information sharing

- Ensure rapid and effective information exchange between agencies, including across local authority boundaries.
- Establish a formal forum for discussing complex cross-border cases to agree shared plans and reduce risk

4. Address the lack of suitable accommodation for people with complex needs

- Advocate locally and nationally for specialist housing and residential provision for homeless people with complex physical and mental health needs.
- Explore alternative or innovative housing solutions with housing departments and partner agencies.

5. Build on systems and practice that already work

- Promote consistent use of advocacy at key decision-making points.
- Involve non-statutory and frontline services in multi-disciplinary planning.
- Share and embed examples of good practice where professionals acted "without prejudice" to meet needs despite disputes.

6. Develop clearer multi-agency governance and escalation arrangements

- Clarify leadership roles within the Partnership for safeguarding people who are homeless or rough sleeping.
- Create clear escalation routes for resolving complex disputes, including cross-border responsibility issues.
- Strengthen SAB/SSP oversight and accountability for system-wide problem solving.

The report concludes that Ferdynand's case highlights an urgent need for stronger cross-border collaboration, needs-led decision making, and governance structures that enable timely, ethical responses for adults with complex needs who are homeless or transient.

Assurance of Swindon Safeguarding Partnership

Our Vision	**To focus on continuous learning and improvement with a clear line of sight on frontline safeguarding practice to improve outcomes for children and adults with care and support needs**				
What does Swindon Safeguarding Partnership need from assurance?	**Accuracy:** Understanding current and emerging issues & assessment of performance	**Adds Value:** Drives improvement across the safeguarding system	**Accountability:** To the population and governance hierarchy	**Authoritative:** It adds to local and national learning	
The core focus of Swindon Safeguarding Partnership assurance	**Neglect**	**Adult Self-Neglect**	**All Age Exploitation**	**Child Sexual Abuse**	
The five 'enablers'	**Independent scrutiny**	**Outcome Based Accountability Scorecards and Partnership Dashboard**	**Multi-Agency audits**	**Section 11/157 /175/Care Act Audits & Walk the Floor**	**Assurance Requests**

What We Have Achieved

Established and implemented a refreshed Quality Assurance Framework

- Agreed and published the 2025-26 Quality Assurance Framework to assure the effectiveness of multi-agency safeguarding arrangements for children, young people and adults with care and support needs.
- Set a clear focus on continuous learning, frontline practice, lived experience and impact on outcomes.
- Aligned the framework with statutory duties under:
    - Children Act 2004
    - Working Together to Safeguard Children 2026
    - Care Act 2014
    - Making Safeguarding Personal

Strengthened governance and oversight

- Confirmed the Quality Assurance Group as the enabler partnership group for overseeing assurance activity.
- Embedded regular scrutiny through:
    - Bi-monthly reporting from chairs of the enabler and priority groups to the Delivery Group
- Used performance data, dashboards and exception reporting to start to identify themes, risks and emerging safeguarding issues.

Delivered a clear multi-agency audit programme for 2025-26

The Partnership agreed audits focusing on priority safeguarding risks, including:

- Vulnerabilities of under 1s
- Multi-agency response to self-neglect and alcohol misuse
- Children experiencing domestic abuse
- Children experiencing sexual abuse
- Exploitation of children
- Exploitation of adults

Each audit included:

- Agreed scope and audit tools
- Frontline practitioner involvement where possible
- Reflective learning sessions
- Action plans monitored through the Partnership priority groups

What We Have Achieved

Strengthened learning, improvement and impact

- Agreed a ‘Closing the Learning Loop’ approach to ensure learning leads to changed practice.
- Fed learning from audits, assurance activity and reviews into the Learning and Development Group.
- Used a range of learning mechanisms:
  - 7-Minute Briefings
  - Multi-agency training and workshops
  - Online learning resources
- Monitored whether learning has translated into improved practice and outcomes.

Increased participation and frontline voice

- Ensured children, young people and adults with care and support needs are central to assurance work.
- Captured lived experience through:
  - Case audits
  - Adult scrutineers
  - Participation networks
- Collected practitioner feedback through:
  - Surveys
  - Practitioner forums

What We Have Achieved

Embedded The Five Quality Assurance Enablers

We have progressed the embedding of the five Partnership enablers:

1. Independent Scrutiny

- Provided independent support and challenge across strategic and operational safeguarding.
- Ensured learning from local and national reviews is analysed and implemented.
- Placed the voice of children, families and adults at the centre of assurance activity.

2. Outcome Based Accountability (OBA) Scorecards and Partnership Dashboard

- Agreed indicators linked to partnership priorities.
- Required all relevant partner agencies to submit data and analysis.
- Used dashboard to start to help us understand performance, trends and areas for improvement.

3. Multi-Agency Audits

- Agreed a thematic multi-agency audit programme for 2025-26.
- Confirmed clear audit methodology covering:
  - Lived experience
  - Early identification and intervention
  - Partnership working and information sharing
  - Governance, policy and procedure

4. Section 11, Care Act and Education Audits

- Required partner agencies to complete bi-annual Section 11 / Care Act audits.
- Implemented a two-year cycle, including:
  - Self-assessment and action planning
  - ‘Walk the Floor’ assurance visits
- Continued annual Section 175/157 audits across education settings.

5. Single Agency Assurance

- Used targeted assurance requests to:
  - Track delivery of audit recommendations
  - Address emerging risks or non-compliance
- Partnership Executives share organisational risks bi-monthly.

WHAT WE NEED TO DO NEXT

- Independent Scrutiny - The Independent Scrutineer role will continue to challenge, support and drive forward the improvement journey of the Partnership.

- Outcome Based Accountability (OBA) Scorecards and Partnership Dashboard - We will have a focus on strengthening analysis of data and using the dashboard to drive decision-making
and demonstrate measurable impact on outcomes for children and adults.

- Multi-Agency Audits - Audits will be strengthened through tighter oversight of findings, including robust tracking of recommendations, evidence of improvement and embedding re-audit activity to demonstrate sustained impact on practice.

- Section 11, Care Act and Education Audits - We will undertake ‘Walk the Floor’ assurance activity, which will provide an alternative focus, support greater triangulation of audit findings and help to provide a clearer picture of effectiveness, and identify system-wide risks and strengths.

- Single Agency Assurance -
We will request assurance from agencies in relation to key practice priority areas identified. This approach will be further strengthened through ongoing oversight of the Partnership risk register and clearer alignment between identified risks, assurance activity and strategic priorities.

Learning and **Development**

"Learning and development in safeguarding is essential to ensure that individuals are equipped with the knowledge, skills, and confidence to recognise, 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."

What We Have Achieved

During 2025-26, the Safeguarding Partnership's Learning and Development Group ensured that its multi-agency learning offer remained aligned with strategic priorities and learning from local and national reviews.

A comprehensive blended learning model was implemented, combining face-to-face training, webinars, themed events, and concise practice resources. The launch of the online SSP Learning Hub has improved accessibility and enabled practitioners to engage with learning flexibly across agencies.

Reach and Engagement

The trend of reduced bookings for chargeable courses continued in 2025-26. The overall number of bookings also decreased compared to the previous two years, although some of this can be attributed to the delivery of various virtual drop-in events for which delegate numbers were not counted.

	2023/24	2024/25	2025-26
Chargeable courses	508	413	336
Free courses	1130	1863	1115
Total	1638	2276	1451

The Partnership also strengthened engagement through:

- Monthly safeguarding themes, widely shared and positively received by practitioners
- Increased use of digital resources, including webinars and 7-minute briefs
- Strong multi-agency participation in both core and specialist training

Impact on Practice and Outcomes

Learning and development activity has had some positive impact on practitioner knowledge, confidence, and practice, although further work is ongoing to strengthen evidence of impact.

Improved Knowledge and Skills

- Participants across training programmes reported increased awareness of safeguarding risks, particularly in areas such as child sexual abuse and exploitation.
- Practitioners described enhanced understanding of local referral pathways and safeguarding responsibilities.

Changes to Practice

Evidence from feedback and follow-up evaluation indicates that some learning has led to measurable improvements in practice, including:

- Greater confidence in identifying and responding to exploitation and abuse
- Improved ability to build trust and communicate effectively with children and young people
- Increased sharing of learning within teams, amplifying the reach of training beyond attendees

Multi-Agency Working

Training has strengthened multi-agency collaboration, with practitioners valuing opportunities to learn alongside colleagues from different sectors and share expertise.

Evidence of Impact from Priority Training

Escapeline training (child exploitation):

- 271 practitioners trained
- 100% of follow-up respondents agreed or strongly agreed that training improved awareness of referral processes and ability to identify and report concerns
- Majority reported tangible improvements in their working practice

- NSPCC DUCSA training (child sexual abuse):
  - 106 attendees across 7 sessions
  - Strong feedback highlighting enhanced professional confidence and practice impact

Embedding Learning

The publication of the Learning and Improvement Framework (November 2025) represents a significant step in strengthening how learning is:

- Identified from reviews and audits
- Disseminated across the partnership
- Embedded into practice to improve outcomes

Supporting resources such as practice briefs, webinars, and e-learning (e.g. professional curiosity) have enabled ongoing reinforcement of key learning themes from reviews.

WHAT WE NEED TO DO NEXT

Ongoing Challenges

While progress has been made, key challenges remain:

- Evidencing impact consistently across all agencies (“closing the learning loop”)
- Low response rates to evaluation and impact surveys, limiting assurance
- Variability in how learning is embedded across organisations

Despite this, available evidence demonstrates clear early impact on practitioner confidence, knowledge, and behaviour, contributing to improved safeguarding practice.

The Partnership will build on this progress by:

- Strengthening evaluation approaches to better evidence impact on outcomes for children, young people, and adults
- Embedding the Learning and Improvement Framework across all partners
- Expanding targeted learning aligned to strategic priorities and review findings
- Introducing a multi-agency competency framework to ensure consistent safeguarding capability
- Promoting professional curiosity, including reporting findings from the practitioner survey and launching Professional Curiosity Day

Reflections and Next Steps

Over the past year, the Safeguarding Partnership has achieved significant progress across key areas of its work, strengthening collaborative practice and driving improvement. Equally important is our clear and honest understanding of the challenges that remain, enabling us to focus our efforts on the areas requiring further development as we strive to become a fully effective Partnership.

There is evidence of strengthened governance, more effective multi-agency collaboration, and an increased focus on evidencing impact rather than activity. Developments in the quality assurance framework, the use of performance data, and changes to roles and structures demonstrate we are self-aware and committed to continuous improvement.

At the same time, the Partnership has maintained a clear focus on areas of ongoing challenge. Across both children's and adults' safeguarding, recurring themes remain, particularly in relation to neglect, self-neglect, exploitation, and variability in frontline practice. While learning is being generated through audits, reviews and training, this is not yet consistently embedded into practice or translated into sustained improvements in outcomes. This reinforces the need to strengthen supervision, oversight, and accountability, and to ensure that improvement activity results in meaningful change for those who access services.

Culture has continued to be an important focus. The Partnership has set a clear ambition to develop a shared safeguarding culture based on curiosity, constructive challenge and collective responsibility.

There are positive foundations in place, including increased participation, stronger practitioner voice, and improved multi-agency learning. However, further work is required to ensure this is consistently experienced across all agencies and at all levels of the system.

The voices and experiences of children, young people and adults continue to be central to the Partnership's work. These insights have increasingly informed both strategic direction and service development, reinforcing the need for approaches that are relational, responsive, and focused on timely and coordinated support.

Looking ahead, the Partnership will focus on embedding learning into everyday practice, strengthening accountability, and demonstrating clear impact on outcomes. This will require sustained leadership, continued partner commitment, and a willingness to challenge and adapt where current approaches are not achieving the desired impact.

Overall, the Partnership is in a stronger position than at the start of the year, with improved alignment, increased maturity, and a clearer focus on impact.

The priority for the coming year will be to ensure that this progress is consistently embedded, so that improvements are not only evident at a strategic level but are experienced in practice and outcomes for children, families and adults across Swindon.

This report was prepared by the Swindon Safeguarding Partnership Strategic Manager, Hannah Woloszczynska and approved by the Partnership Executive on 7th September 2026.

This report will be shared with:

- The National Child Safeguarding Practice Review Panel
- Swindon Borough Council Leader and relevant elected members
- Health and Wellbeing Board
- Community Safety Partnership
- Healthwatch