Swindon Safeguarding Partnership

Annual Report 2019-20

safeguardingpartnership.swindon.gov.uk

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Forward

Thank you for taking the time to read Swindon Safeguarding Partnership Annual Report which covers the period 1st April 2019- 31st March 2020.

The report is published by the three statutory partners (Swindon Council, Wiltshire Police and Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group) who are responsible for putting in place effective arrangements to support the co-ordination, quality assurance and continuous improvement of activity to safeguard children, young people and adults with care and support needs.

I was appointed in March 2019 to the role of independent scrutineer and chair which means that I facilitate key meetings and act as a "critical friend" to support the evaluation of the quality and impact of safeguarding activity in Swindon. This includes chairing a performance and quality assurance meeting for safeguarding children activity.

The report sets out the significant changes that were made to strategic safeguarding partnership arrangements during 2019-20; these were in response to changes in statutory guidance for safeguarding children and young people. A considerable amount of time was spent during the period under review developing the new arrangements and agreeing and recruiting the business support capacity to support the delivery of core functions. Partners recognise there is further work to do in relation to developing the business support arrangements in order to deliver to the agreed work programmes/statutory functions in a more timely way.

In this report, the statutory partners set out critical areas of development to improve the effectiveness of the statutory partnership arrangements including the need for a robust multi- agency quality assurance framework, gathering and using the views of children and adults and their parents/carers to support the evaluation of safeguarding services, and using the learning from serious safeguarding incidents and auditing to make a difference to either practice or service provision as opposed to simply disseminating learning often several months, and at times years, after the incident.

To help with this shared endeavour, I have observed honest and open conversations to evaluate the effectiveness of the partnership and a programme of development has been agreed to strengthen the culture of shared ownership and accountability that is central to effective partnership working and good outcomes for children, adults and their families. Partners have expressed their strong commitment to take action to improve safeguarding services and partnership working however, this has not yet resulted in the desired progress as much of the work programme remains ongoing at the end of the year, although that is not to say that important work hasn't or isn't taking place.

There have of course been achievements and the report also sets out some of those that have been realised during 2019-20 including:

- Completion and publication of all outstanding Serious Case Reviews
- A positive inspection judgement for the Council's Children's Services
- More robust scrutiny of agency attendance at Child Protection Conferences resulting in improved attendance
- Clearer identification of safeguarding concerns through the creation of a multi-agency adult safeguarding E-Referral and interactive Threshold E-Guidance (which went live May 2020)
- Establishing a support network for people with lived experience of hoarding

These achievements are a reflection of the committed individuals who either work directly with children, adults and their families or those with a specialist role in safeguarding in partner agencies; on behalf of the 3 statutory safeguarding partners, thank you for the work you have done in 2019-20 and continue to do so.

Best Wishes

Liz Murphy

Independent Chair, Swindon Safeguarding Partnership

Introduction

About us

Swindon Safeguarding Partnership came into effect July 2019. The Swindon Safeguarding Executive was established to oversee the new Multi-Agency Safeguarding Arrangements for children (formally the LSCB) and adults at risk (LSAB). The duties and functions of the Partnership are set out Working Together 2018 **and** Care Act 2014. The Partnership comprises a core membership of statutory partners from Swindon Borough Council (SBC), BSW Clinical Commissioning Group (CCG) and Wiltshire Police and an Independent Chair. We also have a number of other partners.

Our Ambition

Our ambition is for the partnership to act with intent and purpose to deliver measurable and meaningful improvements in outcomes for children and adults at risk by:

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

Our Purpose

The Swindon Safeguarding Partnership will support, enable and challenge each other to work together to:

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

Our Challenges

During 2019/20, Swindon Safeguarding Partnership has encountered a number of challenges which has impacted on our safeguarding improvement journey.

Progress in delivering our priorities has been affected by capacity and cultural challenges within Swindon Safeguarding Partnership Business Support Unit (SSP BSU) and across the partnership. Extended staff absence within BSU, recruitment delays alongside knowledge/skill gaps have delayed the pace of improvement and impacted on:

- Having robust quality assurance and oversight on the effectiveness of Swindon's multi-agency arrangements due to an undeveloped Partnership Quality Assurance framework and a shortfall in multi-agency audits and walk the floor activity;
- Actively engaging with children, families, and adults with care and support needs and their unpaid carers to influence and improve safeguarding practices and service delivery across the partnership;
- Evidencing the impact of SSP sub-groups on practice and outcomes due to an absence of business plans;
- Evidencing risks associated with multi-agency safeguarding arrangements are being actively managed due to an undeveloped strategic risk register for the partnership;
- Acting on the learning from serious safeguarding incidents in a timely manner;
- Delivering a multi-agency safeguarding Learning and Development Offer and evaluation framework to demonstrate improved safeguarding practice and outcomes.

The World Health Organisation (WHO) declared COVID-19 Pandemic on 11 March 2020. The first recorded COVID case in Swindon was on 6th March 2020. The partnership's response to COVID-19 was swift to ensure minimum disruption to business continuity at the commencement of 'lockdown'. Partners worked together to produce a Standard Operating Process (SOP) to assess the impact of COVID-19 on safeguarding duties ensuring business continuity plans were in place so those most at risk were seen face to face. Strategy discussions, Child Protection Conferences and Section 42 Adult Safeguarding enquiries were facilitated remotely during the full lockdown. The COVID-19 response structure enabled a joined-up approach across the partnership for vulnerable and at risk children and adults with care and support needs. A multi-agency Board is assessing the key areas of risk presented by COVID-19 and overseeing the recovery phase.

There is clear ambition for Swindon Safeguarding Partnership to address the above challenges, however, we recognise it will take time to achieve cultural change to maximise the impact of strengthened leadership whilst continuing to deliver our COVID-19 management response plan. Stronger governance is now supporting better management and co-ordination of our priorities to secure improved safeguarding practices and outcomes. In 2020/21, our priorities include improving multi-agency working to safeguard adults through creating an Adult MASH, ensuring safeguarding referrals and processes are timely and appropriate for keeping children and adults with needs safe, strengthening support for individuals who self-neglect, improving our response to children who are being neglected, developing an all age response to criminal exploitation, and keeping children/young people, adults with needs and their unpaid carers are at the centre of decision making.

Our journey to establishing the new partnership arrangements

March 2019

H&W Board approved Multi-agency Safeguarding Arrangements for Children and Adults at Risk

Appointed Independent Chair and Scrutineer for the new Partnership Arrangements

April 2019

Appointed Strategic Manager: Safeguarding for the new Partnership Arrangements

Held joint LSCB/LSAB Partnership Event to establish new multi-agency safeguarding arrangements

Inaugural meeting of SSP Delivery Group to provide ongoing support with the transition to the new partnership arrangements

May 2019

Published new SSP Safeguarding Arrangements, the Memorandum of Understanding

Reviewed Terms of Reference and membership for Safeguarding Partnership Groups

Partnership submitted the Strengthening Families bid to Department for Education

Children Missing from Home & Care policy revised and published

June 2019

Inaugural meeting of Swindon Safeguarding Executive

Terms of Reference and membership of SSP sub-groups reviewed

Published the new arrangements for Child Deaths (CDOP)

July 2019

The new safeguarding arrangements went live

Partnership session held on Family Safeguarding Model

Published SCR U & Learning leaflet U

August 2019

Published All Age Neglect strategy

September 2019

2 new Development Mangers and an additional safeguarding administrator joined the SSP BSU Team

Published learning leaflet for SCR M (Oxfordshire Safeguarding Children Board SCR M)

Children's Multi-Agency Escalation Policy revised and promoted

October 2019

H&W Board approved SSP Strategy and Safeguarding priorities

Rapid Review RW completed

SSP Eventbrite set up for free localised training offers such as MASH Open day and Right Help Right Time training.

November 2019

Published SCR Q and learning leaflet Q

Launched partnership logo competition with schools

December 2019

Launched SSP

Successful Partnership application for support from the Tackling Child Exploitation Programme

January 2020

New SSP website developed

Published SCR G and learning leaflet G

Shared learning from Local Case Review Y

Rapid Review PMA completed

Safeguarding Adult Review (SAR) TB commenced

Partners signed the new Swindon Safeguarding Partnership Information

February 2020

SSP 365 SharePoint established
Introduced Eventbrite for booking multi-agency training & learning/development events

Undertook needs analysis to inform SSP Training Strategy and L&D offer

Joint Section 11/42 Audit Tool Developed

March 2020

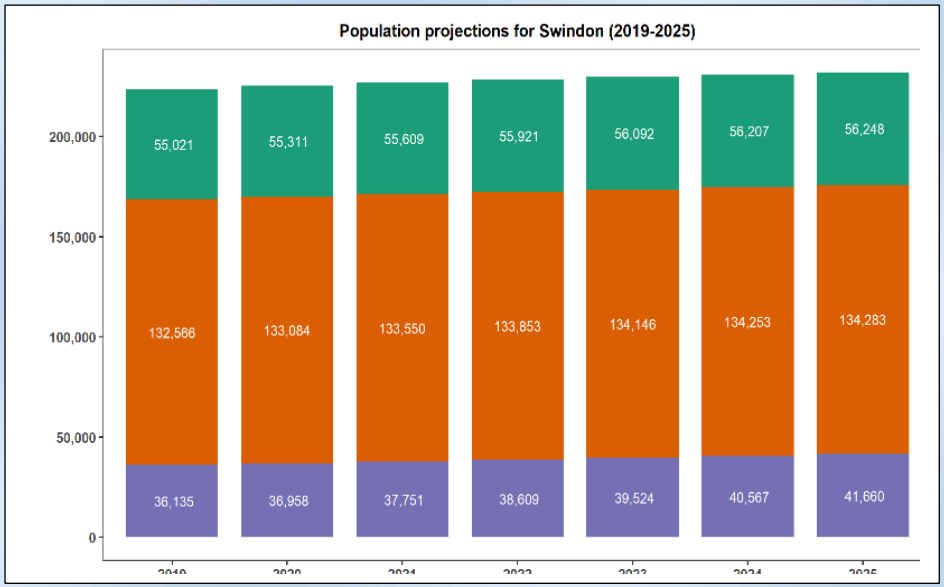
Partnership event on the Strengthening Families Model: Strength based approach, following successful Government Bid – full implementation planned April 2022

Implemented weekly meetings to review the Standard Operating Procedures (SOP) for core multi-agency safeguarding activity for keeping children and adults at risk safe due to Covid-19 Pandemic

Managed the on-boarding of community volunteers on behalf of Compassionate Swindon for shielding and vulnerable residents

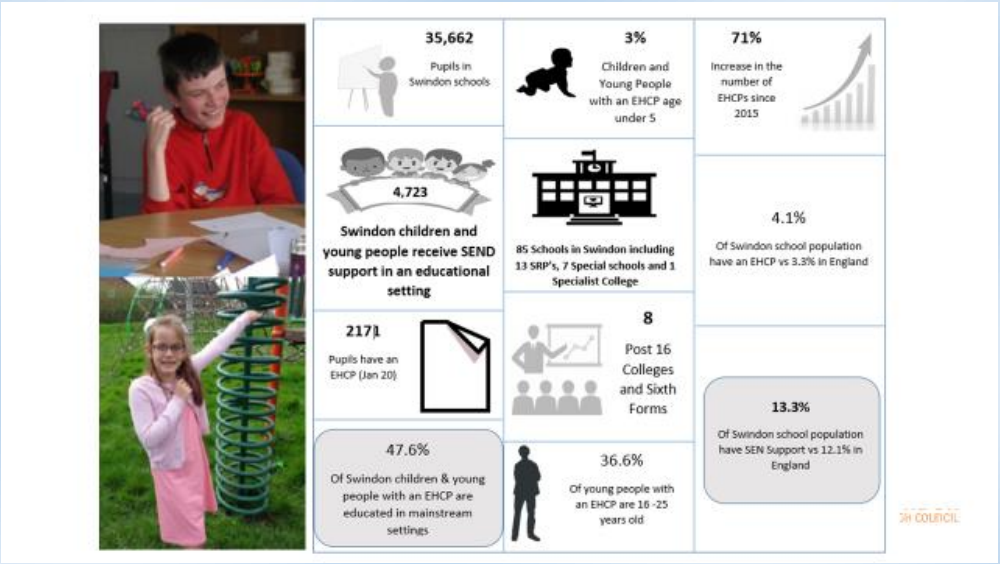
What we know about adults and children in Swindon

Swindon's overall population is predicted to increase over the next few years by around 4% from 223,722 in 2019 to 232,191 in 2025. Data shows that children and young people under the age of 20 make up 24.5% of the population of Swindon. The percentage of Swindon's population aged 65 and over is similar to that of the England average. This population is predicted to increase by 15%, with the number of people 85 years and older increasing from 4,830 in 2019 to 5,306 in 2025.



Based on recent trends, the number of older people living alone is expected to increase, as is the number of older people with dementia expected to increase. The dementia diagnosis rate in Swindon is decreasing and is now 56.1% as at March 2020, below the target rate of 60%. In 2018/19, there were over 1,100 adults in Swindon registered with their GP as having a learning disability, and there are estimated to be over 1,300 adults with autistic spectrum disorders.

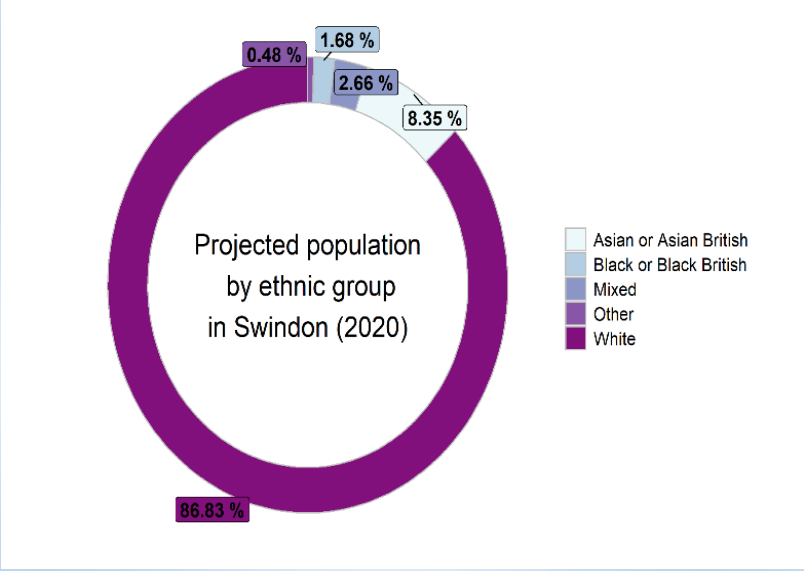
There are a total of 2,335 children and young people (up to 25 years) with Education, Health and Care Plans (EHCPs) in Swindon. Swindon has an increasing number of EHCPs with a marked rate of increase over the past two years. Between 2015 and 2019, the number of children with EHCPs grew by 77% for Swindon, compared to 62% nationally. Between 2018 and 2019 there was a 62% increase in the number of assessments requested (287 in 2018 to 466 in 2019) which impacted on the timeliness of assessments during 2019 and the first quarter of 2020. In March 2020, there were 2200 pupils in Swindon schools and colleges with open EHCPs and 4722 pupils with Special Educational Need (SEN) support.



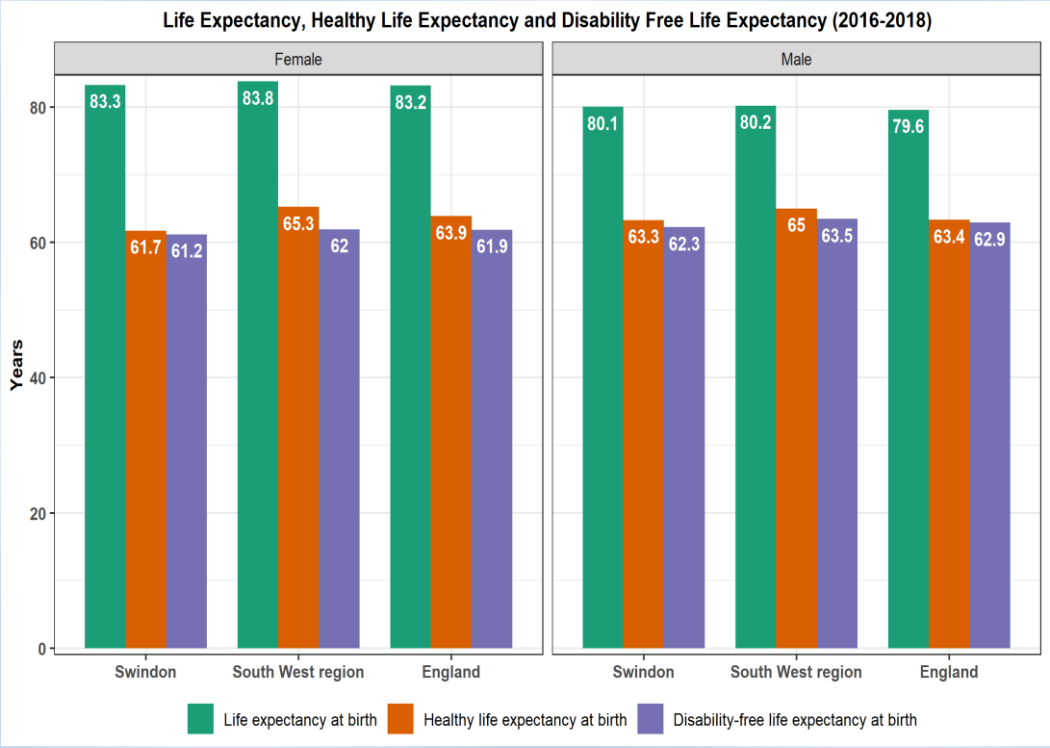
In 2019/20 there were six permanent exclusions and 197 fixed term exclusions (FTE) involving 97 pupils in the primary sector. The number of FTE in primary schools has risen by 47% (63) compared to 2018/19.

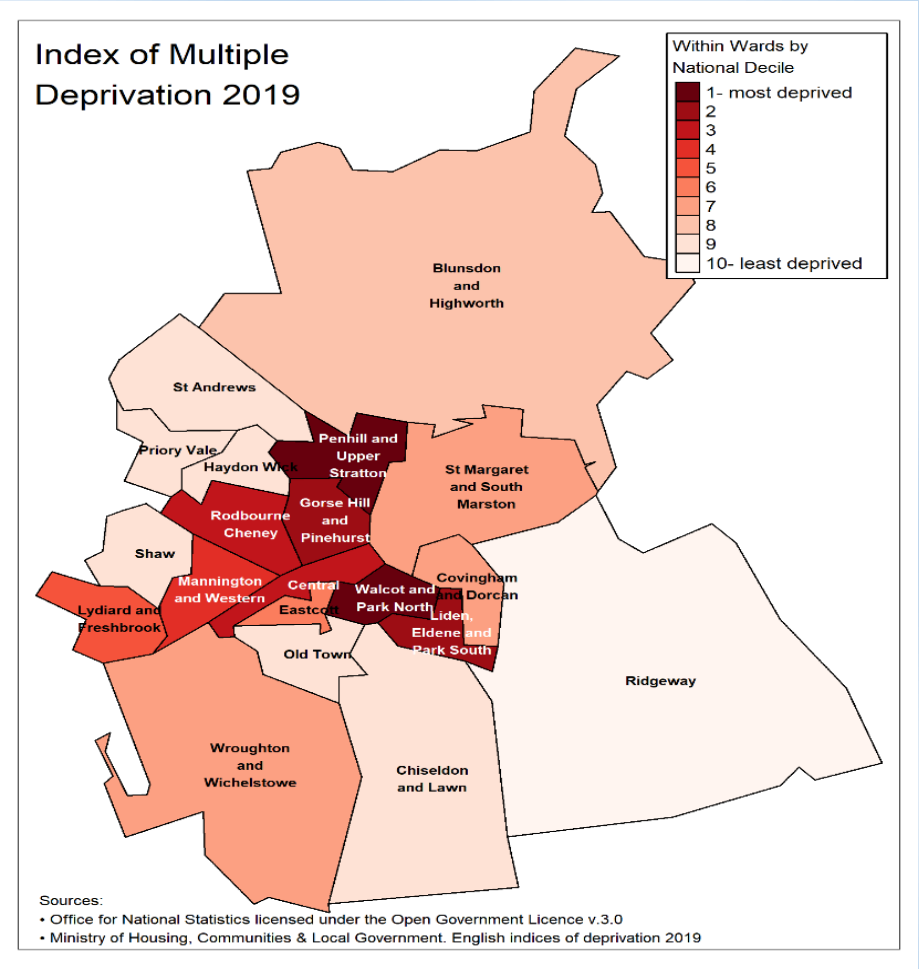
There were 21 secondary school permanent exclusions in 2019/20 (up from 16 in2018/19) and 795 FTE involving 412 pupils. This is an increase of 5 permanent exclusions and a reduction of 50 FTE (6%) in secondary schools compared to the previous year. In 2018/19, the number of secondary school exclusions as a percentage of the school population were higher in Swindon than England and statistical neighbours.

Swindon has a culturally-mixed population with around a fifth of school age children are from a minority ethnic group. People of Asian or Asian-British background form the largest minority ethnic groups in Swindon. At the time of the 2011 census, the number of Non-UK Born residents in Swindon was 26,864, or 12.8% of the then resident population. The Eastern European population make up around 2.7% of the area residents (6,000 people (95%CI: 3,000) in total). Accessing appropriate provision of services depend upon a well-informed understanding of the specific needs of these different communities.



Swindon females are expected to live longer (83.3 years) than males (80.1 years). However, males are expected to spend 79% of their lives in good health, while females are expected to spend 73% of their lives disability free. This is similar compared with the rest of England, except for female healthy life expectancy which is lower in Swindon. There are inequalities within Swindon, between the most affluent and most deprived wards.





Data indicates that around two thirds of adults in Swindon are overweight or obese. Around half the adult population meets the recommended '5 a day' intake of fruit and vegetables, and 61.7% of adults reportedly meet recommended physical activity levels, which is statistically significantly lower than the England average. In terms of wellbeing, in 2018-19, 19.1% of adults reported high anxiety levels, and 9.9% with low happiness scores. This is similar to England and the South West as a whole.

Data indicates that 20.8% of Reception age children in Swindon are overweight or obese, compared to 22.6% for England. By Year 6, this has increased to 33.3% of children falling into the overweight or obese category. In 2018-19, less than half of children aged 5-16 met the recommended physical activity levels. In terms of school readiness, the percentage of children in Swindon achieving a good level of development at the end of reception is similar to that of England. Swindon continues to have an increasingly high number of hospital admissions for self-harm in children and young people aged 10-24 years.

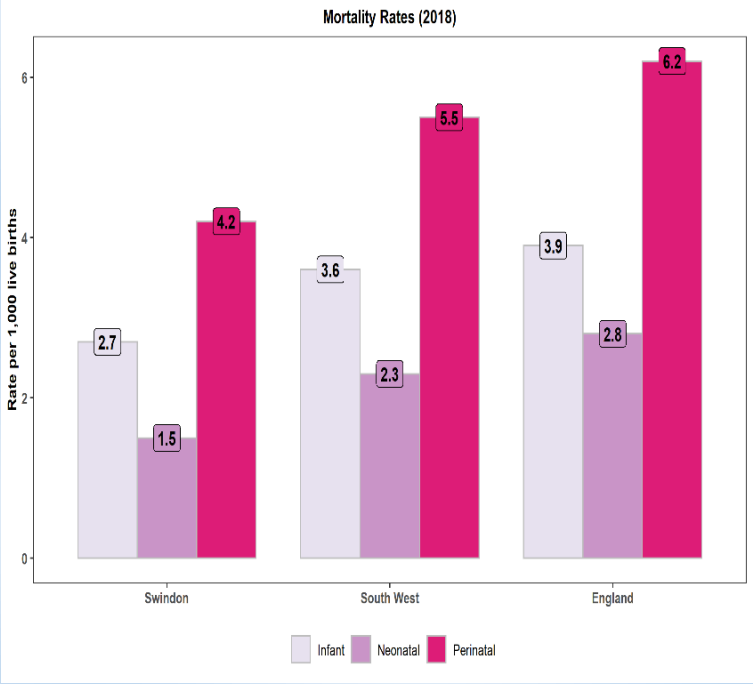
The latest child poverty figures for Swindon (2018/19) show that there were 5,920 children under 16 living in relative low income families – representing 13% of all children in the borough. This was below the average for Great Britain of 18%. However, this rises to 11,042 (24.4%) if child poverty figures include housing costs. In 2018-19, Swindon ranked 121st for child poverty out of 371 local authorities in the UK, and has seen a gradual decrease in the percentage of children living in low income families over the previous five years. In January 2020, 15% (5434) of children were eligible for Free School Meals (January 2020 census).

One in three children in Swindon are **overweight or obese** by the time they reach Year 6

71.2% of children achieve a good level of **development** at the end of Reception year in readiness for school

There were **1,072** hospital admissions for **self-harm** per 100,000 of the population aged 10—24 years in 2018/19

In 2018/19, **5,920** children under 16 were living in **low income** families



Locally, infant mortality is lower than regional and national rates, at 2.7 deaths under 1 years old per 1,000 live births (in 2018), compared with 3.6 for the South West and 3.9 for England as a whole. High levels of deprivation are a key contributing factor.

Under 18 conceptions are higher than the national average with 21.1 for every 1,000 pregnancies compared with 13.5 for the South West, and 16.6 for England (data for 2019). Teenage pregnancy rates in Swindon have remained consistently higher than the South West and England over the past five years.

Although there has been an increase in contacts and re-referrals to Swindon Children's MASH in 2019/20 compared to the previous year, the number of children receiving statutory services has reduced compared to March 2019. Over the year, there has been focussed work to strengthen the early help offer to reduce demand at social care front door through the Early Help Hub and more effective early help interventions and support.

Key Statistics (Social Care)

Measure	March 2019	March 2020	DOT from March 2019	National Average 2018/19	Statistical Neighbours Average 2018/19	PYO 2018/19
Number of Contacts (year to date)	12,189	14,748	⬆	N/A	N/A	12,189
Number of Referrals (year to date)	3,860	3,166 (599 per 10K pop)	⬇	544.5 per 10K pop	566.94 per 10K pop	3,860 (733 per 10K pop)
% of Re-referrals (year to date)	21.2%	27.1%	⬆	22.6%	22.56%	706 (21.2%)
Children in Need (as at)	1,284	775 (154 per 10K pop)	⬇	185.7 per 10K pop (2017/18 data)	160.25 per 10K pop (2017/18 data)	1,284 (262.0 per 10K pop)
Children on a protection plans (as at)	331	170 (36.3 per 10K pop)	⬇	43.7 per 10K pop	45.21 per 10K pop	331 (67.5 per 10K pop)
Children Looked After	352	302 (60.1 per 10K pop)	⬇	65.0 per 10K pop	63.2 per 10K pop	352 (71.1 per 10K pop)

Key: DOT – Direction of Travel; PYO – Previous Year Outturn

Making a difference for children and families

Mark is 13 years old at risk of Child Exploitation. Mark had three missing episodes within a 90 day period and was excluded from school. Mark struggled to regulate his emotions and mood responses and admitted he liked going out with older males who he had befriended online. The Police Early Intervention Team, Family service (FS), CAMHS and Mark's school worked together to support Mark and his family. They focussed on online safety awareness providing parental guidance on internet safety information. The parents began to monitor Mark's phone use each evening and for periods turned off the internet. The FS worker supported Mark around signs of safety, stranger danger and building healthy age appropriate relationships with his peer groups. Mark was also supported to pursue his interest in drama and productions. The FS facilitated regular Team Around the Child (TAC) meetings which helped Mark explore his sexuality and return to education which were the outcomes identified in his Education Health and Care Plan (EHCP). CAMHS have completed a Psychology assessment and are providing ongoing support to Mark to help him manage his emotions. The Family Service has been supporting Mark and his family for five months and there have been no further incidences of Mark going missing overnight and less frequent occurrences of Mark placing himself at risk.

Sally was age 15 when she told her teacher at school that her mum's new boyfriend made her feel uncomfortable and mentioned pictures. The school supported Sally and told her they were going to help, but they needed to speak to children's social care to support them as they were the specialist. The Social worker and police officer visited Sally at school. Sally chose the person from the school she wanted to be with her during the interview. Due to the things Sally said it was assessed that it was not safe for her to return home to her mum at this time. The social worker spoke to mum and it was agreed she would go to live with a family member until the investigation could be completed.

The school, Police and social worker worked closely together to support Sally, during this time. The school nurse met with Sally within school to support her with any worries she had about her sexual health. The social worker supported Sally on a one to one basis to help her recover from the abuse she had experienced. Due to the positive relationships established, Sally was able to tell her story about what her life had been like. Regular meetings between school, the police and the social worker took place with Sally to ensure there was a clear plan in place to support Sally. At first, Sally was really worried about her mum as she had taken on a caring role for her. She was very distressed and upset. The practitioners supporting her helped her to understand that she was a child and it is for the adults to care for her and what her mum's boyfriend had done was wrong. Sally has not returned to live with her mum. However, she is doing really well and is now at college. She is more confident and is now able to make choices for herself. She has a group of positive friendships. There is an ongoing court case and she still receives support from the social worker. Sally told us: "My social worker helped me by showing me what a true family is and to feel wanted and loved by family. If it wasn't for my social worker removing me from where I was, I don't know where or what would have happened to me". Sally also said: "Since I was removed from my mum my social worker has given me so much support like, a shoulder to cry on and she has helped me with finding who I wanted to be so I can be happy." It has showed me that what I was going through ….was not my fault and not to blame myself

What have children and young people have told us?

The partnership wants to give children and families a voice to learn and make sure their views influence the way that services work with children and their families.

I prefer face to face contact – going for a coffee, going to the office is weird

I would like social workers to check in after meetings or court

Keep appointments – come when you say you are coming

Text me and stay in touch

Try and listen to our views. Talk to us not at us!

Key Messages from children and young people

- ✓ For professionals to be more persistent and not give up at the first "no". Young people talked about the importance of professionals checking in regularly. Young people wanted to know that the professionals cared and were interested in their lives.
- ✓ Professionals to develop and use different communication skills and methods to keep in touch
- ✓ Young people to have more opportunities to develop life skills including communication and emotional intelligence so they can ask for what they need and discuss how they are feeling.
- ✓ Young people wanted human conversations, which were not process driven.
- ✓ Young people want to meet outside of offices and professionals to have access to a fund to pay for this, particularly for hard to engage young people. This would help develop trust and communication.
- ✓ Young people wanted professionals who were open and honest even if it was a message the young people would prefer not to hear.
- ✓ Young people wanted professionals to carry out what they had promised and if this wasn't possible to be honest.
- ✓ Professionals valued what the young people have said and recognise that they didn't always consistently deliver best practice.

Call back when you say you are going to

Trust me

Don't keep changing our workers. I have to keep getting used to someone new and I don't like it!

Let me leave the meeting when I am stressed

My Social worker made me realise I would get more if I was calm & not screaming and shouting

Professionals often want information and I'm constantly bombard with questions

Progress against our 2019/20 priorities for children and families

See appendix 1 for key performance children's safeguarding statistics

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

Why is this a priority?
By partners working together effectively and earlier to prevent problems escalating, we will keep children and young people safe reducing the number of families requiring statutory interventions.

What we focussed on:

- Application of the thresholds for intervention by partners
- Multi-agency decision making in MASH
- Information sharing
- Leadership and management oversight
- Early intervention and strength based working

What we did	How it's made a difference
• Refreshed the Swindon Thresholds of Need & MASH Operating protocol, updated the Multi-agency Referral Form (RF1). Established the MASH Strategic Partnership Group in May 2019 to provide steer and oversight for the operation of MASH and introduced MASH Open Events to support better application and understanding of thresholds. • Developed a better coordinated Early Help Offer and Pathway with key agencies working together supported by the Early Help Hub and Team Around the Schools. The Early Help Hub have produced a 7 minute guide to Early Help in Swindon, updated the guidance and organised virtual training to the partnership. • Completed a deep dive of Child Protection Conferences (CPCs) and began the development of the multi-agency standards for	• Swindon's children's social care services rated good overall by Ofsted (previously Requires Improvement). • Good uptake of Children's MASH Open events with delegate representation from across the partnership. • Children and families receive a prompt response to initial contacts (97.2% of contacts into MASH having a decision within 24 hours) and in January 2020, strategy discussions moved into MASH which has resulted in more timely decisions in relation to strategy discussions which are now made within 4 hours. • The relocation of MASH to a secure environment in July 2019 with partners being seated together has led to better information sharing at MASH contact stage.

safeguarding children (although these were published post 31/3/20) and refined processes to support better quality and timely reports and improved attendance by partner agencies at Strategy Meetings and Child Protection Conferences. • Updated and promoted Swindon Local Policies, Protocols and Guidance: the Bruising in Non-mobile Infants, Children Missing from Home and Care; Additional Child Protection Procedures for Disabled Children; Escalation Policy; Health Protocol for Attendance/Contribution at Child Protection Strategy Discussions; Safer Working Practices in Education Settings; and Protocol for Protecting Children who Move Across Local Authority Borders. • Successful bid to the Innovation Fund Project of £577k over 3 years to support children affected by alcohol dependent /alcohol misusing parents. • Successful bid to Early Outcomes Fund of £415k to identify and support children who are at risk of or display early signs of atypical language development from antenatal period onwards, particularly 0-30 months, to intervene at the earliest opportunity and minimise achievement gap by age 5.	• Fewer children and families needing statutory support – as at March 2020, there were fewer children on Child Protection Plans (170 compared to 331 in 2019), a reduction in the numbers of Children In Need (775 compared to 1284 in 2019) and 50 less children being looked (302 compared to 352 in 2019). The Edge of Care service has worked with 19 families to divert their children from care and helped five children return home from care to re-join their families. The volume of open Early Help involvements has increased in 2019/20. Robust pathways between MASH and Early Help Hub (EHH) has led to 100% of EHH referrals receiving an outcome/review within 5 working days. • Health outcomes for our looked after children are good with the vast majority of them having timely access to primary health services which has led to high uptake rates of dental checks, immunisations and health assessments. The March 2020 data shows that 276 out of 301 (91.7%) of children who had been looked after for a year or more as at 31st March 2019, had up to date health assessments. Swindon has a dedicated Children Looked After Health Team that provide swift access to health support and advice, working flexibly to meet children and young people where they feel most comfortable • The majority of eligible children have completed Strength and Difficulties Questionnaires (96.5%) so children's emotional well-being needs are identified and recommendations made to ensure they receive appropriate support and interventions • Better scrutiny and management of allegations through Local Authority Designated Officer (LADO) is minimising the risk to children and ensuring subjects of allegations are dealt with appropriately – improvement in the service was commended by Ofsted

	• 99% of Swindon schools and colleges completed the Section 175/157 Audit: 69.5% reporting staff are aware of Early Help; 74% of schools reporting confidence with their response to peer on peer abuse; 75% rated their internet safety as green or amber; and 100% of schools rated their safer recruitment practice as safe. • The completion and publication of Serious Case Reviews (SCRs) has provided closure for parents and is supporting learning for professionals to improve practice and service delivery in relation to the impact of neglect, escalation, Child Protection Conference processes and professional curiosity. • Following the re-issuing of the Escalation Policy, the safeguarding partnership has monitored usage from stage 2. Four cases were escalated to the safeguarding partnership – three from schools and one from Family Nurse Partnership. Disagreements were resolved but timescales within the escalation policy were not always met.

Reduce the number of children being exploited

Why is this a priority?
To improve understanding and awareness amongst practitioners, parents and in the community to support early identification and disruption of exploitation to keep children and young people safe**.**

What we focussed on:
- Keeping children safe in the community
- Support for those children affected by exploitation
- Holding perpetrators to account

What we did	How it's made a difference
• Broadened the Child Sexual Exploitation (CSE) strategy to include Child Exploitation and Missing Children and published the Child Exploitation initial screening tool	• Responses to individual children identified as being at risk of exploitation, including sexual exploitation are more timely and effective. Young people are supported well by the Opal team (the dedicated child exploitation team), which provides targeted

• Multi Agency Risk Panel (MARP) meetings reviewed risks, quality assured plans for keeping children at risk of exploitation safe and focused on prevention and pursuing perpetrators. MARP uses the **V**ictim, **O**ffender **L**ocation and **T**heme (VOLT) model and has established a process for practitioners to explore National Referral Mechanism (NRMs) for every child discussed at MARP. • Held contextual safeguarding event for 250 people and introduced child sexual exploitation e-learning and an interactive CSE learning tool for parents and professionals • Completed Deep dive and ongoing analysis of MARP activity to identify themes impacting on child exploitation, produced monthly newsletters for multi-agency workforce to share key themes and issues (e.g. part-time timetables, frequent school moves exclusions, loss of significant adult, living with grandparents, dual heritage or from minority group, learning needs and self-harm/mental health issues) • Published and using the Swindon & Wiltshire Child Sexual Exploitation Disruption Toolkit • Implemented regular multi-agency mapping meetings for early identification of groups of children and young people at risk, locations and emerging concerns. • Embedded the SafeCall Service providing support for children with missing episodes and Operation Makesafe to raise awareness of CE in the business community. • In October 2019, the remit of Opal Team broadened to include Criminal Exploitation with a dedicated Child Criminal Exploitation (CE) Officer co-located with the team	preventative intervention and individual direct work with young people to reduce risk. Action plans have mitigated risks and young people have developed self-protection skills. A number of case studies have evidenced improved attendance, more cohesive relationships with family members and prevention of children needing to become looked after. • The child exploitation screening tool is effective in identifying those children at risk of criminal/sexual exploitation and is assisting with decision making and referral. • Partnership working has improved the gathering of intelligence to support local mapping and creating robust profiles of the area. In 2019/20, fewer children have been identified as at risk of Child Sexual Exploitation (CSE), but there was a slight increase in numbers of children at risk of Criminal Exploitation (CE) compared to the previous years. • The Multi Agency Risk Panel (MARP) and the implementation of the Victims, Offenders/people of concern, Location and Themes (VOLT) framework is keeping children safer. The increased use of child abduction warning notices (CAWNs) and National Referral Mechanism (NRMs) has prevented further offending. • Fewer children are going missing and there are fewer missing episodes (reduced from 675 missing children episodes in 2018/19 to 428 in 2019/20). Audits of Return Home Interviews show they are good quality and more timely.

• Completed a multi-agency child exploitation survey to gain insight into awareness and prevention work across the partnership for CE and missing children. • Introduced more robust management of Missing Children process that provides assurance on missing children including out of area children, rate and quality of Return Home Interviews and oversight of repeat missing episodes. • Successful Partnership application for support from the Tackling Child Exploitation Programme	

Children live in safety, free from neglect

Why is this a priority?
Local and serious case reviews have highlighted neglect as an area of practice which requires improvement across the partnership. In Swindon, of those children subject to a child Protection Plan, 54% have a category of neglect

What we focussed on:
- Promoting the use of the NSPCC Graded Care Profile 2 assessment tool in identifying and supporting children experiencing abuse and neglect.
- Better understanding of pathways into targeted services for children experiencing abuse and neglect
- Better oversight and understanding of the prevalence of neglect and understanding of the multiagency response

What we did	How it's made a difference
• Established the multi-agency Neglect Task and Finish Group to oversee improvements in identification and support for experiencing abuse and neglect. • Developed Swindon's All Age Neglect & Self-Neglect Strategy on a page to steer the partnership work around neglect.	• Early evidence indicates the use of GCP2 tool is supporting better identification of neglect which is leading to less drift and delay in meeting the needs of those children experiencing neglect (see making a difference for right decision at right time priority above).

• Developed timeline and implementation plan for promoting and using NSPCC Graded Care Profile 2 assessment tool and trained four additional train the trainers for cascading the use of the tool across the partnership. • Carried out a neglect audit which identified the following areas for improvement: timely core groups, effective use of escalation, tackling drift and delay from legacy and current perspective, and to implement a comprehensive partnership approach to neglect	

Improve quality of practice & ensure children/young people and adults with care and support needs are at the centre of decisions which relate to their life

Why is this a priority?
Provide assurance that partnership working is strong across the safeguarding system and improves outcomes

What we focussed on:
- Ensuring the voice of children and young people are heard
- Effective use of escalation
- Information sharing
- 'Think family' and 'Think holistically'
- Effective supervision and management oversight
- Practitioners are professionally curious

What we did	How it's made a difference
Children • Completed and published outstanding Serious Case Reviews (SCRs) and Learning Leaflets which provided closure for parents/carers and supported learning for professionals • Good attendance at three Children Partnership Meetings, which focussed on learning from Serious Case Reviews and practice improvement in threshold application, neglect, Child Protection Conferences and escalation. • Completed three Rapid reviews and used insight from quality assurance activity to support continuous improvement	• The year has mainly focussed on improving the infrastructure to support the delivery of consistently good quality safeguarding practices (see pages 7-8 of our journey to establishing the new safeguarding partnership arrangements). The next 12 months should provide evidence to demonstrate the impact of the new arrangements on children, families, adults with care and support needs, practitioners and the wider community. • Timely Rapid Reviews reported to National Panel

• Strengthened the voice and influence of children and young people through the Local Authority Participation Strategy and delivery plan (led by the council). • Completed Primary care audit of children on Child Protection Plans to reconcile recording of status of children across SBC and GP SPINE <u>Adults</u> • Refreshed the Safeguarding Adult Review (SAR) Process and initiated one Safeguarding Adult Review (SAR TB) and the local case review KH to learn lessons for the future and improve practice • Good attendance at three Safeguarding Adult Boards with focused learning: service user's experience of a safeguarding planning meeting, adult safeguarding front door, ADASS s42 Framework Making Safeguarding Personal (MSP), Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLs), and Local Case Review Y. <u>Partnership wide</u> • Developed Rapid Review process and refined Safeguarding Adult Review Process. • Developed a communication and engagement plan. • Partners signed up to the new SSP Information Sharing protocol. • Undertook needs analysis to inform SSP Training strategy and Learning & Development offer for 2020/21 and virtual courses and e-learning offer developed. • SSP Website improvements but further improvements in the pipeline. • Revised the children and adult escalation policies and introduced a tracking system to monitor timeliness and outcomes for resolving escalations	• Improved accuracy and timely recording of children's GP by SBC accessing the SPINE and GP surgeries maintaining correct child protection information for children registered at their practices.

Learning from children safeguarding reviews

Rapid Reviews

Swindon Safeguarding Partnership (SSP) submitted three rapid reviews since the legislation changed in 2018 to the National Child Safeguarding Practice Review Panel. Partners have shown a significant commitment to ensure the reviews were completed within timescale and the process has been managed by SSP's Practice Review Group (PRG). The National Panel has agreed with the PRG's decision that the cases did not meet the criteria for a Children's Safeguarding Practice Review (CSPR). The reviews have identified key learning for the local safeguarding system, which aligns to the learning themes identified from local case reviews and published SCRs. These cover:

- Professional curiosity
- Safeguarding supervision and management oversight
- Hearing and reflecting the voice of children and parents/carers
- Identification and impact of neglect in children and adolescents
- Effective use of escalation
- Multi-agency processes for safeguarding unborn/new born babies
- Effective use of transition plans to reduce risk of abuse/neglect

Improvements were also identified in our Rapid Review Process which has led to the partnership receiving more timely referrals and collective decision making by partners on which cases to progress for a rapid review.

Serious Case Reviews

The PRG oversees progress in embedding the learning across the partnership for SCRs. An update on progress for embedding the learning is provided in Appendix 2 (pages 47-49)

Inspection and QA Activity in 2019/20

Ofsted Inspection of Swindon Children's social care services – (July 2019)

Judgement	Grade
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Good

Deep Dives: Child Protection Conferences (CPC), CE and Missing.

Core dataset and Organisational Headline Report: Provided quarterly by all partner agencies covering things to celebrate/share, areas for development, major concerns/risks and priority actions.

Multi-agency Audits (there was slippage in the audit programme): MASH; Child Protection – Information Sharing (CP-IS) Audit, Early Help Assessments, JTAI Children's Mental Health (reported June 2020), Child Protection & Children Looked After Information Systems (reported May 2020), Unborn Baby Protocol audit scoped in 2019/20 but undertaken post March 2020.

Walk the Floor activity by senior managers and SSP independent scrutineer: MASH, Great Western Hospital (GWH) Maternity Department and Swindon Academy to identify good practice and areas for development.

Single Agency Audits: Primary care audit to reconcile recording of GP for children on Child Protection Plans, Neglect Audit, Section 175/157 Audit, GP Practice Safeguarding Self-Assessment; Children's Community Health; Social Care and Safeguarding supervision & training, CCG Health of Children Looked After.

Quality Assurance visits: GP surgeries, Community Health services.

Learning from Case Reviews: Serious Case Review (SCR) U, SCR Q, SCR G, SCR M, Rapid Review (RR) RW, Rapid Review PMA, Local Case Review Y.

Annual Reports: Allegations Management Annual Report, IRO Annual Report, Private Fostering Annual Report, CDOP Annual Report and Overview of the Learning Disabilities Mortality Review (LeDer) Programme 2019.

What needs improving across the children's safeguarding system?

- Stronger strategic leadership and co-ordination of the safeguarding partnership priorities to embed the learning and improve practice and outcomes for children and families across the safeguarding system
- Better understanding and application of thresholds across the partnership (contact to assessment conversion rates remain low and S47s leading to No Further Action remain high)

    - Further embed consistency in application of thresholds across the partnership to improve the quality of referrals including ensuring consent is addressed.
    - Develop a consistent approach in MASH for multi-agency checks and discussions on cases
    - Provide feedback to agencies on the quality of referrals to MASH to promote continuous learning
    - Practitioners seek threshold application advice from agency designated safeguarding lead and agency undertakes regular audits of both the quality and appropriateness of MASH referrals
    - Evidence health capacity in MASH is appropriate
    - Clarity across the partnership of the purpose and status of strategy discussions in supporting holistic risk assessments and multi-agency decision-making

- To maintain accurate data on the Child Protection – Information Sharing (CP-IS) to alert out of hours GP, walk in GP and Accident and Emergency (A&E) doctors if a child is on Child Protection Plan (CPP) or looked after.
- Progress the 'Think Family' approach to assessments to embed the principle of joint assessments between adult and children services when appropriate
- For Early Help Assessments (EHAs) and Child Protection Plans (CPPs) to be consistently good quality so they are accessible, clear and track outcomes which strongly represent the voice of children and families.
- Embed the partnership neglect framework, roll out Graded Care Profile 2 training and utilise GCP2 tools, and strengthen multi-agency working & information sharing (e.g. non-attendance and engagement in education, missed appointments) when supporting children suffering from neglect.
- Focussed work to develop a multi-agency approach for the preparation and management of Joint targeted area inspections (JTAI)
- Better knowledge and support for schools and colleges in: Elected Home Education; Channel and Prevent; pupil awareness in the dangers linked to CSE, CCE, County Lines, Gangs and radicalisation; private fostering; children missing education; contextual safeguarding knowledge; and staff awareness of the criminal offence of up-skirting.

- Greater insight into the prevalence and type of criminal exploitation (informed by National County Lines Coordination Centre (NCLCC) peer review and local intelligence) and establish cross-border links with Wiltshire to develop CE support to tackle all age exploitation.
- Further embed robust systems for providing good quality and regular safeguarding supervision for frontline practitioners, as well as quality assuring and improving management oversight by individual agencies for safeguarding referrals and CPC reports.
- Better co-ordination and multi-agency working to ensure timely identification and escalation of need and risks to safeguard unborn/new born children - unborn baby protocol and guidance for non-mobile babies need to be more impactful on practice, service delivery and outcomes.
- Implement the blended SSP multi-agency training and development offer - utilise the virtual college approach and supplement with themed sessions/briefings which link to learning reviews, multi-agency audits and walk the floor activity. Develop an evaluation framework for monitoring the impact of learning and development on safeguarding practices, service delivery and outcomes.
- Progress the development of a Quality Assurance Framework for Swindon Safeguarding Partnership to provide assurance that partnership working is strong across the safeguarding system

Making a difference for adults with care and support needs

Eve was brought to the attention of the Adult Safeguarding Team by the Police following a welfare visit raised by her daughter. The police noticed Eve was visibly nervous and she requested the officers to leave but had agreed to see her GP. Eve's spouse was always present at her GP appointments, but with Covid providing Eve with the opportunity to see her GP alone she disclosed she had been living in a domestically abusive and violent relationship for over 55 years. Eve told the GP she regularly experienced abusive incidences, had no control over her finances, her spouse controlled who she socialised with and he had cut ties with their now adult daughter 3 years ago. An exit plan was put together quickly by the GP, Eve's daughter, Swindon Woman's Aid (SWA), the police and the Adult Safeguarding Team to move Eve to a place of safety at the refuge. This was carefully co-ordinated through GP appointments so as not to rouse suspicion. On the planned date, police officers, SWA, Independent Domestic Violence Advisor (IDVA) and Eve's daughter arrived at Eve's home and successfully helped her move to the refuge. They were met with resistance by the spouse but the police managed the situation well by entering via the back door, separating Eve and her spouse so Eve could leave with the SWA Independent domestic violence advisor and her daughter. The police remained behind to manage the situation with her spouse. Eve is receiving support to live independently and solicitors are helping her manage her legal and financial affairs. Eve has a care and support plan for moving on from SWA.

Julie is a young person who was living in a residential care home away from Swindon and was supported by staff on a 2:1 basis day and night. Julie struggled to cope with the lack of consistent support staff, and changes in provider leadership during the time she lived there. Julie has Autism Spectrum Condition (ASC) which impacted on her ability to cope with the level of staff changes. Julie needed high support levels in the community as her behaviours were often unpredictable.

Julie's parents played a big role in acting as her advocates and were keen for her to move on to a more tailor made, supported living environment where she could have her own home and staff team. Everyone agreed that it was important for Julie to return to Swindon to restore her connection with family and community. After a carefully planned transition involving social work, provider services and clinical services, Julie moved to a bungalow in Swindon. Staffing was provided by Swindon Borough Council's in house provider service, Building Independent Futures. She settled, initially, quite well and enjoyed her time in her new home. In September 2019 there was a safeguarding concern which was resolved by key partners, including the Police, provider, social work service and Adult Safeguarding Team.

Since that time, there have been two further safeguarding concerns raised by the service, both of which have been resolved through a multi-agency Safeguarding Plan. Julie's support plan is reviewed regularly, and the support provider communicates with Julie's parents informally through 'partnership working together'. Structured visits from her parents continue to be put on Julie's Planner which supports a consistent clear timetable which Julie benefits from, and ensures regular family time.

Support has gone well and there have been no further safeguarding alerts. Julie has settled well and is enjoying her consistent team of support in her own home, in Swindon and close to family. There has been a significant reduction in levels of support, and she is now supported on a 1:1 basis. Julie is learning to become more independent in her home with the support from her core team.

What have adults with care and support needs and their advocates told us?

At start it was good…all people listen and tell me so I know what to think and that this man not a good man. I am not happy now …. I want it at an end, it should finish, nothing more to do, I want peace." These are comments from a client where the safeguarding process has taken a long time (commenced in April 2019) and the final review meeting should have happened in October.

Another client found the safeguarding process very helpful, he said at the time (this is now a closed case) "it was good to have everyone around the table and to meet regularly". This enabled him to understand what was happening and who was doing what. As his advocate I can say the safeguarding meeting forum for him was positive and with advocacy support was the best way and time for him to express his wishes. Having everyone's attention was positive as he had previously been a young person who felt he had not been listened to. He progressed to be more able to self-advocate

My client is of the view that the safeguarding team took steps to act on his behalf without informing/notifying him. He worries that the lack of information/communication breeds mistrust and apathy towards professionals and the entire safeguarding process. My client feels that service users should be treated with a bit more respect through partnership working to achieve outcomes rather than being dictated to.

My client lacked capacity around the safeguarding at the time the abuse took place. He has now recovered and has regained capacity.

He is still very unhappy that the woman who sold his car and most of his belongings did not get arrested even though there was evidence from others. He wants justice and can't accept that the police can't do anything

Communication between the safeguarding team and client's family was poor. Client's mother who is his main carer was not aware that a meeting she was attending was about a safeguarding allegation/concern. According to the mother, not being informed in advance about the safeguarding allegation/concerns showed a lack of respect for her. This poor communication resulted in the safeguarding meeting coming to an abrupt end.

My client could not recall any details around the safeguarding. We have had a number of meetings which I attended. There was good challenge as to why the service provider had not completed the agreed actions.

I have been supporting a mother and daughter who are both victims of abuse. They stated that they thought the two safeguarding managers had "showed respect in a big way". They felt that in the safeguarding meetings and the pre meetings - the safeguarding managers had understood their support needs. Both mother and daughter felt it was ok to leave the meetings if they got too stressful for them. The only negative thing was the way other professionals behaved in the meetings, particularly housing didn't seem to understand or respect the Safeguarding managers

Progress against our 2019/20 priorities for adults with care and support needs

See appendix 3 for key performance adult safeguarding statistics

Safeguarding approach for adults with care and support needs is personalised and achieves meaningful improvement in circumstances enabling them to live safe and well

Why is this a priority?
To ensure professionals work with adults with care and support needs and their unpaid carers to improve or resolve their circumstances

What we focussed on:

- Quality of referrals
- Making safeguarding personal
- Co-ordinated and multi-agency adult safeguarding front door

What we did	How it's made a difference
• Began the review of the Safeguarding Adults Framework and revision of the Thresholds for Accessing Adult Safeguarding (due for completion is 2020/21) • Developed a multi-agency adult Safeguarding E-Referral and interactive Threshold E-Guidance (this went live May 2020) • Progressed the business case and specification for an Adult MASH to improve multi-agency safeguarding decision making. Covid delayed implementation so implementation delayed to 2021 • The SBC Adult safeguarding external audit highlighted the need for improved partnership working within the safeguarding process. This led to establishing the multi-agency Association of Directors of Adult Social Services (ADASS) Task & Finish Group to revise and pilot the multi-agency Adult Safeguarding Policy, Procedures and supporting templates to embed Making Safeguarding Personal, improve risk management and strengthened the role of the Enquiry Manager. This document is awaiting approval.	• Early indication shows the online referral form is supporting a more efficient referral process through the provision of a more complete picture at referral stage. This enables the safeguarding team to identify and re-direct inappropriate referrals earlier in the process. • The tools developed alongside the Adult Safeguarding Policy are already in place and there are early indications of improving practice in Making Safeguarding Personal (MSP) and risk assessments. To date, 75% of individuals have been asked about their desired outcomes but we recognise further improvement is required. • Of the 336 completed enquiries during 2019/20, 101 did not record details as to whether the desired outcomes had been achieved, (compared to 368 in 2018/19). Where satisfaction with enquiry outcomes were recorded, 83% reported outcomes had been fully achieved in 2019/20 compared to 73.9% in 2018/19. In 2019/20, 4.3% of people felt their outcomes had not been achieved compared to 5.1% in 2018/19.

• Developed the Adult Safeguarding Professional Differences Policy – Multi-agency resolution protocol/guidance which is awaiting approval • Safeguarding audit tool developed and audit programme in place to regularly audit practices within SBC's Adult Safeguarding Team. • Launched the Herbert Protocol in Swindon for carers to support vulnerable people who are at risk of going missing • Relaunched the Carers Emergency Card Scheme (jointly run between SBC, CCG and Swindon Carers Centre) to put support in place quickly for a vulnerable adult/child if an emergency prevents their parent/unpaid carer from carrying on with caring responsibilities.	• Improving timescales for completing enquiries and decisions to support vulnerable adults with safeguarding concerns

Reduce the number of adults with care and support needs being exploited

Why is this a priority?
To improve understanding and awareness amongst practitioners, unpaid carers and the community to support early identification and disruption of exploitation to keep adults with care and support needs safe**.**

What we focussed on:
- Keeping adults with care and support needs in the community
- Support for those adults with care and support needs affected by exploitation
- Holding perpetrators to account

What we did	How it's made a difference
• Reviewed and improved the Risk Enablement Panel to make it more effective for providing a multi-agency framework for the co-	• BG was socially marginalised, stigmatised and had no fixed abode. Due to her behaviour, BG ended up being banned from the local

ordination of case planning and decision making to support vulnerable people. New processes designed to ensure the right cases are referred to the panel. The right governance procedures are now in place, an inclusive application form has been designed and is embedded within the Risk Enablement and Positive Risk Taking Policy, Procedures and Guidance. This provides greater clarity in relation to who might be harmed and how. A comprehensive risk assessment process has been embedded which has improved connectivity enabling the better use of resources between and within organisations.	bus service and local shops in Swindon town. BG was verbally abusive to most members of the public and her behaviour had led to her spending time in prison. BG often failed to attend her appointments for support services but would demand to be seen when she turned up unexpectedly. The Risk Enablement Panel (REP) met to plan support for BG. The panel involved Adult Social Care, Mental Health, Housing, Police, SBC Security, Probation, First City Carers, Nelson Trust, Threshold Housing, The Haven, The Night Shelter and Community Safety. Housing offered BG a suitable bungalow to meet her needs with additional protective factors as part of her tenancy agreement. BG also received enhanced mental health support to help her engage more appropriately with the local community. Through the work of the REP, BG has now settled into her own bungalow, effectively self -managing life on a daily basis and is no longer causing disturbances in the local community. • A vulnerable resident who had suffered the bereavement of his wife whilst in hospital, went home with no family support and limited skills and motivation. Through gentle encouragement, signposting and guidance, the resident has gained knowledge and confidence in managing their finances, shopping and living independently. This has led to a reduction in care calls and a volunteer is providing ongoing befriending support.
• Introduction of the online Transitions Referral Form and communication plan to raise awareness with schools and colleges.	• Earlier referrals (from age 14+) to Adult Social Care Transitions Team has helped to ensure earlier planning for adulthood with young people and their families because the Transition Team are able to allocate a Link Worker as soon as a referral has been triaged
• Initiated the multi-agency review of transition pathways and processes by evaluating a sample of transition cases (children aged 14+ and 16+) with frontline practitioners to understand need to	• Initial case evaluation has highlighted areas for development in relation to systems and practice to improve the lived experience of transition for children and young people. This work is starting to improve collaborative working across the partnership.

improve transition planning practice and systems to prevent risk (February 2020). • Initiated the development of multi-agency Transitions Strategy and review of preparation for adulthood protocol (from pre-birth to 25 years) to provide better management and oversight for vulnerable children as they approach adulthood (scheduled to be launched in 2020/21).	

Adults with care and support needs live in safety, free from self-neglect

Why is this a priority?
A high proportion of safeguarding referrals relate to self-neglect and our local learning reviews have identified self-neglect as an area of practice which requires improvement across the partnership.

What we focussed on:
- Enhancing practitioner knowledge of self-neglect and the legal framework
- Develop risk assessment tools and skills to support adults with care and support needs experiencing self-neglect.
- Better multi-disciplinary working to support adults with care and support needs to address the issues leading to self-neglect

What we did	How it's made a difference
• Established the multi-agency Self- Neglect Task and Finish Group to oversee improvements in the identification and support for adults with needs experiencing self-neglect and hoarding. • Published Swindon's All Age Neglect and Self-neglect Strategy on a page to support the work of the Task and Finish Group. • Established a support network for people with lived experience of hoarding	• Good engagement with residents with hoarding behaviours through Swindon's Community Resilience Hub • Greater knowledge and awareness amongst practitioners of self-neglect and hoarding but it is too early to assess the impact of the work undertaken to date • The fire service and safeguarding service has identified concerns regarding a resident with hoarding behaviour due to the extent of the clutter and the potential risk to himself and neighbours. Through regular visits and using a supportive nudge approach, the

• Undertaken a mapping exercise with partners to understand the prevalence and triggers for self-neglect and hoarding in Swindon. • Submitted a multi-agency bid to 'Shaping Places for Healthier Lives Programme' for funding to work alongside service users and the wider community to address the system wide issues impacting on self-neglect and hoarding in Swindon.	resident has taken small but important steps towards clearing space. His health and confidence continue to improve as he sees the impact of reducing his clutter. Although there is a complex and long journey ahead to address the hoarding behaviour, the resident now recognises he can make the change. • Social workers, GP and paramedics were concerned about a resident due to his high levels of health need and vulnerability. The resident was not looking after himself or accessing the medical intervention he required. He would not accept help from statutory services and on occasions, paramedics had resorted to forcing entry. With a gentle non-judgemental approach and an offer of very practical support, the individual has allowed practitioners to support him. He now has a key safe, a dossette box and is registered with a new GP so he could access the medical interventions he requires.

See pages 20-21 for progress on priority to improve quality of practice & ensure adults with care and support needs are at the centre of decisions which relate to their life

Learning from Safeguarding Adult Reviews

The progress and completion of learning reviews initiated in 2019/20 have been impacted by capacity and COVID-19. During the year, the partnership received four referrals for consideration by the Practice Review Group (PRG) for a Safeguarding Adult Review (SAR). One referral met the statutory Care Act criteria and progressed as a Safeguarding Adult Review (SAR), due to Covid there was slippage on the timeline and the report was finalised in October 2020. The learning from this review was shared at the October 2020 Local Safeguarding Adult Board (LSAB). Although two referrals did not meet the Care Act criteria, PRG considered there was important learning for the partnership, hence one case was referred for a discretionary review and the other case was referred for a Learning Disability Mortality Review (LeDer). The timing of the discretionary learning review has again been impacted by Covid and is due to report end of October 2020. Although local case review Y was completed and learning shared at a joint Children's Partnership and Local Safeguarding Adult Board (LSAB) session in January 2020, the adult element of the review remained outstanding and continues to be progressed. The emerging learning from these ongoing reviews have indicated focussed work is required across the partnership in the following areas:

- Professional curiosity
- Self-neglect and hoarding
- Financial abuse
- Multi-agency co-ordination and decision making
- Family involvement
- Mental capacity
- Effective use of transition plans to reduce risk of abuse/neglect
- Informal carers

Inspection and QA Activity in 2019/20

Organisational Headline Report and dataset: Provided quarterly by all partner agencies covering things to celebrate/share, areas for development, major concerns/risks and priority actions

Walk the Floor Activity: Adult safeguarding front door

Assurance: Monitoring of Provider Quality (SBC), AWP Safeguarding Improvement Programme

Multi-agency Audits: Self-neglect; Sexual Abuse – quality of referrals and response; S42 Inquiries – multi-agency response when S42 threshold met

Single Agency Audits: SBC Safeguarding Adult audit; GP Practice Safeguarding Self-Assessment; Adult Safeguarding Audit GWH NHSTFT; Agency Self-assessment on Prevention.

Learning from Case Reviews (work still in progress): Safeguarding Adult Review (SAR) TB, Local Case Review (LCR) KH, SAR Colin (national SCR), LCR PD, and LCR Y

What needs improving across the adult safeguarding system?

- Stronger strategic leadership and co-ordination of the safeguarding partnership priorities to embed the learning and improve practice and outcomes for adults with needs across the safeguarding system
- Improve practice and service delivery within the Adult Safeguarding Team in the following areas: evidencing assessment of risk; screening and response times need to improve in line with guidance; issuing of safeguarding plans; application of statutory duties and the six safeguarding principles cited in the Care Act 2014 throughout the safeguarding process.
- Better understanding and application of adult safeguarding thresholds (contact to assessment conversion rates are low at 23.7%)

- Embed consistency in application of Section 42 (i) and Section 42 (ii) thresholds across the partnership to improve the quality of referrals
- Implement the Adult MASH to improve multi-agency decision-making
- Provide feedback on quality of adult safeguarding contacts to referring agencies to promote continuous learning
- Practitioners to seek threshold application advice from their agency designated safeguarding lead
- Single agency audits of quality and appropriateness of adult safeguarding contacts

- Implement the multi-agency Adult Safeguarding Policy, Procedures and supporting templates to strengthen risk management and the role of the Enquiry Manager supporting a more timely and collaborative person-centred and outcome focussed approach to safeguarding practices and services
- Embed staff knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) to ensure practice is compliant with law and users experience improved outcomes
- Improve inter-agency communication and joint decision making in safeguarding risk assessments
- For Safeguarding Plans to be consistently good quality and accessible with clear outcomes which strongly represent the voice of adult with care and support needs.
- Embed the practice of routinely engaging family members and unpaid carers in safeguarding risk assessment and support planning processes
- Embed the transition planning and risk management pathways to safeguard vulnerable children as they prepare for adulthood
- To enhance practitioner knowledge around self-neglect and hoarding to improve pathways, guidance, tools & training to improve practice and outcomes for cases that do not meet S42 threshold
- Greater insight into the prevalence and type of criminal exploitation informed by National County Lines Co-ordination centre (NCLCC) peer review and local intelligence to establish cross-border links with Wiltshire to develop Criminal Exploitation (CE) support to tackle all age exploitation.
- Partner agencies to evidence robust systems for providing good quality and regular safeguarding supervision for frontline practitioners
- Implement the blended SSP multi-agency adult safeguarding training and development offer utilising the virtual college approach and include themed sessions/briefings linked to learning reviews, multiagency audits and walk the floor activity.
- Develop an evaluation framework for monitoring the impact of learning and development on adult safeguarding practices, service delivery and outcomes
- Progress the development of a Quality Assurance Framework for Swindon Safeguarding Partnership to provide assurance that partnership working is strong across the adult safeguarding system (including a multi-agency core dataset and audit programme)
- Publish Terry Safeguarding Adult Review TB and embed the learning across the partnership

Workforce Development

Overview

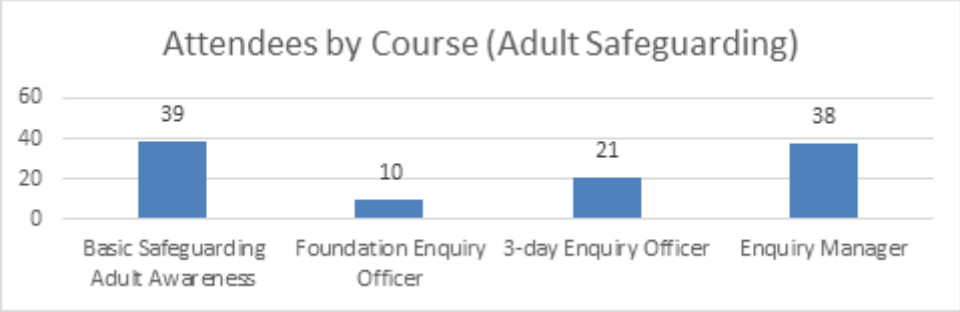
One of the core functions of the Safeguarding Partnership is to deliver and evaluate a high quality multi-agency programme of learning opportunities that meets the development needs of the local children and adult workforce and ensures that the priority safeguarding issues are being progressed.

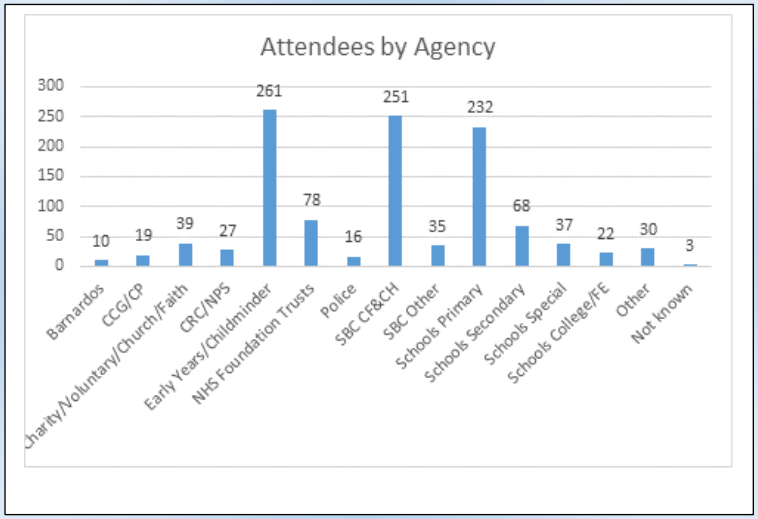
During 2019/20 the Safeguarding Partnership delivered 23 courses covering a range of safeguarding topics including:

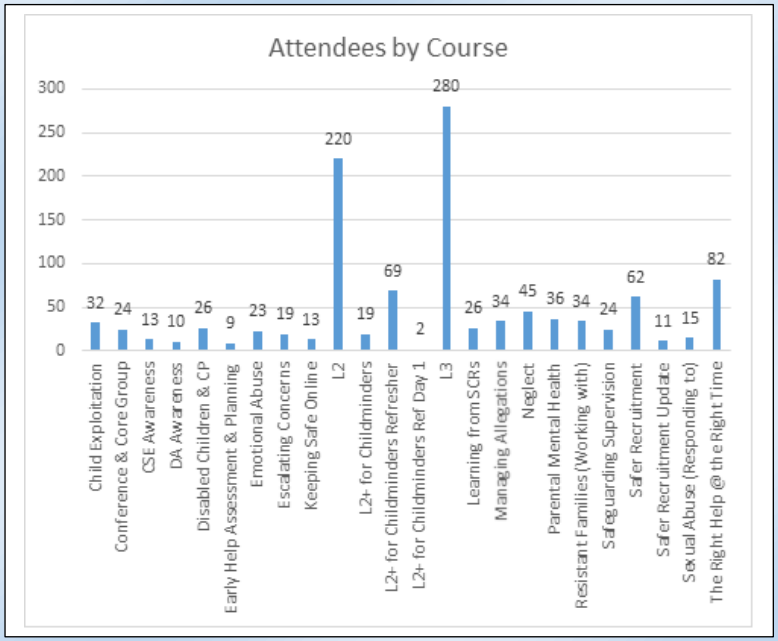
- Managing Allegations
- Conference and Core Group
- Early Help Assessment and Planning
- Right Help at the Right Time - Understanding & Applying Thresholds of Need and Risk
- MASH/ACP Open Morning
- Working with Neglect
- Working with Resistant Families.
- Keeping Safe Online & Cyber Exploitation

In January 2020 there was an interactive session involving safeguarding partners to share an understanding of the values and principles for decision making on safeguarding adult enquiries and S42 practice with the primary focus being the wellbeing of the individual. The training offer for safeguarding adults at risk continues to be reviewed and updated.

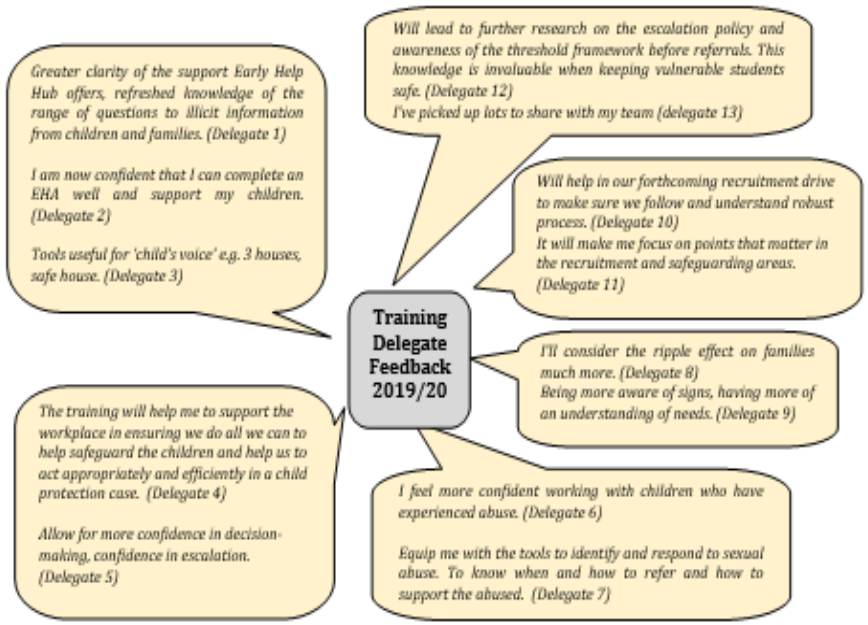
The courses have been attended by more than 1,100 delegates from a wide range of agencies. However, as of mid-March, all face-to- face courses were cancelled owing to the Covid-19 pandemic and national lockdown. The safeguarding partnership has provided a range of free eLearning resources covering a range of topics for both the adult and child workforce via the website.





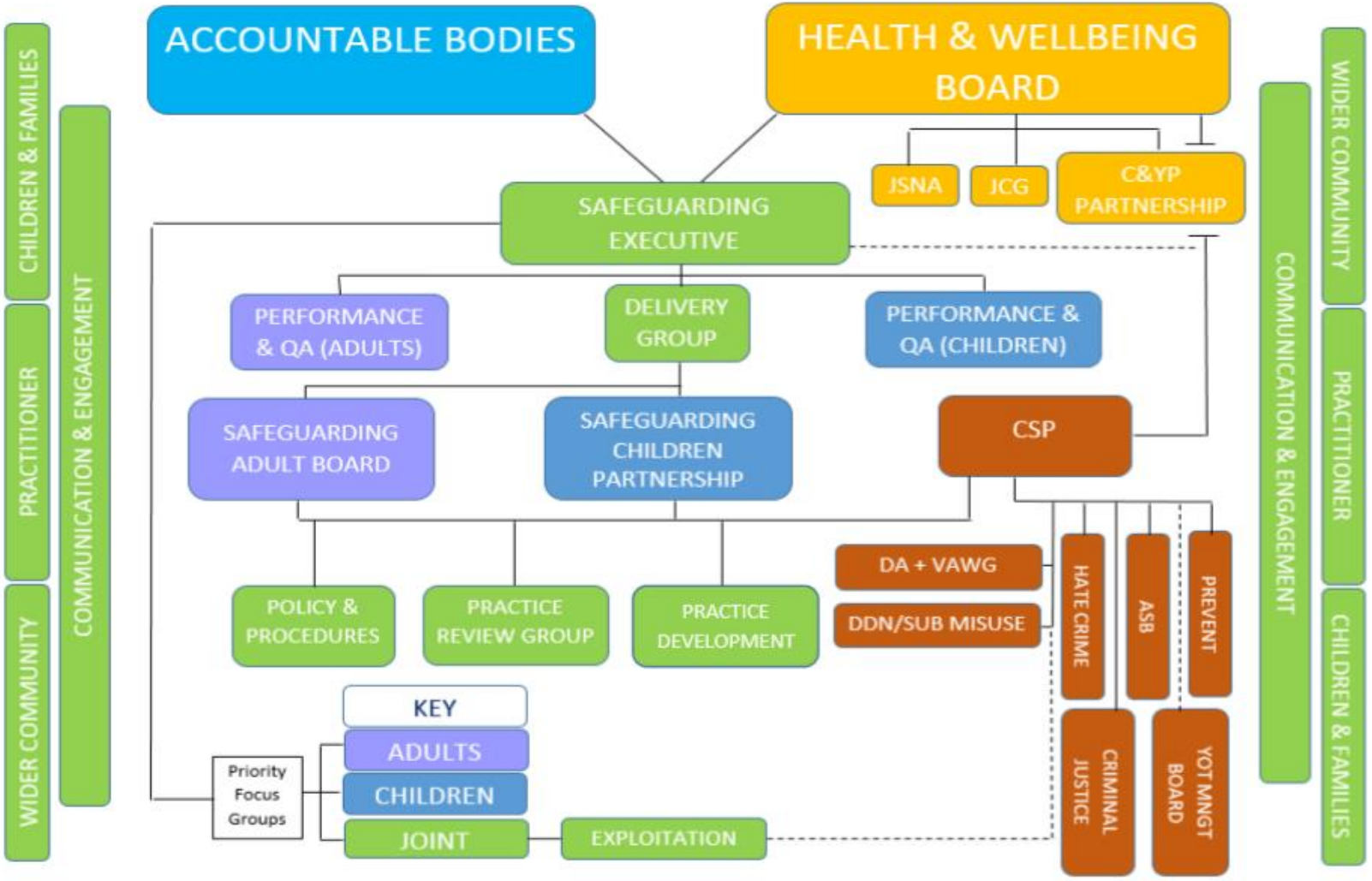


Course evaluation data is collected from delegates at the end of each course; this continues to reflect that training enhances delegate's skills and knowledge in the short term. An evaluation framework is in development for the coming year to review the impact of training and development on frontline practice, service delivery and outcomes.

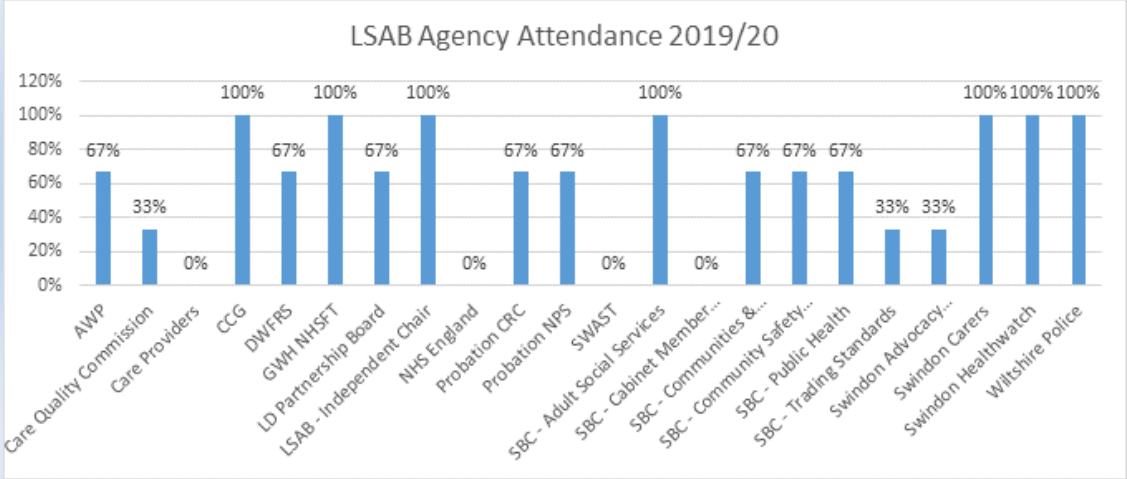


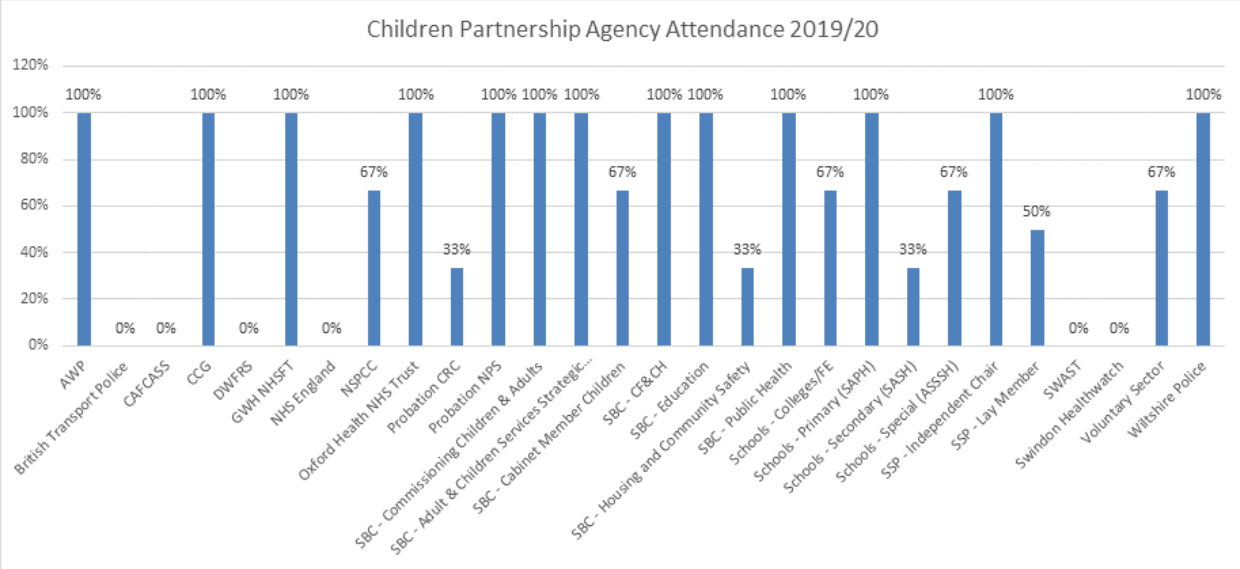
SSP BUDGET 2019/2020	Budget	Outturn Position	Variance
Expenditure			
SBC Staff Terms - Basic		152,577.50	
SBC Staff Terms – National Insurance		14,396.37	
SBC Staff Terms - Superannuation		28,694.43	
SBC Staff Terms - Maternity		-2,234.85	
SBC Staff Terms – Redundancy/Severance		128,267.08	
Transfers – Employee Related		-128,267.08	
Training		292.00	
	201,300.00	**193,725.45**	**-7,574.55**
Mileage & Travel	500.00	-76.94	-576.94
	500.00	**-76.94**	**-576.94**
Materials/Equipment	700.00	353.16	-346.84
Meeting Venues	600.00	1,290.00	690.00
Training Expenditure	50,000.00	51,861.80	1,861.80
Independent Chair	28,200.00	28,082.00	-118.00
Services	1,100.00	1,154.84	54.84
Catering	0.00	180.00	180.00
	80,600.00	**82,921.80**	**2,321.80**
SCR Commissioning	21,900.00	6,508.45	-15,391.55
Total Expenditure	**304,300.00**	**283,078.76**	**-21,221.24**
Income			
Contributions (Police, CAFCASS, NPS, CRC)	-34,500.00	-34,474.00	26.00
Contributions (CCG & GWH)	-92,800.00	-92,799.00	1.00
Contributions (LA)	-122,400.00	-122,400.00	0.00
LSCB Training Income	-49,700.00	-73,310.00	-23,610.00
Reserves Transfers	-4,900.00	39,904.24	44,804.24
Total Income	**-304,300.00**	**-283.078.76**	**21,221.24**

Structure


ACCOUNTABLE BODIES
HEALTH & WELLBEING BOARD
JSNA
JCG
C&YP PARTNERSHIP
SAFEGUARDING EXECUTIVE
PERFORMANCE & QA (ADULTS)
DELIVERY GROUP
PERFORMANCE & QA (CHILDREN)
SAFEGUARDING ADULT BOARD
SAFEGUARDING CHILDREN PARTNERSHIP
CSP
DA + VAWG
DDN/SUB MISUSE
POLICY & PROCEDURES
PRACTICE REVIEW GROUP
PRACTICE DEVELOPMENT
HATE CRIME
ASB
PREVENT
CRIMINAL JUSTICE
YOT MNGT BOARD
KEY
ADULTS
CHILDREN
JOINT
Priority Focus Groups
EXPLOITATION
CHILDREN & FAMILIES
PRACTITIONER
WIDER COMMUNITY
COMMUNICATION & ENGAGEMENT
WIDER COMMUNITY
PRACTITIONER
CHILDREN & FAMILIES
COMMUNICATION & ENGAGEMENT

Board Attendance 2019/20

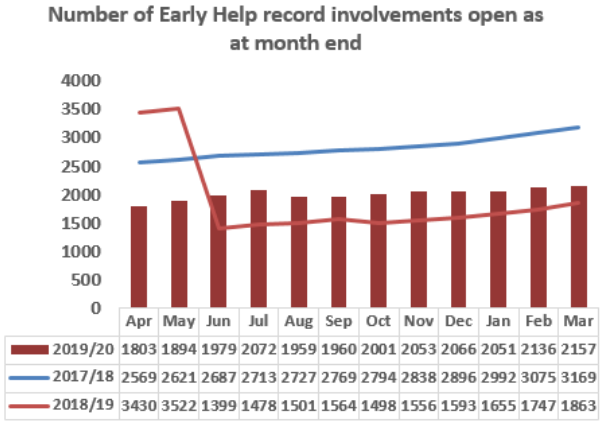




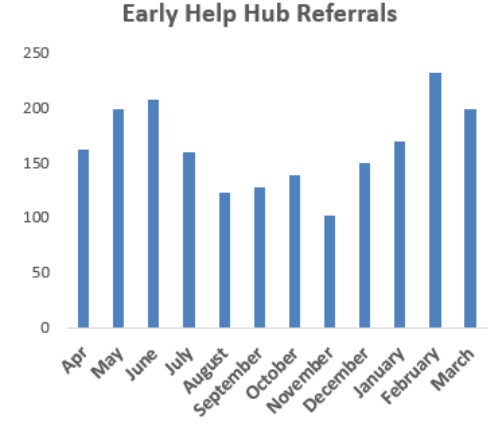
Appendix 1

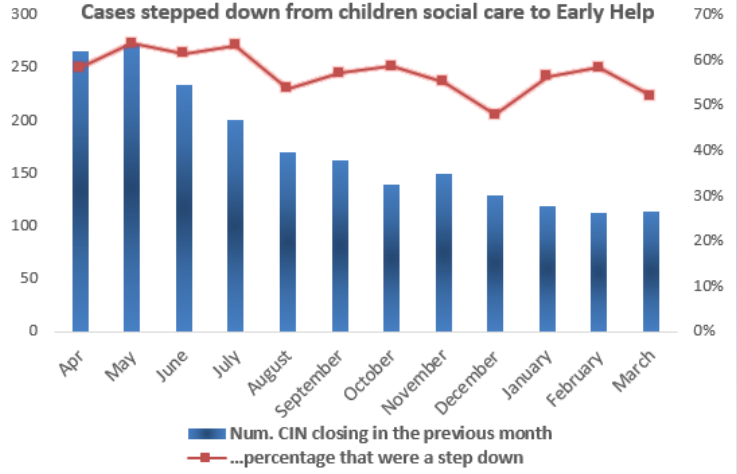
Key safeguarding statistics for children and families

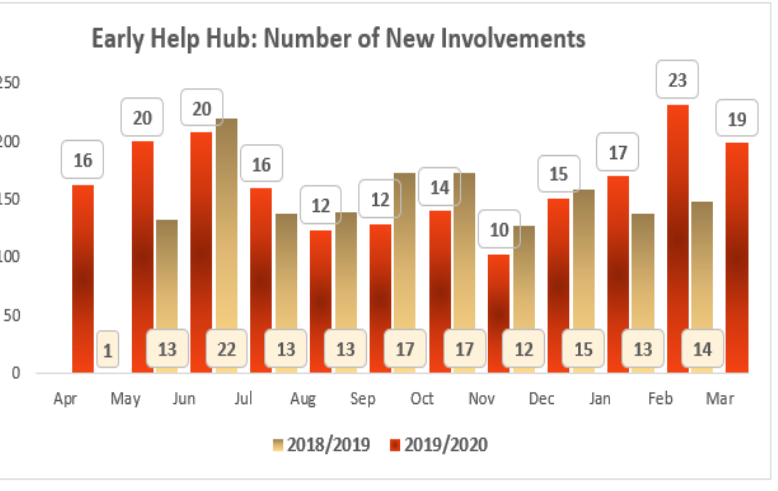
Children, young people and families receive timely and effective early help



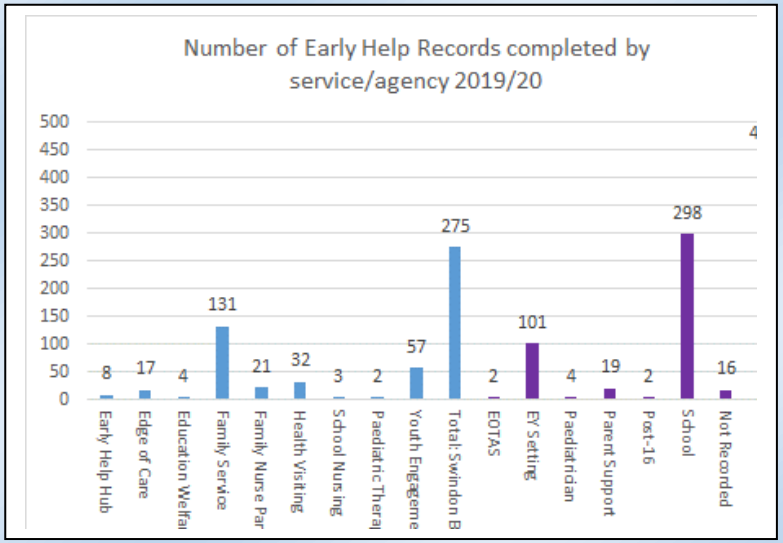
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	1803	1894	1979	2072	1959	1960	2001	2053	2066	2051	2136	2157
2017/18	2569	2621	2687	2713	2727	2769	2794	2838	2896	2992	3075	3169
2018/19	3430	3522	1399	1478	1501	1564	1498	1556	1593	1655	1747	1863





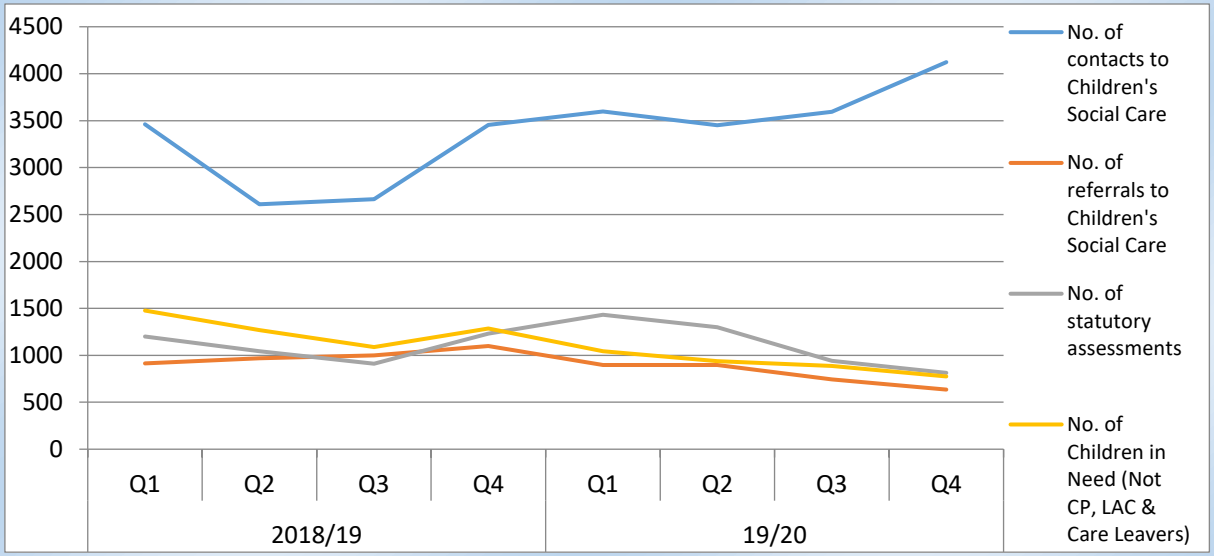


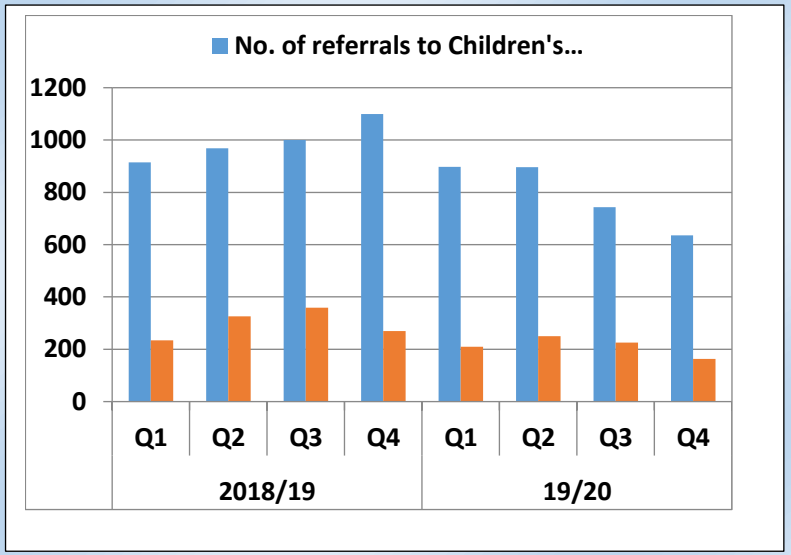
In March 2020, the number of open Early Help Records was 2157, a rise compared to 2018/19. The number of families referred to the Early Help Hub in March 2020 was 199 which is a 34.5% increase from 148 in March 2019. In April 2020, the EHH received 25.2% of all contacts into MASH of which 40.6% were from police. The percentage of cases stepped down to Early Help services from Social Care was 52.1% in March 2020.

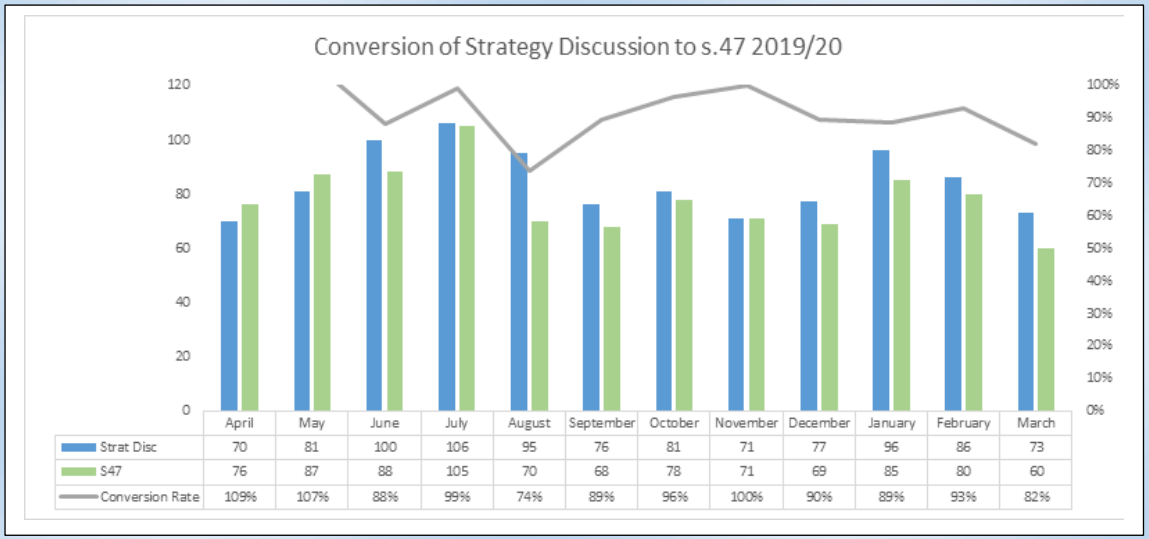


Thresholds and multi-agency decision making 2019/20

In 2019/20 there were 14,748 contacts into MASH, 3,166 progressed for consideration for statutory assessment (21.5%). The cumulative re-referral rate for 2019/20 was 27%.





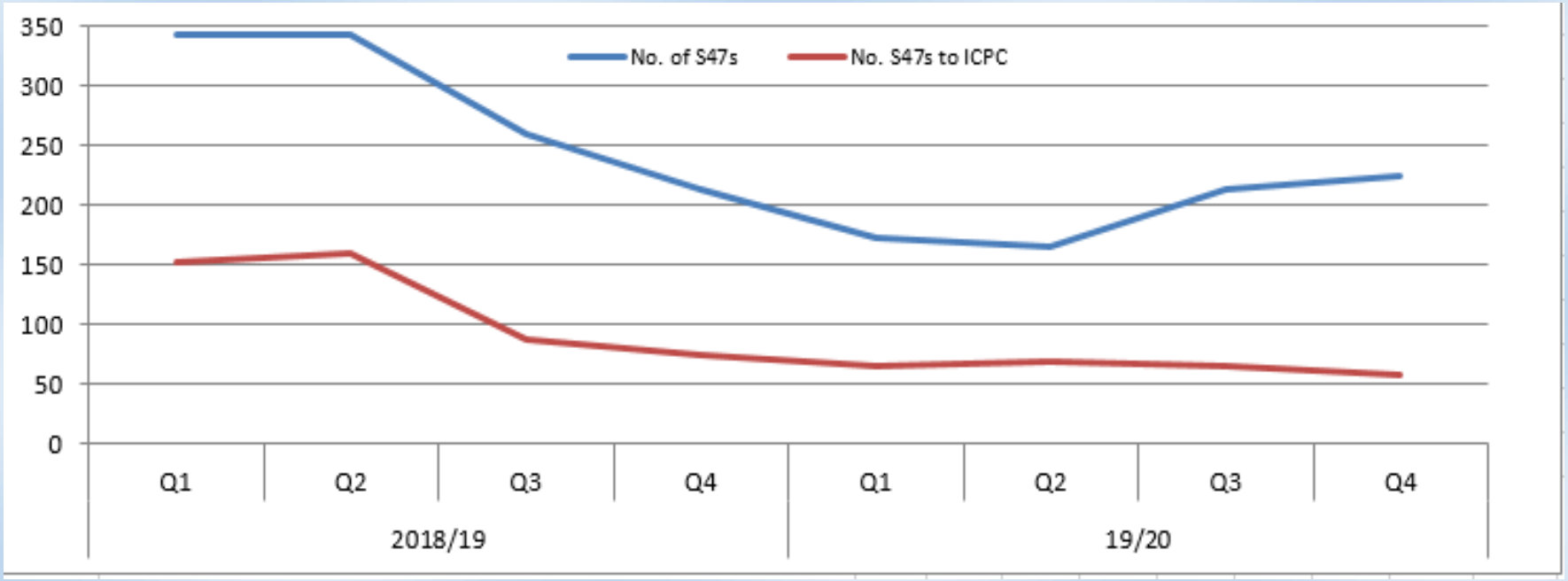


	April	May	June	July	August	September	October	November	December	January	February	March
Strat Disc	70	81	100	106	95	76	81	71	77	96	86	73
S47	76	87	88	105	70	68	78	71	69	85	80	60
Conversion Rate	109%	107%	88%	99%	74%	89%	96%	100%	90%	89%	93%	82%

Conversion rates over 100% ascribed to timing between the two events

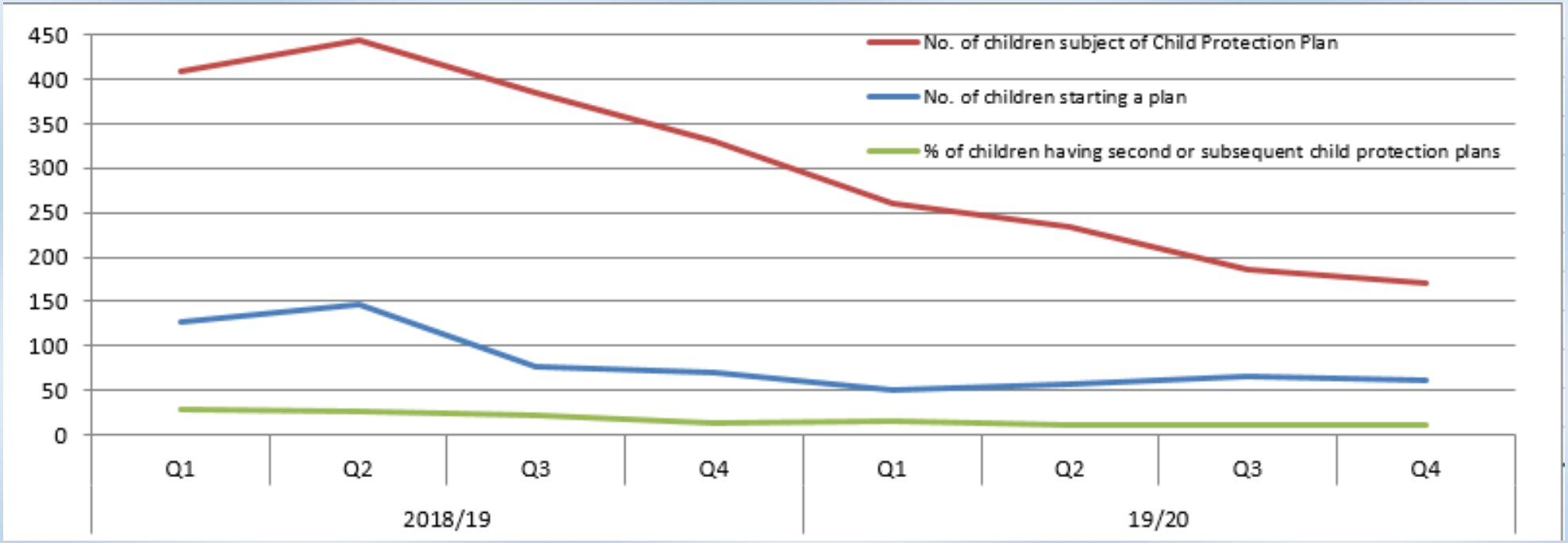
Number of S47s & ICPCs

Measure	March 2019	March 2020	DOT from March 2019	National Average 2018/19	Statistical Neighbours Average 2018/19	PYO 2018/19
Number of Section 47 investigations cumulatively	1,101	937 (172.5 per 10K pop)	↓	168.3 per 10K pop	169.0 per 10K pop	1,101 (224.7 per 10K pop)
Number of ICPCs cumulatively	475	260 (48.4 per 10K pop)	↓	64.8 per 10K pop	63.4 per 10K pop	475 (112.9 per 10K pop)
Rate of S47s going to conference within 15 working days cumulatively	75.4%	94.6%	↑	78.7%	80.44%	75.4%

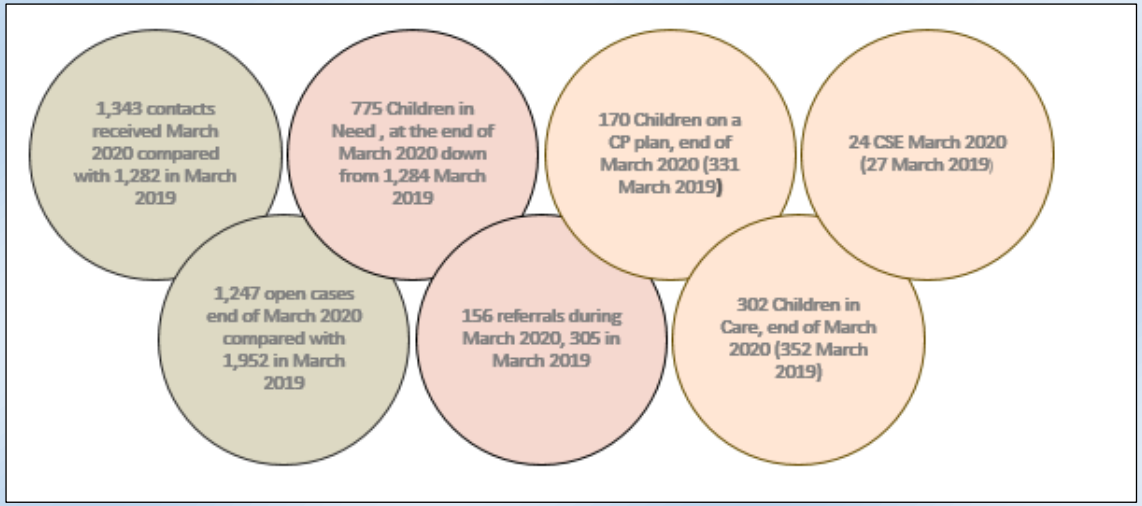


Child Protection Plans

Measure	March 2019	March 2020	DOT from March 2019	National Average 2018/19	Statistical Neighbours Average 2018/19	PYO 2018/19
Number of children on a protection plan	331	170 (34 per 10K pop)	↓	43.7 per 10K pop	45.21 per 10K pop	331 (67.6 per 10K pop)
Duration of Child protection plans – those 2 years or more	1.81%	1.18%	↓	2.14%	3.21%	1.81%
Percentage of children with second or subsequent plans	12.3%	14.53%	↑	20.8%	21.03%	12.3%



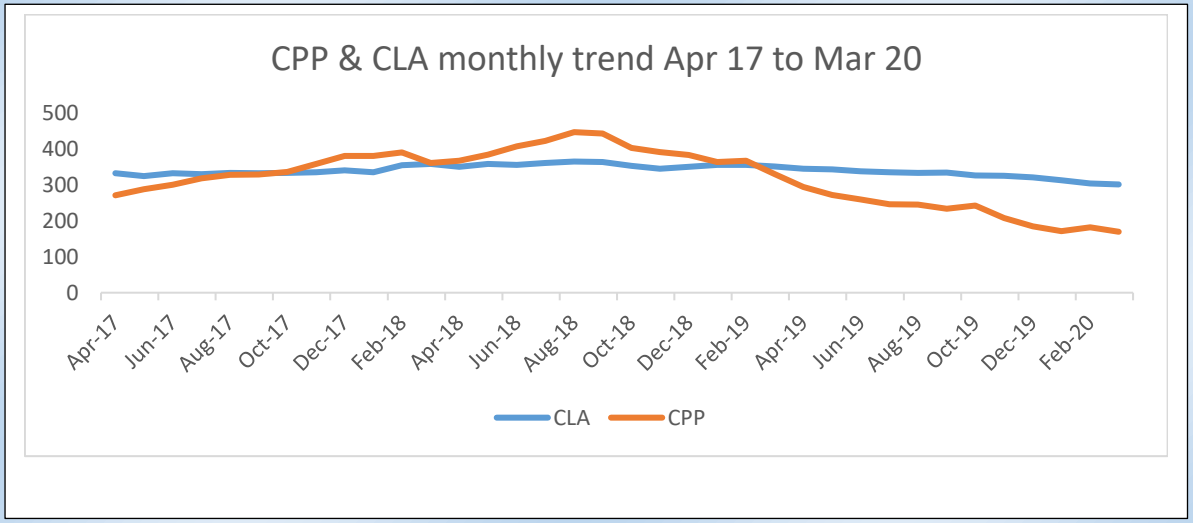
Children in Receipt of Social Care Services March 2020

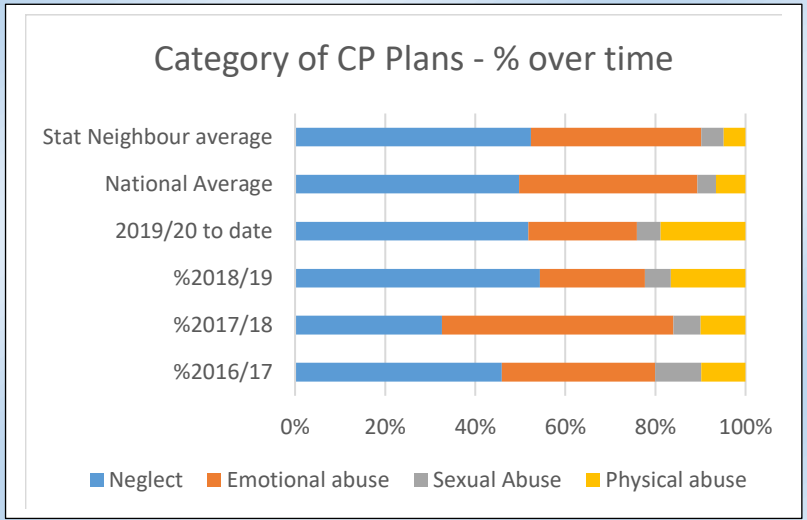


50,239 children in Swindon, aged 0-18

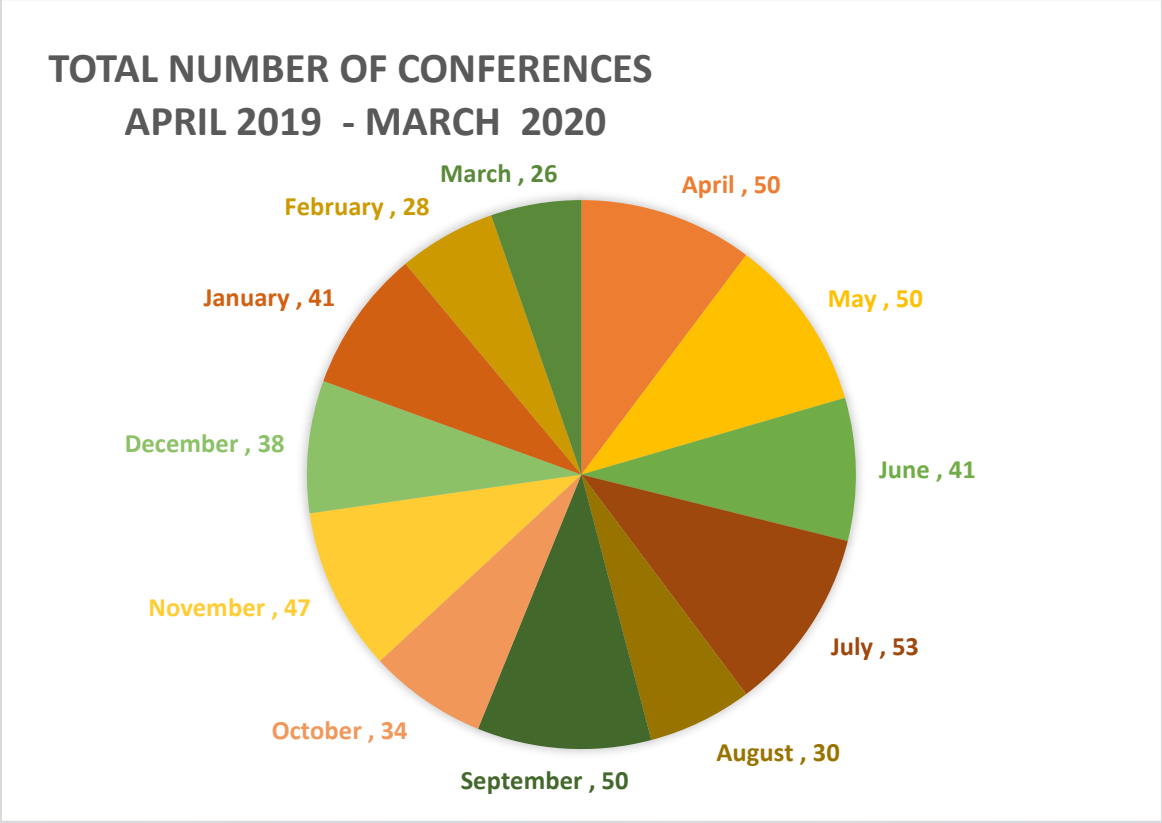
LADO referrals in February 2020: 38

14 Unaccompanied Asylum Seekers at close of February 2020





Child Protection Conference Quoracy 2019/20

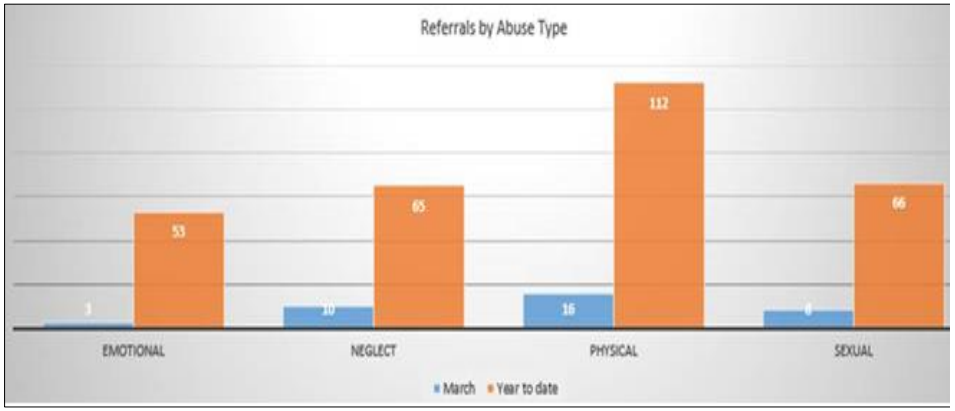


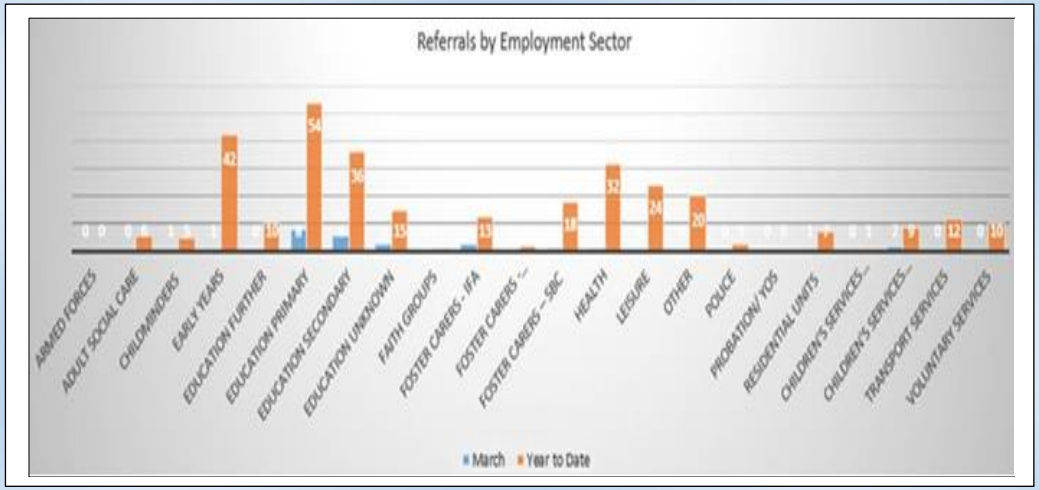
Following the Child Protection Conference Deep Dive, attendance at conferences has improved during the year with 99% of ICPC and 83% of RCPC being quorate at 2019/20 year end. However, the Deep Dive identified the need to improve practices in relation to sharing reports with parents for the Police and across the health economy (GPs, Community paediatrician, Health Visitors, midwife, TAMHS, school nurses)

Allegations Management Service

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Year Total to date
Referrals	16	23	21	22	24	25	31	32	23	38	38	27	320
Allegations	5	8	14	14	13	15	21	23	15	26	28	19	201
Safeguarding	9	5	5	5	1	3	4	2	1	2	2	0	39
Advice	2	10	2	3	10	7	6	7	7	10	8	8	80

Swindon data reflects the patterns seen across the country in terms of referral sectors and types of abuse. The highest number of referrals are from education establishments. There has been an increase in Health referrals this year which is positive but fewer than expected referrals in relation to the Voluntary Sector. There is a range of abuse types, Physical abuse is the highest reason for referral which mirrors national trends.





The Ofsted inspection in July 2019 was positive about the Allegation Management service in Swindon, noting that the service had made substantial improvements since the focus visit in April 2018, and was now a good service. There have been improvements in service efficiency and effectiveness and the average length of open cases has reduced and is in line with government expectations.

Progress update on partnership learning from Serious Case Reviews 2019/20

SCR U

LSCB to consider how it can reinforce to partner agencies the impact of neglect on children's lived experiences - Implementation of Graded Care Pathway Training
Update: GCP2 Training has been rolled out to over 40 staff across the LA. Timeline and programme is in place for GCP2 to be rolled out across the partnership.

How can the LSCB ensure that professionals are meeting to share information and risks and to make a multi-agency early help plan when the threshold for CSC is not met? - Embed New Early Help Model and refreshed the partnership Early Help Strategy to reflect new ways of working
Update: The Early Help Hub has been established and the Early Intervention and Prevention partnership Sub-group is in place to oversee and manage the multi-agency Early Help agenda.

LSCB to continue to raise awareness and promote the LSCB escalation policy.
Update: New SSP Escalation Policy developed and available to all agencies including new process to record timeliness of responses. Escalation Policy to be put into 7 Minute brief for managers to present to their teams across the partnership. The use and impact of the escalation policy is being monitored by SSP BSU.

LSCB to consider how it can reinforce to partner agencies the impact of neglect on children's lived experiences
Update: Neglect is one of the key strategic priorities for the SSP. The children's Neglect framework has been refreshed and signed off by the Partnership in 2019/20 and the GCP2 training is underway.

SCR G

SSP to seek assurance from GWH that practitioners are clear on their use of language in relation to the term "referral" and the difference between this and " notification to the safeguarding mid wife.
Update: All staff have been informed that the safeguarding notification form sent to the safeguarding midwife is not a referral. This was disseminated through the maternity services staff communication newsletters, meetings, and forums. Safeguarding Midwife has also reflected this is safeguarding supervision. Safeguarding Updates are provided for Midwifery staff and has covered the importance of using the right terminology in relation to referrals and the mother & baby notification forms. This is also raised at Safeguarding Supervision sessions.

SSP to contact partner agencies requesting information on how they have implemented the new system for requesting and sharing of information. SSP to complete a DIP Sample audit.
Update: GWH and MASH Swindon Borough Council met in May 2017 to agree the new pathway for unborn babies where safeguarding risks have been identified. Information regarding children – who have reached the threshold of Children Social Care historically and currently are now having this information shared on an

individual basis and generic emails are no longer used. This has strengthened information sharing and the Escalation Policy is used when required by GWH. In January 2020, a sample of 10 cases were included as part of the GWH audit plan and were audited by the Named Midwife and the MASH Manager with the findings shared with SSP PQA sub-group.

CCG to provide information to SSP relating to the role & capacity of Safeguarding Midwife.
Update: The CCG undertook a review of Safeguarding practices within GWH in 2017 and identified capacity issues for the Safeguarding Midwifery Leads which lead to a recommendation to cascade expertise to frontline staff and securing appropriate deputy support. The CCG undertake regular supervision of the Named Midwifery Safeguarding Lead and have carried out QA visits of the maternity department. The CCG are ensuring that the job plans of Named safeguarding leads comply with the intercollegiate guidance on the Roles and responsibilities of Healthcare staff. CCG have confirmed there is sufficient named midwife capacity.

SSP should ensure that the CCG considers the learning and reviews the Swindon Integrated Perinatal Mental Health Pathway
Designated Nurse Swindon Clinical Commissioning Group has informed SSP that a task and finish group will manage this project across BANES, Swindon and Wiltshire (BSW) with the aim of amalgamating the Swindon PMH Pathway with BSW Pathway to create an overarching pathway which addresses local variations. Date for this work to be confirmed.

SCR M

Audit activity to identify barriers to effective joint working and to inform best practice development.
See the Adult See the Child Multiagency Audit undertaken but completion of audit report delayed (shared at Children's PQA on 18.06.20)

Produce and disseminate a Learning Summary and embed processes and pathway in existing training.
The learning from the SCR has been shared with Managers. A further workshop for CF&CH provided along with the Learning Leaflet. Each agency is tasked to review transfer processes in and out of area for children that fall below child protection taking account of the agency statute. New Cross Boarder protocol has been created and ratified by Partnership and is on the SSP website.

SCR Q

Swindon LSCB should initiate a review of the current Child Protection Conference processes to ensure that:

- **Statutory requirements are routinely met**
- **No decisions are made without adequate assessment, the required written reports and the relevant professional expertise to ascertain an accurate risk of harm.**
- **Attendance requirements to ensure that the relevant professionals are present and consideration of whether current quoracy rules are sufficiently robust.**

CRG to consider the audit plans for 2017/18 planned /undertaken by the Conference and Review Team to consider if they meet and have addressed the requirements set out in this recommendation.
Action Plan for the Deep Dive has been completed. Multi-agency Partnership standards for CP have been written, approved and being implemented. The SQA team provide performance data to the SSP in relation to partner agency participation and engagement in child protection conferences. The implementation of the new Swindon Conference Model has been ratified by SSP and training is being rolled out across the partnership supported by the three statutory partners.

The 6 monthly reports on the Child Protection process presented to the LSCB should provide evidence and assurance.
6 Monthly performance reports are shared with SSP PQA.

Survey of use and effectiveness of Escalation Policy is to be undertaken in September 17 by the QA sub group. Outcome of survey to be analysed with recommendations for improvement for the LSCB.
Revised Escalation Policy completed and ratified by Partnership and available to all professionals on SSP website. Escalation practice is endorsed by service managers across the partnership. Use and impact of escalation policy is being monitored by SSP BSU

Key Adult safeguarding statistics 2019/20

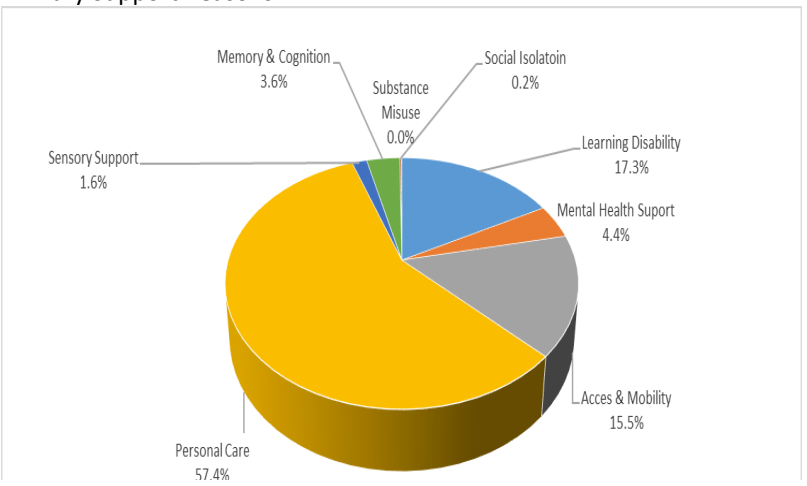
Appendix 3

In 2019/20 4,591 adults were supported by Adult social care

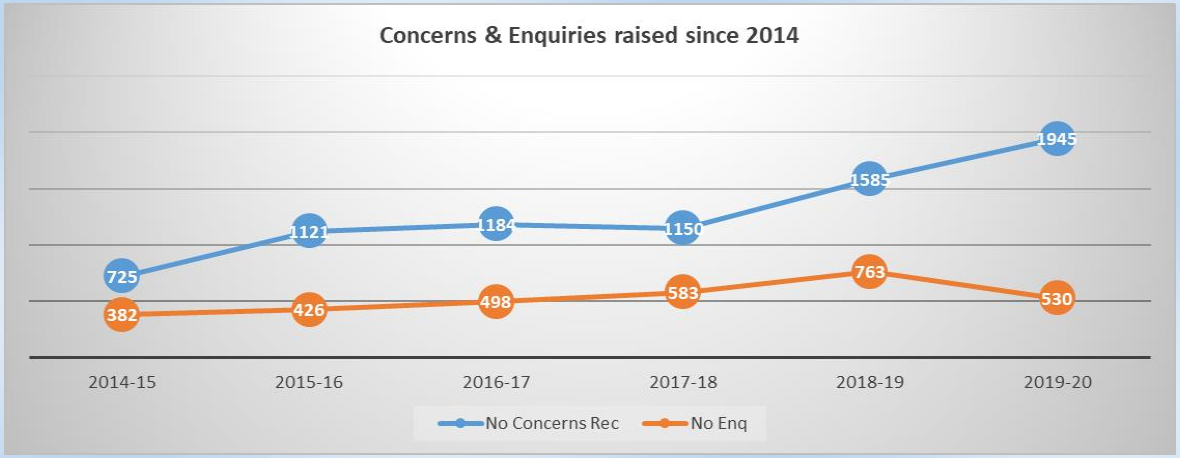
Adult Social Care Clients 2019-20

	18-64		65+			
Client Category	Female	Male	Female	Male	**2019/20**	**2018/19**
Learning Disability	298	413	40	42	**793**	**768**
Mental Health Suport	42	59	58	45	**204**	**252**
Physical Suppport - Acces & Mobility	177	82	312	139	**710**	**1192**
Physical Suppport - Personal Care	199	210	1404	820	**2633**	**2628**
Sensory Support (Dual Hearing,Visoin)	7	4	43	20	**74**	**134**
Support with Memory & Cognition	8	18	87	54	**167**	**191**
Long Term Asylum Seeker Support	1	0	0	0	**1**	**1**
Social Isolatoin	2	3	1	1	**7**	**2**
Substance Misuse	1	1	0	0	**2**	**2**
	735	**790**	**1945**	**1121**	**4591**	**5170**

Primary Support Reasons



Concerns raised

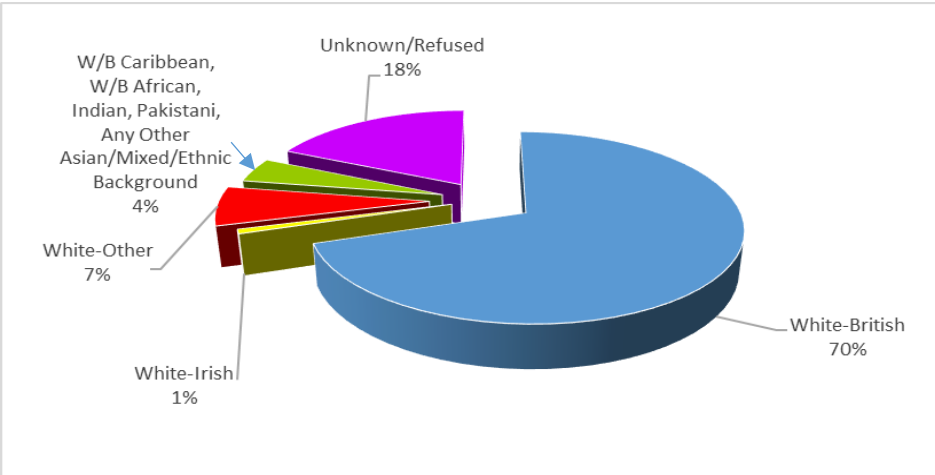


There was an 18.5% increase in the total number of Safeguarding concerns raised during 2019/20 compared to 2018/19. There was a 37% increase in the number of concerns raised for those aged under 65 rising to 1060 compared to 666 in 2018/ 19. Of the 1945 concerns in 2019-20, 1115 (57.3%) were raised for female clients, and 41.6% for males (gender was unknown for 20 recorded concerns)

15% of the concerns raised were for clients who had Learning Difficulties recorded as their primary support reason (PSR). A further 7.7% had mental health/memory & cognition recorded as their primary support reason. There was no Primary Support Reason (PSR) recorded for 923 (47.5%) of concerns raised (a client will only have a PSR if they are in receipt of a long term service). Not everyone who has a safeguarding concern raised about them will be previously known to Adult Social Care, or be in receipt of a long term support service

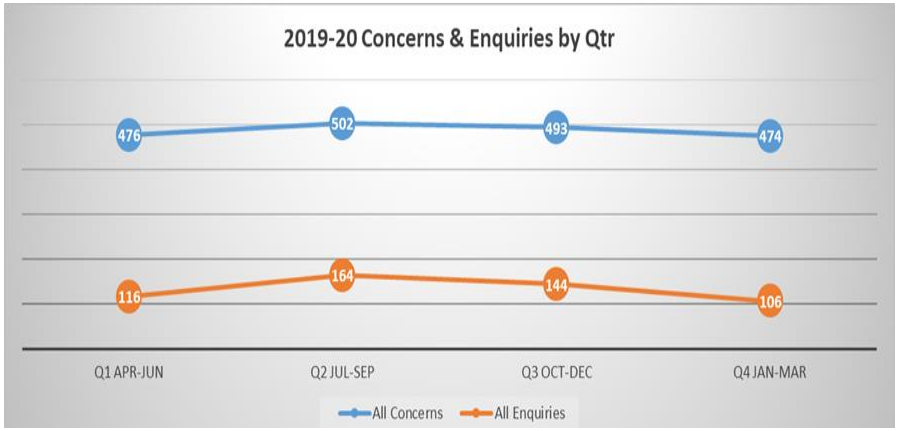
Key Adult safeguarding statistics 2019/20

The level of reported concerns involving non-white British people continues to appear low, however a high number of cases had ethnicity not known or unrecorded with 18% of concerns recorded during 2019-20 failed to capture ethnicity data



Conversion of Concerns to Enquiries
During 2019-20, 530 Enquiries were raised against a total of 1945 concerns, which gives a conversion rate of 27.2%, down from 762 enquiries in 2018-19 where there was a conversion rate of 48%. Work is underway with partners to embed a better understanding and application of adult safeguarding thresholds to help partners determine whether the concern is related to safeguarding or care management.

Repeat Concerns
There were 1945 safeguarding concerns raised for 1431 adults. 1096 (76.5%) adults had a 'single' concern and 335 (23.5%) had multiple concerns or repeat concerns (23.5%). Better uptake of adult Safeguarding Plans should reduce repeat referrals going forward.

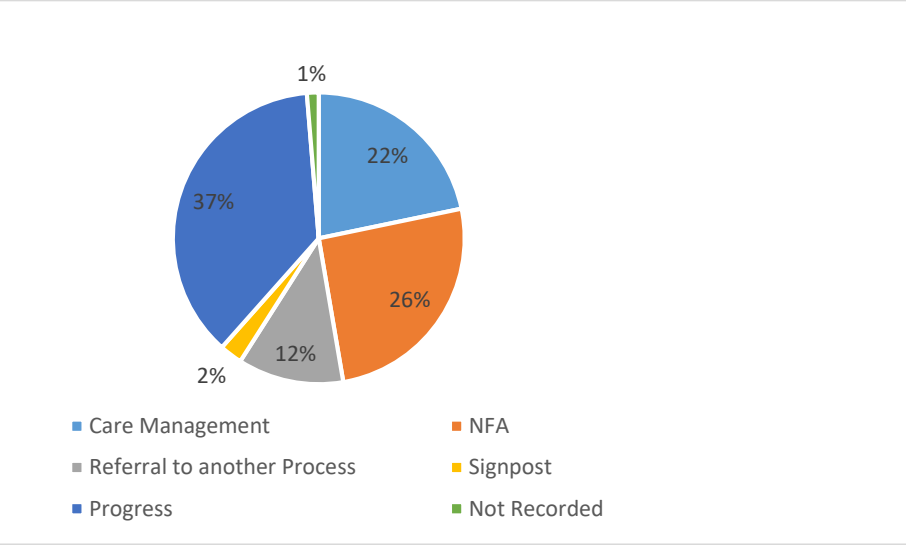


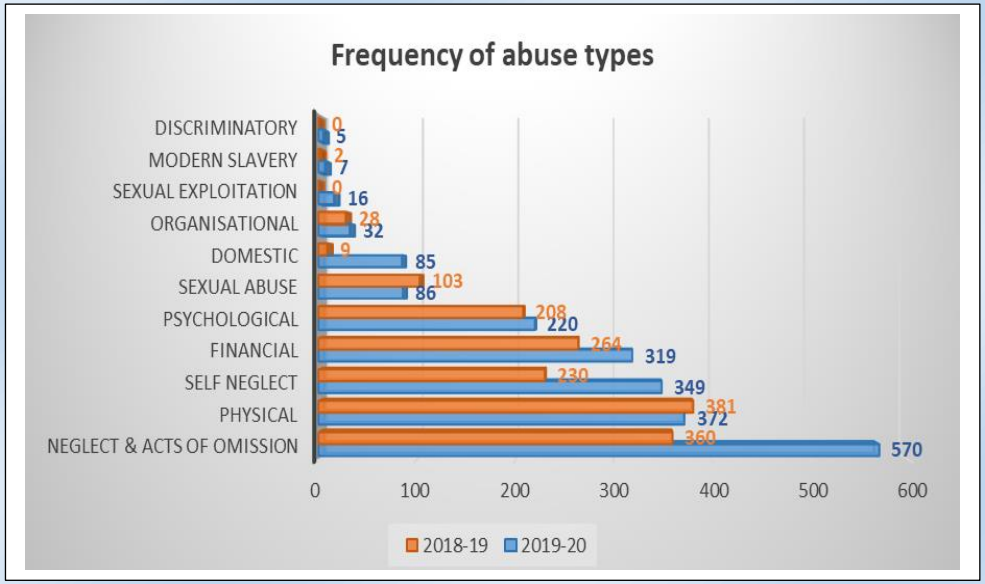
Key Adult safeguarding statistics 2019/20

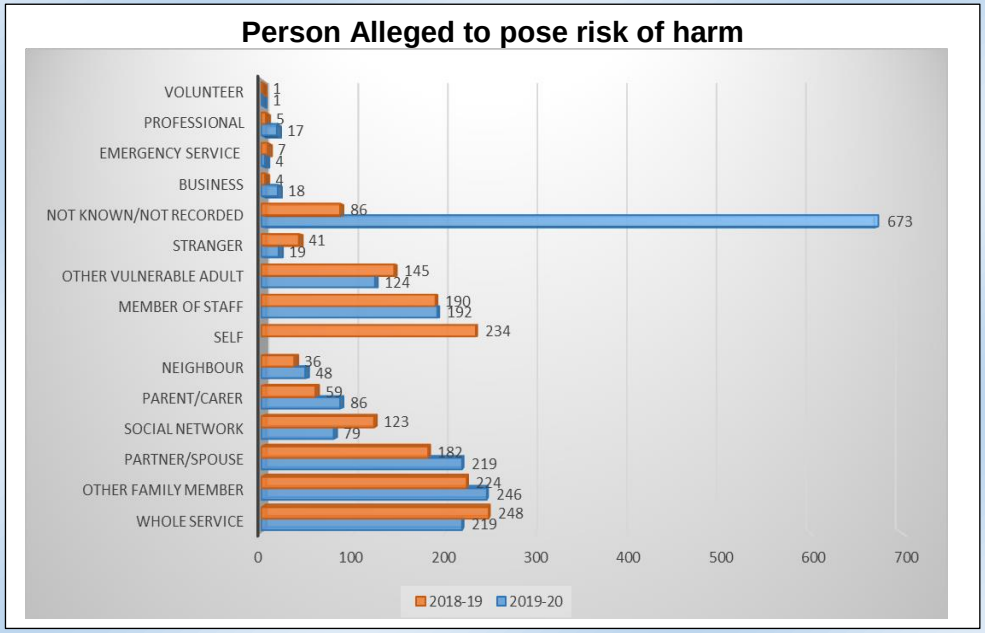
Screening Decisions April – October 2019

Concern Screening Decisions	April -October 2019	%
Care Management	250	21.7
NFA	294	25.6
Referral to another Process	135	11.7
Signpost	29	2.6
Progress	427	37.1
Not Recorded	15	1.3
Total	1150	100%

Of the 1150 concerns with a screening decision, 78.6% (905 concerns) had a screening decision made within 2 days of the concern being received







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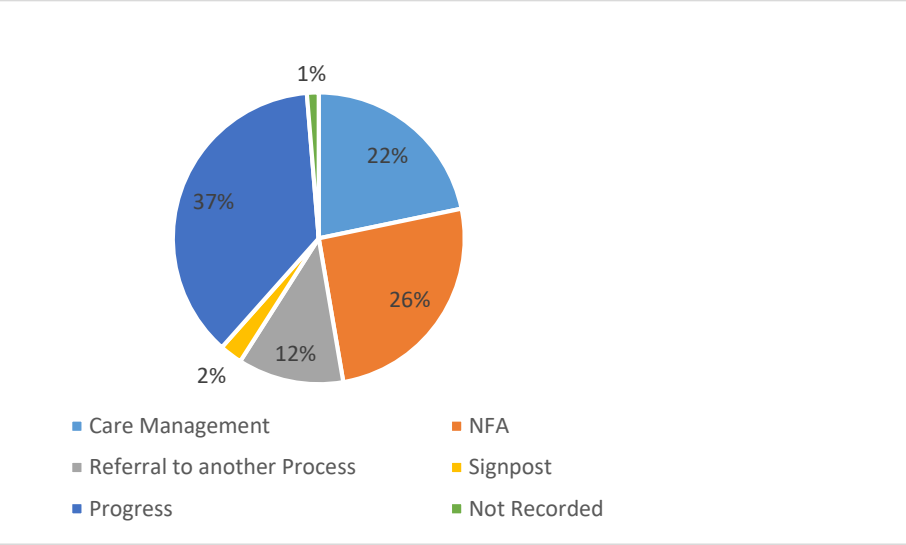
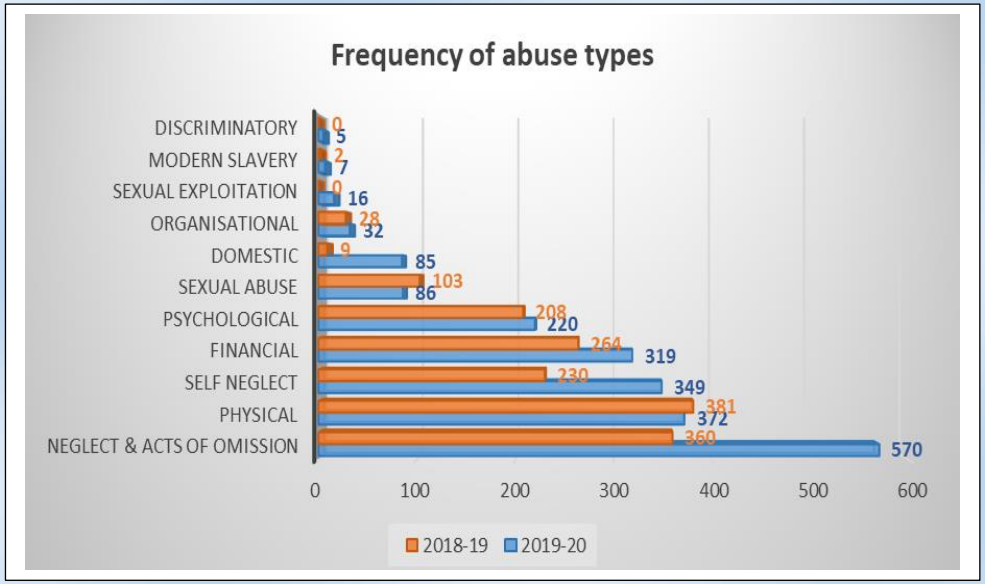
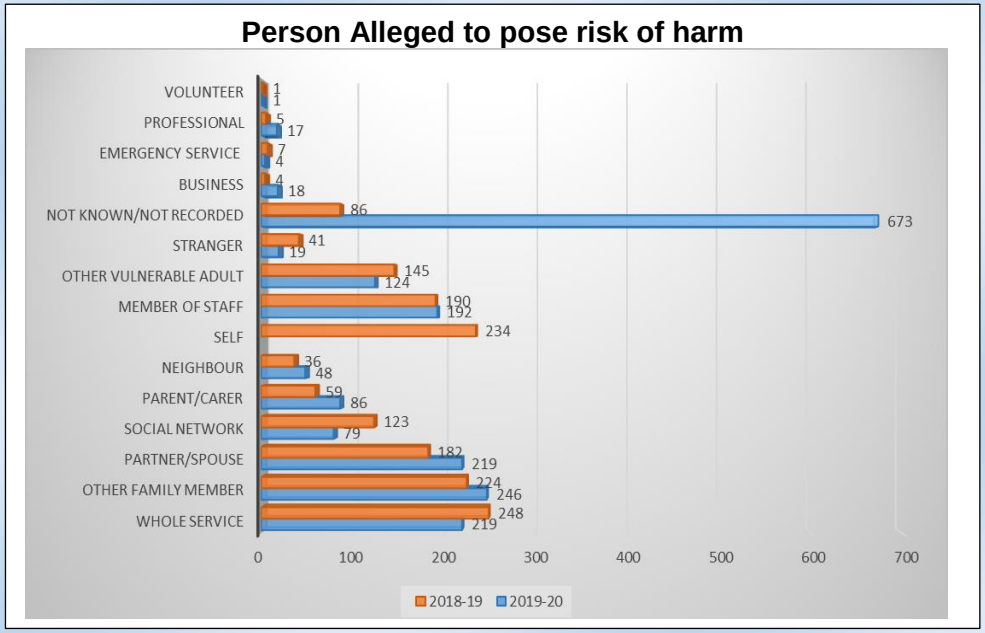






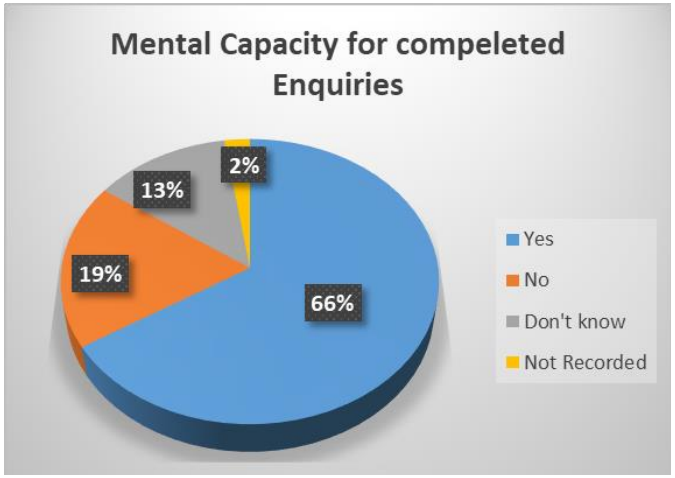
Key Adult safeguarding statistics 2019/20

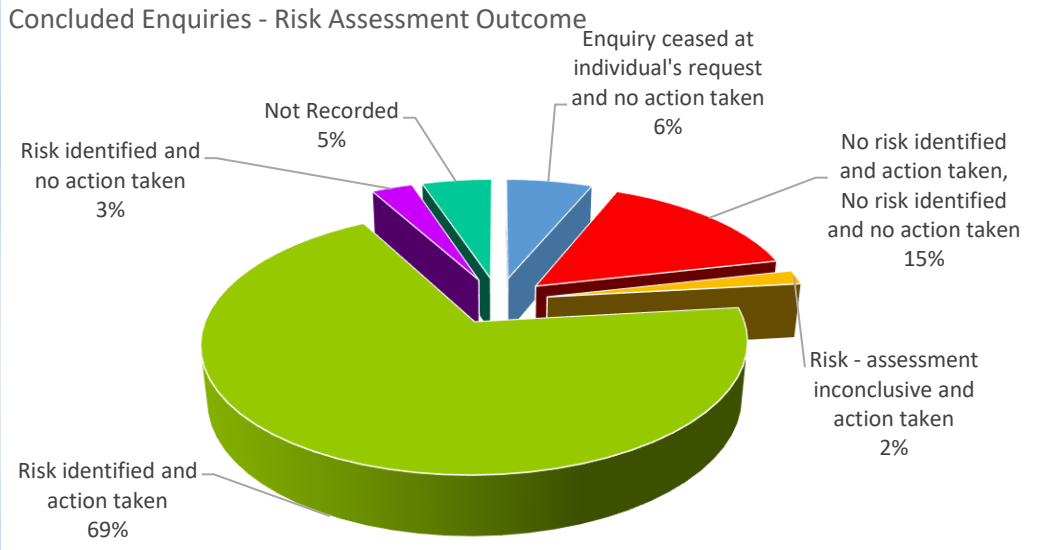
Location of abuse (Enquiries)

	2019-20
Care home - nursing	5
Care home - residential	15
Hospital - acute	7
Hospital - community	6
Hospital - mental health	3
In a community service	10
In the community (excluding community serv	4
Other	6
Own home	94
Not Recorded	380
	530

Mental Capacity

Of the 336 completed enquiries in 2019/20, 66% (222) involved an individual who was considered to have mental capacity to consent to the safeguarding process. 64 (19%) of individuals did not have capacity, capacity status was unknown for 43 individuals and not recorded for 7 individuals. Further work is required to embed staff knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) to ensure practice is compliant with law and users experience improved outcomes.

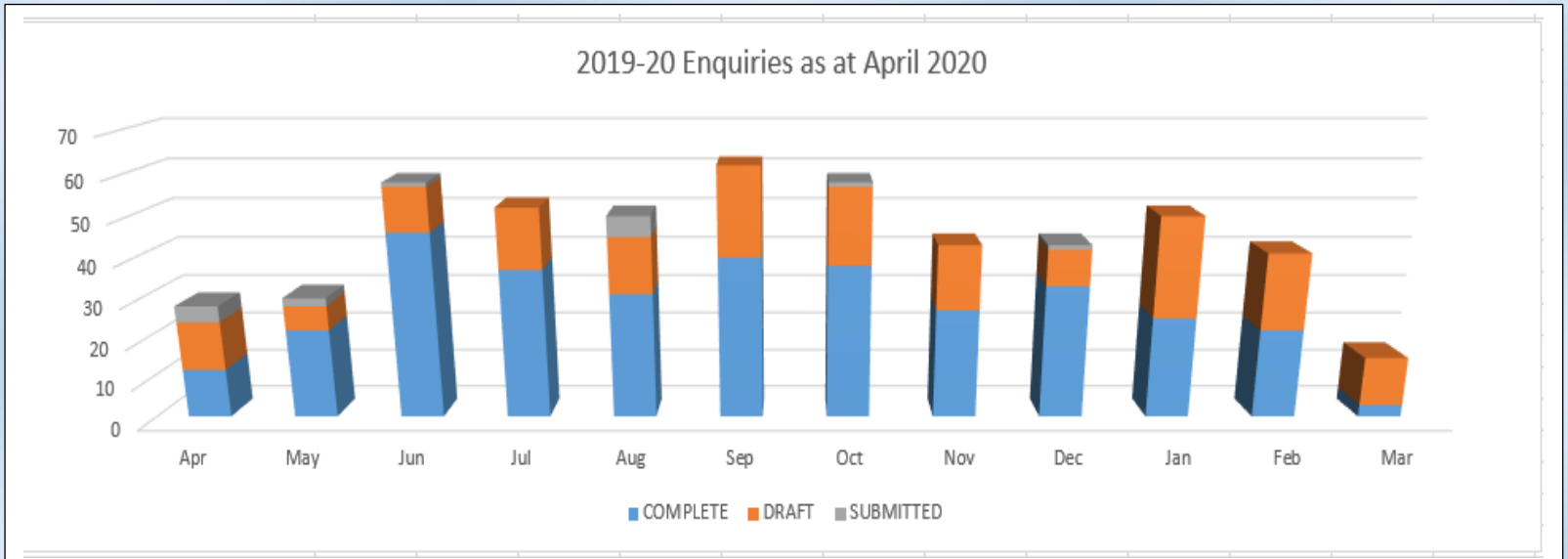




	Final Risk Outcome				
Risk Assessment Outcome	Not Recorded	Risk reduced	Risk remained	Risk removed	Grand Total
Enquiry ceased at individual's request and no action taken	21				21
No risk identified & action taken/ No risk identified & no action taken	51				51
Not Recorded	17				17
Risk - assessment inconclusive and action taken	6				6
Risk identified and action taken		128	18	85	231
Risk identified and no action taken		4	3	3	10
Grand Total	95	132	21	88	336

Key Adult safeguarding statistics 2019/20

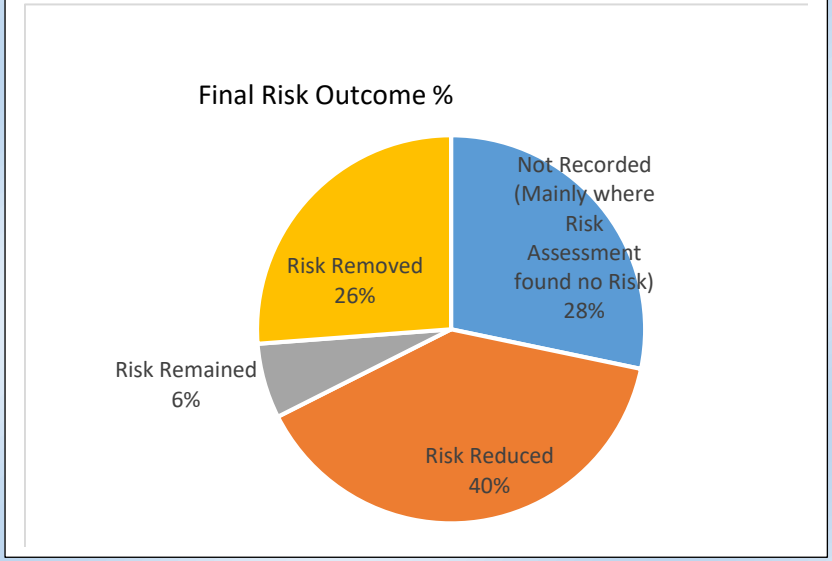
In 2019/20 there was a significant delay in concerns and enquires being progressed. At year end, 336 (63%) of the 530 enquiries were completed, 180 (34%) were still in draft and 14 (2.6%) had been submitted for management approval. The graph below demonstrates that a high proportion of the completed enquiries in 2019/20 remained in draft for a significant period of time. Recent analysis has identified that the outstanding 2019/20 enquiries that remain in draft has reduced to 8%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Total
COMPLETE	12	22	46	37	31	40	38	27	33	25	22	3	336	63.4%
DRAFT	12	6	11	15	14	22	19	16	9	25	19	12	180	34.0%
SUBMITTED	4	2	1		5		1		1				14	2.6%
	28	**30**	**58**	**52**	**50**	**62**	**58**	**43**	**43**	**50**	**41**	**15**	530	**100.0%**

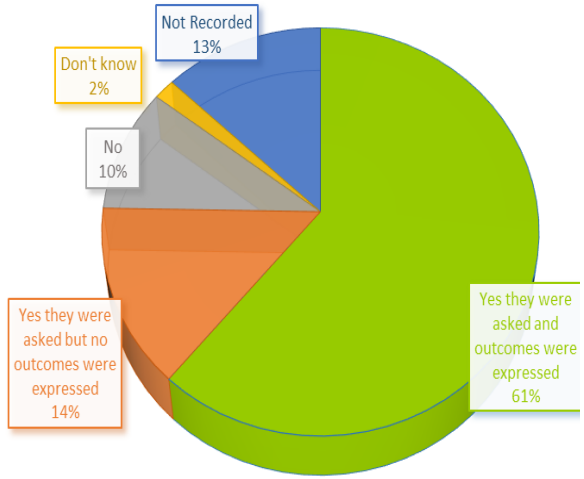
Key Adult safeguarding statistics 2019/20

Final outcome when a risk was identified



The aim is to remove or reduce the identified risk by taking appropriate action or to ensure the risk is managed. Action taken can be against either the person at the receiving end of the abuse, or the person alleged to have carried out the abuse. This can lead to changes to care plans, assistance with the management of finances, or additional training & support. Action was taken in 71% (237) cases. Enquiries ceased at the request of the individual in 6% (21) cases. There was no information recorded in 17 (5%) of cases. Cases which recorded 'risk identified and no action taken' were reviewed, two of the cases were allocated for a more in-depth review by an enquiry manager. The remaining eight cases were due to a recording error with the worker selecting the wrong risk outcome from the drop-down in the enquiry form.

Desired outcomes



Of the 530 Enquiries in 2019/20, 75% of individuals were asked about their desired outcomes, and 61% expressed what they wanted to achieve from the safeguarding enquiry. Of the 53 people who were not asked about their outcomes, 11 did not have the mental capacity to respond to the question.

	2019-20
Yes they were asked and outcomes were expressed	324
Yes they were asked but no outcomes were expressed	75
No	53
Don't know	9
Not Recorded	69
	530

Of the 336 completed enquiries in 2019/20, 101 of the enquiries had no details recorded as to whether the desired outcomes had been achieved. This is being addressed through the Adult Safeguarding Team Improvement Plan. For those cases where the satisfaction with enquiry outcomes was recorded, 83% reported outcomes had been fully achieved in 2019/20, an improvement from 73.9% in 2018/19. 4.3% of individuals reported outcomes had not been achieved (5.1% in 2018/19). In some cases the desired outcome was not achieved due to the enquiry not resulting in a prosecution which the individual had hoped for, and adults not wanting action under the safeguarding procedures but it was felt the risk needed addressing e.g. self-neglecting

	2019-20	2018-19
Fully achieved	195	292
Partially Achieved	30	83
Not Achieved	10	20
	235	**395**

Glossary

ADASS	Association of Directors of Adult Social Services
A&E	Accident and Emergency
CAMHS	Child & Adolescent Mental Health Services
CAWNSs	child abduction warning notices
CDOP	Child Deaths and the Child Overview Panel
CE	Criminal Exploitation
CPC	Child Protection Conference
CPIS	Child Protection Information System
CSE	Child Sexual Exploitation
CSPR	Child Safeguarding Practice Review
DoLs	Deprivation of Liberty Safeguards
EHA	Early Help Assessment
EHH	Early Help Hub
EHCP	Education, Health & Care Plan
FS	Family Service
GCP2	Graded Care Profile 2 (neglect assessment tool)
GWH	Great Western Hospital
IDVA	Independent Domestic Abuse Adviser
JTAI	Joint targeted area inspection
LADO	Local Authority Designated Officer
LeDer	Learning Disabilities Mortality Review
LSAB	Local Safeguarding Adult Board
LSCB	Local Safeguarding Children's Board
MARP	Multi-agency Risk Panel
MASH	Multi-agency Safeguarding Hub
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NCLCC	National County Lines Coordination Centre
NRM	National Referral Mechanism
PRG	Practice Review Group
REP	Risk Enablement Panel
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SSP	Swindon Safeguarding Partnership
SWA	Swindon Woman's Aid
TAC	Team Around The Child
VOLT	Victim, Offender Location and Theme