WARWICKSHIRE SAFEGUARDING

ANNUAL REPORT

2020 - 2021

Contents

Forward from Independent Chair & Scrutineer

Without doubt 2020-2021 has been a very challenging year for everyone involved in safeguarding of children, young people, families and adults.

The Covid pandemic quickly influenced every aspect of work. The Coronavirus Act 2020 did not relax safeguarding and Warwickshire was expected to continue to offer the same level of oversight to children, adults and families. This review will not focus on the Covid related challenges facing Warwickshire or on how everyone involved with the delivery of safeguarding services have risen to the occasion. There are several reports available to help readers understand how well professionals across Warwickshire managed to contain the pandemic and provide high quality services of across the county.

The work of Warwickshire Safeguarding continues to be supported by subgroups. It is apparent that the Executive Team is proactive in ensuring correct representation and attendance of members at these meetings. The subgroups work well, and partners are generally engaging better with each other. Under the leadership of the Executive Team, services were mindful of the pressure everyone was under and were encouraged to fulfil their safeguarding obligations in a measured and proportionate way.

This year I am in a better position to both challenge and scrutinise the effectiveness of these groups. I am conscious of areas of practice that are brought to the attention of the business team in reference to specific case details which may not have been shared with other relevant partners. This lack of recognition is of concern and suggests that our communication may not be as robust as we would like to believe. As a partnership we are more effective in our efforts to share knowledge, however it is evident that our communication does not always reach grass route practitioners. Managers and leaders are urged to consider ways of improving this.

Warwickshire Safeguarding has learnt a great deal from undertaking serious case reviews, SARS and alternative reviews. Each of these reviews has identified areas of good and best practice as well as areas that require improvement. Our ability to scrutinise our shared practice has improved considerably this year, as has the direct involvement of the Executive Team with each of the reviews being undertaken.

I would like to bring attention to four key areas that have emerged as safeguarding risks for us in Warwickshire, namely

- Mental health and the impact of provision, waiting times, diagnosis and care and support for children, adolescents and young adults.
- Self-neglect in adults and older people, particularly those adults who do not meet section 42 criteria who have care and support needs that make them vulnerable to safeguarding risks.
- Continuing concern around our ability to safeguard young people at risk of involvement with gangs, knife crime, county lines, trafficking and organised crime.
- Our ability to demonstrate how well we know the children, young people and adults who have reached our attention through the child safeguarding practice review and safeguarding adult review process, particularly the impact of frequent 'moves' for children in care.

England and Wales went into lockdown in the final week of March, due to the spread of the new coronavirus. Throughout the year Care homes and adults with care and support needs who were not visible, or were unable to receive their usual support, were of huge concern.

This past year has seen an increase in the number of self-neglect cases referred into the partnership due to the individual having experienced significant harm through neglect/self-neglect. I would like to challenge our decision-making in this respect and ask the Executive team to consider those vulnerable adults who do not meet section 42 criteria but would benefit from having their circumstances carefully considered and support provided where appropriate. I am pleased to see work in progress to put a Multi-Agency Risk Assessment Model (MARAM) in place and look forward to reporting on this next year.

In many ways Warwickshire safeguarding continues to function as previously with changes introduced partly as a result of Covid. A huge amount of impressive work has been undertaken this year under the direction of the Warwickshire safeguarding Business team and this is evidenced in the report. The Executive has established itself as a team that is effective in scrutinising but has yet to develop its ability to agree and drive a shared safeguarding agenda as anticipated in the Wood review.

In the coming year I am confident that the Executive and Business Team will continue to drive the work of Warwickshire Safeguarding and I thank everyone for their hard work and commitment during a particularly difficult year.

Elaine Coleridge Smith
Independent Chair & Scrutineer
Warwickshire Safeguarding

Key Facts

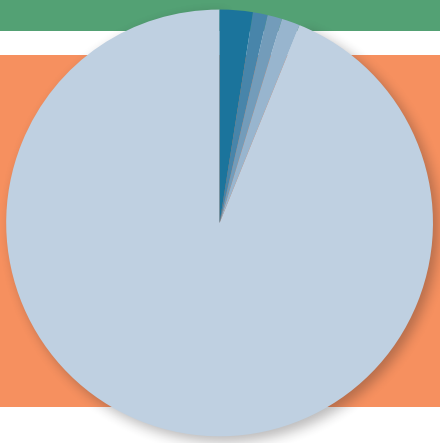
Warwickshire Safeguarding Adults

Individuals involved in Safeguarding Concerns

DEMOGRAPHICS

821 Male
1100 Female

708 Aged 18 - 64
298 Aged 65 - 74
454 Aged 75 - 84
394 Aged 85 - 94
70 Aged 95+



41 Asian/Asian British
18 Black / African / Caribbean / Black British
15 Other Ethnic Group
24 Mixed / Multiple
1441 White
*395 Undeclared / Not Known

2279
Concerns Received
(3144 in 2019/20)

385
S42 Enquiries Received
(3144 in 2019/20)

Concluded Section 42 Enquiries - Top 2 locations or risks:
Own Home | A Community Service

Top 3 Types of Abuse for concluded Section 42 Enquiries

Financial and Material Abuse **29.3%**
Physical Abuse **17.1%**
Phychological and Emotional Abuse **20.7%**

Section 42 Enquiries - Top 3 Primary support reason:
Physical Support | Support with memory and Cognition | Learning Disability

Asked what outcome they want
50.24%
(64.79% in 2019/20)

15
Enquiries involving strangers
(22 in 2019/20)

223
Source of risk known to victim
(231 in 2019/20)

65%
Risk reduced or removed
(68.90% in 2019/20)

18
Alleged abuse by social care staff
(31 in 2019/20)

Outcome fully or partially met
88.30%
(94.94% in 2019/20)

Key Facts

Warwickshire Safeguarding Children

Gender of Children subject to CP plans

53% Male
45% Female
2% Unborn

DEMOGRAPHICS

14,243
Contacts Received
(18,081 in 2019/20)

5,525
Referrals Received
(5,046 in 2019/20)

Warwickshire continues to see an increase in the number of children in care, a trend that has emerged since 31 March 2017. As at the 31 March 2021, there were 860 looked after children, compared to the previous year where there was 754. This was an increase of 106 children in care

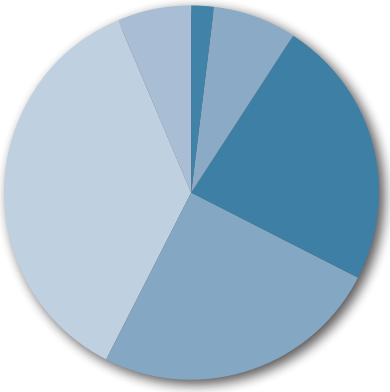
123 of Warwickshire Children in Care missing (120 in 2019/20)

6030 Statutory Child Social care assessment started (5595 in 2019/20)

449 Missing children (475 in 2019/20)

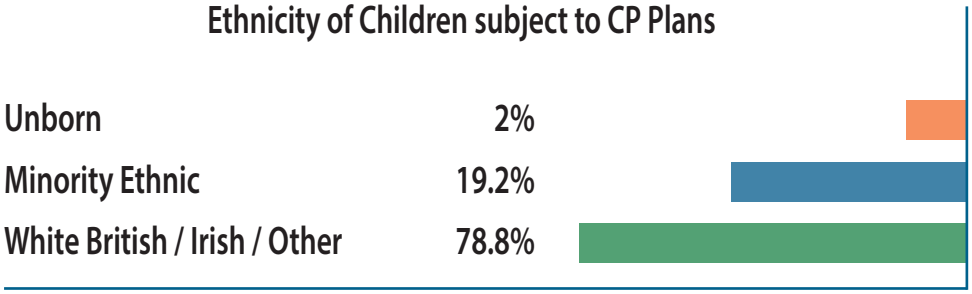
123 of Warwickshire Children in Care missing (120 in 2019/20)

Age group of children subject to Child Protection Plans



Unborn	2%
Under 1	7.2%
Age 1 to 4	23.5%
Age 5 to 9	24.9%
Age 10 to 15	36.1%
Age 16 to 17	6.3%

Ethnicity of Children subject to CP Plans



24.9% of referrals to Children Social Care were referred by Police

3 of the 5525 referrals received resulted in No Further Action (11 in 2019/20)

Referrals received for Children with a disability 1.05% (1.20% in 2019/20)

Top 3 types of abuse for children subject to Children Protection Plan

Multiple Abuse	Emotional Abuse	Neglect Abuse
25%	41%	27%

Keeping people safe during the pandemic

Over the last year, the focus has been on the pandemic and addressing the needs of vulnerable children and adults in unprecedented times. The pressures from the Covid-19 pandemic have presented risks for each partner agency which have been shared at each meeting to allow a greater understanding of the roles and responsibilities and provided the opportunity to explore better collaboration in addressing the issues and challenges faced by the county.

The tripartite partnership has contributed to the strengthening of the positive relationships between Health (CCG) , Police and the Local authority, there has been good engagement from partner agencies, as well as the wider partner membership. There has been consistent representation at the partnership meetings which has led to a greater understanding of how we as a partnership need to work together to protect children and adults at risk and this has factored into essential planning of services during the pandemic.

Demand in services has been high throughout the pandemic. There has clearly been an impact of the pandemic on levels of need and it is considered positive that issues have not been hidden, for example as a result of school closures. Partner agencies introduced innovative ways of working to ensure that needs could continue to be met.

Despite the pandemic the work of Warwickshire Safeguarding continued at pace, through the statutory reviews a number of key themes were quickly identified, for example self-neglect, self-harm and suicide. The learning from the reviews were shared in a timely fashion that enabled all partners to look at how they were responding to these challenging issues, and what improvements were required.
One of the key benefits of increased virtual engagement during the pandemic has been the ability to engage more partners and families in meetings. The partnership recognises there are opportunities to build on this moving forward.

Delivering our strategic priorities

The Executive Board has proved itself to be effective in maintaining oversight, monitoring, and evaluating the work of the subgroups. As a result, the work identified in the individual lead agency statements has been brought together to ensure an overarching delivery of the partnership's strategic priorities across Warwickshire. Examples of this work are provided below:

Exploitation

- **Exploitation Strategy (2020-2023)** - Taking on board the learning identified through its Strategic Thematic Review on the 'Exploitation of children & Adults' in 2019-2020 Warwickshire Safeguarding developed its new Exploitation Strategy (2020-2023) to tackle the exploitation of children and adults across Warwickshire. The strategy recognises the prevalence of exploitation, in all its forms occurring in Warwickshire and sets out the partnership's commitment to working together to foster a greater understanding of exploitation, the impact it has on children, young people, adults with care and support needs, and the wider community, and to improve the lives of those who are at

risk. The partnership acknowledges its approach to tackling the problem must be multi agency and collaborative to ensure those at risk are protected from harm. As a result there is now overall increased awareness of exploitation amongst professionals working with both adults and children and our approach has been broadened to include people who have experienced trauma who may not normally be regarded as having needs for care and support. Training has been expanded to include learning to raise awareness of unconscious bias, victim blaming language and capturing the voice of the child/adult when dealing with cases involving exploitation. In June 2020 Warwickshire Police set up a specialist Child Abuse, Trafficking and Exploitation (CATE) team to enhance the police response to child protection investigations, as well as, investing in training more Modern Slavery and Human Trafficking (MSHT) Specialist Investigators and MSHT Victim Liaison Officers to ensure that we get the response to these complex exploitation investigations that impact upon adults and children right.

- **Missing Protocol** - Warwickshire Safeguarding launched the Philomena Protocol into local practice for responding to children and young people going missing, or deemed likely to go missing, from care placements. The initiative is designed to help locate and safely return children and young people in care as quickly as possible when they are missing. The basis of the scheme is for vital information about the young person to be recorded, which can be used to locate them safely and quickly and to prevent ongoing reoccurrences. The benefits are listed as saving time and resources but most importantly the potential to improve safeguarding of our vulnerable young people by locating them quicker. It involves working with children's homes/carers to establish patterns of behaviour and people and places they frequently visit.

Effective Safeguarding

- **Introduction of new MAC replacing MARF** - Warwickshire introduced a new form to replace the current Multi-Agency Referral Form (MARF) used by partners to raise safeguarding concerns into the MASH (Multi-Agency Safeguarding Hub). The new Multi-Agency Contact (MAC) form has been developed to help improve the management of concerns reported into the MASH. The new form now requires referrers to focus on what is working well for the family, as well as capturing issues of concern. It also contains links to other services which can be considered by the person completing the form.
- **Refreshed the Terms of Reference for the Education Subgroup** – The new membership of this subgroup now provides an improved infrastructure for partner agencies to work directly with all levels of education settings across the county and ensures meetings focus on safeguarding and the inter-relationship with the work of the other partnership subgroups i.e. contributing to the development of the Exploitation Strategy and greater depth of involvement with safeguarding reviews.

Prevention & Early Intervention

- **Education Transformation Programme** - Warwickshire delivered a revised and Integrated Safeguarding Training programme during 2020-2021. The new integrated training offer covered Early Help, online courses and supporting modules, briefings in specific areas and Safeguarding training. Sessions were designed to provide knowledge, skills, confidence and aid and support Designated Safeguarding Leads and Pastoral workers in all education settings across Warwickshire to support prevention and early intervention in safeguarding cases.

- **Appointment of Headteacher leads/Coaches** - Warwickshire strengthened the different levels of support for schools to assist with their management and oversight of safeguarding of children, young people and adults. Headteacher coaches now support designated safeguarding leads within schools and ensure schools engagement in all safeguarding reviews work being commissioned by the safeguarding partnership. The placement of Headteacher leads within the MASH now also provides an additional layer of professional support to schools to help give the right advice and support at the right time when discussing safeguarding concerns.
- **Escalation Protocol** – learning from Child Safeguarding Practice Reviews (CSPRs) and Safeguarding Adult Reviews (SAR's) highlighted practitioner resolution and escalation as a recurring theme, whereby timely conversations may have been able to prevent safeguarding risks from escalating further. Warwickshire Safeguarding launched its new Escalation Protocol in response to this learning to assist practitioners in ensuring they have a clear understanding of the process for escalating and when and how it should be applied; allowing for a written record of each escalation to be retained on record. All practitioners working with children, young people, adults with care and support needs and carers have a responsibility towards their clients to ensure that the child's or adult's welfare is seen as a priority at all levels of practitioner activity. The protocol emphasises that Practitioners are individually responsible for being satisfied about the substance and progress of safeguarding plans for their service users. This protocol recognises this and provides a tool to support individuals to exercise this responsibility when they are concerned about the actions or inactions of other agencies or practitioners.

Learning from Reviews

Safeguarding Reviews

In keeping with its statutory duties under the Care Act 2014 and the Children's Act 2017 and Working Together 2018, Warwickshire Safeguarding considered a number of referrals for review by the partnership relating to children and adults who have either experienced significant harm from abuse/neglect, or have died as a result of the abuse/neglect and there are lessons to be learned about the way in which partners managed their involvement in these cases.

The legislation now defines these referrals as follows; previously known as Serious Case Reviews:

- Child Safeguarding Practice Reviews (CSPR's)
- Safeguarding Adults Reviews (SARs)

During 2020-2021 Warwickshire Safeguarding saw a significant increase in the number of referrals put forward by partner agencies where the referrer considers the circumstances of the abuse or neglect caused to the individual could have potentially been managed differently and where lessons can be learned and improvements to practices identified and implemented. Whilst the increase in cases is concerning, the volume of referrals submitted demonstrates a heightened level of confidence amongst partners in the new approach to the management of reviews, whereby cases involving children or adults are considered side by side offering insight into some of the transitional challenges faced by agencies when working with these individuals. The co-production of Lessons Learned Briefings and 7 Minute Briefings has further strengthened collaborative working across partners.

Warwickshire Safeguarding's Safeguarding Reviews Subgroup is responsible for ensuring that SARs and CSPRs in Warwickshire are carried out appropriately and effectively so that issues and lessons are identified, disseminated, and acted upon. The Subgroup oversees the implementation of multi-agency and single-agency actions and provides update reports to Warwickshire Safeguarding's Executive Board. In 2020-2021 Warwickshire County Council's Internal Audit team scrutinised Warwickshire Safeguarding's management of recommendations from its safeguarding reviews and found the new systems put in place by the partnership provided good levels of transparency, accountability, and traceability.

Provided below is a breakdown of the referrals received by Warwickshire Safeguarding during 2020-2021 and their progression:

Total number of referrals for review received 2020 - 2021:

- Children = **13** CSPR referrals
- Adult = **7** SAR referrals

Total number of referrals progressed to Review 2020 - 2021:

- Children = **7** CSPR referrals were put forward for progression to formal CSPR review
- Adult = **6** SAR referrals were put forward for progression to formal SAR review / reflective learning review / thematic review

Breakdown of referrals received by Area:

Name of District / Borough	No. of referrals relating to Children	No. of referrals relating to Adults
Rugby	1	1
Nuneaton & Bedworth	8	2
Stratford On Avon	0	0
Warwick District	0	3
North Warwickshire	2	0
Out of County	2	1

Breakdown of reviews by Area:

Name of District / Borough	No. of Children's reviews	No. of Adults reviews
Rugby	1	1
Nuneaton & Bedworth	4	2
Stratford On Avon	0	0
Warwick District	0	2
North Warwickshire	1	0
Out of County	1	1

Themes of abuse recorded in referrals:

Children = There have been high levels of self harm / suicides amongst the cases referred into the partnership for review, followed by cases of neglect, physical and sexual abuse

Adults = A large proportion of the referrals have related to cases of neglect and self-neglect

Reviews published in 2020-2021

Children = Warwickshire Safeguarding published its Serious Case Review into the case of Alice and Beth.

Alice and Beth were born outside of Warwickshire to Clare and David. Clare and David's relationship ended due to reports of domestic abuse. Clare then went on to form a relationship with Ethan which also came to an end. Clare moved to Warwickshire stating she was fleeing her previous partner. At this point, Alice was 3 and Beth was a little over 1 years old. Prior to the move Alice and Beth were known to their local Children's Services at that time due to concerns raised separately by David and Ethan regarding Clare's lifestyle and her care of the children. At the time of Clare's relocation to Warwickshire, the other local authority Children's Services had already initiated a section 37, which was in progress following concerns over David's volatile behaviour at a family court hearing over contact with the Alice.

Shortly after moving to Warwickshire, Alice was taken to hospital on two occasions after Clare had reported she had suffered seizures. On the second occasion Alice was admitted and remained in hospital for treatment of a respiratory infection. Alice responded well to treatment and was discharged four days later. Seven days after her discharge, Clare called for an ambulance stating that Alice had suffered another seizure. Alice was taken to hospital where she was pronounced dead.

A little over two weeks later, late in the evening Clare contacted the NHS 111 line and stated that Beth appeared drowsy. Paramedics attended the scene and found Beth to be unconscious. Emergency care was provided at the scene and Beth was conveyed to hospital where she was pronounced dead.

The death of Beth, and the results of a further Home Office postmortem examination of Alice, led the police to investigate both deaths. The investigation revealed that the cause of both Alice and Beth's deaths was believed to be third party interference with the normal mechanics of breathing.

The review focused on the following areas of consideration to help support improvement in practice:

- Where concerns were raised, was risk effectively identified? Were assessments undertaken when required, and were they effective?
- Was the cumulative effect of concerns raised considered, in particular the presentation of Alice at hospital and the presence of domestic abuse in the family?
- Was information appropriately shared between agencies, particularly when the family moved between areas?
- Following Alice's death was there appropriate consideration of the ability of Clare to care for Beth?
- To identify any areas of good practice in the case.

A copy of the full report and lessons learned briefing can be downloaded from the website by clicking here.

Adults = Warwickshire Safeguarding published its Safeguarding Adults Review on the death of Peter.

The subject of this review, Peter had a history of medical conditions including, chronic pancreatitis, vitamin D deficiency, hypothyroidism, type 2 diabetes, hypertension, alcohol liver disease, cataract, peripheral neuropathy and anxiety. Peter was admitted to hospital in April 2018 with reduced mobility. He was discharged in early June 2016 with medication. He was made homeless whilst in hospital and was provided temporary accommodation, on discharge, in a hotel. At the end of June 2018 Peter was found deceased in his hotel room by family members. He was seen by police and ambulance staff and described as very thin, virtually emaciated.

The review focused on the following areas of consideration to help support improvement in practice:

- Effective use of assessments and using these to identify individual's care and support needs and providing appropriate timely support, proportionate to their care and support needs.
- Assessment of mental capacity in decision making.
- Effectiveness of discharge arrangements which recognise care and support needs of the individual, are based on assessment of need and ensure appropriate arrangements are made to cater for these needs.
- Availability of suitable accommodation for persons with care and support needs.
- Maintaining oversight and management of patient's ongoing health needs following discharge from hospital.

A copy of the full SAR report can be downloaded from the website by clicking here.

Recurring themes within reviews

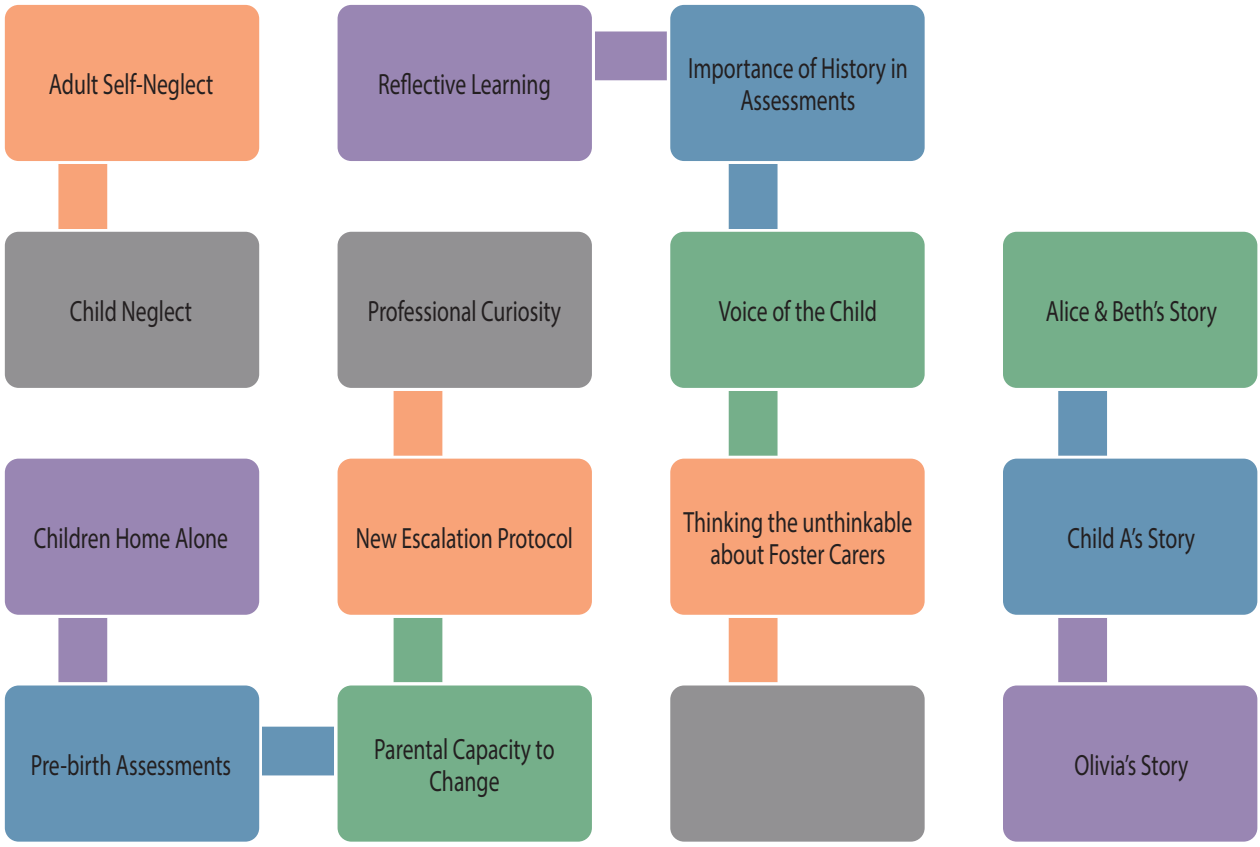
During the course of undertaking its reviews, Warwickshire Safeguarding has identified a number of recurring themes which have appeared frequently demonstrating the need for further development of practice/understanding amongst professionals.

Warwickshire Safeguarding has responded by developing resources for the following recurring key themes to support this improvement and will be assessing the effective use of these tools as part of its ongoing assurance work with partners:

- **Thinking the unthinkable** - "Safeguarding is thinking the unthinkable and then figuring out how to reduce the probability of the unthinkable happening" (Graham Fawcett). Adults or young people rarely disclose abuse and neglect directly to practitioners which makes identifying abuse and neglect difficult for practitioners across agencies. Practitioners need to develop relationships with children, young people and adults, away from carers, and practice 'respectful uncertainty' to any information they receive, keep an open mind and think objectively about the evidence presented, even if this may be challenging and difficult to imagine.
- **Professional curiosity** - Professional curiosity is the capacity and communication skill to explore and understand what is happening to children, young people and adults within a family, rather than making assumptions or accepting initial explanations. This can be described as the need for practitioners to practice 'respectful uncertainty' and being open to exploring different understandings
- **Escalation** - All practitioners working with children, young people, adults with care and support needs and carers have a responsibility towards their clients to ensure that the child's or adult's welfare is seen as a priority at all levels of professional activity. When working with practitioners from other agencies there may at times be differences of opinion or concerns about practice that arise. The new Escalation Protocol provides 3 key stages and should be used in all situations where there are concerns about practice, decision making or resource allocation.
- **Identification of Neglect in children** - Neglect differs from other forms of abuse in that there is rarely a single incident or crisis that draws attention to the family. It is repeated, persistent, neglectful behaviour that causes incremental damage over a period of time. It relates to the lack of a parent's capacity to meet the physical & emotional needs of the child. There is no set pattern of signs that indicate neglect other than that the child's basic needs are not being adequately met. Remember; a child might not understand that they are being neglected. Neglect in adults is equally complex and needs to be responded to in the same way.
- **Voice of the child** - This is a phrase used to describe the real involvement of children and young people. It does not only refer to what children say directly, although it is essential this is heard, but it refers to many other aspects of their presentation. It means seeing their experiences from their point of view and taking into account the child's daily lived experience. The phrase means more than simply seeking their views; is about enabling them to take as active a role as possible in decision making
- **The importance of history** - Opportunities to reduce the risks to children, young people and adults are often missed because critical information in the family history has not been shared with agencies working with the children/adults. Therefore, interventions to support have not been based on a full understanding of the family history. Family functioning and history is a key part of assessments and includes both genetic and pyscho-social factors. The experience and history of parents, and their experience of parenting, will have significant impact on the child's/adults lived experience.

Communicating the learning from reviews

- **LLBs & 7MBs** – Warwickshire Safeguarding embarked on developing a new approach to ensuring key points of learning emerging from its reviews are shared across the wider partnership at all levels, to encourage reflection and improvement in safeguarding practice. Lessons learned briefings and 7 Minute Briefings are now published alongside all review reports and are targeted at both professionals working with children and adults, as well as the Warwickshire community at large. As part of Warwickshire Safeguarding's annual assurance work the Executive Board will be seeking evidence from practitioners that these briefings are being used to support their work. During 2020-21 the following list of briefings were published:



- **WS News Bulletin** - Warwickshire Safeguarding launched its new quarterly News Bulletin in February 2021 designed to introduce the wider Warwickshire community and practitioners to help
  - Promote learning from Child Safeguarding Practice Reviews (CSPRs) and Safeguarding Adults Reviews (SARs) to support improvement in practice
  - Report on any changes/updates to safeguarding policy and procedures; and
  - Publicise forthcoming safeguarding events/seminars and share new safeguarding resources

- **Training** - Warwickshire Safeguarding delivered a series of online training sessions targeted at health professionals, newly qualified social workers and headteachers. Newly qualified social workers and headteachers were introduced to the work of the local safeguarding partnership and how they can support learning through the safeguarding reviews work and the importance of lessons being drawn from the reviews and their application in practice. Over 350 GPs and other health care professionals across the county joined on-line training to gather the learning from safeguarding reviews, which highlighted key areas of improvement flagged up by the reviews, where this impacts on the work of health professionals. Feedback from participants indicated this to be an extremely helpful and relevant session which helped them develop a more in-depth understanding of some of the safeguarding challenges and how they can support overcoming these in future cases. Provided below are some of the responses from participants in terms of what they will do differently based on the learning shared at the session and how this will be applied in clinical practice:

Interesting to hear how covid has changed how people have stopped attending A and E. Makes you think about asking how someone is doing that looks after children

Increased awareness on the need for professional curiosity

I learnt what the impact of Covid-19 had caused re-safeguarding, how emotional abuse had increased. Was surprised that domestic abuse no surge of increases had happened. Encourage patients to attend GP/ A+E for essential appointments

7 minute briefing literature and how to apply own knowledge to practice

It was good to highlight the early help service www.warwickshire.gov.uk/children-families/early-help-warwickshire

Be open minded - Think of unthinkable - Never assume - Be wary of assumptions. Pay attention to how people look and behave as to the attention paid what they are saying

I am planning to expand the Practice review of vulnerable people to include those with Learning Disability and autism as well as shielding and dementia and mental health

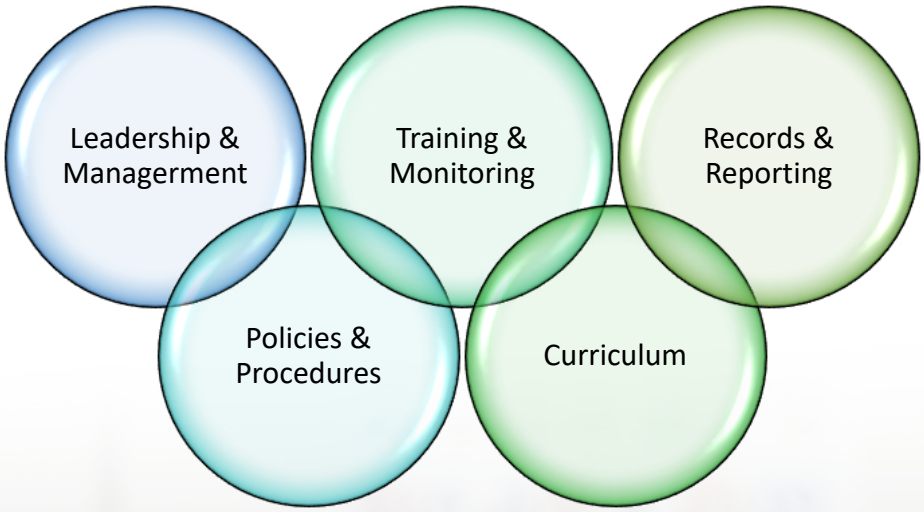
We have continued to do baby checks and immunisations through covid so have had opportunities to ask and observe will definitely be more observant though now

Good to see that meeting can still take place remotely

Working with Education Settings

Annual Safeguarding Audit

Warwickshire undertook its annual section 175 audit of schools and colleges to assess and evaluate the effectiveness of safeguarding arrangements. This year, a total of 276 responses were submitted from 292 contacted settings (i.e. Schools, colleges and alternative providers). The audit focused on scrutinising practice in the following five areas:



Each setting was requested to evaluate their arrangements by selecting one of the following options:

- **Emerging** – Aspects require initial or immediate action.
- **Developing** – Actions are being actioned and progressed but require further development to embed in the setting.
- **Established** – Aspects are fully embedded in practice and are consistent and effective

Based on the responses received the following recommendations for action were identified. The responsibility for overseeing and monitoring actions against these recommendations sits with Warwickshire Safeguarding's Education Subgroup, who provide the Executive Board with regular updates on progress and seek assurance on the impact on practice:

Recommendations for Settings (schools, colleges and alternative providers of education)	**Recommendations for Warwickshire County Council (WCC)**	**Recommendation for Warwickshire Safeguarding partnership**
1. Settings should ensure the Governor responsible for safeguarding (including early help) on the governing body cascades the core information from training to the rest of the governing body. Settings may also wish to consider inviting other governing body member to attend safeguarding training. 2. Safeguarding (including early help) should be a standard agenda item on each governing body meeting and senior leader team meeting. 3. Settings should ensure that the Warwickshire Safeguarding's '7 minute' briefings are used as an integral part of staff training, senior leadership team and governing body meetings. 4. Settings should prioritise Early Help training for ALL Designated Safeguarding Leads as part of their role. 5. Members of Setting Senior Leadership Teams should encourage their DSLs to attend WCC's DSL Network meetings. 6. Safeguarding requirements that have recently gained greater prominence such as Children Missing Education (CME), Forced Marriage, Hate Crime, Mate Crime, Private Fostering and Trafficking scored lower suggesting settings need to put a greater emphasis on supporting staff training in these areas. 7. Settings should look to strengthen the role of the Designated Teacher for CLA/CPLA in terms of training, holding information and reporting to governors/proprietors on progress and attainment of this cohort. 8. Settings should ensure reflective supervision time for DSLs and Deputy DSLs	1. WCC will produce a check list for schools to support induction around Safeguarding. This will be included within the whole staff training slide deck to support greater consistency. 2. WCC will triage responses from individual settings who responded to the audit. Settings who consistently answered 'Emerging' to questions within the audit will be supported to enhance their safeguarding practice via Headteacher coaches, Targeted Support Officers, access to the Integrated Safeguarding Training Programme and generic School Improvement through WCC. 3. WCC will design a training suite for 2021-22 which responds to the core themes and requirements for the education sector highlighted in this audit return. 4. WCC will plan to deliver Safer Recruitment Training and will produce a schedule in the autumn term for settings.	1. Warwickshire Safeguarding, in conjunction with the Education Subgroup will further review the '7-minute guides' available to schools to ensure appropriate themes are supported

Voice of the Child/Adult

Making Safeguarding Personal (MSP)

Making Safeguarding Personal requires partners agencies to ask individuals and/or their representatives what outcomes they would like to achieve from their safeguarding intervention. Throughout the Covid-19 pandemic, Warwickshire continued to support service users to express their views/desired outcomes. During the course of 2020-21 Warwickshire concluded **289 s42 safeguarding enquiries** of these **171** individuals/their representatives were asked for their views and desired outcomes, out of which

- **157** individuals/their representatives expressed their views and desired outcomes
- **14** individuals/their representatives did not wish to express their views and desired outcomes
- **86** of the concluded s42 enquires recorded that the individual's outcomes had been fully achieved
- **77** of the concluded s42 enquiries recorded that the individual's outcomes had been partially achieved
- **13** of the concluded s42 enquiries recorded that the individual's outcomes had not been achieved

Advocacy

Local authorities have a duty to arrange for an independent advocate to be available to represent and support certain persons (Children and adults) for the purpose of facilitating those persons' involvement in the exercise of functions by local authorities. Advocacy is a process of supporting and enabling people to:

- Express their views and concerns
- Access information and services
- Defend and promote their rights and responsibilities; and
- Explore choices and options

In line with government guidance when the pandemic hit advocacy within Warwickshire was changed to be delivered virtually via phone, tablet, computer or ipads to ensure children, young people and adults in need of this service continued to be supported. Access to additional resources was shared and partners worked together to ensure that people who required advocacy support could still access the service. As restrictions eased outdoor visits took place following risk assessments and the use of PPE.

Unlike the National picture, Warwickshire maintained s steady flow of referrals for advocacy support but noted a higher number of complex cases throughout COVID highlighting the number of issues being faced by customers. Commissioners across Coventry & Warwickshire worked with advocacy service providers (Voiceability and Barnardos) to ensure that communications outlining the duty to refer to advocacy remained and that services were still being offered and delivered to those in need.

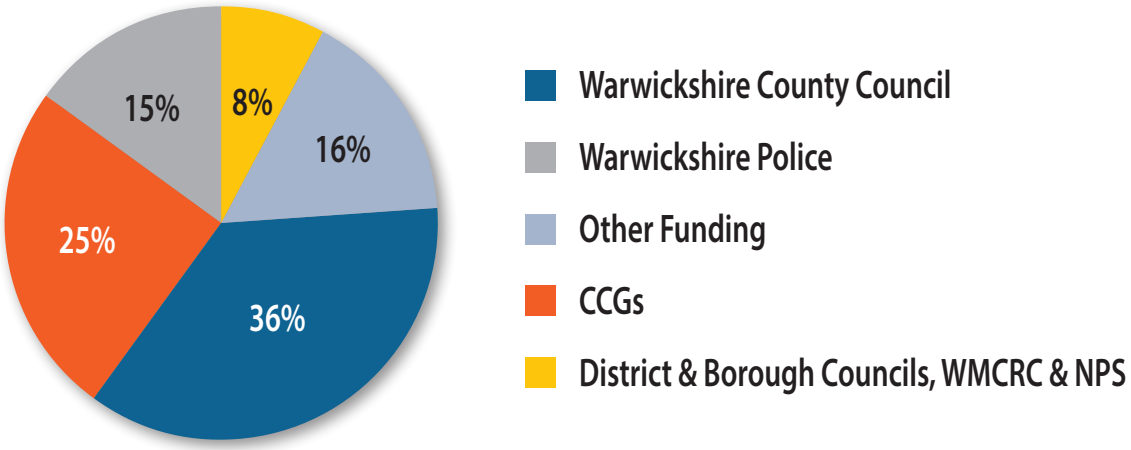
During 2020-21 **a total of 55 adults with care and support needs** were supported by an advocate to help them with their safeguarding issues.

A further **197 referrals for Children's Advocacy service were supported** by Barnardo's to ensure children and young people received the help and information they needed to enable them to understand their rights.

Funding

Partner Contributions 2020 - 21

Budget = £339,073



Looking Ahead/Conclusion

On reflection of the work undertaken by the partnership over the course of this last year, there are a number of areas that need to be progressed and developed further to help strengthen the partnership's relationships, links into other initiatives being progressed by other services and maintaining oversight of assurance of safeguarding practices. Moving forward, Warwickshire Safeguarding will be looking to

- Build on its assurance activities through its strategic thematic reviews and use the learning from these to help support improvement in core safeguarding practice. Whist we need to keep improving, it is important that we do not see changes to structures and organisation as the solution unless there is clear evidence they are at the root of any issues. Maintaining stability and avoiding unnecessary changes will support improvement.
- Looking at ways to effectively link in with cross cutting themes and issues such as domestic violence, suicide, mental health and exploitation where there are existing initiatives (for example the suicide prevention group). While it is important that we understand their relevance to safeguarding and embed good practice, we need to be careful we are not broadening the scope of the board too widely.
- Encourage other partners, both statutory and voluntary, to become more involved in supporting the work of Warwickshire Safeguarding to avoid them feeling less valued and involved than they were under the preceding arrangements.

Member Attendance

April 2020 - March 2021 - Partner attendance at meetings

	1	2	3
Age UK Coventry & Warwickshire			
Barnardo's			
Care Quality Commission			
Councillors - Portfolio Holders			
Coventry & Warwickshire Clinical Commissioning Groups			
Coventry & Warwickshire NHS Partnership Trust			
District & Borough Councils			
George Eliot Hospital			
Healthwatch Warwickshire			
National Probation Service			
Office of the Police & Crime Commissioner			
Princethorpe School			
South Warwickshire NHS Foundation Trust			
University Hospital Coventry & Warwickshire			
VoiceAbility			
Warwickshire & West Mercia Community Rehabilitation Company			
Warwickshire County Council			
Warwickshire Fire & Rescue			
Warwickshire Police			
WCAVA			


Warwickshire
age UK


Care Quality
Commission


Warwickshire
& West Mercia
Community Rehabilitation Company
PROBATION


Cafcass
Children and Family Court Advisory and Support Service


WARWICKSHIRE
CAVA
COMMUNITY & VOLUNTARY ACTION


WARWICK
DISTRICT
COUNCIL


WARWICKSHIRE
FIRE & RESCUE SERVICE


NHS
George Eliot Hospital
NHS Trust


NHS
Coventry and Rugby
Clinical Commissioning Group


Warwickshire
County Council


NHS
University Hospitals
Coventry and Warwickshire
NHS Trust


Princethorpe
College


BOROUGH
RUGBY
COUNCIL


NHS
Warwickshire North
Clinical Commissioning Group


healthwatch
Warwickshire


National
Probation
Service


NHS
West Midlands
Ambulance Service
University NHS Foundation Trust


VoiceAbility


NHS
South Warwickshire
Clinical Commissioning Group


NHS
South Warwickshire
NHS Foundation Trust


North Warwickshire
Borough Council


Coventry and Warwickshire
Partnership
NHS Trust
NHS


Police and Crime
Commissioner
Warwickshire


STRATFORD-ON-AVON
DISTRICT COUNCIL


Warwickshire
POLICE


Nuneaton
&
Bedworth


The Polesworth School
ENSURING EXCELLENCE


NHS
England