YEARLY REPORT

Royal Borough of Windsor & Maidenhead
SAFEGUARDING PARTNERSHIP

2024-2025

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INTRODUCTION

Welcome to the Safeguarding Partnership's yearly report. This is our annual opportunity to share the work undertaken to ensure that local multi-agency safeguarding arrangements are robust and effective.

2024 - 2025 was a year of transition for the Partnership's business arrangements. Some areas of the Partnership's business have not progressed as rapidly as we would have wished, and where this has been the case, we are clear about it in the report.

Since the appointment of a full-time Business Manager with administrative support in November 2024 we have seen a marked improvement in the amount and quality of work provided. We fully anticipate that next year's annual report will better demonstrate the results of the work that has been started this year.

Stephen Evans
Chief Executive, Royal Borough of Windsor & Maidenhead
Lead Safeguarding Partner as defined by Working Together 2023

Jason Hogg
Chief Constable, Thames Valley Police
Lead Safeguarding Partner as defined by Working Together 2023

Sam Burrows
Interim Chief Executive, Frimley Integrated Care Board
Lead Safeguarding Partner as defined by Working Together 2023

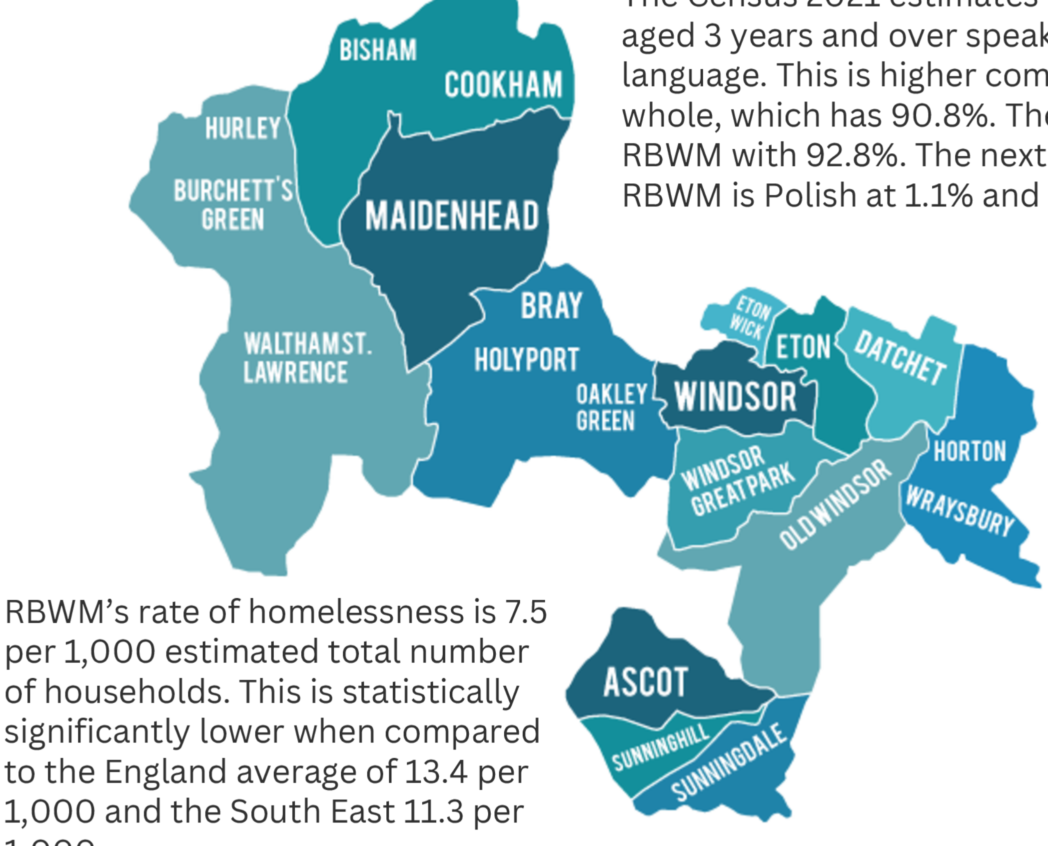
WINDSOR & MAIDENHEAD - OVERVIEW

The Royal Borough of Windsor & Maidenhead (RBWM) is a unitary authority in Berkshire, Southeast England, at the heart of the Thames Valley. The borough is centred on the town of Windsor, with other major settlements in Maidenhead and Ascot. The authority covers an area of some 197 square kilometres.

The ONS estimates that in 2024 there were 158,943 residents in RBWM. This equates to a population density of 7.9 persons per hectare, which is higher than the figure of 5 persons per hectare for the South East region, and 4.4 persons per hectare for England as a whole.

RBWM's population has a median age of 42 years, which is older than the median age for England (40 years). 19% of residents are children aged under 15. This compares to 18.4% for England. 62.2% of RBWM's residents are of working age (aged 16-64), this compares to 62.9% in England. RBWM has 18.9% of residents that are aged 65 years and over, which compares to 18.7% seen nationally.

RBWM has a lower proportion of white residents (79.8%) when compared to the South East and England with 86.3% and 81% respectively. The next largest ethnic group in RBWM is Asian/ Asian British with 13.1%. This is higher than both the South East region and England with 9.6% and 7% respectively. (Source: 2021 census).



The Census 2021 estimates that 91.3% of residents aged 3 years and over speak English as their main language. This is higher compared to England as a whole, which has 90.8%. The South East is higher than RBWM with 92.8%. The next largest main language in RBWM is Polish at 1.1% and Panjabi at 1%.

RBWM is ranked 150th out of 151 upper tier local authorities for their average deprivation rank. This means there is considerably less deprivation in RBWM than in England as a whole. RBWM is also ranked 304th out of 317 local authority districts. Both ranks are based on local authorities as at 2019.

RBWM's rate of homelessness is 7.5 per 1,000 estimated total number of households. This is statistically significantly lower when compared to the England average of 13.4 per 1,000 and the South East 11.3 per 1,000.

SAFEGUARDING - FACTS AND FIGURES

	Number of people living in RBWM	155,239
	Number of children living in RBWM	34,281
	Referrals to Children's Social Care throughout 2024 - 2025	1,585
	Children on a Child in Need Plan	275
	Children on a Child Protection Plan	86
	Children reported missing from home throughout 2024 - 2025	105
	Children with an Education, Health and Care Plan	1,289
	Children electively home educated	292
	Adult Social Care assessments in year	3,468
	Adult Social Care requests in year	3,454
	Adult Social Care reviews in year	1,128
	Service(s) provided by Adult Social Care	4,916

PARTNERSHIP GOVERNANCE AND SUB-GROUP STRUCTURES

Lead Safeguarding Partners' Oversight Group
(did not meet during 2024-2025)

Partnership Executive Steering Group (meets quarterly)
Chaired on a yearly rota basis by the
Delegated Safeguarding Partners from
Thames Valley Police, Frimley ICB and RBWM

Case Review sub-group

Chair: Thames Valley Police

Performance Data sub-group

Chair: Vacant

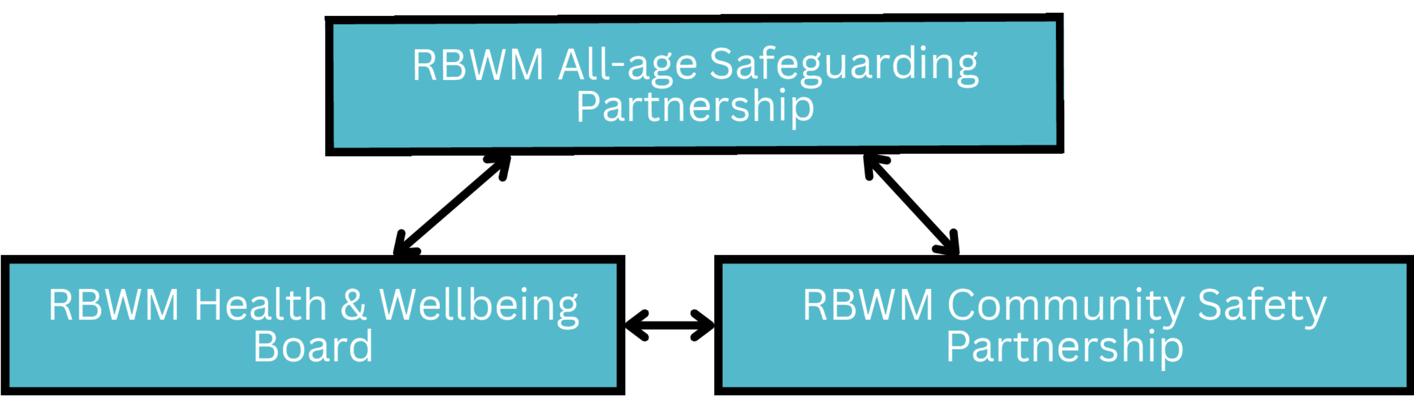
Quality Assurance sub-group

Chair: Children's Social Care

Child Sexual Abuse Task and Finish Group

Relationships with other strategic boards

The Safeguarding Partnership is an entity required by law. It sits alongside and is complementary to, other statutory and non-statutory multi-agency protection arrangements. Through a combination of shared membership and reporting arrangements, these strategic groups are sighted on each others' work and common aims.



THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

Domestic Abuse

The Domestic Abuse Act 2021 provides a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence but can also be emotional, controlling, coercive and economic abuse. It is very common. In the vast majority of cases it is experienced by women and is perpetrated by men.

The Community Safety Partnership leads on responding to domestic abuse and its annual report for 2024/2025 is available here.

Why is this a priority for us?

Domestic abuse continues to feature prominently in the most serious and complex cases the Partnership deals with in the contexts of Safeguarding Adult Review referrals and Children's LSCPRs.

Families First

The Families First Partnership (FPP) Programme is a national UK government initiative to transform children's social care by promoting early intervention, multi-agency collaboration, and integrated services, with the goal of keeping families together and preventing crises.

Why is this a priority for us?

Safeguarding partners must collaborate strategically to implement system-wide reforms that improve child protection and family support. They must oversee local services to ensure a seamless, multi-agency approach.

Child Sexual Abuse

In November 2024, the Child Safeguarding Practice Review panel published the report "I wanted them all to notice", which dealt with protecting children and responding to child sexual abuse within the family environment.

The report has uncovered significant and long-standing issues. Children who are sexually abused by someone in their family are frequently not being identified by practitioners, nor are they receiving the response needed for their ongoing safety and recovery. The report findings are discussed at greater length on Page 14.

Why is this a priority for us?

The report made 6 specific recommendations to safeguarding partnerships concerning:

- Strategic planning
- Professional knowledge, skills and confidence
- Enquiries and investigations
- Assessment of people presenting risk of sexual harm
- Talking to children
- Health

A task and finish group with good multi-agency representation has been created to respond to the National Panel's recommendations. The outcome of this work will feature in more detail in the Partnership's yearly report for 2025/2026.

STATUTORY DUTIES

Private Fostering

The Partnership has reviewed RBWM's Private Fostering arrangements and is assured of their effectiveness, in line with the requirements set out in Section 7 (7.10) of the National Minimum Standards for Private Fostering. The assurance report is available here.

Child Death Overview Panel (CDOP)

RBWM's CDOP remains a well-established and effective mechanism for multi-agency review of child deaths. The CDOP has published its 2024/25 Annual Report, and the Partnership is assured those statutory responsibilities under Working Together 2023 and the Child Death Review: Statutory and Operational Guidance (England) are being met. The Panel's latest report is available from the Partnership's website, here.

Safeguarding Self-assessment Audit Panel

The Partnership continues to host this Pan-Berkshire assurance mechanism. Panel meetings are held every 6 months where agencies are invited to submit their self-assessments to a multi-agency panel of their peers. In the spirit of 'critical friends' robust challenge is provided with a constructive approach and a focus on learning

Pan Berkshire Policies and Procedures

As practice develops to take account of new learning, so too must the policies and procedures that shape safeguarding practice.

There are separate arrangements for maintaining the local safeguarding procedures for children, adults and families across Berkshire.

Children's Safeguarding Policies and Procedures are managed on behalf of all the Berkshire Boards/Partnerships by colleagues in Brighter Futures for Children in Reading. RBWM's Policies and Procedures for children and families are available here.

Adults' Safeguarding Policies and Procedures are managed on behalf of all the Berkshire Boards/Partnerships by colleagues in West of Berkshire Safeguarding Adults Partnership Board. RBWM's Policies and Procedures for Adult Safeguarding are available here.

The Policies and Procedures groups meet quarterly to review the policies and procedures and respond to local and national developments.

Management of allegations and concerns - staff working with children

Section 11 of The Children Act 2004 sets out the statutory requirement for local authorities to have in place clear procedures for responding to allegations of harm or abuse of children by staff or foster carers.

The annual report on such work is available on the Partnership website, here.

LEARNING FROM PRACTICE

Case Review sub-group

This multi-agency group meets every quarter to:

- co-ordinate referrals for review processes
- co-ordinate responses to statutory review processes
- commission review processes where required
- quality assure review outcomes
- promote learning opportunities arising from reviews

Serious incidents (Children)

The Royal Borough of Windsor & Maidenhead is required to notify the Child Safeguarding Practice Review Panel if it's known or suspected that a child has been abused or neglected and;

a) the child dies or is seriously harmed in the local authority's area.

b) the child dies or is seriously harmed outside England while normally resident in the local authority's area.

The local authority is also required to notify the Secretary of State for Education, and Ofsted of the death of a looked after child regardless of known or suspected abuse or neglect.

In the year April 2024 to March 2025 there was one such serious incident following the death of a child resident in Windsor and Maidenhead. The death was not suspicious and on the basis of information gathered at the time, there was no evidence of abuse or neglect. Delegated Partners agreed that a rapid review of the death was not justified as the death was subject to another statutory review process by the Child Death Overview Panel.

No new Child Safeguarding Practice Reviews

The Partnership did not commission any Local Child Safeguarding Practice Reviews within 2024/2025, although there have been two established children's reviews ongoing throughout this period. The cases are detailed on the next page.

Safeguarding Adults Reviews

In 2024/2025 the Partnership received 8 referrals for Safeguarding Adults Reviews (SARs) following the deaths of 7 adults. These referrals were subject to scrutiny by a multi-agency 'Thresholds' group to see whether the circumstances of the cases met the criteria for a SAR under Paragraph 44 of the Care Act 2014.

One of the cases that met the criteria for a SAR was that of a 37-year-old man who died in hospital following an episode of suspected acute behaviour disorder (ABD).

The second case to be the subject of a SAR involved a 51-year-old man who died following a sustained bout of alcohol and substance consumption.

Both of these review processes will begin in earnest in 2025-2026 and their outcomes will be reported in next year's yearly report.

Two of the deaths resulted in tabletop reviews where learning briefings (one on the mental health of asylum-seekers and the other on the dangers associated with hoarding and fire risks) were produced and disseminated.

One case that did not meet the threshold for a SAR and resulted in a referral to the Community Safety Partnership for a Domestic Abuse Related Homicide Review.

LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS

Ongoing Reviews

The two reviews summarised on this page have been running throughout the year 2024-2025. This is not unusual for complex reviews involving different local authority areas and multiple agencies.

At the end of the year the 2 reviews have not been concluded or submitted to the Child Safeguarding Practice Review Panel.

'Ben' - Learning summary Review findings (so far)

Ben is a pseudonym. The review was initiated following Ben's fall when he was aged 3, from a first floor window of a locked bedroom. Ben survived the fall with minimal injuries.

- Neglect of the children in the family was not clearly identified and addressed
- Agencies' engagement with the oldest child lacked a trauma-informed approach
- The impacts of domestic abuse on adults and children were not recognised
- There was little understanding of children's lived experiences and their voices were not heard sufficiently in decision-making

'Ella' - Learning summary

5 months before her 18th birthday, Ella ended her own life.

Review findings

- A previous child protection concern was not dealt with in a timely way
- The delayed assessment of risk did not consider the voice of the child sufficiently. Nor did it consider relevant contextual safeguarding risks.
- Ella's further education college did not receive her Child Protection file from her previous school
- A Mental Health Support Service (MHSS) in county 1 refused to accept a referral from a MHSS in county 2 due to a mistaken understanding of the referral criteria
- Health colleagues did not share details of the imminent risk to Ella with her parents or with children's services

So what has changed?

- Children's services have restructured teams, added capacity and reduced workloads to support assessment work
- Children's social care now see children at least twice during the assessment stage of a case
- Mental Health Clinicians are now involved in discussions about referrals

THE 'NATIONAL PANEL'

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

The Panel and its purposes

The Child Safeguarding Practice Review Panel ('The National Panel') was established under the Children and Social Work Act 2017 and operates under the relevant legislation and statutory guidance. The Panel has the power to commission reviews of serious child safeguarding incidents and to work with local safeguarding partners to improve learning and professional practice.

The National Panel is funded by the Department for Education (DfE) and is accountable to the Secretary of State for Education, although it acts independently from Government.

The multi-agency make-up of the Panel reflects the focus on joint responsibility across safeguarding partners enshrined in law.

The Chief Social Worker for children and families is a standing member of the Panel. Panel members come from diverse professional backgrounds and have longstanding operational and strategic experience within the multi-agency network with responsibilities for safeguarding children, including local authority children's services, police, health, and education.

The Panel's key functions include:

- **Commissioning National Reviews** of child safeguarding cases that are complex or raise issues of national importance.
- **Reviewing local Child Safeguarding Practice Reviews** (CSPRs) submitted by Safeguarding Partnerships to identify systemic patterns, emerging issues, and areas for improvement across safeguarding partnerships and agencies.
- **Promoting Child-Centred Practice** by incorporating the voices and experiences of children, families, and communities into the learning process to inform improvements in safeguarding.
- **Providing System Leadership** through its oversight and review functions, working with national organizations and safeguarding partners to encourage sharing of best practices and drive positive changes in the child protection system.
- **Informing Policy and Practice** by using evidence and data from reviews to drive improvements in policy and professional practice at local, regional, and national levels.

LEARNING FROM THE NATIONAL PANEL - 1

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

Safeguarding children in Elective Home Education (EHE)

In May 2024, the Child Safeguarding Practice Review panel published its third briefing paper.

Between August 2020 and October 2021, 27 rapid reviews referred to the Panel featured children who were educated at home. These rapid reviews were analysed along with 15 associated Local Child Safeguarding Practice Reviews.

The following key themes emerged from the National Panel's research:

- Parents need information to understand exactly what elective home education means.
- Children at risk of harm may disclose abuse to a known person. Children educated at home may not have access to people working in universal services that can act to protect and help them.
- Relationships between EHE teams in local authorities and parents/carers of children who are electively home educated can vary considerably.
- Legislation and guidance do not give practitioners regular access to children who are educated at home.
- Elective home education teams within local authorities can lack necessary capacity and safeguarding knowledge.
- Information sharing between EHE teams and other professionals working with the child or family can be problematic as they may sit within different teams and service areas within local authority children's services.
- Use of School Attendance Orders is rare.
- It is important for local safeguarding partnerships to have an evidence-based understanding of safeguarding issues as they relate to local elective home education practice.

The Partnership's response to this learning

Elective Home Education (EHE) is part of the core business of RBWM's Pupil Inclusion and Support Team.

6-weekly multi-agency meetings with Elective Home Education/Children Missing Education/Special Educational Needs teams are effective to discuss ongoing cases and strategies and to cross-check data on the EHE database with schools' Starters/Leavers forms.

Pupils not receiving immunisations as a result of their absence from school are provided with access to immunisations and advice.

Joint home visits are undertaken by the Pupil Inclusion and Support team and social workers. An EHE alert on the information system (LiquidLogic) ensures that all relevant colleagues are aware when a child is electively home educated.

Impact of the Partnership's response

The Partnership will not consider the report until August 2025. The outcomes will be reported as part of next year's yearly report.

LEARNING FROM THE NATIONAL PANEL - 2

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

“I wanted them all to notice”

In November 2024, the Child Safeguarding Practice Review panel published a national child safeguarding practice review that investigated the experiences of 193 children who were sexually abused by a family member.

The review looked at 136 child safeguarding incidents – the most serious cases of abuse and neglect – and found over 75% of the children sexually abused by a family member were under the age of 12.

The following key findings emerged from the review:

- **Children are ignored and disbelieved and risk is misunderstood and minimised** - The report reveals a system in which children are all too often ignored or disbelieved, do not receive the protection they need and in which the risk posed by adults within the family is frequently misunderstood or minimised. Importantly practitioners from all agencies lack the support, confidence and guidance required to intervene effectively to help and protect children.
- **Existing risk of harm -** Over a third of incidents featured a family member with a known history of sexual offending or who was known to present some risk of sexual harm. This included convicted sex offenders and family members who had been previously prosecuted for sexual abuse, including rape, moving into a home with young children without a strong risk assessment.

The long-term impact of child sexual abuse - In several of the serious incidents reviewed, children had self-harmed, been diagnosed with depression or had begun misusing substances or alcohol. Seven children tragically took their own lives, and ten children were known to have become pregnant as a result of the sexual abuse, with the youngest being just 11-years-old at the time.

The Partnership’s response to this learning

The National Panel’s report was considered by the Executive Steering Group in December 2024. It was agreed that a multi-agency task and finish group should be established to provide a response to the challenges posed in the review report.

Impact of the Partnership’s response

As the task and finish group had not finished its work at the year end, the impact of its work is not yet known. By April 2025, work was underway on auditing the local response to reports of child sexual abuse. The outcomes of the task and finish group’s work will be reported as part of next year’s yearly report.

LEARNING FROM THE NATIONAL PANEL - 3

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

“It’s Silent”: Race, racism and safeguarding children

In March 2025, the Child Safeguarding Practice Review panel published its fourth briefing report about 53 children from Black, Asian and Mixed Heritage backgrounds who died or were seriously harmed between January 2022 and March 2024.

These children were subject to horrific abuse, including sexual abuse, fatal assault and neglect, with 27 children dying as a result.

The report sought to understand the specific safeguarding needs of children from these specific ethnic backgrounds and how agencies helped to protect them before it was too late.

The following key findings emerged from the research:

- **Limited Attention to Race and Ethnicity -** the analysis reveals a concerning lack of focus on race, ethnicity, and culture in both safeguarding practice and reviews. This oversight has resulted in insufficient critical analysis and reflection on how racial bias impacts decision-making and service offers to children.
- **Silence on Racism -** the report identifies a pervasive silence and hesitancy to address racism and its manifestations. This silence renders the safeguarding needs of Black, Asian, and Mixed Heritage children invisible, both in practice and in the system for learning from reviews.

Missed Opportunities - in failing to acknowledge race, racial bias and racism, the current system misses many opportunities to learn from incidents where Black, Asian, and Mixed Heritage children have been seriously harmed or died. This failure to see the totality of children’s lives or to scrutinise how racial bias may have affected decision-making leaves children vulnerable and at risk of harm, without the necessary support and protection.

The Partnership’s response to this learning

The National Panel’s report will not be considered by the Executive Steering Group until May 2025.

Impact of the Partnership’s response

This will not be known until the Partnership considers the report and its response in August 2025. The outcomes will be reported as part of next year’s yearly report.

PERFORMANCE AND EFFECTIVENESS

Assurances of effectiveness

There is a range of existing quality assurances provided to the Executive Steering group on a regular basis:

- Aidhour [Scrutineer function] (Quarterly)
- Partnership report (Yearly)
- Domestic Abuse Strategy (Yearly)
- Private Fostering (Yearly)
- Safeguarding Self-Assessment Audits (Six-monthly)
- Pan Berkshire Policies and Procedures for Children and Adults (Quarterly)
- Partnership Business Manager's report (Quarterly)
- Child Death Overview Panel's report (Yearly)
- Local Authority Designated Officer (LADO) report (Yearly)

Performance Data sub-group

Early efforts to establish this sub-group have not been as successful as hoped. Whilst partners continue to collect their respective datasets, the challenge has been to choose which indicators best show how effective local safeguarding arrangements are.

This work requires a renewed approach over the coming year to provide the Executive Steering Group with the information it requires.

Quality assurance sub-group

This sub-group was created to capture the more qualitative type of evidence of safeguarding effectiveness. As the year has come to an end, the sub-group has a new chair and a renewed sense of purpose. As the sub-group is relatively newly-established, its primary aims have not yet been fully realised.

These are early days however and there are plans in place to gather a richer collection of information from:

- single and multi-agency audits
- self-assessments and peer review processes
- complaints and compliments

Evidence of the impact of this work is not yet available but will feature as part of next year's yearly report.

PARTNERSHIP BUDGET

Contributions from partner agencies

The Partnership's total budget for the financial year 2024-2025 was £132,299 and it was made up from the following contributions:

Organisation	Amount	Proportion
RBWM Adult Social Care	£50,590	38.2%
Frimley Integrated Care Board	£41,013	31%
RBWM Achieving for Children	£30,225	22.8%
Thames Valley Police	£8,820	6.7%
Berkshire Health Foundation Trust	£1,323	1%
The Probation Service	£328	0.3%
Total	£132,299	100%

Partnership costs

The Partnership's business office arrangements have been established with the minimum requirements necessary, namely one full-time business manager and one full-time business support officer. This model is considerably smaller than equivalent safeguarding partnership business arrangements across Berkshire.

Cost category	Amount	Proportion
Employee related expenses	£99,729	75.4%
Supplies and services	£32,570	24.6%
Total	£132,299	100%

End of year outturn

£55,967 was unspent at the year end. This was due to the lack of full-time staff in post during the year and review chair/author fees that will not become due until the financial year 25/26.

AREAS FOR DEVELOPMENT

During 2024-2025 there has been much work done to establish basic systems and reporting lines to ensure that the Partnership is effective in its aims.

Re-establishing the Partnership infrastructure in the absence of business support has meant that developmental work to tackle the strategic aims outlined in page 3 of this report, has been delayed. Whilst this report is clear on the strategic aims and direction, it is not yet sufficiently detailed on the impact of the Partnership's work.

As the work of the Quality Assurance sub-group develops, the evidence of impact will become clearer.

There are a number of areas for development in 2025-2026 that will need to be prioritised by the Partnership:

Concluding longstanding review processes

Review processes locally have become unnecessarily drawn out. Most of the reason for this is down to the way in which the chairs and authors were appointed.

Any future commissioning arrangements will be based on a robust and agreed process to avoid the unfortunate repetition and delays to the process that are challenging for families and practitioners alike.

Establishing the Lead Safeguarding Partners' (LSPs) Oversight group

This is a core statutory requirement and there are plans to convene the inaugural meeting in November 2025.

Sub-group configuration

The expected productivity from the sub-group structures during this year have not been realised. Whilst the Case Review group continues to oversee all review activity effectively, the Data and Quality Assurance sub-groups have been less effective.

Raising the profile of safeguarding in education

Schools, colleges, early years and childcare settings, and other educational providers (including alternative provision) all have a pivotal role to play in safeguarding children and promoting their welfare. Their insight and cooperation are vital to the successful delivery of multi-agency safeguarding arrangements.

To this end, a new sub-group has been formed to ensure that the 'Keeping children safe in education' guidance is complied with. The sub-group will be chaired by the Deputy Director for Education.

The voices of children, adults and families

The voices of children, adults and families should be at the heart of local safeguarding arrangements through direct feedback, informing policy and practice.

This is an area of work where partnerships have historically struggled to provide evidence of engagement and impact.

Service-user engagement is considered as part of the independent scrutiny arrangements and will have a higher priority in the year to come.

INDEPENDENT SCRUTINY ARRANGEMENTS

The Partnership has a dual approach to independent scrutiny. Two independent members (unpaid) sit with the Partnership's Executive Steering group to scrutinise decision making.

In addition, the Partnership commissions the services of Aidhour Ltd., a social enterprise company that offers specialist consultancy support.

Evaluation is the key

Independent scrutineers evaluate and contribute to the published multi-agency safeguarding arrangements and this annual report, alongside feeding into the wider accountability systems such as inspections.

The Safeguarding Partnership is keen to know your experience of reading this yearly report.

Is there anything missing that you'd like to know more about?
Is the report clear enough?

We are always looking for ways to improve the reach of our important safeguarding messages.

Any and all feedback you can provide would be welcome to: safeguarding.partnership@rbwm.gov.uk

Aidhour is regarded as a 'critical friend' to the Partnership. For the first time this year, the work undertaken by Aidhour is structured around the functions identified in Working Together 2023.

In its' quarterly updated workplan to the Executive Steering Group, Aidhour provides safeguarding partners and relevant agencies with:

- independent, rigorous, and effective support and challenge at both a strategic and operational level
- assurance to the whole system in judging the effectiveness of the multi-agency safeguarding arrangements through a range of scrutiny methods, such as attendance at sub-group meetings, deep dive reviews, reviewing data and reports, and consultation
- oversight to ensure that statutory duties are being fulfilled, quality assurance mechanisms are in place, and that local child safeguarding practice reviews and national reviews are analysed, with key learning areas identified and effectively implemented across the safeguarding system
- assurance that that the voice of children and families is considered as part of scrutiny and that this is at the heart of arrangements through direct feedback, informing policy and practice
- independent advice when there are disagreements between agencies and safeguarding partners
- opportunities for two-way discussion and reflection between frontline practitioners and leaders

FEEDBACK FROM INDEPENDENT SCRUTINEERS

Sally Mortimore
Independent Scrutineer and managing Director of Aidhour

The role of the independent scrutineer is to carry out the independent scrutiny function as set out in Working Together to Safeguard Children 2023 the independent scrutineer provides the critical challenge and appraisal of the multi agency safeguarding partnership arrangements in relation to children and young people the row forms part of these arrangement and focuses on providing assurance in judging the effectiveness of the arrangements to protect children and support a culture and environment conducive to robust scrutiny and constructive challenge.

The Independent Scrutineer role to the Royal Borough of Windsor and Maidenhead is provided through a team approach, through the Aidhour team consisting of senior managers with backgrounds in Health and Children's Social Care.

The team have been represented on all subgroups of the Partnership and attended almost all of these meetings during the year. They have also observed a variety of other meetings such as Children Safeguarding Reviews. The team meet with the Business Manager on a monthly basis to discuss how the workplan has been progressed. However, since February 2025, they have not been present during Executive meetings beyond presenting updates on their workplan.This was a decision made by the Executive that scrutineers are a commissioned service and therefore did not need to attend.

As set out in previous sections of this report, whilst the appointment of a business manager and admin support has been extremely helpful in moving the business of the partnership forward, it has been disappointing that progress in some subgroup work plans has been very slow. For example, the newly formed Quality Assurance and Performance subgroups have yet to agree on a cross-partnership quality assurance framework and dataset from each partner to be submitted for analysis. Currently, this means that progress against identified outcomes has not been effectively measured. Consideration must also be given to how feedback from children and families can be meaningfully collected and collated so it can be accessed when required to influence changes in practice, support evidence of impact, and inform audit findings.

Another area that has been delayed is the rollout of learning from Local Children's Safeguarding Practice Reviews (LCSPR). Currently there is no mechanism for measuring how effective learning events may be following a review and whether the lessons learned from reviews impact on practice. The Independent Scrutineers have shared their concerns with the Partnership, and these have been acknowledged. It is important that the Partnership Executive ensures that there is some formal record of issues raised by the independent scrutineers and the partnership's response to any findings or recommendations made as the scrutineers progress their work plan.

Continued overleaf...

FEEDBACK FROM INDEPENDENT SCRUTINEERS

Continued from previous page:

It is important to note that throughout the year, no issues of significant concern were identified in the safeguarding practices of partner agencies. Agencies were observed to collaborate effectively within a culture of mutual respect and support, as also noted in the recent Ofsted report.

We are looking forward to reporting on our involvement with practice week that took place in October 2025 in the next report. Our focus going forward will be to support the development of the quality assurance group and the agreed multi-agency data set in order that the Safeguarding Partnership can assure itself that it is making a positive impact in safeguarding and promoting the welfare of children in the Royal Borough of Windsor and Maidenhead.

Sally Kemp
independent Scrutineer

Thank you for asking me to review the yearly report. It seems clear, well written and accurately describes the progress the Safeguarding Partnership is making, as well as being open about the challenges. I appreciate the openness and honesty about the areas that need further attention.

Paul Bevis
Independent Scrutineer

There has been an impressive revamping of the structure and processes of the Safeguarding Partnership this year. The organisational structure has been streamlined, and terms of reference far more clearly identified. Information is collated, distributed and recorded much more coherently. Meetings that I have attended have been more focused and business-like.

There has been a refreshing acknowledgement that the Partnership requires a more data-informed approach to both the current position and trends over time. In the past there has been considerable reporting of 'work done' with little evaluation of impact. The Partnership has recognised the need to base future priorities on the use of qualitative judgement supported by a focused use of quantitive data.

The appointment of a full-time Business Manager and an administrator was well-judged, and the current incumbents are at the forefront of driving the RBWM Safeguarding Partnership towards being an even more effective coordinator of the tireless and professional work of the partner agencies in safeguarding children and vulnerable adults.

There is a risk that the work of the Safeguarding Partnership will be undermined due to a lack of business resource, with a consequent risk of reputational damage to RBWM.