Bwrdd Diogelu Annibynnol Cenedlaethol Cymru

National Independent Safeguarding Board Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Annual Report
2022–23

Contents

Introduction

The National Independent Safeguarding Board is pleased to present the Annual Report for 2022-2023. This report marks the end of the second three-year term and the start of the third term of the Board (2023-2026).

The Board welcomes the recent arrival of three new board members from the third sector, the independent sector, and statutory sectors respectively, bringing new energy and greater diversity of perspective, to the work of the board at the outset of its third term.

It is also important to acknowledge the significance of the contribution of the members whose term came to an end in May 23. Between them, they brought an important degree of continuity and much wisdom and relevant expertise. Additionally, the Board wishes to recognise the significance of the role played by Jane Randall as previous chairperson, in strengthening the Board as an entity and in securing a collaborative basis for the Board's ongoing engagement with partners.

In this year of Board transition, the annual report reflects the work and achievements of the Board in its second term and the plans for going forward.

In reviewing the 2022-23 safeguarding year, the National Independent Safeguarding Board (NISB) has drawn on a wide range of sources of intelligence, with the work of the 6 Regional Safeguarding Boards, being of particular importance. The NISB has also drawn significantly on its commissioned independent research including a recently concluded Child Practice Review National Thematic. This has helped us to identify 3 key messages of strategic significance for strengthening future safeguarding practice and effectiveness across Wales.

Key Messages:

- **Volume, Complexity and Capacity** – The level of need and the complexity of the needs experienced by families is more acute than ever. This continues to generate significant new demand for preventative and remedial safeguarding services in most, if not all Regional Board areas. By contrast the safeguarding workforce appears to be at its least resilient. The additional and growing pressure that comes with these demands, raises serious challenges for all senior decision-makers and requires sustained collective attention, resource, and support at the highest level.

- **Understanding Safeguarding Impact & Effectiveness** – There is a broad consensus about the need to agree a widely shared approach to measuring and capturing the impact and effectiveness, of safeguarding practice across Wales as a whole. The NISB urges all relevant agencies in all Regions to take the next step in piloting a prototype of an All-Wales Safeguarding Performance Framework during 2024-25.

- A **Culture of Safeguarding Learning** remains at the heart of best practice in Wales. Learning is embodied in the Wales Adult and Child Practice Review Process and should continue to guide national learning. Nevertheless, it is imperative to strengthen the effectiveness and impact of learning. To do so, we urge all to embrace the findings and recommendations arising from the recently published **CPR Thematic - "Risk, Response and Review"** (October 2023) and agree a transparent and deliverable implementation programme.

National Independent Safeguarding Board [NISB]

Duties and Responsibilities

The National Board has three primary duties set out in the Social Services & Well-being (Wales) Act 2014:

1. *To **provide support and advice** to Safeguarding Boards with a view to ensuring that they are effective*
2. *To **report on the adequacy and effectiveness of arrangements** to safeguard children and adults in Wales*
3. *To **make recommendations** to the Welsh Ministers as to how those arrangements could be improved (S.132 (2)).*

In addition, eight specific responsibilities of the National Board are set out in *Working Together to Safeguard People*, the *Part 7 Guidance on Safeguarding*. They are that the National Board:

1. ***works alongside** Safeguarding Adults Boards and Safeguarding Children Boards to secure consistent improvements in safeguarding policy and practice throughout Wales (para 246)*
2. *will **engage with the chairs** of the Safeguarding boards, and relevant inspectorates…at least twice a year (para 258)*
3. *will **stay abreast of evidence and policy** approaches to safeguarding and protection in other parts of the UK and beyond in order to learn from those and to evaluate Wales' relative performance (para 261)*
4. *where a **theme of concern** is identified… the National Board could recommend to Welsh Ministers that the matter be escalated to Welsh Government for exploration or to the relevant inspectorate (para 263)*
5. *will use mechanisms to regularly **engage with a range of expert reference groups**, practitioners and individuals (para 264)*
6. *will **publish** its own **annual reports** including any **work it is planning**. It will also hold an annual engagement event or events (para 265)*
7. *has a specific duty under section 133 (2) (d) of the Act to "**consult with** those who may be affected by arrangements to safeguard adults and children in Wales." It will use that duty to enhance its understanding of and extend its experience of safeguarding and protection in Wales (para 266)*
8. *will* **consider the learning from the 'user engagement' activities** *of the Safeguarding Boards (para 266).*

Annual Report of the National Independent Safeguarding Board

The information that must be contained in the National Board's Annual Report is specifically described in The National Independent Safeguarding Board (Wales) Regulations 2015.

Membership of the National Independent Safeguarding Board April 2022 – March 2023

Tony Young
(Chair)

Lin Slater
(Vice-Chair)

Tessa Hodgson

Carys James

Des Mannion

Artie Meakin

Jane Randall
(Departing Chair May 2023)

** The 2019 – 2022 Term was extended for one year by reason of the national COVID Pandemic ending in May 23 rather than May 22. Two of our three new 23-26 board members (Carys James and Artie Meakin) joined the board in Nov, in effect towards the end of the 22-23 year with Des Mannion taking up membership in May 23.*

Overview of Safeguarding 2022-2023

No overview of the safeguarding landscape over the last year can fail to enter a note of concern regarding the enduring impact of the COVID 19 Pandemic on capacity and resilience, particularly across the whole safeguarding workforce. All 6 Regional Annual Reports cite this as a key enduring issue. We know from observing the debate during our direct regular engagement with all six Regional Boards, that the damaging impact of the epidemic continues to exacerbate the pre-existing recruitment and retention challenges across the sector. When combined with the double jeopardy of an ongoing cost of living crisis, which in turn further undermines the resilience of families, the demands on a workforce depleted in both capacity and expertise, continue to grow. Knowing this is small comfort to Regional Boards, since it re-doubles the imperative not only to ensure that safeguarding is stronger, better and more effective, but that all children and adults remain safe at all times; agencies know they have to do more with less and do it better, a safeguarding challenge that few would envy.

In preparing this report and reviewing safeguarding effectiveness across Wales overall, the Board would wish to highlight the extent to which, despite these pressures, all regions are able to evidence energy and application in endeavouring to meet the challenges and improve effectiveness.

Any reading of the evidence shared with the National Board regarding the steps being taken by Regional Boards is both impressive and reassuring. Their overall programmes of work, their developmental initiatives in response to emerging threats, the support, training, and resources dedicated to learning and improvement, all demonstrate unflagging determination to protect children and adults from abuse.

Clearly there remain areas of weakness, some of which are significant, and it is difficult to see how it could ever be otherwise given the scale and continuously evolving forms of abuse. Where weaknesses are evident, Boards, agencies and professionals are seen to be acting to address them, as it is right to expect. As the work of the Board's academic partners in undertaking the 2023 Thematic Child Practice Review demonstrates however, this relentless professional and Regional Board effort requires continuous collective attention at the highest level within all relevant constituent agencies and Government bodies.

Previous Board Term Legacy

The National Independent Safeguarding Board is still a comparatively new feature in the safeguarding landscape since the first Board was established in 2016. It has taken two terms for it to settle into its role and define its identity alongside a complex mix of long-established and full-time professional agencies.

In this context, the National Independent Safeguarding Board is committed to building on the important legacy and achievements of the previous Board term. Amongst the key positive gains that the previous board secured, **3 Core Commitments** will continue to occupy the capacity and focus of the Board going forward.

Sustaining Collaborative Relationships with Regional Safeguarding Boards (RSBs)

Survey feedback from our colleagues in the regions confirms our own belief that the previous board was successful in establishing collaborative and productive relationships with all 6 Board regions. These relationships have matured to foster a sufficient level of trust to enable healthy independent challenge and critical appreciation. In addition, our relationship is characterised by a significant measure of co-production. For example, colleagues from each of the RSBs have worked closely with the NISB during the last 12-18 months to support the development of a national safeguarding performance framework (see below).

In effect therefore, through its work with RSB colleagues, the NISB is now able to engage constructively with all statutory agencies and a diverse mix of independent and third sector agencies at a senior level, across Wales as a whole. This acts as a source of good intelligence concerning the effectiveness of policy and practice across Wales and regarding emergent safeguarding issues.

More importantly, it enables the Board to work in partnership with regions in pursuit of new initiatives and solutions.

Strengthening Relationships with Key National Stakeholders

During its second term, the board invested significant time and effort in building 'standing' relationships with Care Inspectorate Wales, Health Inspectorate Wales, the Education Workforce Council Wales, Social Care Wales, His Majesty's Inspectorate of Constabulary, His Majesty's Inspectorate of Probation and Prisons, the Older Persons and Children's Commissioners for Wales, the Welsh Audit Office, Association of Directors of Social Services Cymru, Estyn, the Violence Prevention Unit, the NHS Wales Safeguarding Network, the Five Nations Safeguarding Network and the Wales Council for Voluntary Services, amongst others. Survey feedback from colleagues in some of these agencies also confirms the benefits of maintaining close partnerships and promoting regular dialogue and debate at a national and UK & Ireland level, regarding questions of safeguarding policy and practice.

Progressing the "Shaping the Future of Safeguarding" in Wales Programme

This programme of work has been the Board's key driver during most of its second term and in contrast to its softer networking activity, has focused more analytically on exploring challenging questions relating to effectiveness on the ground.

This is a broad-based programme, intended to understand, evidence, profile, and promote a rounded understanding of safeguarding effectiveness across Wales. As such the programme rests on three principal domains:

- Evaluating practice and professional effectiveness.
- Understanding whole system performance.
- Capturing and learning from the Lived Experience of those directly impacted by safeguarding policy and practice.

Our commissioned academic partner Professor Michelle McManus and her colleague Emma Ball, (previously of Liverpool John Moores University, now Manchester Metropolitan University) have been central to this programme producing a series of commissioned reports, firstly on mapping out and evaluating the configuration of all multi-agency 'front door' arrangements in every local authority area in Wales (*Evaluation of Integrated Multiagency Operational Safeguarding Arrangements in Wales, August 2020*[1]); and secondly an evaluation of their effectiveness – answering the 'what works well' question (*Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales: What does good look like? November 2022*[2]). These key reports for the NISB, have set the baseline for the board's current and future work in its third term.

1. safeguardingboard.wales/wp-content/uploads/sites/8/2021/01/Final-report-Phase-1-January-2020.pdf
2. safeguardingboard.wales/2022/11/15/shaping-the-future-of-safeguarding-in-wales-project-findings-from-liverpool-john-moores-university

Child Practice Review Thematic

Risk, Response and Review: Multi-Agency Safeguarding: A thematic analysis of child practice reviews in Wales. Oct 2023

As the commissioners of this report, the NISB is pleased to be able to share its analysis and findings as a basis for national shared learning and constructive debate about how best to strengthen safeguarding effectiveness for children at risk across Wales and to further reduce the likelihood of significant harms occurring in future. We also believe that the learning it identifies, is highly transferrable to the other nations of the UK.

Although this report was published very recently and the bulk of the work was undertaken beyond the 2022-23 timeline of this Annual Report, it is appropriate to highlight it here simply because it completes an important suite of reports that began with the `Shaping the Future' Programme. More importantly, the report surfaces key messages which need early consideration by all safeguarding agencies and professionals. The report's 11 recommendations are therefore set out for consideration by Welsh Government at the end of this Annual Report.

The Report sets out the findings of an analytical review of 33 Child Practice Reviews (CPRs) that were undertaken by the six Regional Children's Safeguarding Boards (RCSB) in Wales between 2013 and 2021, identifying a number of areas where change is imperative in order to reduce likelihood of future harm, to improve practice and to strengthen safeguarding systems.

Equally the authors also noted an abundance of evidence of good and excellent safeguarding practice being carried out across Wales to protect and safeguard children. The report endorses the effectiveness of the CPR Model, this being a model that was developed in Wales and has become embedded in the work of the six Regional Safeguarding Children Boards, since its inception (Social Services and well-being (Wales) Act 2014: Working Together to Safeguard People Volume 2-Child Practice Reviews).

However, the report also makes the case that at the level of boards, there is evidence of the need to strengthen the action-planning-review cycle, following the completion of learning events and final reports, to ensure that learning is sustained over the longer-term.

In the main, areas of improvement are all linked to strengthening collective ownership at the level of operational safeguarding systems, multi-agency collaboration, information sharing, the confidence to challenge parents and others and the need to tackle under- capacity in the workforce. None of these factors are singular or offer simple solutions and all require concerted collective commitment at all levels, to further reduce risk and ensure that good practice is sustained over the long term.

The Report can be found here – **safeguardingboard.wales/2023/10/02/risk-response-and-review-multi-agency-safeguarding/**

Our 2023-2026 Commitments – A Balance of Continuity & Change

Given the advent of a third term and a 'new' membership, it was important at the outset to suspend assumptions about future priorities and enable new and established members to engage in a 're-set', albeit predicated on our pre-existing statutory duties as a board. We have therefore, used the period between May and Sept 2023, to engage in a shared review and debate concerning the previous and current work programme of the NISB.

This included a facilitated (Wendy Rose, Senior Research Fellow, Open University) day workshop in July 23, which provided members with the opportunity to review board achievements to date, share perspectives and to identify and debate what is or should be important for the board going forward. In addition, the event provided an opportunity to engage with the Albert Heaney, Chief Social Care Officer for Wales, and other key colleagues working on the national agenda.

In sum, the key conclusions of that process of reflection, have identified the following key commitments going forward:

During the 3 Year Term and effective from July 2023, the NISB will...

- **Ensure continuity** with the work of the 2019-2023* board, particularly with regard to maintaining a collaborative culture and building on shared productive activity with Regional Boards.
- **Ensure continuity** in building and extending dialogue with key national and UK wide safeguarding partners.
- **Ensure continuity in the NISB's 'national learning' role** – by
  - Continuing to ensure annual publication of an ***independent national thematic*** report drawn from Adult Practice Reviews and Child Practice Reviews (alternating annually between APRs/CPRs) published by RSBs in the previous two-year period.
  - Hosting an annual safeguarding seminar/conference to share national learning from APRs/CPRs and other independent Reviews.
- **Publish the 2023 Independent Child Practice Review National Thematic Report** (2 October 2023)
- **Continue the Shaping the Future Programme of work through proceeding with the implementation of a National Safeguarding Performance Framework and Promoting Collective Responsibility**
- **Finalise a Development Partnership with Manchester Metropolitan University** – to enable direct work with Regional Boards, provide capacity for the NISB and support implementation as above.
- **Oversee Action in relation to the Independent Inquiry into Child Sexual Abuse** (IICSA) Establish an effective methodology and reporting regime, to enable the NISB to exercise independent advisory oversight regarding the Welsh Government's response to the recommendations for government made by the Independent Inquiry into Child Sexual Abuse.

» **Re-cast the way the NISB works** – arising from our all-day review in July, it was agreed that the following areas needed to be 're-booted': –

– **Develop a NISB Communications Strategy, including a review and re-set of the NISB Website** – the consensus is that this is an area where we have been less active or successful. In 2023/4, we intend to redevelop our approach to promote a more outward looking, inclusive and contemporary website that seeks to engage a wider audience.

– **Review and re-set the format and focus of the NISB Annual Report** – to encourage readership. Our approach will be to significantly simplify the format, concentrate on key messages and incentivise more active feedback.

– **Review and re-set the format and focus of the NISB Annual Workplan** – maintaining brevity, simplicity and focus on key workstreams will govern our approach here also. See **safeguardingboard.wales/work-plan**

The Work of the NISB During the 2022-23 Year

NISB Strategic Duty 1:

To **provide support and advice** to Safeguarding Boards with a view to ensuring that they are effective.

Each NISB member is linked to a Regional Safeguarding Board (RSB) and all members attended their respective RSB meetings and development events during the year. When combined with the following, this acts a key source of intelligence concerning emergent themes and overall effectiveness at RSB level:

- Bi-monthly meetings between RSB chairs, WG and the NISB
- Engaging and meeting regularly with RSB Business Managers & WG

This NISB Annual Report draws significant intelligence concerning effectiveness, through Board member attendance at each of the Regional Boards throughout the year. As part of the Board's annual review of safeguarding effectiveness (in keeping with the strategic duty above) each NISB member undertakes a review of 'their' allocated board, drawing on their respective Annual Report. The detailed reviews undertaken by NISB members in relation to each RSB during 2022-23 are set out in Appendix III of this report.

NISB Strategic Duty 2:

To **report on the adequacy and effectiveness of arrangements** to safeguard children and adults in Wales.

Shaping the Future of Safeguarding in Wales" – a NISB Partnership Programme with Professor Michelle McManus of Manchester Metropolitan University

Throughout the year, ongoing work deriving from the "Shaping the Future Programme", as previously noted, has continued, involving an intensive, probing, and comprehensive 'whole-system' examination of safeguarding across Wales. This has resulted in the widest evidence gathering process of its kind in Wales to date, including 138 interviews with professionals from across all agencies and finally a granular review of 33 Child Practice Reviews.

The breadth and significance of this key driver of the Board's work has been amply summarised by Professor McManus and Emma Ball and key extracts from that summary are reproduced below.

This Programme began in 2020 with a study to explore integrated multi-agency operational arrangements across each of the 22 Local Authority areas.

This led to a large-scale national evaluation to determine 'what good looks like' within multi-agency safeguarding. This study had three workstreams: exploring practitioner perspectives, understanding experiences and views of service users and insights from performance management teams, alongside an analysis of safeguarding metrics collected by RSBs.

1. Shaping Future of Multi-agency Safeguarding Arrangements Evaluation

Evaluation Workstreams for the Shaping the Future of Safeguarding in Wales included:

After completing the Shaping the Future evaluation, two research project outputs were developed in partnership with the National Independent Safeguarding Board and the Regional Safeguarding Boards:

- The Collective Safeguarding Responsibility Model: 12Cs
- The National Multi-Agency Safeguarding Performance Framework for Children.

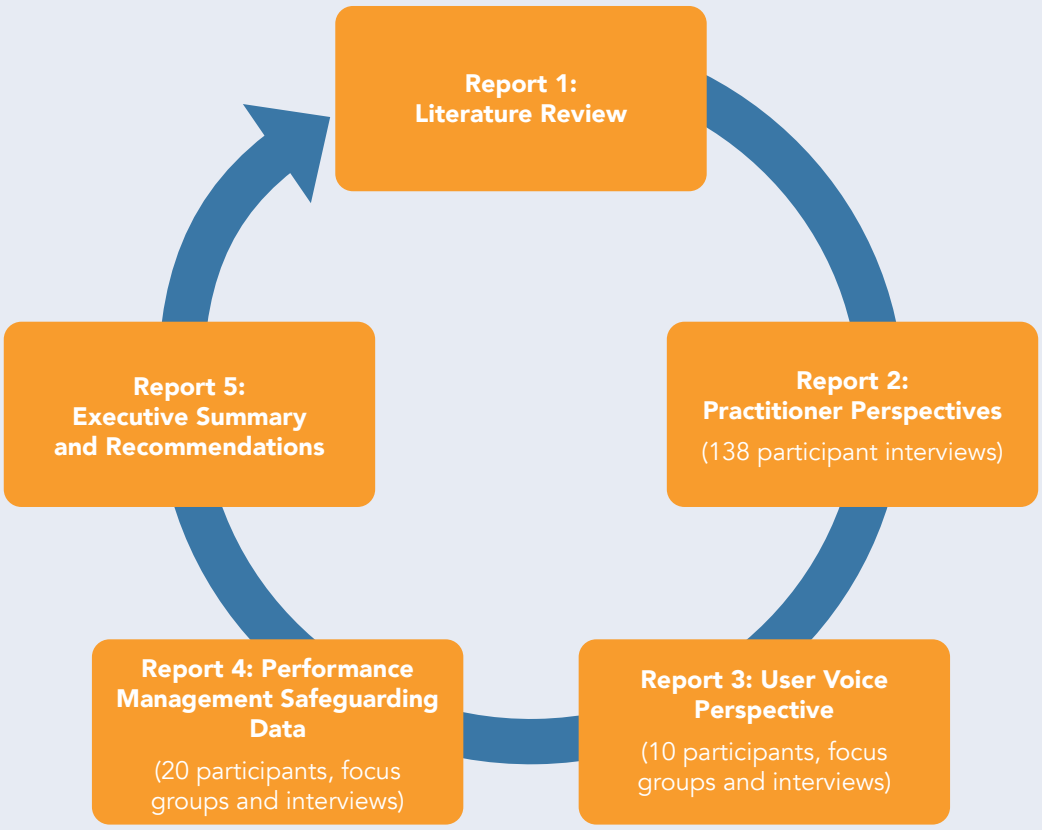
A separate piece of work was commissioned by the NISB in February 2023 to undertake a Thematic Analysis of Child Practice Reviews (CPRs) across Wales. This report identified a number of areas where change is imperative in order to reduce likelihood of future harm, to improve practice and to strengthen safeguarding systems.

Figure 1: Outline of Projects Completed

Recommendations have been made to the National Independent Safeguarding Board and the wider safeguarding workforce, which require transforming into meaningful action. The Collective Safeguarding Responsibility Model: 12Cs is seen as a key tool, alongside the National Performance Framework, in enabling safeguarding arrangements to provide assurances of the effectiveness of their multi-agency safeguarding practice.

Further summary information on each of the studies from Figure 1 are outlined below.

Five Evaluation Reports were completed as part of the Shaping the Future of Safeguarding Wales:



Alongside key recommendations, key outputs from the Shaping the Future of Safeguarding evaluation included:

2. The Collective Safeguarding Responsibility Model:12Cs[3]

The Collective Safeguarding Responsibility Model: 12 Cs, illustrates the enactment of *'Safeguarding is Everyone's Responsibility'*. The model offers a guidance tool for Regional Safeguarding Boards, Safeguarding Partnerships and Local Authorities to demonstrate measures which are being adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.

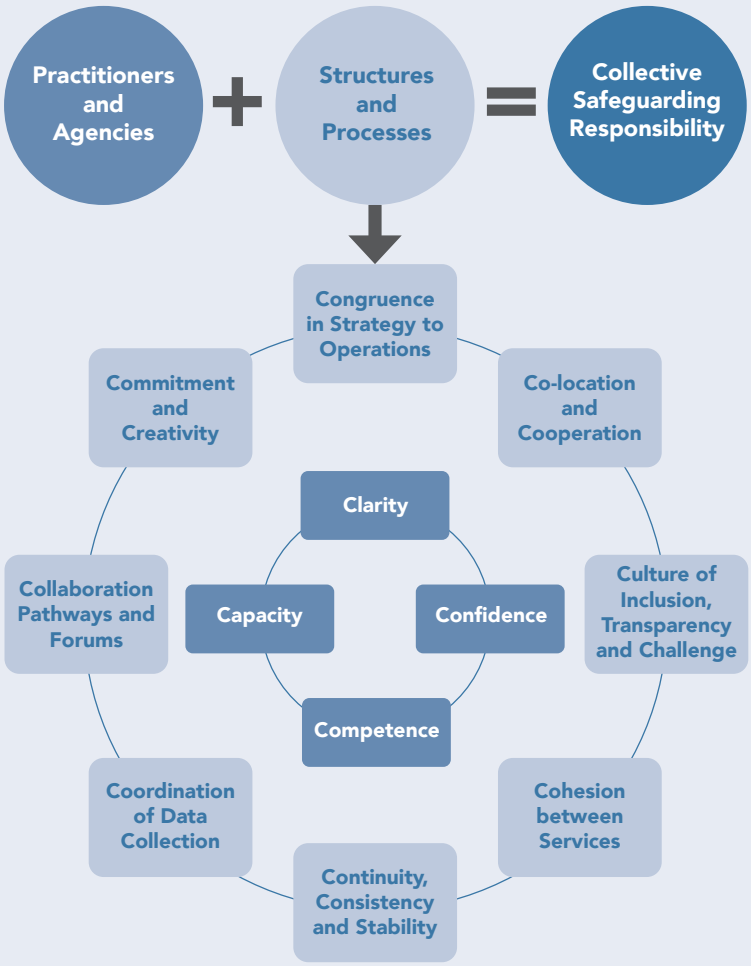


Figure 2: The Collective Safeguarding Responsibility Model: 12Cs

At the time of writing the ongoing development of the 12Cs Collective Safeguarding Responsibility Model will include a Governance Self-Assessment Framework, to enable participating regions to assess and evidence the extent to which they meet the broad criteria set out in relation to each of the 12 components.

An additional key output from the Shaping the Future of Safeguarding Wales work was:

3. Separate report available

3. National Multi-agency Safeguarding Performance Framework

The Performance Framework asks RSBs to answer key questions around 5 key domains utilising qualitative metrics and qualitative narrative. The purpose is to assure the National Independent Safeguarding Board that their safeguarding practice is effective at delivering on its objectives and that this can be evidenced. The Performance Framework was developed to include 5 elements/ domains for which metrics can be provided by RSBs to demonstrate performance.

Core metrics have been agreed by RSBs, with more information found within the National Multi-agency Safeguarding Performance Framework (NMSPF) Prototype Briefing Report.

4. Thematic Analysis of Child Practice Reviews (CPRs).

A Briefing Report and Full Report was produced on completion of this work, which examined 33 Child Practice Reviews (CPRs) that were undertaken by the six Regional Children's Safeguarding Boards (RCSB) in Wales between 2013 and 2021. The research team conducted descriptive, inferential, and thematic analyses of 33 CPRs. The analyses identified common trends in terms of risk factors and the multi-agency safeguarding response across this cohort of reviews. In addition, we analysed the quality and consistency of the reviews themselves. We sought to highlight the challenges, support better practice, and remove barriers to effective safeguarding across the entire professional safeguarding network. Key areas of focus within the report included:

i. Risk: Index Child and Family Characteristics within CPRs

This includes descriptive information to identify trends within the child and family characteristics and risk indicators.

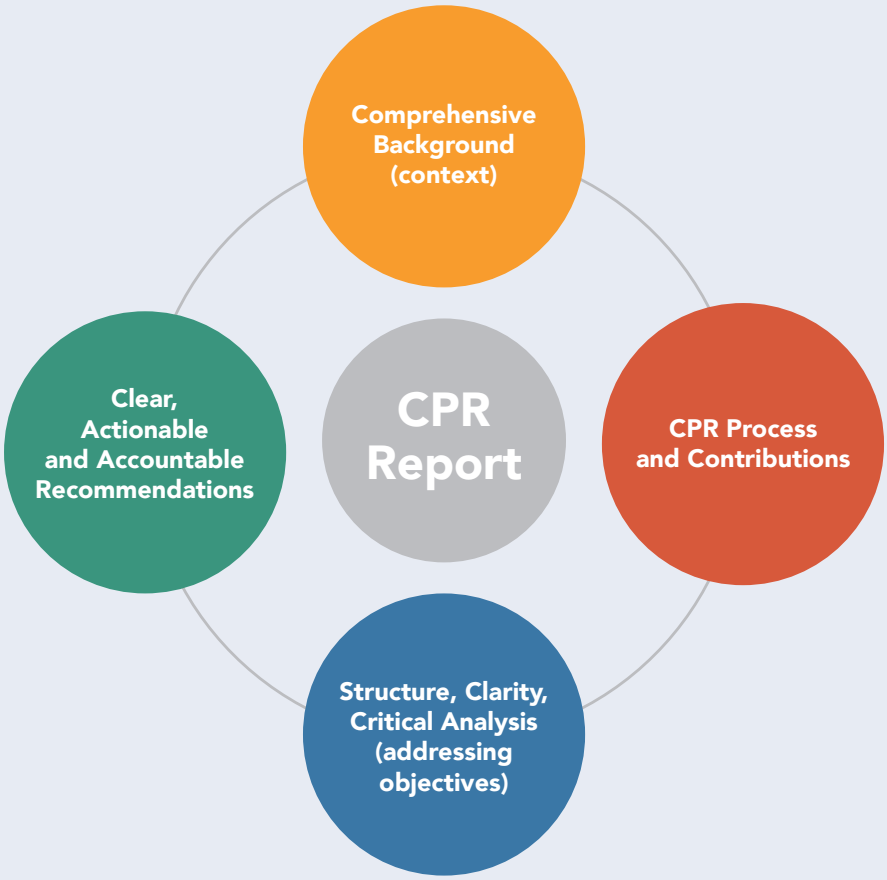
ii. Response: Organisational and Agency Involvement Prior to the Index Incident

This includes descriptive information to identify which organisations and agencies were aware of the child and/or family members prior to the index incident. This stage also includes the thematic analysis of the CPR multi-agency learning and response, with four key themes identified including:

1. Practitioner and Agency Challenges
2. Structures and Process Barriers
3. Wider influences on Practice and Processes
4. Identified Good Practice

iii. Review: Quality of CPRs

Given that the information contained within the CPRs aims to act as a key facilitator to drive learning, change, and action, it is important to explore the CPR reports themselves, in terms of structure, content, and adherence to the CPR processes.



Model of CPR Quality and Consistency

Key recommendations from the analysis of Child Practice Reviews have been identified and targeted at:

- **Practitioners and Managers**
- **Authorities and Boards**
- **Policy Makers**

In the main, areas of improvement are linked to strengthening collective ownership at the level of operational safeguarding systems, multi-agency collaboration, information sharing, the confidence to challenge parents and others and the need to tackle under-capacity in the workforce.

None of these factors are singular or offer simple solutions and all require concerted collective commitment at all levels, to further reduce risk and ensure that good practice is sustained over the long term.

* National Thematic Review of 33 Child Practice Reviews Undertaken in Wales A Report by Professor Michelle McManus and Emma Ball (Research Associate) of Manchester Metropolitan University, and Professor Louise Almond (University of Liverpool).

Single Unified Safeguarding Review Model

NISB members continued to actively contribute to the Welsh Government's **Single Unified Safeguarding Review** proposals in relation to deliberations regarding governance and the development of guidance to promote meaningful family and community engagement.
The Board submitted a separate and detailed technical critique in response to the national consultation exercise which concluded on 9th June 2023. Welsh Government published its response to the consultation 29th September 2023 which the Board is yet to consider at the time of writing.

Although it may be concerning that the SUSR programme has been subject to a series of delays, it is equally understood that this reflects the significant complexity of the programme's ambition. The extent of the work and capacity needed to engage appropriately with professionals on the ground and to secure change whilst maintaining the stability of a system already under acute pressure, may have been underestimated. Nevertheless, the Board is reassured by Welsh Government's declared determination to 'get it right' rather than simply deliver it against potentially unrealistic timescales. That said, the sector appears to be signalling mixed 'wait and see' messages.

The Board's reading of this, is that the overwhelming majority are welcoming the ambition and the concept inherent in the SUSR but that a significant number remain concerned about the potentially critical and destabilising impact on Regional Safeguarding Boards, of the additional duties and responsibilities that will accompany the change.

Inescapable questions remain about likely additional burdens on Board Chairpersons, Board Business Units and Board budgets. In addition, and of critical significance to the future effectiveness of Regional Boards, are the challenges associated with recruiting and retaining a sufficiency of skilled reviewers, from what is already a finite pool. Proposals and processes intended to address a range of critical issues regarding recruitment, retention, training, and standards, amongst others, were under development by the SUSR team at the time of writing, but it remains to be seen whether these prove sufficient to overcome what is already an intractable challenge; all stakeholders will be anxious that they do so.

The National Board is committed to playing its part in supporting successful implementation wherever it can, since the changes that will come with the SUSR are amongst the most significant for safeguarding professionals in a generation.

Horizon Scanning

An important part of the Board's activity is maintaining a watch on emergent issues in other policy areas that may have significance for safeguarding in Wales. Of relevance here, is our membership the work of the Five Nations Safeguarding Network (England, Northern Ireland, Ireland, Scotland, and Wales) which plans, hosts, and delivers a programme of relevant policy work throughout the year. In 2022-23, this included work in Ireland and Scotland relating to the development and strengthening of measures to protect the individual liberties of those subject to statutory protection (for example, equivalent Liberty Protection Safeguarding arrangements).

NISB Strategic Duty 3:

To make recommendations to the Welsh Ministers as to how those arrangements could be improved (S.132 (2)).

The National Board's networking arrangements with the professional safeguarding community in its widest sense across Wales as a whole, act as a key source for gathering intelligence regarding emergent national issues. Taken together with this 'soft-intelligence', the National Board's capacity to commission reputable independent research, has played an increasingly important role in evidencing areas that require programmatic, systemic, or policy change, including in those areas where government has a crucial role to play.

In the introduction to this report the NISB identified 3 key messages for all those engaged in safeguarding. These are repeated here along with the recommendations to Welsh Ministers.

Key Messages:

- **Volume, Complexity and Capacity** – The level of need and the complexity of the needs experienced by families is more acute than ever. This continues to generate significant new demand for preventative and remedial safeguarding services in most, if not all Regional Board areas. By contrast the safeguarding workforce appears to be at its least resilient. The additional capacity that comes with these pressures, raises serious challenges for all senior decision-makers and requires sustained collective attention, resource, and support at the highest level.

- **Understanding Safeguarding Impact & Effectiveness** – There is a general consensus about the need to agree a broadly shared, approach to measuring and capturing the impact and effectiveness of safeguarding practice across Wales as a whole. The NISB urges all relevant agencies in all Regions to take the next step in piloting a prototype of an All-Wales Safeguarding Performance Framework during 2024-25.

- A **Culture of Safeguarding Learning** remains at the heart of best practice in Wales. Learning is embodied in the Wales Adult and Child Practice Review Process and should continue to guide national learning. Nevertheless, it is imperative to strengthen the effectiveness and impact of learning. To do so, we urge all to embrace the findings and recommendations arising from the recently published **CPR Thematic – "Risk, Response and Review"** (October 2023) and agree a transparent and deliverable implementation programme.

The Recommendations to government set out here arise from the board's work during the 2022-23 year. In addition, the Board felt it was appropriate to include recommendations developed in the current year (2023-24) that arise from the recently finalised Child Practice Review Thematic*, because it is important to initiate the dissemination of the learning and promote implementation of the recommendations at the earliest opportunity.

Previous Recommendations to Ministers and Progress to Date

With the agreement of the Deputy Minister for Social Services, any recommendations made previously by the National Board will continue to be included in our annual reports until they are completed, as agreed.

Annual Report 2018-2019

Recommendation

"Welsh Government should continue to develop the data collection in relation to the abuse of older people and to ensure this data is analysed effectively to understand the prevalence of abuse of older people and their experiences."

*Welsh Government Update – **COMPLETED***

Substantial progress has been made in developing a relevant data set, which can be accessed at **tatswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/social-services-performance-and-improvement-framework/adults/adult-safeguarding**. In addition, a new Adult Receiving Care and Support Census (ARCS) has been developed over 2022, to start collecting individual level data on all adults who receive care and support from local authority social services. By being an individual level collection, the ARCS will provide a highly granular breakdown of the services provided and who is receiving them. It will fill many of the data gaps which currently exist and allow detailed analysis and understanding of the adult social care population.

Annual Report 2019-2020

Recommendation

"Welsh Government should set a timetable for the publication of the Statutory Guidance for Children Electively Home Educated in Wales as a matter of urgency."

*Welsh Government Update – **COMPLETED***

Statutory Guidance for Children Electively Home Educated in Wales was published in May 2023.

Recommendation

"Welsh Government should honour the commitment made to amend the regulatory framework around independent schools and the Education Workforce Council to include a requirement that all teaching staff and all school leaders in independent settings register with the Education Workforce Council (EWC)."

*Welsh Government Update – **COMPLETED***

From May 2023 an independent schoolteacher or an independent school learning support worker were required to register with the Education Workforce Council.

Annual Report 2020-2021

Recommendation

"Welsh Government should ensure that a review is undertaken to understand the impact and legacy on safeguarding in Wales of the Covid 19 pandemic. Welsh Government Update August 2022."

*Welsh Government Update – **ONGOING***

As reported last year, this is being undertaken as part of much wider national inquiry which is unlikely to produce relevant findings for some considerable time.

Annual Report 2021-2022

Recommendation

Shaping the Future of Safeguarding in Wales' (NISB Programme) "By the end of 2022 there will be recommendations from the completed work. The NISB recommends working collaboratively with the Deputy Minister and key stakeholders to take these forward in the coming year."

Recommendation

"In light of the national concerns around workforce deficits, the NISB recommends support for inclusion of workforce data in the prototype national multi-agency performance framework to ensure consistent monitoring and consideration of potential solutions to mitigate the impact on safeguarding practices."

*NISB / Welsh Government Update – **ONGOING***

Both recommendations have benefited from substantial additional development time and support by the NISB during 2022-23, in close collaboration with senior representatives from all Regional Boards. The headline outcomes of that work and outline performance framework have recently (Sept 2023) been shared with Welsh Government colleagues and the Deputy Minister, who has welcomed the ongoing work. The NISB and Welsh Government have agreed to move towards collaborative implementation of a performance framework prototype during 2023-24 and to support the voluntary adoption of the '12Cs' accountability framework by relevant partners.

New Recommendations to Ministers 2023-2024

1. Shaping the Future of Safeguarding in Wales Programme (Appendix 1)

The NISB commends two new platforms that have been developed in partnership with colleagues from Manchester Metropolitan University. These interlinked products are the ***National Safeguarding Performance Framework for Wales***, underpinned by a comprehensive ***Model of Collective Accountability, the 12Cs.***

In commending these new models to Welsh Government and all safeguarding agencies, the Board acknowledges that they are voluntary frameworks and that it is a matter for Regional and other partners to decide the extent to which they adopt them. Nevertheless, the NISB will be utilising these documents as a basis for re-shaping its own 2023-24 and 2024-5 Annual Reports and seeking tangible data, that evidences performance, from each of the 6 regional boards during the same period.

It is recommended that Welsh Government endorses the ongoing work associated with these developmental projects, currently being undertaken with colleagues in the 6 Regional Board areas and with Welsh Government officials.

2. Risk, Response and Review: Multi-Agency Safeguarding – A Thematic Analysis Child Practice Reviews in Wales 2022/23, October 2023, Professor Michelle McManus; Emma Ball. Manchester Metropolitan University.

As the commissioner of this important thematic report, the NISB commends its 11 Recommendations to Welsh Government and in particular to all agencies and individuals involved in safeguarding practice.

It is recommended that:

2.1 Welsh Government endorses the findings of this report and supports the implementation of the 11 recommendations made in the report and reproduced here.

1. RECOMMENDATIONS FOR PRACTITIONERS AND MANAGERS

For those professionals and agencies who work within safeguarding, our review highlighted several areas to consider:

1.1 Multi-Agency Partnership Training

We recommend that regular multi-agency training ensures common understanding, facilitates regular discussions of different agency perspectives and strengthens roles and expectations in recognising and managing safeguarding concerns. This can help to overcome collaboration barriers and enable more proactive responses where there is uncertainty about decision-making regarding thresholds for intervention, agency expectations and individual responsibilities. Training should specifically address:

- Understanding the child's voice as the daily lived experience of the child within their environment, how to best record, appropriately share and utilise within decision-making and interventions.
- Undertaking a 'Whole Family' approach and developing competent and confident workforce in applying 'Professional Curiosity'. Practitioners need to be clear on individual agency responsibilities and the processes and pathways for collating intelligence in identifying emerging risk. This includes co-occurring and interacting risk factors and with an understanding of the dynamic impact of past, present and potential risks in the continuing assessment of harm and risk.
- Key thematic areas in case studies of neglect and poor home conditions, which were identified as key interacting risk factors within the analysis, as well as within wider reports. Training should explore the roles and responsibilities of different agencies, but also the real-life challenges in transferring knowledge and theory into practice to identify pathways of interventions and support.

1.2. Professional Curiosity

We recommend that strategic discussions are initiated at LA and RSB level which focus on how Professional Curiosity is encouraged, facilitated and embedded into practice as a shared approach within and between all relevant professional agencies. Issues around agency expectations and limits within sectors and roles can be addressed in training. However, more clarity is required to explore how curiosity is embedded, supported, reviewed and monitored for maximum and continued effectiveness.

1. RECOMMENDATIONS FOR PRACTITIONERS AND MANAGERS

1.3 Prioritising Support and Supervision for all practitioners:

- Managers should ensure there is clarity on expectations for formal safeguarding supervision for relevant practitioners. This should include details on the frequency, duration and objectives of supervision and demonstrate an understanding of how this will be internally reviewed and monitored.
- RSBs must be assured that regular and effective supervision is taking place across sectors, which may require, for example, returned reports from relevant agencies to the RSBs. This monitoring will provide confidence that supervision across safeguarding partners is purposeful, impactful and of sufficient quality. Supervision should also seek to include how best to facilitate collaboration with key partners.
- Managers should also seek to provide and review informal opportunities for practitioners to access safeguarding support.

2. RECOMMENDATIONS FOR AUTHORITIES AND BOARDS

For those organisations responsible for the delivery of safeguarding, our review highlighted several areas to address:

2.1. Threshold Uncertainty, improving Decision-Making, Agreement and Challenge

Whilst we acknowledge there are debates about the term 'thresholds', within this review it is used to describe a decision-making process in determining next steps and access to service intervention/response at a particular point in time. This review identified the need for:

- Multi-agency Thresholds – guidance should be agreed regionally to clarify expectations and as a point of reference for practitioners when making safeguarding referrals. Areas of concern, often subject to ambiguity and different interpretations, for example neglect, should be addressed. This should also include clear pathways for progressing concerns and challenging decisions should a safeguarding concern remain after a threshold decision has been reached.
- Local polices and protocols relating to managing emerging or escalating concerns and resolving professional differences should provide transparent and accessible pathways and processes. This should be referenced in the Multi-agency Threshold guidance and monitored as part of internal reviews.

2.2. Working towards a unified health record

This review has highlighted the key, but complex, nature of Health agencies within safeguarding. Whilst acknowledged as challenging, urgent work is required to further drive the facilitation of a unified health record. This requires:

- Bringing information from a range of Health services such as GP surgeries, Midwifery Services and Health Visitors is particularly vital to enable a whole family focus, when identifying emerging safeguarding concerns. In the absence of shared IT systems, consideration must be given to develop mechanisms which enable prompt routine information sharing and which promote relationship development between these practitioners.
- To address the complexity of the NHS and its divisions, we recommend the development of a nationally led Safeguarding Health Working Group, with stakeholders to consider the barriers and opportunities for collaboration and effective information sharing of low level and emerging safeguarding concerns.
- Any working groups should seek to liaise with the Department for Education (DfE) regarding their pilot work to improve multi-agency information sharing using a 'Consistent Child Identifier1'.

2.3. Measuring Effectiveness within Safeguarding Arrangements

Clearer evidence is required from RSBs/ LAs in demonstrating the effectiveness of their multi-agency safeguarding arrangements.

- RSBs and Local Authorities are encouraged to adopt the Collective Safeguarding Responsibility Model: 12Cs (Ball & McManus, 2023) as a toolkit. The 12Cs model details 12 components across "Practitioners and Agencies" as well as "Structures and Processes". This will help to identify challenges and inform more targeted work, as well as identify best practice.
- RSBs need to improve transparency in meeting the recommendations of CPRs. Each RSB CPR completed should be subject to internal annual review (e.g., as part of annual audits/corporate safeguarding reports). Given all CPRs provide a list of recommendations and required actions, the RSB should seek to collate all recommendations and actions required to improve safeguarding responses. This process should seek to identify common themes, share lessons and to better understand the improvements required across the region.

3. RECOMMENDATIONS FOR POLICY MAKERS

For those individuals responsible for shaping the continued development of our approach to safeguarding, our review highlighted several areas to address:

3.1. CPRs Quality Assurance

The full report undertook detailed analysis of the CPRs themselves, including the quality of the report and adherence to processes within guidance and legislation. Recommendations highlight that:

- CPRs should complete the 'core tasks' aspect of the review process, as defined by the terms of reference. We have drawn attention to the full list of recommendations and the template provided in our full report. This template should be adopted to ensure detailed information is consistently provided within CPRs.
- The timelines from case referral to sub-group to report completion should be reviewed. Many CPRS took more than double the suggested 6 months. Expectations must be managed and challenges acknowledged for future review processes.
- Moving towards the Single Unified Safeguarding Review (SUSR) process in Wales, these recommendations should be considered by The National Steering Group to improve the quality and optimise learning across all multi-agency reviews.

3.2. Development of Automated Safeguarding Referral/Report Portals

Given the complexities identified within safeguarding agencies and organisations that circle the family unit (see Model of Multi-Agency Connections, Considerations and Complexities), alongside the various potential Safeguarding Pathways (see Appendix 4 in full report), prioritisation should focus on building automated portals for professional safeguarding concerns to be received, reviewed and managed. This would enable increased opportunities for effective information sharing of softer intelligence and concerns.

- In receiving notifications of submissions alongside unique referral reference numbers it would encourage follow-up from referrers regarding any decision making and feedback. This would increase capabilities in searching and collating information on a child, wider family and household in determining a holistic picture of concerns raised.
- We note that this would require additional resource to implement and would need to work within current systems and pathways, such as MASHs/Safeguarding Hubs and Information, Advice and Assistance (IAA) front door processes.

3.3. Review of the 'Not Brought' Protocol to maximise this policy into practice

The 'Not Brought' Protocol was identified in many CPRs as requiring further implementation into practice, particularly regarding missed health appointments.

» A national 'Not Brought' protocol for all agencies needs to be developed to sit across RSBs. This should allow for a clear pathway of action, specifying the roles and responsibilities of each agency that is notified of information, should it require actioning.

3.4. Recording and Guidance relating to neglect and home conditions

Several CPRs identified issues with practitioners being unsure what detail was required to be reported to ensure accurate capturing of information. As per other recommendations within this review, the impact on all family members needs to be considered in these assessments and recording.

» Safeguarding records should detail the various, cumulative, and continuing concerns raised, what action was taken, and the longevity of any changes made. This would allow for increased application of current guidance such as the All-Wales Safeguarding Procedures; All-Wales Practice Guide on Safeguarding Children from Neglect (2021).

» RSBs should seek to review how neglect and concerns regarding home conditions are recorded, and who takes ownership and responsibility for these concerns, using their ability to extract information identifying escalating and/or continuing lack of progress from relevant agencies.

» Authorities should seek to develop multi-agency infrastructure nationally, to promote the sharing of softer safeguarding intelligence and to build a more accurate understanding of harms being recorded.

» Wider and more consistent use of the Information Advice and Assistance system may also offer a route to develop this.

3.5. Implementation of the 12Cs as a Guidance Framework and Audit Toolkit

Consideration must be given to how agencies can facilitate collaboration, joint-working and instil a collective responsibility for safeguarding. The Collective Safeguarding Responsibility Model: 12Cs (Ball & McManus, 2023) was developed as part of the National Evaluation Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales (McManus et al., 2022).

- We recommended that this model be implemented to support existing Guidance Frameworks, and Audit Toolkits across RSBs and LAs to help demonstrate any measures adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.

- Implementing the 12C framework would require RSBs/ LAs to respond to each of the 12Cs in turn to evidence what has been put in place or is planned to be implemented, to address this area. There is also an option to grade progress made within each of the 12Cs, which can be reviewed annually and monitored.

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