Bwrdd Diogelu Annibynnol Cenedlaethol Cymru

National Independent Safeguarding Board Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Annual Report
2023–24

Membership of the National Independent Safeguarding Board
April 2023 – March 2024

Tony Young
(Chair)

Lin Slater
(Vice-Chair)

Tessa Hodgson*

Carys James

Des Mannion

Artie Meakin

** Tessa Hodgson resigned from the board with effect from July 2024;*
a member vacancy remains and will be subject to recruitment during 2025

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Introduction

The National Independent Safeguarding Board is pleased to present the Annual Report for 2023-2024.

This annual report (2023-24) reflects the work and achievements of the Board in the second year (2023-24) of its fourth term but also takes account, both of work undertaken during the first 6 months of the current year, at the time of writing (Oct 2024), and aspects of the Board's 2025-27 plans.

Before setting out its report, the Board takes this opportunity to recognise the contribution of Tessa Hodgson, who resigned from the board in June 2024, due to the competing demands of her important leadership role in local government. Having been a valued member of the board since 2019, Tessa undertook a range of important roles for the Board. Perhaps more importantly, Tessa often acted as a source of wise counsel and incisive observation, particularly in reminding us of the significance of the way safeguarding is experienced and understood by children, families and the public.

In reviewing the 2023-24 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 (RSBs), being of particular importance. The NISB has also drawn significantly on the work of our commissioned independent research and development partner, Professor Michelle McManus and her team from Manchester Metropolitan University (Man Met), including, most importantly, their National thematic analysis, **Risk, Response and Review: Multi-Agency Safeguarding, A thematic analysis of child practice reviews in Wales** published in October 2023 (McManus M, Ball E, Almond L, Manchester Metropolitan University, 2023). This report has added significantly to our ability to understand the current national picture in Wales, relating to the effectiveness, impact and quality of safeguarding systems and practice.

3 Key Safeguarding Messages – Progress during 2023-24

In the Board's previous annual report (2022-2023) three key safeguarding messages were identified. Having reviewed the 2023-24 Annual Reports of each of the 6 Regional Safeguarding Boards (RSBs) and engaged directly with each RSB during the last 12 months, we comment below on the progress made over the year in addressing these complex themes.

Volume, Complexity and Capacity

The level and complexity of need experienced by families, remains at its highest ever and all agencies report that growth in the level of need continues unabated. This in turn, continues to generate significant new demand for preventative and remedial safeguarding services in most, if not all Regional Board areas. The picture concerning the resilience of the safeguarding workforce is no less discouraging, being reported as a continuing and critical challenge. Taken together, this volatile co-occurrence, of the two most fundamental dimensions for safeguarding effectiveness, remains very worrying and begs the question of whether more urgent intervention is needed at quantum by government, in tackling poverty and workforce resilience.

Progress during 2023-24

Whilst RSB Annual Reports evidence one or two excellent examples of interventions aimed at tackling workforce challenges, these tend to be isolated; taken together across Wales as a whole, there has been no measurable change in the assessment reported in 2022-23.

Understanding Safeguarding Impact & Effectiveness

The broad consensus, about the need to agree a widely shared approach to measuring and capturing the impact effectiveness, of safeguarding across Wales as a whole, continues to be a key plank of the Board's work.

Progress during 2023-24

All regions and safeguarding agencies have devoted substantial time and effort in collaboration with the Board and our academic partners (Man Met), to develop a model National Multiagency Safeguarding Performance Framework (NMSPF). Much of the necessary background work has been completed and detailed progress has been achieved for a NMSPFC (Children). Whilst it had been our plan, to launch and pilot the framework as a 'prototype' on 1st April 2024, this proved however, to be too ambitious in the face of the complexities of measuring safeguarding 'effectiveness' (as opposed to 'counting facts'), begging all kinds of questions about capturing qualitative intelligence, lived experience and workforce patterns. The revised position at present, is that the Board aims to launch a prototype on 1st April 2025 and test 'proof of concept' during the 2025/6 year. At the time of writing, the NISB/ManMet Strategic Safeguarding Partnership is arranging further workshops in each RSB region to enable us to progress a NMSPFC in April 2025.

A Culture of Safeguarding Learning

This 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 our published **Risk, Response and Review: Multiagency Safeguarding, A thematic analysis of child practice reviews in Wales, 2023** and agree a transparent and deliverable implementation programme to address the key challenges to effectiveness. safeguardingboard.wales/2023/10/02/risk-response-and-review-multi-agency-safeguarding/

Progress during 2023-24

It is notable that the majority of RSB's have already been able to report considerable progress in responding to some, or all, of the report's recommendations. This suggests real commitment to active learning and the implementation of change by RSBs, in pursuit of tangible improvement. Whilst it is too early to arrive at a well-formed overall judgement, as to the Wales-wide impact of the thematic learning on the ground, the Board expects to gather specific intelligence from all regional boards' 2024-5 Annual Reports next year (July 2025), and that this will enable a clearer understanding of where progress has been made and where it remains challenging.

"Learning" as a fundamental element of ensuring effectiveness and tangible improvement, remains integral to clinical governance and best practice development across Wales. There is ample evidence of ongoing active challenge and review in relation to a substantial cohort of cases across all Regions, that have met the threshold for a practice review, during the period. Nevertheless, signals from most Regional Boards, that the Adult and Child Practice Review (CPR & APR) process is under increasingly unsustainable pressure cannot be ignored, without attention to questions of augmenting resources and capacity and supporting and renewing 'reviewer' skills.

We note the welcome advent of additional reviewer training during the year to date (at the time of writing), ahead of the very recent launch of the Single Unified Safeguarding Review (SUSR) Framework in October 2024. We also understand however, that regional boards remain unclear as to how the additional burdens that may accompany the new framework, will be met. Whilst the advent of the SUSR heralds a coherent and single national overview of all APR/CPRs/DHRs/Mental Health Homicide/Offensive Weapons Homicide Reviews, and of learning and recommendations for best practice, it is to be hoped that the full benefit of this new model, can be fully achieved.

We welcome the imminent launch of the SUSR in Oct 24 but are obviously unable to comment on its impact at the time of writing. This will feature in the NISB's 2024-25 Annual Report.

A National Multi Agency Safeguarding Performance Framework: 5 Key Domains of Safeguarding Effectiveness

As part of developing a coherent and consistent approach to gathering and analysing intelligence about all-Wales safeguarding effectiveness, the National Board identified the following 5 Key Questions during the 2023-24 year, that we believe all relevant agencies and bodies should address, on an ongoing and annual basis.

1. Safeguarding Process

- How is the board assured that arrangements are effective in **identifying** and **responding** to safeguarding concerns?
- What are the **outcomes** of regional safeguarding processes and interventions?

2. Multi-agency Activity and Data

- How does the board assure itself that existing **protocols between agencies work effectively**, when individuals are identified as at risk from harm?
- What **data** is collected around this, how is it shared and what evidence has emerged in the period?

3. Thematic Hotspots

- What **key thematic sources of harm** which require a safeguarding response locally are evidenced in Board data?
- What **steps** have been identified to response to this thematic evidence?

4. Service User Feedback

- What are the RSB's **objectives regarding collecting service user feedback** in relation to direct safeguarding activity?
- What do the **metrics** that capture this feedback tell the Board?
- How does the Board plan to respond to this evidence and over what timescale?

5. Workforce Information

- What is known about **the profile** of the safeguarding workforce?
- How is **recruitment and retention** affecting delivery of safeguarding duties?
- To what extent is **multi-agency training** provided to and taken up by the safeguarding workforce?
- What evidence is available to assure the Board that agencies understand and respond to the **well-being and support** of the safeguarding workforce?

With 2023-24 being the first year in which these 'Five Questions' have been 'established', all Regional Safeguarding Boards, were asked to respond to each question in their 2023-24 Annual Reports. Although this exercise was treated as something of a 'pilot year', the board is encouraged with the level of buy-in to the questions and is pleased to be able to set out the results as summarised in the table below.

In more general terms, the National Board would wish to headline the following messages emerging from regional responses to each of the 5 Questions, for the first time: -

- All Regional Boards submitted responses or intelligence that sought to address each question.
- This has enabled the National Board, to surface a wide range of rich intelligence, not previously visible to the National Board, regarding safeguarding development and improvement and the challenges of securing and sustaining it, across Wales as a whole.
- All RSBs were clearly able to demonstrate strengths in understanding their own effectiveness in some domains but not in all.
- Not all responses demonstrated coherence, meaningfulness or consistency in terms of metric data and this was to be expected. This is the subject of ongoing work to develop a National Performance Framework.
- Some regional boards noted that they believed that further definitional guidance and advice, to enable more meaningful responses to the 5 Questions, would be welcome.
- The NISB/ManMet Strategic Safeguarding Development Partnership will provide a national workshop, to enable RSBs and the NISB to reflect on the further refinement of the 5 Domains and Questions in early 2025.

5 Key Questions
National Themes from Regional Boards 2023-24

It should be noted that unsurprisingly, RSB responses often fell into more than one domain or were attributed to one domain by one RSB, whilst another RSB might attribute the same intelligence to a different domain.

1. Safeguarding Process

- How is the board assured that arrangements are effective in **identifying** and **responding** to safeguarding concerns?
- What are the **outcomes** of regional safeguarding processes and interventions?

- All RSBs provided evidence of robust and active Board-level Quality Assurance processes and arrangements.
- Some RSBs evidenced partner agency self-assessment, in terms of data collection, community engagement and responding to the findings and recommendations of Adult and Child Practice Reviews.
- Most RSBs featured work that aligned with the NISB/ManMet-led development of a National Performance Framework.
- One Board highlighted a strong commitment to evidencing safeguarding outcomes and understanding impact for children and families and cited noteworthy supporting evidence.
- Several responses cited concerns that arrangements for 'assurance', concerning safeguarding processes, were over-reliant on Local Authority intelligence and arrangements and therefore lacked insight on a multi-agency basis.
- All RSBs cited the crucial and often highly effective role of RSB Sub-Groups, dedicated to this domain.
- A majority of RSBs reported robust processes but few were able to evidence 'outcomes'.
- One board highlighted innovative work in establishing a 'Board Risk Register', which was considered at every meeting; a methodology to capture and report on 'take-up' assurance data and patterns; and an ongoing overall 'Data Dashboard', including active RAG Monitoring of agreed board actions.

2. Multi-agency Activity and Data

- How does the board assure itself that existing **protocols between agencies work effectively**, when individuals are identified as at risk from harm?
- What **data** is collected around this, how is it shared and what evidence has emerged in the period?

- Taken across all RSBs, responses to this domain were highly variable, generally under-developed and relatively weak, often missing opportunities to exploit the potential of existing metrics, to 'tell the story' around prevalence, patterns of demand or similar. Responses rarely moved beyond being descriptive, rather than analytical. Much of this is associated with the inherent challenges of utilising metric data meaningfully but there were some striking examples that sought to tackle the challenge.

- Some RSBs cited evidence of good data analysis as part of Board business e.g. regarding criminal exploitation; Police Protection Notices; Policy & Procedures tracking and multi-agency audits.

- Similarly, data analysis had led one board to develop a tool to support practitioners in managing 'Threshold Uncertainty'; where there are adult safeguarding concerns. The same board's data analysis identified a significant strategic gap in making coherent linkages across strategic partners and forums in respect of children at risk outside the home; this was seen as undermining opportunities for developing a collective analysis to support the targeting of prevention and early intervention.

- Metric Data was more often cited where a board sought to understand and address specific phenomenon or system failure. We know, from our own attendance at all RSBs however, that all boards are active and often very effective at different times, in tackling specific phenomena in this way. The question is whether a reasonably disciplined and broadly consistent approach could be integrated more effectively into Board level data reporting and analysis, across a wider range of data as a matter of routine, rather than in response to a discrete problem or emergent issues alone.

3. Thematic Hotspots

- What **key thematic sources of harm** which require a safeguarding response locally are evidenced in Board data?
- What **steps** have been identified to response to this thematic evidence?

All Boards are known to be very active in identifiying thematic hotspots in-Region, albeit how this is achieved is not always clear and may simply reflect an appropriate response to emergent pressures during a given period. It remains an open question as to whether there is more scope for the excellent work that is supported in this domain to have greater all-Wales visibility and be shared effectively, to promote learning. This suggests potential scope for the development of some form of more general safeguarding 'learning portal' that interfaces with RSBs. Among the hotspots identified by RSBs, the following merit a highlight:

- **Suicide** – Having previously identified suicide as a theme requiring further attention, one board evidenced a well-established response to suspected and attempted suicides being offered at an earlier stage. Whilst this is due to be evaluated for 2024-2025, the Board reports that no individual who had been supported through this pathway, had gone on to commit suicide.

- **Transitional Safeguarding** – Having evidenced an in-built 'binary' approach to older children and young people subject to exploitation, the board is developing a multi-agency programme to address this risk.

- **Poverty** – One Board evidenced a notable emphasis on engaging a wide range of partners concerning the impact and challenges of poverty and its impact on safeguarding adults and children.

- **Criminal Exploitation** has been identified in one board's data as the most prevalent risk of harm outside of the family home and has led the Board to highlight the need for a national strategy to meet the response. The pilot of a RSB 'Risk Outside the Family Home Pathway' is being planned. Criminal exploitation in general, was cited by several boards, as a growing safeguarding challenge.

- **Self-neglect** – this area and its attendant challenges in terms of being able to intervene or prevent critical conditions, was cited by several boards as a major source of adult risk.

- **Harmful sexual behaviours amongst children and young people** was cited by one board as resulting in work to support the early identification and prevention of inappropriate and problematic behaviours to reduce the liklihood of escalation to serious harm.

- **Case Reviews** – One board cited very positive work in giving 'service users' and their families opportunities to engage in Child and Adult Practice Review processes and in encouraging direct feedback to the SUSR team at the end of the process. The Board's Business Unit has been working alongside the SUSR team and other Board areas to ensure feedback from families is embedded into the development of the SUSR in a meaningful, collaborative way.

4. Service User Feedback

- What are the RSB's **objectives regarding collecting service user feedback** in relation to direct safeguarding activity?
- What do the **metrics** that capture this feedback tell the Board?
- How does the Board plan to respond to this evidence and over what timescale?

It is widely acknowledged that gathering and analysing meaningful data and intelligence is very challenging in this area across the public sector as a whole and particularly so in safeguarding. Nevertheless, all boards evidence a strong commitment to drawing more fully on 'lived-experience', as a rich source of intelligence. Some interesting examples in RSB Annual Reports included: -

- A parent/peer advocacy network to evidence positive stories about personal change as a result of safeguarding
- A Junior RSB drawing membership from Youth Clubs
- The use of a video produced by young people was described as impactful on practice
- A survivors' panel established by the regional VAWDSV group, has undertaken a variety of commissioned work including providing training for the judicary.
- Initiatives also included the Identification of the unmet needs re non-verbal children or those with communication barriers; the identification of bullying and racism in educational settings; the development of a multi-agency practitioner guide to promote active engagement with lived experience.
- A preventative pre-birth service, offering support to parents up to the age of one year has resulted in a positive response from service users.

5. Workforce Information

- What is known about **the profile** of the safeguarding workforce?
- How is **recruitment and retention** affecting delivery of safeguarding duties?
- To what extent is **multi-agency training** provided to and taken up by the safeguarding workforce?
- What evidence is available to assure the Board that agencies understand and respond to the **well-being and support** of the safeguarding workforce?

- Whilst all regions cite very signficant and persistent workforce challenges, this is a domain that presents a challenge in terms of being able to capture, analyse and report on workforce patterns, particularly on a multi-disciplinary basis.
- Most boards appear committed to finding a way of addressing this critical safeguaring success factor and some regions have cited creative and effective approaches to the challenge, as highlighted below. That said, there were examples of a vacuum in some RSB Annual Reports.
- Meanwhile, all RSBs' Annual Reports evidenced well-developed and wide ranging training programmes that appear to be 'current', relevant, accessible and aimed at practitioners and operational managers.
- Some Highlights include: -
  - A notably comprehensive approach to workforce in one board region, evidencing robust analysis; with the ability to identify greater stability in respect of leavers and starters amongst safeguarding professionals and to understand the current status and impact of health visitor workforce demography and sustainability; strong awareness of the benefits of professional support and welfare were also described in this example.
  - In another region, workforce steering groups are providing a focus for staff retention and wellbeing activities. Staff development and carrer opportunities are noted to be key and a 'grow our own' pathway has been established in social care.

3year Strategic Safeguarding Development Partnership 2024-2027

It became clear to the National Board during 2023, that there was a danger of research and recommendation 'overload' unless additional capacity could be injected into the sector to support and encourage Regional Boards, partners and statutory agencies, to take forward the recommendations for change and development. This capacity was not available through the National Board itself or elsewhere and it became necessary to commission a development partnership.

Utilising a significant proportion of the NISB annual Budget, a match-funded partnership was established with Manchester Metropolitan University to enable a 3year programme (2024-2027) of policy, practice, and QA development work, to be undertaken in direct collaboration with regional boards and other partners; work commenced in April 2024. Much of this work will be shaped by the recommendations arising from the Child Practice Review (CPR) Thematic undertaken in 2023: "Risk, Response and Review", including further work in relation to the national multiagency performance framework and the "12Cs" (a model for promoting and enhancing more effective collective responsibility and for monitoring standards on both an interagency and inter-disciplinary basis).

The work of the partnership is now underway, and all Regional Boards are fully committed to engaging with the programme that includes areas of work detailed in the following section of this report.

Development of a National Multi-Agency Safeguarding Performance Framework

Children's PF – This programme of work continues to steadily progress in close and productive collaboration with all RSBs (RSB Business Managers, Senior L.A. Operational Leads) and some regional/national agency representation. Further regionally based, collaborative workshops, are underway at the time of writing, with more planned over the forthcoming year (2025-26) along with the offer of direct support to individual RSBs, through the NISB/Manchester Met Strategic Safeguarding Partnership. This requires an adjusted timescale with plans to agree a prototype for piloting with effect from April 2025-2026.

Adults PF – With a view to initiating work to progress a performance framework for adult safeguarding, Professor McManus, undertook a Rapid Literature Review of Adult Safeguarding in Wales (MAMRA, April 2024). This was based on a UK literature review and undertaken in close consultation with key expertise and leads from all RSBs and elsewhere in Wales. The report of findings was shared with 40+ senior leaders at a national round-table event, convened by the partnership on 19th June 2024. The report was well received, stimulating an appropriately challenging debate about key considerations and prompted a high degree of commitment from key regional and national players, to support the development of a performance framework for adult safeguarding.

The key objectives of this review, were to explore:

- Definitions of 'adult safeguarding' in Wales.
- Understanding the nature of Adult Safeguarding (forms/categories of safeguarding concerns).
- Legislation, policy and guidance relevant to safeguarding adults in Wales.
- Performance Management/measures that exist within adult safeguarding.
- Multi-agency responses to adult safeguarding, including partnerships, decision-making, good practice, challenges and key recommendations.

The National Board is currently planning to host a conference in Nov 2024, focusing on Adult Safeguarding at which this and other significant reports, findings and learning will be shared, including learning from England and elsewhere.

Our 2024-2027 Commitments
A Balance of Continuity & Development

During the 3 Year Term and effective from July 2024, the NISB will:

» **Ensure continuity with the work of the board**, particularly about 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 supporting learning from the new SUSR process and 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 2024 Independent Adult Practice Review National Thematic Report** (Due Nov 2024).

» **Continue the "Shaping the Future Programme" of work** through proceeding with the implementation of a **National Multiagency Safeguarding Performance Framework and Promoting Collective Responsibility**.

» **Oversee Welsh Government Action in relation to the Independent Inquiry into Child Sexual Abuse (IICSA)**.

» **Consider emergent findings from National Reports relating to the management of Professional Allegations** with a view to identifying potential areas for development.

» **Review the role, scope, and functions of the NISB** with a view to developing and preparing recommendations for change (January 2025), to the Deputy Minister.

» **Enhance the focus on Adult Safeguarding as a priority**, with a view to re-balancing of development activity, accordingly, taking its lead from the findings of the NISB/ManMet Partnership's Adult Thematic 2024 and from emergent evidence, available through the SUSR Repository.

Strengthening Relationships with Key National Stakeholders

The current board (2023-2026) continues to invest 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.

Developments that have emerged from our dialogue with 'external' partner stakeholders that merit a highlight are as follows:

- **Older Peoples Commissioner (Wales) (OPC)** – The NISB has continued to strengthen its relationship with the office of the OPC, through engagement with the **National Action Plan to Prevent the Abuse of Older People**. This work has been welcomed as the first of its kind in the UK, to better protect older people in Wales, who are experiencing or at risk of abuse.

- The Board was pleased to welcome the progress being facilitated by **Social Care Wales** in developing the **National Safeguarding Training, Learning and Development Standards** and the accompanying **Framework** which have been well received and now implemented.

- **Liaison with Inspection and Regulation bodies** – our engagement with relevant inspectorates both devolved and non-devolved, remains important for our understanding of wider developments and emergent challenges and for the most part these continue to be positive.

  That said we have become concerned that inspectorates appear to be subject to some of the same financial pressures that have brought many public-facing health and care services to the brink of crisis. It is self-evident that in the wider context of service delivery struggling to meet need with diminished resources, the role of inspection becomes even more significant, as a key safeguard against risk and a source of assurance. We have learned that budget reductions appear to carry the risk of a commensurate retrenchment of the professional workforce, with potentially worrying impact for the inspectorate's capacity to monitor standards and risk in relevant settings. The NISB will be seeking further insight and information on the true extent of any impact of these reductions, during the current year and reporting in our 2024-5 Annual Report, on what emerges.

The work of the NISB during the 2023-24 year in relation to its current statutory duties

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.

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 Strategic Safeguarding Development Partnership Programme with Professor Michelle McManus of Manchester Metropolitan University

The National Board's "Shaping the Future Programme" has continued to provide the overall platform for the work undertaken by Manchester Metropolitan University ("Man Met") as the Board's strategic partner. This programme continues to build on the series of reports reflecting an intensive and probing, 'whole system' examination of safeguarding across Wales.

Taken together, these reports provide the most comprehensive evidence gathering process of its kind in Wales to date, including interviews with professionals from across all agencies and finally a granular review of 33 Child Practice Reviews, published in Oct 2023.

The breadth and significance of this key driver of the Board's work has been amply summarised by Professor McManus and Emma Ball and were outlined in summary form in the Board's 2022-23 Annual Report. Fig 1 below, illustrates the projects completed to date, under the "Shaping the Future" programme and further detailed research reports, findings and recommendations can be found here.

Figure 1: Outline of Projects Completed*

* Elements 2,3 & 4 of this diagram continue to support and drive key elements of the National Board/Man Met Strategic Safeguarding Development Programme and are referenced throughout this annual report.

Thematic Analysis of Child Practice Reviews (CPRs) Oct 2023

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:

Risk: Index Child and Family Characteristics within CPRs

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

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:

- Practitioner and Agency Challenges
- Structures and Process Barriers
- Wider influences on Practice and Processes
- Identified Good Practice

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.

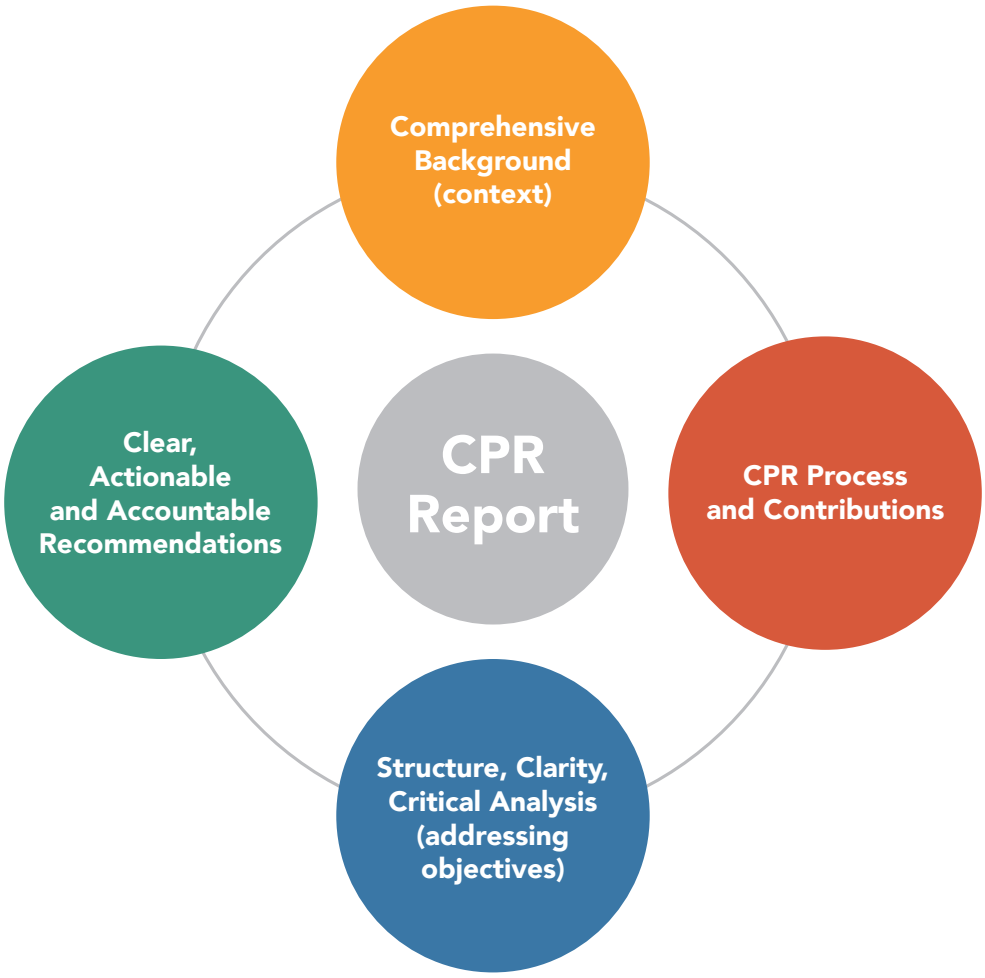

Figure 2: Model of CPR Quality and Consistency

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**, during 2023-24 and since. The National Board submitted a separate and detailed technical critique in response to the national consultation exercise which concluded on 9th June 2023; The Board is yet to view a demonstration of how the repository is expected to function in practice and is as yet unable to comment meaningfully on its potential.

It is noted at the time of writing that the SUSR framework has been formally 'launched' and established as the defined basis for the conduct of all Adult and Child Practice Reviews where these coincide with Domestic Homicide Reviews. It is noted that this new framework now includes Mental Health Homicide Reviews and Offensive Weapons Homicide Reviews.

The Board's reading of this, is that the overwhelming majority are welcoming the ambition and the concept inherent in the SUSR. Some boards remain concerned however, about the potentially critical and destabilising impact on Regional Safeguarding Boards, of the additional duties and responsibilities that will accompany the change, particular reference to 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 in the course of being implemented by the SUSR team and subject to dialogue between the SUSR and RSBs, at the time of writing. It remains to be seen whether these prove sufficient to overcome what is already a chronic challenge for some.

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. The Board welcomes the SUSR team's recently announced commitment to ensuring a strategic review of progress and impact at the end of the first full year.

Independent Inquiry into Child Sexual Abuse (IICSA)

As part of its inherent statutory duty to advise Welsh Government Ministers on the *"effectiveness of safeguarding arrangements in Wales"*, the NISB agreed to perform an *"advisory oversight role"*, in monitoring the commitments made by Welsh Government in response to the 6 recommendations made to WG by the Inquiry. Whilst IICSA published its final report and concluding recommendations on 20 October 2022, the subsequent action plan, agreed by WG in response to the Inquiry's recommendations, remains active and in progress.

Here, the National Board confines its comments on the extent to which the actions agreed by WG are effectively progressing; the board is able to reach a view on the basis of quarterly monitoring reports provided by WG, aided in addition, by periodic dialogue with Welsh Government officials.

From its establishment in March 2015, the Inquiry set out to investigate whether public bodies and other institutions in England and Wales – including religious, sports, schools, custodial, health and social care settings – have appropriately fulfilled their responsibilities to protect children from sexual abuse and exploitation.

The final report made **20 recommendations, 6 of which were addressed to the Welsh Government**. These were:

R1. **A single set of core data relating to child sexual abuse and exploitation** – in effect requiring improvements to data collection, consistency, population profiling, amongst other elements. This recommendation was accepted by WG.

The NISB is content that good progress is being made with a view to establishing a coherent and integrated data set. Work is progressing and subject to ongoing monitoring.

R2. **Child Protection Authorities for England and Wales.** This recommendation was accepted by WG noting however, that WG contend that the functions recommended for such an authority are already satisfied by the pre-existing statutory framework in Wales and the establishment of the NISB.

Whilst the NISB endorsed WG's response to R2, it should be noted that the NISB is of the view that it is now timely, in light of more recent strategic safeguarding developments in Wales, and wider learning, to review the scope, role and remit of the NISB, ten plus years after its establishment.

R3. **A cabinet-level Minister for Children.** This recommendation was accepted by WG. WG believes that this was achieved and remains part of the ministerial portfolios previously established in Wales.

The NISB agrees that this recommendation has been met and requires no further comment.

R4. **A public awareness campaign.** This recommendation was accepted by WG.

The NISB is content that WG is able to evidence substantial programmes of development in support of this recommendation and is clearly committed to this as an ongoing area for development and continual innovation. Work is in progress and subject to ongoing monitoring.

R13. **Mandatory reporting of child sexual abuse in certain circumstances.** WG accepts this recommendation in principle but is of the view that this requires a substantial programme of work to explore the implications for pre-existing statutory frameworks affecting reporting. A complex programme of work is underway to assess existing arrangements and the potential for strengthening them.

NISB endorses the proportionate approach currently underway and awaits further progress reports.

R16. **A national guarantee of specialist therapeutic support for child victims.** This recommendation was accepted by WG.

NISB endorses the WG's response to this recommendation. Aided by collaboration with external expert organisations, the WG continues to pursue a wider range of related developments to better understand, improve and strengthen the range, quality and accessibility of therapeutic services to child victims. Work is in progress and subject to ongoing monitoring.

Other Developments Relevant to Strategic Duty 2

Safeguarding Adults

The balance of much of the development work sponsored by the National Board, over recent years, has tended to feature children's safeguarding more prominently than adults. To some extent, this reflects the fact that the pre-existing practice and statutory safeguarding children's frameworks, have benefitted more substantially and consistently from closer policy attention over a longer period (40 years plus). Although the Board has continued to give Adult safeguarding priority, the Board recognised at the conclusion of 2023-24, that this needed to be materially expanded and enhanced and that 2024-25 should be a year when the Board would turn its attention more fully to adults. Being the tenth anniversary of the Social Services and Well-being (Wales) Act 2014, it was also timely to reflect on the extent to which the Act's aspiration, to put adult safeguarding on the same footing as children's, has been achieved.

On balance however, if it remains difficult to effectively capture reliable comparative intelligence, in order to evaluate effectiveness in relation to children, it appears to be doubly difficult to do so in respect of adults. This being so, any attempt to effectively assess the extent to which adult safeguarding has attained broad equivalence, when compared with children's, is unlikely to yield helpful answers.

Nevertheless, there have been some very helpful early signs of movement and development during the last 6-9 months (at the time of writing) which set some clear benchmarks in terms of gathering data, identifying broadly measurable objectives for strengthening safeguarding adults overall and in reaching a better understanding of the factors that impact on the risk of adult abuse. These include the advent of the Welsh Government's suite of performance measures in March 24 and more recently, the publication of the Welsh Government's **National Action Plan to Prevent the Abuse of Older People**. The NISB-Man Met Partnership has also provided workshops in-year, to share what has been learned from a 'desk-top' literature review of what is 'known' about adult safeguarding practice. If these developments have come on stream towards the end of the 10year anniversary of the Act, they are nonetheless very welcome and signal reasons to be hopeful that the agenda is now benefitting from overdue attention.

At the time of writing, the Board is also awaiting the outcome and publication of a research-led Thematic Review of those Adult Practice Reviews, undertaken over the preceding 2+ years, in Wales; this work has been undertaken as part of the NISB/Man Met Strategic Safeguarding Partnership. As part of scoping out that Thematic, the partnership agreed to collaborate with Professors Michael Preston-Shoot and Suzy Braye, in light of their recent review, of over 600 similar cases in England. Already, this has yielded invaluable transferable learning for Wales, although much of what has been learned makes for worrying reading.

Horizon Scanning

An important part of the Board's activity is maintaining a watch on emergent issues in other policy areas and beyond the borders of Wales that may have significance for safeguarding in Wales.

Of relevance in this respect, 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. Albeit National Board members have attended events organised by the network, Wales has been engaged as a somewhat passive participant in the work of the network during the last two board terms and this largely reflects the limitations of the NISB's capacity and time. Nevertheless, we recognise that Wales has much to share in the context of the Five Nations and that it would be appropriate for the NISB to play more of a role in facilitating or contributing Wales-based learning across the UK and Ireland, resources allowing.

Board members were able however, to attend (virtually) an **Inaugural International Adult Safeguarding Conference in October 2023** in Dublin, hosted by the School of Nursing & Midwifery, Trinity College Dublin. This Health Research Board-funded conference explored current issues in safeguarding adults in Ireland and internationally. The conference enabled attendees the opportunity to participate actively with the presenters during the keynote presentations and concurrent sessions.

Keynote presentations included:

Abuse in gendered institutional contexts: Sexual victimization of older adults in long-term care facilities (Thomas Goergen, German Police University, Muenster, Germany).

Sessions around Capacity & Decision making, the role of Advocacy in Adult Safeguarding.

Legislative gaps in Adult Safeguarding in Ireland; and the Safeguarding Journey so far in England, (Dr Gillian Manthorpe).

The Conference keynote sessions can be viewed on You Tube by searching "Inaugural International Adult Safeguarding Conference on Friday 27th October 2023".

Listening to Children and Adults

As part of its general duty to report on the adequacy of safeguarding arrangements in Wales, the National Board is required to *"consult with those who may be affected by arrangements to safeguard children and adults in Wales." (Section 133 (2) (d) of the Social Services and Well-being (Wales) Act 2014.* To date, the capacity of the Board makes it unrealistic to attempt a truly comprehensive or meaningful process of engagement directly with such a wide and highly diverse population or to identify a coherently representative group to represent such a diverse range of experiences. The Board is, therefore, necessarily reliant on drawing such messages from engagement and consultation activities undertaken by Regional Boards and their respective member agencies and by others, including the Children's Commissioner and the Older Persons Commissioner for Wales.

There is good evidence within the body of this report, that the engagement of Regional Boards, with those receiving preventative and protective safeguarding services, provides a rich source of information about what helps and what agencies could do better. Nevertheless, the National Board recognises the critical importance of 'listening' to children and adults affected and is currently working with the Regional Boards to support service user feedback by highlighting this as one of the Five Key Domains for safeguarding effectiveness.

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.

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 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 Update

The challenges associated with workforce are reflected in the "5 Key Domains of Safeguarding Effectiveness" discussed on pages 5 and 9 of this report. In effect, intelligence about how Regional Partners capture, analyse and monitor safeguarding workforce patterns is now established as one of 5 Key Questions on which RSBs are required to comment in their Annual Reports. This has not yet resulted in a coherent national safeguarding workforce data set albeit it is understood that this something that the Association of Directors of Social Services Cymru, is working on in collaboration with Social Care Wales.

Recommendation ***COMPLETED AND SUBJECT TO ONGOING DEVELOPMENT***

Recommendations to Ministers 2023-2024

1. Shaping the Future of Safeguarding in Wales Programme

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.

Welsh Government updated position provided October 24

Welsh Government officials have continued to support the development of a Performance Management Framework for Safeguarding Children and Adults whilst ensuring that other elements of data collection, for example, local authority data collection that relates to safeguarding, is taken into account. Officials have linked the Board and Manchester Metropolitan University with the National Office for Care and Support to this effect. Additionally, work being done to develop data sets around child sexual abuse by the CSA Centre of Excellence has also been shared with the National Office and Manchester Metropolitan University.

The 12Cs collective responsibility model has been recommended to Regional Safeguarding Boards (RSBs) and NISB has made this part of their annual reporting mechanisms. There is further work required from RSBs and NISB to ensure that this is well embedded post the initial year. Welsh Government officials continue to endorse this work with RSBs.

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.

Welsh Government updated position provided October 24

We note within the Thematic Review of Child Practice reviews this is a recommendation for Welsh Government. We are mindful though that it is Regional Safeguarding Boards who will implement the 11 recommendations. The NISB Chair and Board members attend meetings with Business Managers and RSB Chairs and are observers at RSBs.

The annual reports from the Regional Safeguarding Boards are shared with the NISB and will outline details of how they have worked to achieve the recommendations within relevant reports.

However, we feel the following additional information may be of assistance.

Recommendation 3.1 of the Thematic Review relates to the improvement of the quality of Reviews. This will be achieved through the development of the Single Unified Safeguarding Review (SUSR), the Wales Repository managed by Cardiff University and the new Guidance on completion of reviews. The SUSR launched on October 1st 2024. The NISB Chair is a member of the SUSR Strategy Group. The SUSR Team have attended NISB Board Meetings to provide updates.

Any incidents that meet the threshold for a Domestic Homicide, Mental Health Homicide, Offensive Weapon Homicide, Child or Adult Practice Review from October 1st will be managed under the new SUSR process.

The purpose of these meetings will be to share information about new SUSRs and ongoing Child and Adult Practice Reviews; consider quality; identify issues that the SUSR Strategy Group need to be informed of and potentially the Ministerial Advisory Board; ensure Ministers are briefed promptly and accurately.

Recommendation 3.2 relates to development of an automated referral portal that all agencies can access.

Information sharing has been consistently raised throughout Child and Adult Practice Reviews as an area of learning. The issues identified in terms of information sharing are varied and not solely linked to a technology enabled referral process. Whilst the benefits of a referral portal are understood, the development of such a system without a multiagency wider system consideration would limit the achievements of such a system.

Welsh Government officials have shared with the NISB the work undertaken this year by Health, who have completed a Strengthening Safeguarding in Health Review. There are technological solutions being piloted in Wales that explore how data can be captured from multiple systems to create a multiagency dashboard to support information sharing and decision making.

Recommendation 3.3: The 'Not Brought' Protocol is on the work plan for the Safeguarding Services in the NHS to review and a further update will need to be requested from them once this work has been completed.

Recommendation 3.4: Recording and Guidance relating to neglect and home conditions. The principles of the recommendation are agreed and understood. The details contained within the recommendation relate to Regional Safeguarding Boards, local authorities and the All-Wales Safeguarding Procedures.

RSBs are all represented on the Wales Safeguarding Procedures Project Board where national guidance and guides are developed and agreed. Welsh Government officials are also members of the Project Board and Welsh Government provide funds annually for the development of All Wales Practice Guides.

Recommendation 3.5: Implementation of the 12Cs as a guidance framework and audit toolkit. This has been answered above under Recommendation 1 of the Annual Report 2022-2023.

Recommendations to Ministers 2024

The Board is agreed that the recommendations made to Ministers in December last year, within the 2022-23 Report already provide a substantial agenda in terms of delivering policy improvement and managing change and the Board looks forward for the Minister's response, one year on. The Board therefore resolved only one additional recommendation arising from the 2023-24 year.

The role, scope and remit of the National Independent Safeguarding Board

The National Board has for some time been gathering views and intelligence about the effectiveness of Wales-wide governance arrangements and related policy and practice. As a result, the Board has been able to add substantial value, to a more fully evidenced understanding of safeguarding effectiveness and practice in Wales, over the last two Board terms. This has been achieved through a range of continuous and strategic development activities with key regional and national partners on a firmly collaborative basis; an approach which has been widely welcomed and which has enabled the Board to establish significant degree of confidence and trust in the "National Independent Safeguarding Board" as a constructive and effective national entity. The Board is also of the view however, that this has been achieved despite, rather than because of the current structure and capacity of the National Board, as conceived some 10 years ago, under the auspices of the Social Services and Well-being (Wales) Act 2014.

The Board is also acutely aware of demands from principal safeguarding professionals for greater clarity nationally, in relation to overall governance and for a clearer sense of overall national direction in key policy areas (e.g. understanding performance and effectiveness). It is also evident, from our programme of national and regional safeguarding events, that there is a clear appetite across the Wales safeguarding community for continuity in the longer-term research, learning and development journey that the Board has initiated as a trusted professional partner. That said the Board remains concerned that the activities it has engaged and sustained, despite the limits of Board resource and capacity, are unsustainable under the current model. This does not imply substantial augmentation of resource in order to secure a sustainable model. What it does imply however, is a modest level of additional resource and capacity and a commensurately modest re-casting of the Board's role, scope and function.

It is timely therefore, at the 10th anniversary of the Act and some 7 plus years after the establishment of the inaugural National Board, to review whether the National Independent Board and its range of current activities and aspirations, are appropriate and sustainable.

The National Board Recommends that the Welsh Government commissions a formal review of the role, scope and remit of the NISB, in close consultation with the current National Board membership and with a view of building on and enhancing what has been achieved to date.

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru

National Independent Safeguarding Board Wales

Ariennir gan Lywodraeth Cymru
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