Bwrdd Diogelu Annibynnol Cenedlaethol Cymru

National Independent Safeguarding Board Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Annual Report
2024–25

Who's who at the National Independent Safeguarding Board

Tony Young
(Chair)

Lin Slater
(Vice-Chair)

Carys James
(Until Summer 2025)

Artie Meakin

Des Mannion

Dave Street
(Joined Autumn 2025)

John Williams
(Joined Autumn 2025)

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Introduction

The National Independent Safeguarding Board is pleased to present the Annual Report for 2024-25.

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

In reviewing the 2024-25 safeguarding year, the National Independent Safeguarding Board (NISB) has drawn on a wide range of sources of intelligence, with the work of the six Regional Safeguarding Boards (RSBs) being of particular importance. 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). The core of this work has been set out in two national thematic reports to date: *Risk, Response and Review: Multi-Agency Safeguarding, A thematic analysis of child practice reviews in Wales* (published October 2023) and the *Thematic Review of Adult Practice Reviews Wales* (published March 25). These two seminal reports have 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. At the time of writing, the report of the findings of a further bi-annual Child Practice Review Thematic Report, through the lens of lived experience, is imminent.

3 Key Safeguarding Messages – Progress during 2024-25

At the outset of the Board's current three-year term, three components impacting on safeguarding effectiveness were identified and these have remained key. Having reviewed the 2024-25 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 three complex themes.

1. Volume, Complexity and Capacity

Progress during 2024-25

RSB Annual Reports evidence continued efforts and some excellent examples of interventions aimed at tackling workforce challenges and these are typically specific responses to pressures affecting a single Local Authority. All Boards report activity in supporting and maintaining the wellbeing of their staff groups. This is to be welcomed and is consistent with the findings of previous NISB reports and recommendations, namely that better and more systematic support for practitioners is needed. Additional information appears to suggest some early "signs" of greater stability, a slowing down of workforce turnover/attrition and a reducing over-reliance on agency staff. These examples tend only to be indicative and are not based on established evidence in all areas. Taken together across Wales as a whole, there appears to have been little measurable change in the assessment reported over the previous two years and it is too early to have confidence that these more positive indications signal a sustainable and widespread pattern of strategic reform.

2. Understanding Safeguarding Impact & Effectiveness

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

Progress during 2024-25

As in 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).

Children: Much of the necessary background work was completed, particularly in relation to Children in 2023-4. Whilst it had been our plan to launch and pilot the children's framework as a "prototype" from April 2025, including a defined and agreed set of "nationally agreed" multi-agency measures, this aim proved to be too ambitious. Nevertheless, the work undertaken by our ManMet colleagues has facilitated a much greater degree of consensus about a range of optional measures that boards may draw on, in order to evidence impact and effectiveness.

Adults: We also recognise that despite the Board's declared intention, no comparable work has yet commenced since our publication of a Thematic Review of Adult Practice Reviews at the beginning of 2025 (McManus, 2025), largely due to capacity constraints. There is clearly work to do in reviewing the current level, range and utility of multi-agency data relating to adults. The Board recognises that this gap needs to be addressed, and this will be reflected in the Board's 2026-27 Annual Workplan.

In considering the broader picture, the National Board sets out (pg 8-11) significant concerns regarding the current weaknesses in reporting on comparative patterns and trends at the national level in relation to children; similar concerns are relevant to adults.

3. A Culture of Safeguarding Learning

This remains at the heart of best practice in Wales. Learning is embodied in the Wales Child and Adult Practice Review (since extended and re-cast as part of the Single Unified Safeguarding Review (SUSR) and should continue to guide national learning.

Progress during 2024-25

Children's Thematic 2023: The key recommendations identified by Professor Michelle McManus and Emma Ball, are set out in the Man Met/NISB report "Risk, Response and Review: Multi-Agency Safeguarding, a thematic analysis of child practice reviews in Wales 2023." These recommendations were targeted at professionals, agencies, strategic leaders and decision-makers. All Regional Boards were required to provide a report to NISB, setting out the response and progress to each of the reports 11 recommendations.

Regions: All regions have evidenced substantial work being undertaken in response to some or all of the recommendations. This reflects real all-Wales commitment to active learning and to the implementation of change by RSBs, in pursuit of tangible improvement. The details of this progress can be found in the Annual Reports of each of the Regional Safeguarding Boards.

Health: It is recognised that some of the report's recommendations require sustained long-term effort to achieve them. In this context, we welcome the establishment of the Strengthening Safeguarding in Health Delivery Group in NHS Wales, to provide oversight and drive the implementation of priority recommendations made to Welsh NHS Services. Four dedicated workstreams are now leading and making progress on:

- Developing a Quality Statement for Safeguarding
- Establishing clear frameworks for accountability and assurance
- Establishing a learning Framework for safeguarding
- Exploring opportunities to use digital tracking systems to strengthen safeguarding.

In addition, Care Inspectorate Wales published its findings following their all Wales "Rapid Review' inspection of child protection registration practice in late 2023. The release of their findings broadly coincided with the publication of our NISB/ManMet "Risk, Response and Review" report and many of the same issues identified in one report were echoed in the other. Similarly, the effective reporting year for agencies to respond to the recommendations of both reports was 2024-25; again, the findings and recommendations of both, have been well received and embraced by Regional Safeguarding Boards.

We also note the launch of the **Single Unified Safeguarding Review (SUSR)** Framework in October 2024 although an evaluation of its impact and success during that period is yet to be concluded. We welcome the additional training that has been developed and delivered; this is seen to be of a good standard and has been very well received by regional boards and practitioners across Wales. We also welcome the SUSR's work with our ManMet partnership in embracing the i-Recommendation Framework that was developed as a result of the NISB/ManMet partnership report "A Thematic Review of Adult Practice Reviews, Wales" (March 2025).

CPR/APR Reviewer Shortages: As things currently stand however, we have also been made aware of an abiding concern in several regions, that the "skills supply-side" in terms of available and suitably experienced/skilled case reviewers, continues to be under real and unrelieved strain, bearing in mind the wider remit and additional burden of taking on new responsibilities relating to Domestic Homicide, Mental Health Homicide and Homicide with an Offensive Weapon. Whilst a sizeable number of reviewers and chairs has now been trained in the SUSR process, these individuals are often challenged in balancing demanding day jobs with undertaking reviews and they have limited capacity. This long-standing challenge appears to reflect the wider underlying workforce deficit across all agencies cited above and remains largely problematic. This requires a more coherent long term workforce strategy. The National Board would wish to contribute to any national initiative to find a way of addressing this crucial barrier, on a scale commensurate with the problem.

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

Launched in 2024-5 as part of developing a coherent and consistent approach to gathering and analysing intelligence about all-Wales safeguarding effectiveness, the National Board was pleased to see all Regions engaging with this "Five Domain Framework" in their 2024-25 Annual Reports. This appears to suggest that these domains are becoming "institutionalised" as a shared national framework for reporting safeguarding effectiveness, much as the Board recommended to Ministers last year.

The five Domains are set out here as five Key Questions. What follows below is a summary of each Regional Safeguarding Board's response to each question as captured in their respective Annual Reports for 2024-25.

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?

National Themes from Regional Boards 2024-25

The National Board highlight the following messages emerging from regional responses to the Five Questions in 2024-25, the second year of the Five Domain Framework:

Messages Overall

- All Regional Boards (RSBs) submitted responses or intelligence that sought to address each question. This has enabled the National Board, to surface a wide range of rich intelligence, 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.

- The National Board is encouraged by a range of initiatives across most regions aimed at strengthening data analysis. These developments illustrate a commitment to utilising the power of metric data more effectively and a growing willingness to resource the necessary skills and capacity, to do so.

- Not all boards were able to evidence an effective balance between an emphasis on strong and positive partner relationships and coherent and effective strategic planning, some being stronger in one or the other. Where boards did evidence strong strategic planning, they were able to harness wider resources to strenghten safeguarding effectiveness, typically in areas such as housing and community engagement.

Responses to each of the Domains in 2024-25
The 5 Key Questions

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, albeit to date this programme has still achieved only partial success overall.
- One Board highlighted a strong commitment to evidencing safeguarding outcomes and understanding impact for children and families and cited as noteworthy supporting evidence.
- Another Board has considered ways to deliver citizen-lead approaches to safeguarding, including citizen representation on the Regional Safeguarding Board and increasing awareness of how citizens can provide feedback on safeguarding practices.
- 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.
- In some Boards, the use of a strategic Board-level Risk Register, open to all partner agencies, allows for the escalation, review and mitigation of any barriers that affect multi-agency partners from effectively responding to safeguarding concerns.
- All RSBs cited the crucial and often highly effective role of RSB Sub-Groups, dedicated to this domain.
- One Board has established an annual programme of reporting to the Board by specific agencies on a rotational basis.

- Several boards reported good progress in the adoption of SUSR policy and procedures.
- Several boards cited the persistent gap around effective information sharing systems.
- Only one of the six Boards was able to evidence tangible 'outcomes", even whilst all Boards provided excellent examples of work designed to improve outcomes for individuals. Innovative work was noted in a number of areas. This includes a Multi-Agency Safeguarding Tracker (MAST) in West Glamorgan. This digital platform is designed to facilitate the secure sharing of information between safeguarding which allows all agencies to identify individuals who may need support or services, reduce the risk of individuals falling through the cracks of the health and social care system, and ensure that practitioners have the right contact information when they need it. MAST does not trigger or create referrals; rather, it provides a real-time view of safeguarding activity and interventions. An evaluation following a period of live testing has recommended that this product be "scaled-up" through onboarding other partner agencies and a MAST Pan-Wales Webinar delivered to colleagues across Wales attracted significant attention. The Cwm Taf Morgannwg Safeguarding Board has been recognised for effective multi-agency working in receiving two Wales Safe Communities Awards.

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?

National Data Reporting: Children – Authored by Professor McManus

The National Board is clear that high-quality safeguarding practice relies on the availability of accurate, timely data, accompanied by meaningful analysis. Robust intelligence is essential not only for understanding levels of need and patterns of harm, but also for supporting improvement activity and enabling leaders to make informed decisions about how best to protect children across Wales.

Historically, safeguarding data for children was published within the former *Social Services Performance and Improvement Framework* on the legacy StatsWales platform. These datasets were available up to 2023–24 and included extensive information on registrations, categories of abuse, age-related patterns, visits, core groups and Section 47 Children Act 1989 activity. Under the new StatsWales website, however, these safeguarding datasets do not currently appear to be accessible, despite the expectation that 2024–25 data now exists. Additionally, there has been no publicly available written analysis of safeguarding trends for children across Wales. The only published output is a very brief Welsh Government statistical note issued in March 2025, which provides minimal interpretation of the data.

This lack of analysis is particularly concerning given that our review of the available data indicates significant emerging trends that are currently receiving no national scrutiny:

- **Substantial variation between local authorities**

  There are striking differences in the rate of children on the child protection register. In 2023–24, Merthyr Tydfil recorded 146 per 10,000 children on the register during the year, compared with a Wales average of 113 per 10,000. Bridgend recorded an even higher rate of 205 per 10,000, while some areas such as Neath Port Talbot (57 per 10,000) and Newport (61 per 10,000) reported much lower rates. Similar variation is seen across the main abuse categories. Without national interpretation, it is unclear whether these differences reflect levels of underlying need, differences in thresholds, local practice, or data quality.

- **Rising physical abuse across several age groups**

  Physical abuse registrations have increased markedly across Wales, rising from 489 children in 2020–21 to 745 in 2023–24. This increase is particularly pronounced among children aged 10–15, where registrations grew from 102 to 223 over the same period. Such changes would usually trigger national discussion or inquiry, yet no published analysis currently highlights or explains these trends.

- **High levels of emotional abuse and neglect**

  Emotional abuse remains the most frequently recorded category of harm, with 1,386 children placed on the child protection register under this category in 2023–24 (a rate of around 22 per 10,000). Neglect also remains consistently high. While some age groups (such as 1–4-year-olds) show decreases over time, others show increases or fluctuating patterns. These meaningful differences are currently invisible without systematic reporting.

- **Older children are consistently under-represented**

  Children aged 16–18 account for the lowest number of registrations across nearly all categories of abuse and have remained comparatively static across the four-year period. While the low numbers may relate to how the data categorises older adolescents or how child protection processes are used for this age group, the absence of national commentary means there is no examination of whether this reflects unmet need, different risk pathways, or systemic barriers in practice.

- **Gaps and inconsistencies in the available datasets**

  Important indicators, including some measures relating to core groups, visits and child exploitation, are missing for particular years. These gaps significantly constrain the ability to undertake trend analysis, assess performance or understand changes in safeguarding demand. These inconsistencies are not acknowledged or explained in any public output.

Why this matters

Together, these findings show that Wales holds a substantial body of safeguarding data, but the lack of national analytical reporting means that important trends, risks and variations in practice are currently going unnoticed. The absence of narrative interpretation makes it difficult for safeguarding leaders and strategic, corporate or political decision-makers, to understand what is driving demand, where pressures are emerging, or whether children are being protected consistently across local authorities.

Recognising this gap, the Board has commissioned an analytical review to establish a coherent, reliable and regularly reported dataset that will strengthen national oversight, support local learning and enhance transparency across the safeguarding system.

Regional Safeguarding Board Data

Each of the Regional Safeguarding Boards and their partner agencies, is at a different developmental stage in their deployment of data; in some cases scant reference is made to data as a key evidential source although even here, data is often cited in relation to a highly specific emergent issue, triggering further investigation. In the best examples, data is used not just to monitor performance, but to shape strategy, allocate resources, and anticipate future demand. The development of the National Multi-Agency Safeguarding Performance Framework (NMASPF) will further strengthen oversight of safeguarding practice across Children's and Adult's Social Care but, as West Glamorgan Regional Safeguarding Board have commented in their annual report, *"in today's high-stakes environment, where public trust, fiscal responsibility, and citizen outcomes are under constant scrutiny, strategic leaders across the partnership landscape must embrace data as a core asset. This is not about technology for its own sake, it is about using data to lead smarter, act faster, and deliver better"*.

In our 2023-4 Annual Report, we reported that regional 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, identify patterns of demand or similar across the region. By contrast, the Boards' 24-25 Annual Reports provide more evidence that they are working hard to move beyond the fragmented or descriptive, and towards a more coherent and analytical use of local data.

Generally, Boards' understanding of professional safeguarding practice within a multi-agency context across the region, utilises local authority data which aligns with the Welsh Government performance indicators, captured and considered at Board, or within a quality and assurance group of the Board. In some Boards, the Police forces and Health Boards also provide data on key measures related to their safeguarding activity and practice. Examples of Board data submitted across agencies often includes information in relation to children at risk, section 47 Children Act 1989 investigations, children on the child protection register, looked after children (LAC), exploitation and modern-day slavery and hospital admissions because of self-harm. For adults at risk, information is commonly provided in respect of, for example, section 126 Social Services and Well-being (Wales) Act 2014 enquiries and the seven-day enquiry, domestic abuse, and provider performance. Boards generally offered explanations for the likely cause of an increase or decrease where statistical change was noted, ranging from structural service changes to campaigns raising public awareness but these were not always available or could not be evidenced.

Although Boards did not directly cite trend data, there was strong evidence of data-driven analytical work around Child Sexual Abuse, homelessness and Duty to Report patterns in health and care settings.

Several boards evidenced data analysis using Power BI particularly in the development of innovative solutions to emergent trends, most of which are cited in Domain Three – "Thematic Hotspots", with one Board working with the wider regional partnerships to capture information about Risk Outside the Home (ROTH).

Taken together, these developments illustrate the RSBs commitment to utilising the power of metric data more effectively and a growing willingness to resource the necessary skills and capacity, to do so. WGRSB, in their annual report, provide a clear and compelling key message: *"..data is not a back-office function – it is a leadership imperative, and funding is required to create opportunities for those that can open up this space for the Safeguarding Boards (Data- Scientists, -Engineers, -Analysts). The future of safeguarding, to prevent and protect, depends on our collective ability to:*

1. Champion a data-first culture.
2. *Invest in infrastructure, talent, and tools.*
3. *Embed data in strategic planning and governance.*
4. *Lead with transparency, accountability, and vision."*

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 identifying 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 whether there is more scope for the excellent work 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 highlighting:

- **Recurring Family Referrals** – work being undertaken to understand the patterns associated with this familiar phenomenon and "sub-threshold" concerns.
- The need for measures to help shape and **improve practice in adult safeguarding** in relation to **mental capacity, consent,** and unwise choices.
- **Myth busting in information sharing** – with a training resource that seeks to **enhance practitioner confidence** to share information more readily, proactively and proportionately within the confines of the law.
- North Wales Regional Safeguarding Board has taken an innovative approach in response to **violence in schools**. *Adolescence* tells the story of how a family's world is turned upside down when 13-year-old Jamie Miller is arrested for the murder of a teenage girl who goes to his school. The four-part Netflix series includes themes of incel culture, misogyny, and the treatment of women. In response to the impact of this TV series, the Board has **developed a 7-minute briefing to raise awareness of the concerns around the growth of the incel culture**.
- **Risk Outside the Home** and abuse perpetrated by people in **Positions of Trust** has surfaced in other board areas.

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?

By definition, safeguarding is first and foremost about people, whether in families or otherwise, involving highly personal, confidential and often intimate relationships. Accessing the experiences of people in this regard, in order to improve practice, is fraught with self-evident challenges. 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:

- User experience feedback from Child Protection Conferences leading to practice improvements. (Gwent RSB)
- A number of Youth Empowerment developments stemming from feedback underway (West Glamorgan RSB), for example, Know your rights'; Father and son sessions; Stay safe in sport; digital feedback mechanisms amongst others.
- West Glamorgan RSB and Mid and West RSB have both made significant strides in developing practice foregrounded in the voice of citizens. For example, both Boards have used the Most Significant Change (MSC) approach to capture the stories of individuals within either Children or Adult Services, or both, and this has given some unique and hitherto different perspectives of their response to need and risk.
- The work of the Survivors Panel in Mid and West Wales has directly influenced workstreams associated with this work with focus given this year to the impact of post-separation abuse and counter-allegations made by perpetrators of domestic abuse.
- During Safeguarding week, West Glamorgan RSB engaged with their local communities to understand what safeguarding meant to them.
- In supporting the capture of lived experience of service users, North Wales RSB have developed the Guidance document "Lived Experiences of the Adult". This has been developed to enable practitioners to consider the adult's experience and ensure that lived experience remains central to any action taken to safeguard the adult at risk.

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 significant 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 safeguarding success factor and some regions have cited creative and effective approaches to the challenge, as highlighted in the examples below. These provide some assurance to the National Board. 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.

Highlights from this section include: -

- A notably comprehensive approach to the 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 Mid and West Wales, staff development and career opportunities are noted to be key and a "grow our own' pathway has been established in social care. This has continued to be a success, and in 2024, produced a further seven newly qualified social workers for Children's Services. The programme estimates to have another five students qualify for children's services posts in the year 2025.

- Long-term recruitment strategies in Pembrokeshire include the "Golden Hello", relocation packages and social media campaigns. To ensure pay is not a barrier to new recruits, pay and salaries have been benchmarked alongside other local authorities within the region.

- In the Mid and West, the Board has oversight of the trends within the care, nursing home and domiciliary care sector. Assurance is provided via regional robust reporting mechanisms to the RSB. Reports this year have reflected waiting lists for domiciliary care have reduced during 2024/25, however providers are needing to be creative to ensure they are actively recruiting as well as retaining staff. Reliance on overseas workers is significant across all sectors.

3-year Strategic Safeguarding Development Partnership 2024-2027

The National Board's established Safeguarding Development Partnership is in effect at its half-way stage – "18 months in" (at the time of writing) and will achieve its 2-year milestone in the current financial year (2025-26).

The Board is unanimous in believing that this "development-partnership model", drawing on a highly skilled academic institutional resource, has made the single most significant contribution to the impact of the National Board since the relationship with Professor McManus was established in 2020-21 and that it has filled a significant gap in collaborative development capacity across Wales and its Regions. The substantial body of evidence-based "outputs" (five National reports in the period 2021-25 addressing key Wales-wide strategic challenges) flowing from this relationship speak for themselves. Detailed research reports, findings and recommendations can be found here.

Whilst the work of the partnership continues until April 2027 and will include the key programmes of work set out below, we remain convinced that this partnership model needs to continue well beyond 2027. It is now timely for the National Board to reflect on the range and impact delivered in partnership with ManMet and consider potential succession arrangements in order to sustain and strengthen an embedded and collaborative programme of evidenced-based development.

The NISB/ManMet Partnership will be hosting its annual conference in November 2025, with the bi-annual theme of learning from Child Practice Reviews.

NISB 2024-2027 Commitments
A Balance of Continuity & Development

During the Three Year Term and effective from July 2025, NISB will:

- **Ensure continuity with the work of the board** in promoting a collaborative culture and shared activity with Regional Safeguarding Boards.
- **Ensure continuity in building and extending dialogue** with key national and UK-wide safeguarding partners.
- **Enhance the focus on Adult Safeguarding as a priority**, with a view to re-balancing 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.
- **Ensure continuity in 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 2025 Bi-Annual Independent Child Practice Review National Thematic Report** (Due Nov 2025).
- **Continue the "Shaping the Future Programme" of work** being delivered by our NISB/ ManMet Safeguarding Development Partnership , including follow up-work programmes emerging from national research-based ManMet/NISB reports published to date; review and development of adult safeguarding performance metrics; contributing to development work to strengthen shared thresholds for decision-making in adult safeguarding.
- **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 and contribute to areas for development arising in the wake of the recently published North Wales RSB report Our Bravery Brought Justice (September 2025), the Child Practice Review undertaken following the conviction of ex-head teacher Neil Foden for sexual abuse against children.
- **Contribute to the Welsh Government's National Review of Governance,** building on the governance discussion paper recommended to Ministers, by the National Board in early 2025.

» **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.

The work of NISB during the 2024-25 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, with the exception of West Glamorgan RSB and more recently in relation to North Wales. Unfortunately, this has been due to the fact that the Board has been without a full membership complement for over 12 months. Any reduction in our membership has a disproportionate impact, in effect reducing its already limited capacity.

Nevertheless, when operating at full capacity, our close relationship with RSBs is a key source of intelligence concerning emergent themes and overall effectiveness. In addition to regular attendance at their respective RSB each NISB member undertakes an annual review of their allocated board, drawing on its Annual Report and this in turn forms part of the Annual Report of NISB.

NISB Strategic Duty 2:
To **report on the adequacy and effectiveness of arrangements** to safeguard children and adults in Wales.

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. The ongoing collaboration with RSBs in developing a performance framework to support information capture about safeguarding systems and practice progress against five key safeguarding domains is an important element of understanding effectiveness across Wales as a whole.

Thematic Analysis of Child Practice Reviews (CPRs) October 2023: Implementation of Recommendations

Given that the publication of the report (November 2023) occurred later in the annual planning cycle, the effective year for implementation was 2024-5. Based on progress reports submitted and visits to all Regional Boards by the research team and by National Board members during the year, the team has captured the overall picture across Wales. All Boards provided a comprehensive response to the recommendations and indicated how learning was being used to inform current practice and inform ongoing or new development plans.

The stubbornness of long-standing blockages to effective information sharing are an oft cited system failure. Meanwhile the ability of RSBs and agencies to solve or address them to the extent they might wish or can realistically achieve without intervention at a national level inhibits effective national solutions. More encouraging, there is good evidence that partners are exercising grip themselves for example in the current pilot of The All Wales Integrated Referral system.

Single Unified Safeguarding Review Model

NISB members continued to actively contribute to the Welsh Government's **Single Unified Safeguarding Review**, during 2024-25.

It is noted, at the time of writing, that the SUSR framework was formally "launched", in October 2024 and was established as the defined basis for the conduct of all safeguarding reviews. It is clearly much too early to comment effectively on the impact of the framework, save for our earlier observation concerning the very positive training programme and challenges in securing reviewers. 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) – update 13 November 2025

As part of its inherent statutory duty to advise Welsh Government Ministers on the "effectiveness of safeguarding arrangements in Wales", NISB agreed to perform an "advisory oversight role", in monitoring the commitments made by Welsh Government in response to the six recommendations made to the Welsh Government by the IICSA Inquiry. 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.

Here, the National Board comments on the extent to which the actions agreed by Welsh Government are progressing. The National Board's comments are based solely on quarterly monitoring reports provided by Welsh Government, aided by periodic dialogue with Welsh Government officials. The final report made 20 recommendations, six 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 Welsh Government.

NISB recognises that tangible progress is being made in establishing a coherent and integrated data set. This recommendation is being taken forward as a priority action in the ten-year Strategy for Preventing and Responding to Child Sexual Abuse.

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 NISB.

In our previous annual report NISB recommended to Welsh Ministers, that Welsh Government should initiate a "review (of) the scope, role and remit of NISB, ten plus years after its establishment."

At a United Kingdom level, Baroness Casey's audit of group-based child sexual exploitation (May 2025), raised concerns about the complexity of safeguarding governance, noting that "the multitude of organisations and splits in responsibilities do present challenges for clear, decisive leadership, effective partnership working and sharing of information."

Subsequently, (October 2025) the Welsh Government confirmed its intention to commission an independent review of governance arrangements for safeguarding within Wales. We anticipate that this review will consider whether existing arrangements satisfy this recommendation.

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

NISB agrees that this recommendation has been met.

We note that this was accepted on the basis that the Welsh Government and its Cabinet are signatories of the UN Convention for the Rights of the Child, including a requirement that all advice to Welsh Ministers has regard to the Convention and the rights of children.

During the period of this report two Ministers and two Deputy Ministers held key roles in respect of children:

- *The Deputy Minister for Social Services*
- *The Minister for Health and Social Services*
- *The Deputy Minister for Mental Health and Well-Being*
- *The Minister for Education and Welsh Language*

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

NISB is content that Welsh Government can evidence activity in support of this recommendation and is clearly committed to this as an ongoing area for development and continual innovation.

The National Board notes additionally, that a publicity campaign will be taken forward annually by the "Prevention" workstream group that will sit beneath the 10-year Strategy for Preventing and Responding to Child Sexual Abuse.

R13. **Mandatory reporting of child sexual abuse in certain circumstances.** Welsh Government 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 has received a detailed update on Welsh Government's work to date, in the context of devolved and non-devolved powers and legislation and potential next steps.

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

NISB endorses the Welsh Government's response to this recommendation. Welsh Government commissioned an external body to map support for children and adults in Wales affected by child sexual abuse. This work identified gaps in specialist provision for children and adults. Welsh Government will continue to progress this work and to report to NISB.

National Action Plan to Prevent the Abuse of Older People

In February 2024, Welsh Government published its plan, setting out the measures it will take across Welsh Government to ensure that older people are protected from all types of abuse. These were represented under three key objectives:

Key Objective 1 – Older people are supported to live independently and with dignity.

Key Objective 2 – Older people experiencing domestic abuse or sexual violence can access relevant support.

Key Objective 3 – Older people are protected from becoming at risk of abuse or neglect.

In June 2025, Welsh Government published an update on how year one actions (February 2024-February 2025) have been achieved. These are summarised by Welsh Government as:

- Begun work on the successor to the Dementia Action Plan, guided by evaluation findings and stakeholder engagement.
- Developed a Resident Wellbeing Toolkit in partnership with Age Cymru to ensure that care home residents can express their needs throughout their care journey.
- Successfully delivered payments through the Carers Support Fund to 11,687 carers in 2024/25.
- Strengthened public engagement.
- Published the Code of Practice for Llais, enhancing access, involvement, and influence over service design.
- Launched the Single Unified Safeguarding Review (SUSR) in October 2024.

Further actions under the 3 key objectives have now been set out for Year 2.

While the National Board welcomed the advent of a National Action Plan in 2024, it also raised questions as to its breadth and reach in relation to the key role of statutory safeguarding and the impact of statutory adult protection agencies, in meeting **Key Objective three**, preventing and mitigating risk; this remains a largely unexplored question in the framing of the Plan. It is also disappointing that some of the key actions for Year One were not progressed. Broadly these concerns were:

- The development and publication of guidance on areas of practice frequently highlighted by RSBs and referenced in the NISB/ManMet Adult Thematic 2023;
- "Self-Neglect Non-Statutory Supplementary Guidance", planned for publication in the Spring of 2025;
- Practice guidance on ways of identifying and preventing financial abuse and Guidance for practitioners about appropriate information-sharing when concerned about adult safeguarding;

» Nevertheless, we welcome the fact that these are now included in actions for Year Two and we will be paying close attention to these developments in the forthcoming period.

The Annual Progress Report against the plan's objectives would also benefit from some reference to the expected **outcomes for older adults**. Additionally, because some actions are described as *"ongoing"* or *"continuous"*, it is unclear how progress toward specific objectives will be measured. In order to monitor and capture the impact of the Plan more transparently, it would be helpful to clarify how completion will be determined, what outcomes are expected, and what must be achieved for the work to be considered successful and effective in preventing the abuse of older people.

As we have stated earlier in this report, robust intelligence is essential not only for understanding levels of need and patterns of harm, but also for supporting improvement activity and enabling leaders to make informed decisions about how best to allocate resources for safeguarding. In our recommendations to Ministers in our 2019-2020 annual report we indicated that:

"The Welsh Government should ensure that the Technical Guidance of the Social Care Performance and Improvement Framework includes information about the abuse of older people by collecting data broken down by age group."

We are therefore pleased to note the progress made with regard to this recommendation.

Of particular note is the first release of data identifying the number of adults receiving care and support during the year (2023-2024), who were also the subject of safeguarding enquiries that resulted in a protection plan. This is an important and welcome development. This data has recently been published on the Welsh Government StatsWales, webpages and provides insight into the profile of adults receiving care and support at both local authority level and across Wales, by category of "abuse", age group and gender.

It is understood that the data in this first and recent release are considered as "official statistics in development" (Office for Statistics Regulation (OSR)) until acknowledged data issues are improved. Nevertheless, with proper analysis and regular reporting this is welcome in establishing important building blocks for an adult safeguarding dataset for Wales.

Other Developments Relevant to Strategic Duty Two

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.

Religious Organisations and settings

The National Board has received a number of informal suggestions from different sources, concerning the significant gap in the apparatus and capacity of Wales to understand the extent of safeguarding challenges affecting a substantial cohort of individuals working in or as members of religious settings or organisations; several of the relevant cases involved have included the most egregious forms of physical and sexual abuse and the abuse of power and professional authority.

Some of these concerns were amply highlighted by the work of IICSA and re-surfaced following the publication of the Makin Report in England (November 2024 www.churchofengland.org/safeguarding/reviews-and-reports/john-smyth-review). More recently, here in Wales, substantial concerns have arisen in consideration of reports of national interest, for example,Caldey Island and in respect of the Church in Wales.

The examples that we are aware of, or that have attracted national media attention also include significant opportunities for national shared learning across statutory and non-statutory areas. Bearing in mind outstanding IICSA calls for a "National Children's Authority" given further impetus by the Casey Report (www.gov.uk/government/publications/national-audit-on-group-based-child-sexual-exploitation-and-abuse), we believe that this gap, specifically in relation to religious organisations, merits attention and development, notwithstanding the potential scale, organisational diversity and complexity implied. There is currently no single means of ensuring effective and coherent national oversight, scrutiny and transparency, far less of accountability, in the sphere of religious observance and settings across Wales and this is a missed opportunity in terms of significant national safeguarding learning. We are aware that some initial steps in this direction were initiated by Welsh Government's "Safeguarding & Advocacy Team", involving a single meeting with religious organisations in 2021-23 but believe no further developments have ensued.

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 Minister for Children and Social Care, any recommendations made previously by the National Board will continue to be included in our annual reports until they are completed, as agreed.

Governance

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

The National Board Recommends that the Welsh Government commissions a formal review of the role, scope and remit of 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.

Update October 2025

The Board welcomes the September Ministerial announcement that Welsh Government is initiating a national safeguarding governance review in keeping with its 2023-24 recommendation to Ministers. We look forward to engaging with the process.

Recommendations to Ministers 2024-2025

The National Board makes two recommendations.

Recommendation 1 – Annual National Safeguarding Intelligence Report

This report has made reference throughout to a prevailing and strategically significant absence in Wales of any single and authoritative national source of data intelligence that provides a publicly accessible narrative analysis of safeguarding-related data on an annual basis. And yet we know that this is not for the want of data itself, which exists in myriad forms. In recognising this gap, the National Board has been engaged in a programme of work that has been concerned with stimulating and supporting Regional Safeguarding Boards and other relevant stakeholders to effectively address the vacuum within the safeguarding sector as a whole.

The National Board has met with a measure of success in this direction, particularly in establishing the *Five Domains of Safeguarding Effectiveness*, (see page 8) as part of our NISB Annual Reporting framework. The Board also continues to prioritise work on pursuing opportunities to do so and this will be reflected again in our 2026/7Work Plan.

At present the Board is in the process of promoting the notably innovative work being championed in particular by West Glamorgan RSB and reflected in others, notably in Cardiff and the Vale RSB. We are currently in the process, for example, of planning senior Round-table events to take advantage of this and other data development initiatives, as part of our ongoing *Shaping the Future* partnership with Man Met.

As outlined on page 14 of this report, we have also engaged Man Met to examine all publicly available data of relevance for the previous period to date, in order to enable an analysis at the all Wales level and explore any evident barriers and opportunities for developing a coherent narrative approach annually. We continue to be acutely aware, that only by addressing this strategic issue, can the National Board comprehensively discharge its Statutory Duty, namely *"to advise Ministers of the effectiveness of safeguarding in Wales"* and that our capacity to do so is significantly constrained without such a core narrative. Building professional and wider public confidence in statutory safeguarding has perhaps never been as critically important as it is now and in the view of the National Board, engaging that confidence relies very heavily on being able to *"Tell the National Safeguarding Story"*; at present, the means to do so simply does not exist.

The National Board commends the work undertaken under the auspices of our NISB *"Shaping the Future of Safeguarding Man Met Partnership"* in this regard and believe that it can continue to make an enabling contribution to strengthening the power of metric analysis in developing an ongoing national narrative.

It is Recommended to Ministers that government prioritises the development of an effective and accessible Annual National Safeguarding Intelligence Report in readiness for publication in the third quarter of any given year, with effect from September 2026.

Recommendation 2 – Religious organisations and settings

As indicated, we have received a number of informal suggestions that there is a significant gap in the apparatus and capacity of Wales to understand the extent of safeguarding challenges affecting a substantial cohort of individuals working in or as members of religious settings or organisations; several of the relevant cases involved have included the most egregious forms of physical and sexual abuse and the abuse of power and professional authority, some of it clearly institutional abuse. Some of these concerns were amply highlighted by the work of IICSA and more recently have arisen in consideration of reports of national interest including Caldey Island, he Church in Wales, the Meakin Report in England and others. The examples that we are aware of, or that have attracted national media attention, also include significant opportunities for national shared learning across statutory and non-statutory areas.

Bearing in mind calls for a "National Children's Authority" given further impetus by the Children's Commissioner and the Casey Report amongst others, we believe that this gap specifically in relation to religious organisations merits attention and development, notwithstanding the potential scale, organisational diversity and complexity implied. There is in effect, no way currently of surfacing even a measure of coherent national scrutiny and transparency, far less of accountability, even if only "soft accountability", in the sphere of religious observance and settings. We are aware that some initial steps in this direction were initiated by Welsh Government's "Safeguarding & Advocacy Team", involving a single meeting with religious organisations in 2021-23 but believe no further developments have ensued.

It is recommended to Ministers that Welsh Government Commission a National Review of Safeguarding in Religious Organisations in Wales.

This review to:

- Scope and map the range, number and 'reach' of religious organisations in Wales and identify the extent and nature of safeguarding challenges to consider.
- Identify any evident priority issues for consideration.
- Engage with 'the sector' in this exercise, in so far as a 'sector' can be identified.
- Consider the development of a forward programme of work to stimulate greater visibility, enhance public accountability and promote greater shared learning.

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru

National Independent Safeguarding Board Wales

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