Overview Report:

Joint Inspection of Child Protection Arrangements

2019 – 2024

September 2024

Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

HMICFRS
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Estyn

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Foreword

We are pleased to be publishing this report which presents the findings from our series of joint inspections of child protection arrangements (JICPA). The focus of this work was to understand how well partner agencies communicate and work together to promote the welfare of children and protect them from abuse and harm.

We know from our inspectorate assurance processes and this recent JICPA work, that positive outcomes for children are predicated on healthy safeguarding partnership arrangements being in place across key organisations. Most significantly, when there is good multi-agency communication and information sharing, this provides insight into a child's life.

Child practice and case reviews across Wales and the UK continue to highlight challenges in information sharing and collaboration between agencies. Getting this right is critical for professionals working together in safeguarding circumstances, so that they understand the risks to children and for necessary actions to be taken to keep them safe.

Our inspections have highlighted what these challenges mean in reality for children, parents and carers, and staff, at various points throughout the safeguarding and child protection process.

The impact of poor safeguarding processes is ultimately felt by children at risk of abuse or harm, and their families, if they do not receive the care and support they need in the timeliest manner. It is essential that access to a range of services provided by statutory and third sector services is achieved promptly and through a co-ordinated approach. Identifying a child's needs at an early stage can increase protective factors that positively influence a child's safety and well-being and decrease risk factors that may be adversely affecting a child's life.

This series of joint inspections has provided an opportunity for our inspectorates to come together to highlight the importance of multi-agency safeguarding arrangements, and our work has enabled us to identify areas for improvement, and to highlight areas of good practice.

We want to take this opportunity to thank staff working within both health and social care sectors, education, police, and probation services, who endeavour to provide safe and effective support to children and young people on a daily basis. Their dedication and commitment provides a strong and positive basis upon which to improve.

To close, we would like to express our thanks to the staff who helped inform our work by sharing information, participating in our interviews and focus groups, and for completing our surveys. In addition, to children, young people and their parents or carers who supported us by participating in our work.

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Background

Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in each of the six regional safeguarding boards (RSBs) between 2019 and 2024. His Majesty's Inspectorate of Probation (HMIP) participated in the first two pilot Joint Inspection of Child Protection Arrangements (JICPA) which focused on exploitation of children. Our remaining inspection programme centred on protecting children aged 11 and under.

This report outlines our main thematic findings across these inspections as well as the effectiveness of both partnership working and the work of individual agencies across Wales.

Our inspections reviewed the:

- response to allegations of abuse and neglect at the point of identification
- quality and impact of assessment, planning and decision-making in response to safeguarding notifications and referrals
- protection of children aged 11 and under at risk of abuse and neglect
- protection of children and young people at risk of exploitation
- leadership and management of child protection
- effectiveness of the multi-agency safeguarding partner arrangements in relation to this work.

Summary

Across Wales, local authorities and partners exercise their functions under the Social Services and Well-being (Wales) Act 2014 and endeavour to ensure they make a positive contribution to the well-being and safety of children who need care and support.

Overall, leaders have an informed understanding of the prevalence of need and risk in their area. They understand the experiences of children and families who need help and work together to plan strategically for this. Leaders within organisations articulate a shared vision and work proactively together. Operational practice is positively supported by regional safeguarding arrangements.

Safeguarding processes are most effective when there is shared understanding across partnerships. Wales has highly committed and motivated professionals who demonstrate a good understanding of the nature of work in relation to children and families who are at risk of experiencing abuse, neglect and exploitation.

Many local authorities and partners work to a clear person-centred ethos, promoting and supporting children being looked after within their own family wherever this is in their best interests. Some partnerships, however, do not have a clear model of intervention for working with families. The most beneficial models centre on what needs to change in families to keep children safe and focus on strengths and the factors that can support change to minimise the risk of harm.

Local authorities and partners have responded to unprecedented demand by resourcing additional staff such as temporary agency workers to meet statutory duties. In some local authorities, there is a challenge to establish a permanent workforce whilst planning to reduce dependency on temporary staff. An unstable workforce inhibits opportunities for children to form stable, trusting, and significant relationships with a consistent worker. Children, parents and carers tell us how persistent changes to staff make it extra challenging to move on in their lives. In some areas, partner agencies such as police forces and health boards, are struggling to resource the increase in levels of child protection activity.

Overall, suitable systems are in place to facilitate effective partnership working where a child is at risk of abuse, neglect and exploitation. During the series of JICPAs, there was an increasing understanding of criminal exploitation and the complex inter-relationships between this and other forms of exploitation. Responding to contextual safeguarding brings a relatively new dimension to the management of extra-familial harm. There is a need to embed expertise about exploitation and the contextual safeguarding concept into practice and ensure there is full understanding across professional groups.

Across Wales there are a wide range of services available to support children and to meet individual needs. In the best examples, despite challenges of working with increasingly complex circumstances, agencies are resilient in identifying interventions, offering services and working to achieve positive outcomes.

What we found

Multi-agency partnership arrangements

Strengths

Children across Wales tell us they can form good relationships with professionals working with them from across a range of agencies. Notwithstanding the recruitment challenge across the sector, some social workers have long standing relationships with young people. In Neath Port Talbot (NPT) practitioners across the partnership make significant efforts to engage with children. Our review here identified how police officers engage with children and their families and seek their views, their representations, and concerns on visits and prevention interviews. This practice, however, is not consistently seen across Wales.

The characteristics of strong early intervention centres on positive partnership arrangements. In responding to abuse and neglect allegations, co-location of multi-agency staff and clear lines of communication, has strong benefits. In Newport and Cardiff for example, agencies such as the police force, local authority and health board have worked together to co-locate personnel at safeguarding hubs. This has enabled timely sharing of information and decision making. In the Cardiff Multi-Agency Safeguarding Hub (MASH), there is prompt information sharing between agencies at daily multi-agency domestic abuse meetings. In NPT, close working arrangements are evident between key partners in the Single Point of Contact team (SPOC), with the Police Referral Unit embedded in the SPOC team.

Clear pathways to facilitate early intervention and clarity about preventing harm, both in youth justice and social care, and a consistent and well understood process for professionals to refer concerns about children to children's services are essential. This ensures children and families receive appropriate and timely intervention. A proactive approach to ensure thresholds are understood across agencies is paramount. In NPT, multi-agency peer review meetings provide opportunities for dialogue about children where operational issues have been identified. When undertaken constructively with multi-partner contribution, these types of forums provide excellent opportunity to develop common understanding whilst respecting individual agency roles. This requires the principal statutory partners to lead and facilitate collaboration.

Accurate completion of Multi-Agency Referral Forms (MARF) or in the case of the police, Public Protection Notices (PPNs), is another essential element of an effective response process to abuse and neglect allegations. In Newport, the MARF clearly guides the referrer to ensure the information provided assists the decision-making process and ensures consistency in the referral process. When a decision is made to take no further action in relation to PPNs received at the Newport hub, an Early Intervention Team reviews these referrals and contact is made with the family the same day.

In general, professionals identify children in need of help and protection and report their concerns accordingly. The best examples of child protection practice are when there is a shared understanding of the concerns regarding significant harm and agencies consider the impact this is having on the child. In Denbighshire, this was evident in child protection conferences, which operate a clear strengths-based approach whilst ensuring the Care and Support Protection Plan (CASPP) makes an explicit link between risk and safety.

Safeguarding meetings are mostly well attended by partners. Child protection conferences, especially the Initial Child Protection Case Conference (ICPCC), are effective forums for timely information-sharing, planning and decision-making. These are attended by multi-agency groups. Independent Reviewing Officers (IRO) and child protection conference chairs have a critical role in overseeing the quality of practice and provide a valuable contribution in challenging delays where necessary. Most IROs can prioritise visits to children prior to Children Looked After (CLA) reviews, building meaningful and consistent relationships with them.

The Space Well-Being Panels convened in Gwent ensure a partnership approach for families accessing a range of preventative interventions. In NPT, the Police Community Support Officer (PCSO) embedded in the Team Around the Family (TAF), is a member of the Early Intervention Panel and attends home visits with TAF workers.

Despite demand on the Child and Adolescent Mental Health Service (CAMHS), there are excellent examples of CAMHS staff working collaboratively to provide essential support for children. For example, a self-harm pathway has been jointly created between the Education Psychology Service (EPS) and the Denbighshire CAMHS to safely manage incidences of self-harm and suicide ideation in schools. As a consequence, CAMHS has dedicated staff to respond to concerns raised in education settings. In Powys, the presence of senior CAMHS practitioners with backgrounds in social work has markedly enriched the team dynamics and multi-agency collaboration. Work between the local authority and CAMHS is proactive and collaborative. In NPT, CAMHS staff make follow up telephone calls to families when young people have not been brought to appointments. This approach is particularly important when working with young people who may be reluctant to engage.

Many local authorities are developing their own therapeutic services to fill gaps in service areas. These local authorities felt they shouldn't be funding therapeutic services and that the costs should be covered by local health boards. In NPT, the local authority has been developing its own in-house therapy service for CLA, which includes an in-house therapy team and a Multi-Agency Psychological Support (MAPS) team to support placement stability and permanence.

Across schools in Wales significant work has been undertaken over recent years to develop a range of interventions to support the needs of pupils, including those at risk of harm and those subject to a Care and Support Protection Plan (CASPP). School based counselling services provide a consistent broad range of therapeutic services.

Operation Encompass is another example of effective partnership. The police use alerts from Operation Encompass to provide schools with early notifications of young people affected by domestic abuse incidents. This system allows schools to consider support for the child prior to their arrival at school at the start of the day.

During the series of JICPA, approaches to risk assessment in Wales in relation to exploitation were evolving at different rates. Partners generally work to a shared ethos of safeguarding children at risk of exploitation. In Newport, statutory and third sector providers, such as St Giles and Barnardo's, work to a shared ethos of safeguarding children and young people. Services are commissioned to provide diversionary preventative services to children who are at risk of criminal exploitation. Projects focusing on serious organised crime and early intervention are well established and provide practical and peer support to children who have been identified as being at risk.

In Gwent, agencies have worked together to develop a Child Exploitation Assessment tool. This is a tool that combines both child sexual and criminal exploitation factors. It provides opportunity for professionals to collaborate, share information, evaluate risk via the multi-agency group and develop plans to mitigate risk.

A model of working that identifies and addresses contextual harm in communities has been developed in Cardiff. The SAFE (Safeguarding Adolescents from Exploitation) model recognises children and young people can be at risk of or subjected to harm through exploitation and abuse from adults and people outside of their family network. The local authority has been successful in securing Youth Endowment Funding (YEF) to deliver the Keeping and Staying SAFE project which aims to tackle youth violence and criminal exploitation.

Many regions have introduced Multi-Agency Child Exploitation meetings which provide valuable opportunity to oversee and coordinate work with children who are vulnerable to potential exploitation.

In NPT, return home interviews are shared with partner agencies in a targeted manner, providing professionals with new information about a child's experience. A Barnardo's worker provides an effective conduit between police and social services, which enables workers to identify approaches to reduce missing child episodes, emergent needs, and to adapt plans to manage risks. The police missing persons team has links to police intelligence officers. They ensure information and intelligence is drawn out from return home interviews, with associates and locations updated on records and intelligence logs created where appropriate. This means information can be used to help prevent future missing episodes, and to locate the child should they go missing again. In Cardiff, a designated missing persons coordinator based in the SAFE service acts as a dedicated link for partners.

There are examples of healthcare professionals receiving training in criminal exploitation issues and Adverse Childhood Experiences (ACEs), to support assessment to establish whether a child is being criminally exploited. Some healthcare staff are using the Child Sexual Exploitation Risk Questionnaire (CSERQ) screening tool to support early identification of sexual exploitation.

In Denbighshire, there is good partnership attendance at the Multi-Agency Risk Assessment Conference (MARAC) meeting. An agenda which focuses on parents with children means there is a child at risk focus. The meeting is chaired by a detective inspector and all relevant staff groups submit written reports. Weekly meetings help the partnership to promptly respond to domestic abuse risks.

The police and other safeguarding organisations work effectively in several themed multi-agency risk management meetings. This includes the MARAC for domestic abuse and Multi-Agency Public Protection Arrangements (MAPPA) for sexual and violent offenders.

In Cardiff and Vale University Health Board (CVUHB), Independent Domestic Violence Advisors (IDVAs), funded via the Police and Crime Commissioner (PCC), are based within the safeguarding team and includes an IDVA specifically to work with young people aged 11 to 17 years. A dedicated domestic abuse lead in social care has established positive links across other services including third sector partners. The post holder is a qualified and experienced social worker, dedicated to supporting practice development and delivery of training across the multi-agency group.

A multi-agency Violence Prevention Team, funded by the Home Office, is also based in Cardiff, which includes a nurse and a patient advocate, who are based in the Emergency Department at University Hospital of Wales. The team provides support and makes onward referrals to services for any victim of violence with injury. Home Office evaluation has to date been positive.

Multi-agency training (face to face and virtual) is available across Wales and is generally well received. We found examples of bespoke training arranged to support specific areas of practice. For example, in Cwm Taf Morgannwg University Health Board (CTMUHB), paediatricians have implemented bespoke training for partner agencies. This includes training on the key roles and responsibilities of staff when undertaking a child protection medical examination, to ensure they are aware of the correct pathways and process for this. In Gwent, the police force has

improved the training provided to custody staff, and to healthcare professionals within Aneurin Bevan University Health Board (ABUHB), to ensure safeguarding concerns are recognised and reported correctly through submission of PPNs.

What needs to improve

A Regional Safeguarding Board (RSB) is responsible for ensuring systems and processes are in place for the effective management of the Child Protection Register (CPR) and its accessibility to partner agencies. The CPR lists all children in a local authority area who are at risk of or are suffering significant harm, and who are currently subject of a Care and Support Protection Plan (CASPP).

It is essential the police and healthcare professionals can access the CPR, both in and outside office hours. In most areas, access to the register works well. For example, we found Emergency Department staff can promptly check if a child attending the Emergency Department is named on the CPR, and if applicable, can share key information with multi-agency partners.

However, we found examples where some staff teams could not consistently access information on the CPR, such as those working in Integrated Sexual Health Units (ISHU) and were instead reliant on self-disclosures from children or family members. This increases the risk staff could miss opportunities to identify a child at risk, to inform relevant others of the risk, and seek further information from partner agencies if required.

A common theme found across Wales is the lack of feedback to partners about child safeguarding referrals and Duty to Report (DTR) outcomes. In September 2023, the report **Rapid review of child protection arrangements** was published and highlights the need for children's services to communicate information about Duty To Report outcomes in a timely manner to the person who made the initial report. If information is not shared with referrers, it will negatively impact on their ability to work effectively with families, about the risks to the child and the measures needed to safeguard the child.

In some areas of Wales, third sector missing children's workers, such as those identified in Neath Port Talbot, engage well with the police. They provide support to children who meet service criteria for Return Home Interviews and aftercare. However, in other parts of Wales, we found inconsistency in completion of and recording the accounts of Return Home Interviews for children. This means vital information about the risks of children absconding and the ability to locate them in future occurrences is not readily available to responders.

There are missed opportunities to have multi-agency input at the point of initial strategy discussions where professionals would have a relevant role and valid contribution to make. Multi-agency strategy meetings to review the conclusion of a Section 47 enquiries are also often not convened or relevant agencies do not always attend. Sometimes, professionals are not invited or do not attend strategy meetings and core groups. This can mean there are gaps in information sharing as partners will have valuable information and intelligence to share. Key professional representation at core groups is imperative as this is also where the detailed child protection plan is developed and reviewed.

Key safeguarding documents such as minutes of strategy meetings, core groups and CASPP are not routinely made available to the key professionals working with a family as highlighted in the **Rapid review of child protection arrangements**. This can impact on the clarity and understanding of the risks and actions implemented and the communication of these. This could result in children not always being adequately safeguarded.

All agencies should work together to ensure there is a clear understanding of thresholds and appropriate access to services, so families receive the right support in a timely way. Multi-agency referral and Duty To Report guidance is important, and this must be embedded into practice. Key partners, such as schools and healthcare staff should understand and act by reporting concerns about abuse or harm directly to social care or the police, and appropriately utilise the support of early help services where it may be appropriate.

Demand across Wales is such that access to many statutory and third sector services can be delayed, with waiting lists evident. This means opportunities to address and mitigate safeguarding concerns at the earliest stage may be missed. There are delays in some areas in obtaining a CAMHS assessment, which means there can be delays in children receiving timely interventions to address their mental health needs. This is compounded by the increased demand following the pandemic and means children do not always get the help and support they need at the right time.

Whilst we recognise the positive work of engagement with children, this is often not reflected adequately in the child's records. Too frequently, assessments reviewed in children's services did not incorporate information about what matters to children, nor the outcomes children and families wished to achieve. The voice of children and families should be prioritised but is often poorly represented.

Children's voices, wishes and feelings can be well promoted at child protection conferences by professionals, but less often through children's direct contribution to the conference. An active offer about advocacy is available across Wales, but this must be strengthened to improve opportunity for children's views to be represented, working with the commissioned provider to achieve this. Where voice is prominent, this leads to improvements in the help and support to families.

Children's services led assessments are often imprecise with limited analysis. Whilst most assessments identify risks, more rigorous analysis including the impact on the child will better inform the Care and Support Protection Plan. The development and implementation of safety plans requires greater clarity to enhance the focus on what parents need to change with the right support, rather than a list of services and over emphasis on parental compliance. Improvement is required in recording the strengths, and particularly the protective factors in children's lives. This is important because it is the basis of strengths around families that ultimately provides most effective protection.

To help engagement with parents, concerns about their children need to be more explicitly broken down using plain language. Broad statements lack specificity and make it challenging to evidence progress against identified needs and risks. Plans should have clear actions and outcomes and highlight an agreed understanding about risks between parent/carers and professionals. Shared implementation of safety plans and their review is also inconsistent, too often the focus on risk and safety diminishes over time as highlighted in the report, **Rapid review of child protection arrangements**. Core groups should have a greater focus on progress against the child protection plan to avoid delay. This is particularly important in complex family situations with longstanding neglect. Agencies need to consistently work together to ensure measurable actions are in place to improve outcomes for children living in these circumstances.

Whilst the emphasis on quality assurance and auditing of practice is evident in most children's services, a multi-agency approach to auditing is variable. Multi-agency audits must be completed routinely. For example, to learn from the findings and to disseminate improvements, such as the good practice we found within some agencies. Agencies could do more joint monitoring to understand the impact of their interventions, including early intervention practice.

Health boards

Strengths

In most health board areas, there is clarity in the operational and strategic governance structure. Leaders and managers use their expertise to challenge and support practitioners and promote continuous improvement. Safeguarding teams across health boards have a particularly important role in supporting healthcare staff. This is illustrated in Betsi Cadwaladr University Health Board (BCUHB) where the safeguarding team have developed and implemented innovative practice across departments within the district general hospital. This has included safeguarding ambassadors across the health board and IDVAs in hospitals.

All health boards in Wales are required to complete an annual Safeguarding Maturity Matrix (self-assessment tool), with the aim to self-evaluate performance, provide assurance, share practice and drive improvements for a consistent approach to safeguarding. It is positive to note these are being completed and scores are submitted to the National Safeguarding Team in Wales, to inform the national picture through the safeguarding network to the Chief Nursing Officer. An annual peer review process is in place to identify and share examples of good practice, and to collaborate improvement. However, there is no formal triangulation to establish the evidence behind the health board's self-assessment, and we found in some areas, what was documented was not always compliant with the Wales Safeguarding Procedures.

Partners having confidence to constructively challenge each other is an important part of safeguarding practice. In Cwm Taf Morgannwg University Health Board, a multi-agency case discussion forum is in place, providing a safe space for partners to discuss and professionally challenge where differences arise. The Concerns Regarding Inter-Agency Safeguarding Practice (CRISP) protocol is also utilised to support practitioners in finding a resolution when they have a professional disagreement in relation to safeguarding practice.

We found good examples across health boards with capturing the voice of the child, and children's views being considered when they come in to contact with healthcare professionals. A scoping exercise undertaken with children in BCUHB considered the child's journey through the Emergency Department and how this could be improved. Feedback from the exercise highlighted staff were more confident when assessing children, and the process gave children a stronger voice in shaping future practice in the Emergency Department. Cardiff and Vale University Health Board has a well-established Youth Board in place, which is consulted for relevant initiatives, policy development and pertinent staff interviews in relation to a child or young person.

Health boards have a mostly positive approach to learning and development in relation to safeguarding. For example, in BCUHB and Cwm Taf Morgannwg, learning from reviews, such as child practice and domestic homicide reviews are delivered through training events, 7-minute briefings and learning bulletins. A programme of audit also reflects areas of concern and determines whether lessons have been learned and improvements are embedded in practice. Powys Teaching Health Board demonstrates its commitment to continuous improvement, through the scrutiny and learning processes in place. This includes reviews of serious incidents, concerns, reports, and sharing the learning identified to help improvement.

Safeguarding supervision is an opportunity for support, challenge and learning related to safeguarding cases, which is generally accessible to all relevant staff across Wales. Best practice is evident in health boards that use a safeguarding supervision database to capture staff compliance with mandatory supervision.

There are positive examples of information exchange led by healthcare staff, such as health visitors sharing important information with primary schools when children start nursery education.

In Swansea Bay University Health Board, GPs demonstrate good partnership working through engagement with school counsellors and Youth Offending Services (YOS). GPs provide reports for meetings to share relevant information, ensuring key patient information is shared for multi-agency partners to make an informed decision during meetings.

What needs to improve

There is wide recognition of the importance of understanding the individual circumstances of a child, but maintaining this and documenting the voice of the child requires strengthening in some areas, in particular this can be inconsistent in child protection processes.

There are some very good examples of safeguarding supervision evident across Wales, however there is inconsistency. It is important safeguarding teams strive for high standards and ensure supervision takes place regularly, particularly for complex cases.

The number of different IT systems in use within health boards across Wales, impedes the timeliness of gathering and sharing fundamental information. Key safeguarding documentation is not always adequately recorded, and some records provide only limited information. In addition, access to different electronic records is an issue that can impact on the needs of a child. This means important details about Care and Support Protection Plan, and multi-agency meetings are not always available or accessible in a timely manner to inform progress about a child's safety and well-being.

Compliance with, and recording of mandatory training, is poor in some areas. Whilst there is evidence of commitment to a learning culture, compliance with Level 3 Safeguarding Children training is variable, and in some health boards, this was significantly lower than the national target of 85%. Compounding factors include the impact of the COVID-19 pandemic on the ability to access or complete training and limited resources to develop, coordinate and deliver training. Regular multi-agency training is needed to ensure there is a consistent safeguarding practice approach.

Local authorities (education)

Strengths

Local authorities are operating within a national context of rising levels of child protection referrals and growing complexity of children's and families' needs.

Across all local authorities visited, there is a recognition of the importance and centrality of safeguarding children. These local authorities promote a strong safeguarding culture in their schools and pupil referral units (PRU). Senior leaders in education teams support leaders in schools and PRUs well to ensure that they prioritise pupils' emotional development and well-being.

Effective practice across many authorities includes regular facilitated opportunities for designated safeguarding leads (DSL) to meet as clusters to support each other and to share effective practice and concerns. In the most effective examples, officers from a range of teams share intelligence relating to individual schools and PRUs at regular 'All-Schools Risk'; Team Around the School (TAS); and Multi-Agency Planning (MAP) meetings. This is variable, however, not all local authorities provide these valuable opportunities to strengthen the work of DSLs.

Practice regarding annual school and PRU safeguarding audits is inconsistent and, in turn, audits from schools are variable in quality and usefulness. Where these work well, authorities insist on periodic submissions, and the audits take into account broader safeguarding concerns such as exclusions and pastoral support plans.

Widespread use of digital platforms for all schools and PRUs and service areas across education departments is improving consistency in recording and reporting concerns. This also improves communication and sharing of information between schools / PRUs and service providers and is beginning to be used to monitor trends and patterns from which targeted intervention can be identified. Where this works well, it is also used to monitor and analyse other relevant information such as bullying data. However, the present lack of a consistent system across Wales for recording and sharing information about vulnerable children leads to difficulties and challenges for schools and local authorities in information sharing and analysis. There are existing projects that seek to address this issue. For example, the 'Single View' is a local authority-led project which will collect data from a range of sources including Children's Services, Education, and the Youth Justice Service (YJS) into one system to create a single record for a child. Integrating information from various sources into one unified system would enhance coordination and understanding among relevant stakeholders.

Most local authorities we visited provide their schools and PRU with regular, comprehensive, and relevant support and guidance in child protection matters. This includes model child protection and safeguarding policies and support for managing issues such as challenging behaviour. Nearly all Local Authority Designated Officers (LADOs) provide appropriate training for their school and PRU staff and governors on child protection and a wider range of contextual safeguarding sessions. However, training is too generic and often delivered online, limiting professional dialogue and information exchange.

Across all authorities included in the joint inspections, MASH facilities are working effectively and promoting closer partnership work. Nearly all local authorities promote a high level of inter-agency working across their schools and PRUs. They foster close working relationships across services in supporting the needs of highly complex young people who are on the child protection register and their families.

What needs to improve

Nationally, leaders do not always have a clear enough understanding of thresholds for multi-agency referral submissions to ensure an efficient and proportionate response to managing demand. In many local authorities, although referral guidance is already available, this guidance is not embedded in practice well enough. This means key partners such as staff in schools and PRUs are consistently reporting concerns directly to MASH and not utilising the support of early help services where it may be appropriate.

In around half of local authorities, there are concerns that schools and PRUs do not always share important information when a vulnerable pupil transfers. This can be the case when a pupil transitions from a primary to a secondary school within a local authority, or when they attend a PRU, but also when a pupil moves mid-phase from one school to another, both from within the local authority and from a different authority. Again, introducing a consistent system across Wales for recording and sharing information about vulnerable children would contribute to alleviating these concerns.

Where practice is most effective, in a minority of local authorities, staff at schools and PRUs report that they have appropriate access to social service records and information pertaining to vulnerable children.

Nationally, information exchange between schools, education teams and the police (through Operation Encompass) is functioning adequately. However, across all local authorities, additional and more timely information would allow schools and PRUs to be better informed so that they support children appropriately following an incident. Given there can be delays both in multi-agency responses and in sharing outcomes with schools, insufficient information from the police can be an additional barrier to supporting children on the child protection register and taking swift and appropriate action. Across many local authorities, schools and PRUs reflect there is no agreed process in place for police to send them full information of safeguarding concerns about an adult or child, known as public protection notices (PPNs). Good practice involves sharing proportionate and contextual information so that children can be appropriately supported. Staff also highlight the benefits of receiving timely updates from the police following the issuing of PPNs. There is currently no system to do this across Wales.

Schools and pupil referral units (PRUs)

Strengths

Safeguarding of pupils is a high priority in schools and PRUs across Wales and, as a result, schools and PRUs are committed to ensuring they are safe places for pupils to learn. Vulnerable pupils, including those named on the child protection register (CPR), feel safe and like going to school or their PRU.

Nationally, nearly all staff who work in schools or PRUs understand that early identification, assessment, communication, and intervention are vital across all stakeholders. They recognise the ongoing threat of young people being exploited and that effective safeguarding child protection work requires robust procedures, good interagency cooperation and a workforce that is competent and confident in responding to situations. School and PRU staff at all levels understand their roles and responsibilities in respect of keeping learners safe.

In around half of local authorities we visited, schools talked of the benefits of MASH professionals being co-located and based in person at one location. This was also associated with the perceived benefits of conducting multi-agency meetings in person, rather than using a remote or hybrid model.

Overall, schools and PRUs know pupils and their families well and plan carefully to meet their needs. Where they exist, family liaison officers in schools and PRUs offer valuable support to parents and carers.

Overall, most schools and PRUs are significant and effective contributors in the multi-agency response to ensure children get the right help and protection at the right time. Nearly all designated safeguarding leads have a secure knowledge and understanding of the chronology of pupils who have been named on the CPR. They identify children in need of help or protection and submit multi-agency referrals in a timely manner. Across all local authorities we visited, schools and PRUs work closely with other agencies to promote a child-centred ethos. Staff focus their work on the context of children and their families and recognise the needs of children on their journey to adulthood, with a commitment to ensuring quality of provision to meet these needs.

However, in a minority of local authorities, schools' and PRUs' awareness of and/or access to external early help services is not effective enough. In the current context of increased demand, schools and PRU face significant challenges when they need to access more formal care and support. Early help and intervention systems are appreciated and valued by school leaders but support and response across and within local authorities is too variable. Around half of schools and a few PRUs talk about the frustration of long waiting lists (or other barriers to access) for early help and 'pre-referral' services, limiting the efficacy of these services. Across all schools and PRUs there was a concern about a lengthy waiting list to access CAMHS support. Providers have increased their internal capacity to help support pupils through additional training and the introduction of different initiatives, however, access to specialist provision is still lacking.

Across the local authorities we visited, children receive appropriate support within schools and PRUs, with a comprehensive range of programmes utilised to promote health and well-being. These include emotional health interventions such as the Emotional Literacy Support Assistant intervention (ELSA), mindfulness sessions and adopting whole-school trauma-informed strategies for pupils who have experienced adverse childhood experiences.

Supported by local authority education teams, most schools and PRUs are effective in providing curriculum-based education relevant to all aspects of child protection. Senior leaders in schools and PRUs have generally well-considered plans for implementing the health and well-being aspect of the new curriculum in Wales. Schools, PRUs and maintained special schools offer a wide range of preventative activities to pupils, including lessons on healthy relationships and staying safe online as well as running anti-bullying campaigns. However, nationally, the provision for relationships and sexuality education (RSE) is too variable.

There are identified trusted adults in schools and PRUs for pupils to turn to if they are worried about something. Pupils say they are well supported and listened to by these people if they are distressed or anxious.

Across Wales, schools and PRUs generally monitor attendance of those pupils who are on the child protection register very well and have sound strategies to improve their attendance. With the support of Education Welfare Services, most schools and PRUs respond swiftly and effectively to concerns around attendance of pupils on the child protection register.

Police force

Strengths

Our four police forces in Wales demonstrate extensive and relevant senior leader commitment to safeguarding governance. Leaders provide a clear strategic lead and contribute appropriately to multi-agency partnership planning. The workforce is highly committed and knowledgeable and works effectively in operational partnership arrangements. Police officers consistently attend multi-agency meetings and actively contribute to safeguarding plans.

Forces have robust systems for leaders to manage demand and responses to risk, but some forces don't have enough specialist staff and resources to deal with the complexity of an effective and timely response to child protection demand.

Police recognise the need for effective systems to be in place to share information to protect children and mostly make good use of information on their systems to add value to the referrals they make for children. Force control room staff research police systems to provide valuable information to frontline responders to inform their decision making. With regards to early recognition and assessment of risk, all forces have robust control room systems. They train those staff to recognise risk to children and assign right responses. Police control room supervisors routinely quality assure decision making.

Most forces used warning markers and flags consistently on their information systems to alert staff about risk and vulnerability, but a flag for children who live in foster or residential care is not used by police. A marker would enhance recognition of this vulnerability.

Officers generally know when to record concerns about children's vulnerability on PPN and these are always shared with the local authority. The benefits of sharing with other agencies, however, is not fully recognised. As outlined under the local authorities (education) section above, Operation Encompass is in place across all forces, but it could be improved with the level of detail provided to schools.

Working with the Police and Crime Commissioner (PCC), force leaders commission services to support multi-agency safeguarding provision, involve statutory and non-statutory organisations. In Cardiff the PCC funds a range of initiatives supporting children and families affected by violence and harm, including hospital and community-based provision.

Forces understand the importance of investing in specialist training for child abuse investigators. Children receive better outcomes when supported by specially trained officers. The police and their safeguarding partners have a range of disruption tools and tactics such as problem solving to prevent offenders from harming children.

Areas for improvement

Forces routinely dip sample and audit safeguarding investigations and incidents, but the overall approach to quality assurance would benefit from a multi-agency focus and consistent approach.

Forces have some performance management data, and they are increasingly developing the qualitative aspect of this information. Police consistently record crimes against children and allocate these to appropriate teams and individuals for investigation. Police and partners do not gather enough data to produce timely and refreshed problem profiles of risk areas for children. Performance data and intelligence profiles are not used effectively to drive multi-agency safeguarding strategies and interventions.

Police leaders have not yet instilled a consistent culture of ensuring all staff understand the importance of gathering information about children's ethnicity and demographic information. This is inconsistently recorded and often absent in police records. Victim blaming language continues to feature is some police records.

A more effective and consistent response to children reported as missing can be provided by clearer policy and better coordination. Forces are not consistently following College of Policing Approved Professional Practice guidance on assessment of risk and responses for children who are reported missing. PPNs are not always recorded when children are missing from home or perpetrators of crime.

Officers are not consistent about when and what information they note in records about contextual risk to children and this is not always shared using the forces recognised referral pathways. Minutes and actions from strategy meetings are often not provided in a timely manner nor are they visible on police systems.

PPNs are not always checked before they are sent on, so there is no consistent approach to quality assurance to check key information is recorded such as, the voice of the child, demographic information and risks to other children. Sometimes there can be delay in referrals sent to other agencies.

Officers and supervisors are not maximising the use of Domestic Violence Protection Notices (DVPN) and Domestic Violence Disclosure Scheme (DVDS) to protect children and families from domestic abuse perpetrators. Forces do not have systems in place to make sure DVDS applications are expedited.

In some forces there is effective supervision to make sure the risk management is at the right level, but supervisors don't always escalate risk and challenge delays in providing the services children need.

Officers do not consistently speak to children and record the voice of the child in their reports. This indicates a non-child centric approach. Inconsistency in training on the voice of the child is a factor in this area for improvement.

There are inconsistencies across forces and partnerships in the prioritisation and content of their training offer. Managers do not always recognise the benefits of multi-agency training and make it available to all relevant staff.

Children's services

Strengths

Children's services staff across Wales are dedicated and committed to the safety and well-being of children. They demonstrate resilience in managing increasing demand and complexity. Through the series of inspections, staff had to respond to the COVID-19 pandemic challenges and a deteriorating recruitment position, with many local authorities having to rely on temporary staff to support workforce resilience.

Practitioners consistently tell inspectors about the importance of supportive leadership which they consider significant to help deliver services effectively. The best examples are evident when there is a culture of improvement and mutual support driven by leaders across an organisation. Characteristics of a healthy children's services culture include senior managers communicating effectively with their staff and a supportive, open and non-blaming culture set by leaders. Strong children's services leaders have a line of sight of front-line practice that leads to innovative and evolving service delivery.

In general, practitioners across the multi-agency group accurately identify children in need of help and protection. Children's services mainly respond promptly and effectively to meet these needs, especially where acute risk is identified. In the early phases of intervention there can be effective communication across agencies, with information being shared at key safeguarding forums such initial strategy discussions. Good information exchange enables planning to be well prepared and focused. Multi-agency channels of communication and shared understanding work well when there is a clear and well-understood process for professionals to report concerns about children.

In Cardiff, there is a clear approach to prevent risk escalating in relation to risks associated with exploitation and engaging the community more widely to plans for children's safety. Such a collaborative approach is possible as children's services take a clear strategic lead with emphasis on co-operation across relevant services.

Best practice examples are evident when local authorities demonstrate a positive approach to the management of risk, clearly record the views of children and families, making sure they are clearly listened to and understood. At an individual level, workers seek children's wishes and feelings through child centred practice. The outcome of this work informs the quality of the analysis of risk, and the factors within the child's family and community which can help keep them safe. There are examples of practitioners working through complex family situations, with assessments providing clarity about family situations and supportive family and community networks. Too often, however, this practice is variable as the Care and Support Protection Plan (CASPP) focuses on a list of support services without explicit clarity on safety and outcomes.

The CASPP has greater benefits when it has strong objectives and goals in relation to outcomes for children, with a clear record of progress. The CASPP should clearly demonstrate how work undertaken by professionals and parents is going to explicitly improve outcomes for children.

During the series of inspections, imaginative and innovative support services were being developed to support families and address needs as early as possible before circumstances may escalate. Most local authorities have a range of early help services offering a range of interventions and parenting programmes. Many of these services have a therapeutic value, making positive use of different disciplines such as psychologists. Some children's services have waiting lists across different teams, illustrative of increasing demand. Best practice examples in relation to early intervention and help for families are characterised by seamless and prompt support reaching families.

Practitioners generally demonstrate a good understanding of the cultural needs of the children and families they work with and awareness of the importance of culturally sensitive practice. Local authorities' awareness of an active Welsh language offer is mainly evident, they are committed to strengthening delivery in workforce planning. The sufficiency of Welsh speaking practitioners working across children's services can be variable. Local authorities generally have arrangements in place to provide support and guidance for families where English is an additional language.

Generally, there is a commitment and emphasis in children being supported by advocacy. Many children's services invest time in working with the advocacy provider to promote an active offer of advocacy. In some instances, advocacy could have been better promoted to enable peoples' voice to be better understood. Relatively small numbers of children and young people are attending their child protection meetings.

We found positive relationships between Independent Reviewing Officers (IROs) and social work teams, a balance of healthy challenge being evident across Wales. When the IRO workload is too high, this impacts directly on the quality of their work and opportunities to engage people is reduced. This means children and families can be unprepared and do not understand the significance of important issues being discussed.

Areas for improvement

Too often, practitioner supervision lacks critical analysis and reflection. Whilst we recognise considerable informal support across local authority teams that does not necessarily get recorded, protected time and investment in quality supervision can be absent. A key factor here is managers and practitioners being pressed for time as they manage increasing workload. It is, however, essential that protected time is given to support practitioners to reflect critically on the impact of decisions on a child and family. In the best examples, supervision is reflective, considers the link between research and practice and promotes opportunities for professional development.

Statutory duties such as convening timely child protection conferences and visits to children is a priority for local authorities, but for some compliance can be a challenge, often related to vacancies and changes of social worker (care and support protection plan co-ordinator). It is essential the director of social services consistently monitors and addresses as appropriate, compliance with these statutory responsibilities. This area of practice does not always receive the priority required.

This paragraph reflects the findings of the Rapid review of child protection arrangements. What Matters conversations are recorded in social services records, but these could be improved with greater clarity about what needs to happen to achieve personal outcomes. The 'lived experience' of the child is not always apparent in records. Shared implementation and review of safety plans is often not clear. In some situations, there is lack of clarity about which agencies are responsible for addressing which aspects of the Care and Support Protection Plan (CASPP). People can be overwhelmed by a list of multi-agency services. Plans are often not consistently updated in a timely way following significant changes. There is a clear need for improved consistency in how these are recorded to ensure there is clarity about risk, safety and what needs to happen to be assured about safety.

As referenced earlier in this report, a persistent concern is child protection records not being shared with the core group. Strategy discussions and core groups would be strengthened by ensuring key documents are shared with attendees and absent partners. This would enable all staff to be aware of updates to plans and their role in the protection of children.

Conclusion

The foundation for good multi-agency partnerships is already in place across Wales through strategic arrangements led by the work of RSBs. Strong leadership and clarity in operational and strategic governance across local authorities, schools, police forces and health boards promote a positive safeguarding culture. Collaborations such as Operation Encompass and co-location of staff at front door teams in some areas, demonstrate how partnership arrangements can be effective in facilitating effective communication and information exchange. Ultimately, this leads to improved opportunity to understand family context, relevant risk and safety factors and better informed decision making.

Children and families benefit from a good range of established early help and preventative services. There are examples of timely and integrated approaches providing effective support for children and their families.

Across schools in Wales, the outstanding work undertaken in recent years to develop a range of interventions to support the needs of pupils should be recognised. Schools are a source of a range of important therapeutic services, including for those pupils at risk of harm. Best practice examples are seen when pupils are actively supported to engage with programmes to address their specific needs. School staff can also offer trusted support to children and in many cases, an important conduit between parent/carers and the statutory child protection agencies.

Many of the findings of this report reflect the key conclusions illustrated in the **Rapid review of child protection arrangements** as follows. They highlight again the significance of communication and sharing information across agencies:

1. The importance of agencies having a shared understanding across safeguarding partnership arrangements. More time needs to be invested in ensuring there are clear pathways to facilitate early intervention with clarity about preventing harm. This should be promoted through threshold documents being clearly understood and applied across all agencies. This helps ensure children and families receive appropriate and timely intervention. The 2023 rapid review recommended regional safeguarding boards and the National Independent Safeguarding Board support a national drive to improve a shared understanding and awareness of thresholds and relevant guidance.

2. Both the JICPA and 2023 rapid review identified a varied approach to multi-agency auditing of key aspects of safeguarding practice. This means reflective opportunities to identify areas for development and good practice can be missed.

3. The benefits of integration and co-location of ‘front-door’ services (providing information, advice and assistance and / or a multi-agency safeguarding hub) also features positively in both reviews. They highlight how this can support the understanding of roles and responsibilities and the application of consistent thresholds.

4. Safeguarding meetings convened in line with WSP are established forums for timely information-sharing, planning and decision-making. The effectiveness of these forums, however, is inconsistent. Too often, the shared implementation of Care and Support Protection Plan (CASPP) and review of these plans, can lose focus on risk and safety. Core group meetings are forums that need to maintain a focus on progress against the CASPP.

5. An accurate understanding of family's circumstances and the lived experience of children can be weak as children's services led assessments are often imprecise. Whilst assessments can identify risks, more rigorous analysis is often not evident and the impact on the child unclear. A future focus for children's services is how to create protected time for skilled practitioners to enable them to utilise critical thinking and be more reflective in practice.

6. Collaborative partnership working with families by local authorities and partner agencies is key to achieving effective and timely decision-making. The best models of child protection practice facilitate a shared understanding of the identification and management of risk, both with parents / carers and across agencies. When applied effectively, they provide an on-going focus on what needs to change to be assured about a child's safety. In addition, an emphasis on safety ensures key strengths in families and the community can be utilised to reduce the risk of future harm. The 2023 rapid review recommended a clear model or practice framework should be adopted to support and improve clarity for practitioners across agencies about the requirements and expectations of operational practice.

7. Information sharing between agencies is an ongoing barrier for effective child protection working. The 2023 rapid review highlighted how agencies have different systems for recording, and the disconnected systems are limiting information sharing. It recommended the Welsh Government should work alongside health boards, and equally local authority and education services, to commission centralised, accessible IT systems. It also recommended children's services must communicate information about duty to report outcomes in a timely manner to the person who made the initial report.

8. Children and parents can experience many changes in social workers which impacts on the quality of their relationships and the important and sensitive child centred work required to ascertain their individual views. Such practice is undertaken but is not routinely evident across Wales. Opportunities to capture the voice of the child are subsequently not reflected in assessment and decision-making process. Children's services continue to make concerted efforts to address workforce shortfalls through different recruitment and retention strategies.

What next

We expect regional safeguarding boards to take the important learning from this report and lead on the dissemination of learning across Wales. Extensively, this learning replicates that identified in the 2023 rapid review. RSBs, working in conjunction with the National Independent Safeguarding Board, already have in place actions plans derived from the rapid review. This report provides another opportunity to highlight what works well and the areas of child protection practice that require improvement. It is important the momentum for change in such an important practice area, the protection and safety of children, is maintained and led by RSBs.

Appendix 1

Terms that reflect the proportions referenced in this report are shown below:

Nearly all	=	with very few exceptions
Most	=	90% or more
Many	=	70% or more
A majority	=	over 60%
Half	=	50%
Around half	=	close to 50%
A minority	=	below 40%
Few	=	below 20%
Very few	=	less than 10%

Appendix 2: Glossary

ABUHB *Aneurin Bevan University Health Board*

BCUHB *Betsi Cadwaladr University Health Board*

CAMHS *Child and Adolescent Mental Health Services*

CASPP *Care and Support Protection Plan*

CIW *Care Inspectorate Wales*

CLA *Children Looked After*

CP / CPR *Child Protection / Child Protection Register*

CPCC *Child Protection Case Conference*

CVUHB *Cardiff and Vale University Health Board*

CTMUHB *Cwm Taf Morgannwg University Health Board*

DSL *Designated Safeguarding Lead*
Is the person appointed to take lead responsibility for child protection issues in schools and Pupil Referral Units (PRUs).

DTR For the purposes of the Wales Safeguarding Procedures, a ***duty to report (DTR)*** to the local authority means a referral to social services who, alongside the police, have statutory powers to investigate suspected abuse or neglect.

ED *Emergency Department*

ELSA *Emotional Literacy Support Assistant*
Is a social and emotional intervention programme delivered by trained staff in primary, secondary schools and PRUs.

HIW *Healthcare Inspectorate Wales*

HMICFRS *His Majesty's Inspectorate of Constabulary and Fire and Rescue Services*

IDVAs	***Independent Domestic Violence Advisors*** Are trained to provide specialist advice and support to victims of domestic abuse.
IRO's	***Independent Reviewing Officers***
JICPA	***Joint Inspection of Child Protection Arrangements***
MARAC	***Multi Agency Risk Assessment Conferences*** They are regular meetings of professionals who discuss how to help individuals who are most at risk of serious harm due to domestic violence and abuse.
MARF	***Multi Agency Report (Referral) Form***
MASH	***Multi Agency Safeguarding Hub*** A single point of contact for all new safeguarding concerns.
NPT	***Neath Port Talbot County***
Operation Encompass	A partnership between police, schools and PRUs. One of the principles of ***Operation Encompass*** is that all incidents of domestic abuse are shared with schools and PRUs, not just those where an offence can be identified.
PCCs	***Police and Crime Commissioners*** Aim to cut crime and deliver an effective and efficient police service within their police force area. They are elected by the public to hold Chief Constables and the force to account, making the police answerable to the communities they serve.
PPN	***Public Protection Notices***
PRU	***Pupil Referral Unit*** A type of school established and maintained by a local authority to provide suitable education for children and young people who, by reason of illness, exclusion or otherwise, may not receive such education (section 19 of the Education Act 1996)
Rapid Review of Child Protection Arrangements	In response to a number of tragic child deaths across Wales and England, in November 2022, Welsh Government asked Care Inspectorate Wales (CIW) to lead on a multi-agency rapid review of decision making in relation to child protection.
Return Home Interviews	All Wales Practice Guide: Safeguarding children who go missing from home or care. In some areas of Wales third sector missing children workers work in partnership with the Police. They provide support to children who meet service criteria to provide ***Return Home Interviews*** and aftercare.
RSB	***Regional Safeguarding Board***

S47	Under ***Section 47*** Children Act 1989, a local authority has a duty to investigate if it appears to them that a child in its area is suffering or is at risk of suffering significant harm.
TAF	***Team Around the Family*** An early intervention and prevention service that aims to support families to help them achieve their individual goals by offering advice, guidance and support.
WSP	***Wales Safeguarding Procedures*** Detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect.