Mark Hackett, Chief Executive, Swansea Bay University Health Board
Emma Woollett, Chair, Swansea Bay University Health Board
Andrew Jarrett, Director of Social Services, Neath Port Talbot CBC
Keri Warren, Head of Children and Family Services, Neath Port Talbot CBC
Andrew Thomas, Director of Education, Neath Port Talbot CBC
Karen Jones, Chief Executive, Neath Port Talbot CBC
Ali Davies, Principal Officer, Youth Justice & Early Intervention Service
Jeremy Vaughan, Chief Constable, South Wales Police
Alun Michael, South Wales Police and Crime Commissioner
Nic Davies, Regional Probation Director, Wales

Date: 16 September 2021

Dear Colleague,

Joint Inspection of Child Protection Arrangements (JICPA): Neath Port Talbot County Borough Council, Swansea Bay University Health Board, Wales Probation Service, South Wales Police - June 2021

Between 28 June and 2 July 2021, Care Inspectorate Wales (CIW), Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Probation and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect in Neath Port Talbot (NPT). This inspection included an evaluation of how local services responded to child exploitation.

This letter outlines our findings about the effectiveness of partnership working and of the work of individual agencies in NPT.

Scope of inspection

The JICPA reviewed:

- the response to exploitation at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- the protection of children and young people at risk of exploitation, (evaluated through a deep dive assessment of the experiences of these children)
- the leadership and management of this work
- the effectiveness of multi-agency safeguarding partner arrangements in relation to this work.

We have endeavoured to use plain language to describe the findings from the JICPA. There are a number of terms mentioned we describe here:

Term or Phrase	Definition
ACEs	Adverse Childhood Experiences
ACC	Assistant Chief Constable
BCU	Police Basic Command Unit

CAMHS	Child and Adolescent Mental Health Service
Care Experienced	A child or young person who is either looked after or who has previously been looked after (for example an older young person who has 'left care' aged 18, a child who has returned to birth family, or an adopted child)
CAWNs	Child Abduction Warning Notices
CCE	Child Criminal Exploitation
CLA	Children Looked After A child or young person who is currently in the care of the local authority
CPR	Child Protection Register
CSE	Child Sexual Exploitation
CSERQ	Child Sexual Exploitation Risk Questionnaire
DTR	The statutory *duty to report* to the local means a referral to social services who, alongside the police, have statutory powers to investigate suspected abuse or neglect.
EAL	English as an Additional Language
EAT	Early Action Together Programme
EWO	Education Welfare Officer
ED	Emergency Department
FAST	Family Action Support Team
ISHU	Integrated Sexual Health Unit
LBGTQ+	Lesbian, gay, bisexual, transgender, queer or questioning
LIO	Police Local Intelligence Officer
MIU	Minor Injuries Unit
MAPPA	Multi-agency public protection arrangements are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders
NAIRA	No Apparent Immediate Risk – Absent Police new risk grading for missing children
NEET	Not in education, employment or training
NRM	National Referral Mechanism
PCC	Police and Crime Commissioner
PCSO	Police Community Support Officer
PPN	Public Protection Notice
PSC	Police Public Service Centre
PPU	Police Public Protection Unit
RSE	Relationships and sex education
SPOC	Local Authority led partnership in Single Point of Contact
SWP	South Wales Police
SBUHB	Swansea Bay University Health Board

THRIVE	Police risk assessment tool used to assign a priority level to an incident
WGCADA	West Glamorgan Council on Alcohol and Drug Abuse
YJEIS	Youth Justice and Early Intervention Service referred to as YOS
YOS	Youth Offending Service

Summary of findings

The local authority and partners (the partnership) have exercised functions under the Social Services and Well-being (Wales) Act 2014 (the Act) and strive to ensure these make a positive contribution to the well-being and safety of children who need care and support. Their work was supported by a positive approach to regional safeguarding arrangements with strategic managers proactive in progressing key areas.

We found suitable structures and relationships in place to facilitate effective partnership working where a child was at risk of exploitation. Statutory functions in relation to promoting safety and well-being were being fulfilled. Partners, both statutory and third sector providers such as St. Giles and Barnardo's, were working to a shared ethos of safeguarding children and young people at different levels of vulnerability. This was evident as leaders within these organisations clearly articulate a shared vision. Managers have worked purposefully across the partnership to support identification of and to tackle exploitation. We found a culture of relationship building with people at the heart of practice across organisations.

There is growing understanding across the partnership of criminal exploitation and the complex inter-relationships between this and other forms of exploitation; as well as a contextual safeguarding response bringing a relatively new dimension to the management of extra-familial harm. There is a need, however, to embed expertise about exploitation and the contextual safeguarding concept in to practice and ensure there is full understanding across professional groups.

There was evidence of effective partnership working where a child was at risk of Child Sexual Exploitation (CSE); systems were well developed to support practitioners across organisations, share information and manage risk to maximise the safety of children. Whilst multi-agency exploitation meetings provide a good forum for sharing information, these meetings need to be used more consistently to shape and adapt children's safety plans and improve the co-production of these with young people. Whilst improvement is required, work reviewed reflected the commitment, persistence and flexibility of the approaches used by staff to encourage young people's engagement.

Children's services leaders have a line of sight of front-line practice with plans leading to innovative and evolving service delivery in many areas. Staff told us about very supportive leadership which was highly regarded. There was a culture of improvement and mutual support driven by leaders across the organisation. This has been maintained during the pandemic. Staff were forward thinking and look to research and best practice to inform their work. The local authority has not adopted a specific risk model. Staff spoken with were not aware of underpinning documents that would help provide consistency and a shared framework for understanding of risk.

The local authority has a positive approach to the management of risk where the views of children, young people and families are clearly listened to and understood. Fundamental to care and support for children in NPT, was supporting them at home and in their communities. Practitioners knew the children and families they worked with well and have ensured positive relationships were developed.

We found the local authority has worked hard to shape its services in the context of the Act. The local authority's Information, Advice and Assistance function was delivered through the Single Point of Contact (SPOC) service which provided a distinct access point for children with eligible need and for preventive interventions. There were clear pathways established to facilitate early intervention, help for families and clarity about the prevention offer, both in youth justice and social care.

Although disrupted by the pandemic, strategic partnership support for management of risk was evidenced by investment in relevant (joint) staff training across the partnership; some single agency and on-line training has been sustained during the pandemic. Robust safeguarding training delivered by the local authority has effectively supported schools to recognise early indicators of exploitation, as well as enhanced training for school staff who educate and support highly challenging young people known to be at risk.

The Youth Offending Service (YOS) has embarked on an improvement journey resulting from a poor inspection outcome for the previous consortium arrangements in 2018. The service is now fully integrated within NPT and has a number of plans in place to address the shortcomings previously identified. Practice is improving as a result. The YOS and the police have a shared understanding of the importance of avoiding formal criminal justice outcomes for vulnerable children where appropriate.

Significant changes have occurred in the probation sector over the past year. The inspection week coincided with the launch of the new probation service resulting from the merger of the private sector community rehabilitation companies and the public sector probation service. Many of these changes were implemented 18 months early in Wales and the new unified probation service has a head start in NPT. The size and scale of this change cannot be underestimated. The partnership needs to understand the implications of these changes and assure itself the systems and processes designed to safeguard children, are consistently and effectively implemented. This includes effective information sharing arrangements, consistent attendance at operational and strategic partnership meetings and access to briefings and training on local child safeguarding priorities, including exploitation.

Senior managers in the Swansea Neath Port Talbot Probation Delivery Unit were determined to make the new probation structures work. They recognised the challenges involved. The pandemic adds a layer of complexity and means staff cannot develop peer networks in the new organisation in the office setting that would normally take place. There are local advantages, the private and public sector organisations were previously co-located and so there are some working relationships established between staff in the two constituent agencies.

South Wales Police (SWP) demonstrated a clear commitment to child protection and tackling exploitation of children in NPT. This was evidenced by the priorities in the Police and Crime Commissioner's (PCC) Police and Crime Plan and the Chief Constable's

Delivery Plan. The force was also proactive in producing and reviewing other strategic plans and assessments in line with changing or emerging threats. The best examples of police safeguarding vulnerable children included prompt action to identify those at risk and information exchange across police teams and partners.

SWP has undertaken a programme of training to upskill staff in issues relating to vulnerable children. This has included widespread training on Adverse Childhood Experiences (ACEs) and a trauma informed approach under the Early Action Together Programme (EAT). More bespoke training has been provided to call handlers, custody officers and the Public Service Centre (PSC) missing person team.

School staff understood early identification, assessment, communication and intervention are vital across all stakeholders. They recognised 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. There was close working with other agencies with an ethos that was child-centred. School staff focused their work on the context in which the child and their family found themselves and recognised the needs of children on their journey to adulthood, with a commitment to ensuring quality of provision to meet these needs.

The local authority promotes a high level of inter-agency working across schools. There was evidence of close working relationships across services in supporting the needs of highly complex young people and their families. Education officers and school staff were routinely involved in safeguarding multi-agency meetings. The Education and Lifelong Learning Directorate promotes a strong culture of inclusivity. Schools access support and guidance from teams across the directorate.

We identified Swansea Bay University Health Board (SBUHB) safeguarding leadership teams have oversight of front line healthcare services, and there were good processes in place for reporting to appropriate governance groups and committees. We also found examples where staff described good engagement with safeguarding leads in both primary and secondary care. There was an appetite for ongoing improvements driven by safeguarding leads at both operational and corporate levels.

There was good safeguarding knowledge and awareness demonstrated across health care staff and GPs. There was good communication between different health disciplines, although some staff reported inconsistencies. Robust safeguarding processes were observed in both the Emergency Department (ED) and Minor Injuries Unit (MIU), with innovative practice developments and a strong learning culture evident. Processes to identify when a child attending either setting was subject to a care and support protection plan were in place.

Well-being

Strengths

Safeguarding processes were understood across the partnership. Safeguarding meetings were well attended by partners, were timely and proportionate, and information was shared. Risks and needs were analysed with multi-agency actions set to safeguard and manage risk.

Across the partnership we saw daily communication through formal and informal mechanisms and escalation processes applied when appropriate. There were various examples of a proactive approach to ensure thresholds were understood across agencies. The multi-agency peer review meetings for example, provided opportunity for dialogue about children where operational issues had been identified.

Children's services practitioners have a clear understanding of child protection procedures. Initial decision-making seen was timely and there was evidence of management oversight. When a Duty to Report (DTR) was received by SPOC there was clarity in relation to indication of significant harm, with prompt and proportionate initial action taken to protect children. There was clear evidence staff recognised the signs of exploitation and the risks associated. Social workers demonstrated a good understanding of the impact of domestic abuse on children, information sharing around domestic abuse was also evident.

We saw some examples of the police mitigating risk and disrupting perpetrators for children at risk of CSE. This included providing briefings about at risk children to frontline police officers, patrolling hotspot locations and robust policing of bail conditions and curfews to protect children. The police made use of Child Abduction Warning Notices (CAWNs) to restrict perpetrator access to children and provide further safeguards.

The review of cases highlighted several National Referral Mechanism (NRM) investigations. The quality of these investigations varied, but where an investigation was conducted by detectives, the response was timely and the investigation was comprehensive, providing the best opportunity to identify and pursue offenders. In other investigations we saw wider risk to other children or from perpetrators was not always identified and acted upon.

We saw police call handlers recognised children as vulnerable and completed THRIVE risk assessments to support the prioritisation of calls for service. They have immediate access to the most up to date information held on Niche and Control Works (call logs). This includes warning markers for children who are at risk from criminal exploitation or have a care and support protection plan. This not only supports their decision making but provides front line staff with the necessary information to support their response.

When children had been categorised as missing from home or care, there was clear supervisory oversight, both within the PSC and the Basic Command Unit (BCU). In addition, the records detailed appropriate risk assessments, and, in most cases, officers were proactive in trying to locate the child. This was not the case for children categorised as 'No Apparent Immediate Risk – Absent' (NAIRA).

When a child is accepted onto the CSE protocol, we saw evidence of the use of a police master occurrence log for recording the outcome of all multi-agency meetings. Strategy meetings and multi-agency meetings were well attended by staff and records provided detailed accounts of the information shared by partners and the agreed safeguarding plan. These records were added to Niche, which ensures officers and staff can quickly access information that will support their action and decision making.

The quality of return home interviews was good. These were shared with partner agencies in a targeted manner, providing professionals with new information about the child's experience. The Barnardo's worker provides an effective conduit between police and social

services, enabling workers to identify ways to reduce missing episodes, emergent needs and to adapt plans to manage risks. Critically, this service gives children a stronger voice.

The police missing team has links to 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.

We found positive use of the Child Sexual Exploitation Risk Questionnaire (CSERQ) screening tool by Children Looked After (CLA) Nurses, ED and the MIU staff, to support early identification of CSE. Appropriate referrals were made where required. All children attending the ED were checked to establish if they were named on the Child Protection Register (CPR) which staff at ED and MIU had access to. Staff we spoke with at the ED knew of the existence of the CPR and told us about a tick box on the triage card. This meant if required staff could share key information with multi-agency partners. In most cases where it was required, we identified body mapping of injuries being used in MIU, but this was not consistent in the ED.

GPs and healthcare staff had good knowledge and understanding in relation to both individual and their teams' professional responsibility towards safeguarding and protection of vulnerable children. Appropriate coding systems were noted in GP records. The systems we viewed provided prompts to practitioners highlighting if a child had a care and support protection plan, was a child in need or a child looked after. This meant all practitioners had access to key information prior to and during consultations with parents and children.

The Contextual Risk Panel has rigorous processes in place to quality assure practice and identify further support where appropriate. This forum provides benefits across the partnership but specifically from the perspective of education, this offers a valuable opportunity for sharing of information to provide a coherent approach to identifying and managing pupil needs.

The youth service has strong working relationships with Careers Wales to support post-16 learners. Levels of support vary across tiers, for example at Tier 1, the service intervenes with hard to reach pupils who are highly vulnerable and are not in education, employment or training (NEET). The Youth Service works well with the local authority CLA team to prioritise support for CLA and care experienced young people. This targeted support, along with that provided by Cynnydd, is effective in providing additional support for those young people who potentially are at risk of becoming NEET. This work is contributing to the relatively low reported number of young people who are NEET in the county.

The school based counselling service was committed to supporting young people across schools and has been proactive in its approach throughout the pandemic and as pupils return to full time education. They are seeing an increase in referrals to the service as pupils return. Schools have increased their support for pupils' mental health by expanding their capacity to provide interventions using initiatives such as Emotional Literacy Support Assistants and enhancing school based counselling services. This has helped reduce the risk of deteriorating mental health due to the delay in support from Child and Adolescent Mental Health Service (CAMHS). Pupils as young as five years can now access school based counselling services.

The local authority has developed a successful network of support in all secondary schools and the college provided by the Cynnydd service. Schools and social work staff consistently reported on the high quality of support, advice, and guidance Cynnydd staff provide working with identified pupils. As part of the local authority Early Intervention Panel outcomes, Cynnydd workers can be directed to support specific pupils who are on the cusp of requiring statutory care and support plans.

There have been strong school inspection outcomes for care, support and guidance including safeguarding; in the last three years all schools received good or better judgements for Estyn's inspection area 4 (Care support and guidance including safeguarding). This is higher than the national average for both primary and secondary schools.

Secondary schools have strong pastoral programmes for pupils at risk of Child Criminal Exploitation (CCE) and CSE. Secondary head teachers said this work has been strengthened significantly over recent years and they are confident their pupils are given the right information and skills to help them deal with challenges within their community.

The majority of schools were sharing information appropriately when a vulnerable pupil moved from one school to another school. Many schools use an online platform for this purpose, however, there were concerns a minority of schools do not always share important information when a vulnerable pupil transfers. Schools acknowledged the work of the Wellbeing team in supporting transition but had concerns the service may not have the capacity to support pupils consistently.

The quality of information recorded on SPOC DTR forms submitted from schools varied, but overall, they provided SPOC staff with sufficient information to make a decision on next steps. The quality of referrals from schools has improved significantly over recent years due to training and the common format now used for all DTR. Schools are more skilled in supporting positive outcomes for children and their families.

In line with their child protection policy, nearly all schools had appropriate systems in place for staff to refer concerns to designated safeguarding officers. In most instances, school officers ensured DTR forms were processed in a timely manner. In nearly all schools, staff recognised the signs a pupil may be involved in CCE and CSE.

Education Welfare Officers work with primary school clusters and have been successful in reducing the rate of persistent absenteeism. The local authority keeps data on the attendance of pupils named on the CPR; rates range from 0% to over 95%. Access to data linked to school absence is important given the link between pupils not being in school and increased risk of exploitation.

The YOS have access to a wide range of resources and specialist staff and can respond to the complex needs of children at risk of offending. Staff use both therapeutic and restrictive interventions, for example curfews and exclusion zones. Many young people reported restrictive measures helped them stay away from high risk situations.

The YOS are respected by colleagues and they drive innovation both in their own practice and with their partners. They have adopted contextual safeguarding principles and their

community risk profiling meetings are an example of this approach. Where they identify a locality presents risks to children such as a public park where drug dealers operate, they work with partners to explore opportunities for disruption. This work is at an early stage and not all relevant agencies are participating yet. They have developed an understanding of the local drug market and how children can become involved in it.

Areas for Development

Contextual safeguarding is a key concept at the core of NPT's partnership approach to safeguarding. The probation staff we met, however, were unaware of the term. We found the contextual safeguarding agenda also needs to be strengthened further across all schools. There is a need to ensure staff across all agencies understand the interconnections in relation to contextual safeguarding (extra-familial risk) and the role played by carers and parents in promoting well-being and safety.

While responses were mainly timely, the quality of children's services assessments was inconsistent. The format of documentation was helpful but a more explicit focus on strengths and outcomes was required and the child's voice was not always captured well enough. Whilst the majority of assessments identified risks, more rigorous analysis including the impact on the child was needed to effectively inform planning.

There was a commitment to the use of safety plans that identified the child and families' own support networks. The relationship between this and care and support plans needs to be more clearly defined. The development and implementation of safety plans requires attention, greater clarity is required in making these focused documents to support care and support safeguarding arrangements. Partners also need to take shared responsibility for the implementation of safety plans. Similarly, whilst strategy meetings were being held with appropriate representation across agencies, the quality of the minutes was inconsistent and often lacked specificity and clear actions.

All staff across agencies were enthusiastic about the concept of contextual safeguarding being developed. It was noted a number of complex pathways were being developed to respond to the range of risks identified. This creates potential confusion for partners who need to ensure planning is consistent and clear with regard to the inter-relationships between contextual safeguarding and other child protection processes. The risks posed or safeguarding needs of others, including siblings, involved in the same incident or on the periphery were variably addressed across agencies.

Some partners were insufficiently familiar with Multi-Agency Public Protection Arrangements (MAPPA) and the significance of this process in the management of risk and the safeguarding of criminally exploited young people. Some agencies also underestimated the serious risk some of these young people pose to others. For some situations we saw how MAPPA could have brought these perspectives together into a credible multi-agency approach to managing risk and to safeguard a young person. Conversely, we also found some young people who had been made subject to MAPPA procedures where the combined risks they faced, and the risk they posed to others, would have been better managed in an alternative forum.

In the small number of probation cases reviewed there was insufficient professional curiosity which impacted on risk assessment and management. Information was available

from partner agencies such as the YOS and social services which would have assisted in making assessments, however, this was not always sought by the probation practitioner.

Staff at the Integrated Sexual Health Unit (ISHU) did not consistently have access to CPR information and were reliant on self-disclosures from children or family members. This meant staff could miss opportunities to identify risk factors and seek further information from other agencies if required. SBUHB should review the processes in place to ensure ISHU are aware of how to access this important information in a timely manner.

In some cases, we found police officers used inappropriate language to describe at risk children. Comments included ‘appearing to be streetwise’ and ‘not unusual behaviour as he goes missing every night’. These comments demonstrate a lack of awareness by some officers of the risks faced by these children. More should be done to ensure staff have the required skills and knowledge.

The force has introduced a new risk grade for missing children, NAIRA. This can be used for children aged 14-17 years. NAIRA cases are managed by a new missing person team within the PSC. This team should confirm that the case is appropriate to be managed as NAIRA and contact the reporting person to discuss what actions they should take to try and locate the child. The NAIRA category can be used for up to six hours (or until 3am when the team finish working) at which point the incident will be escalated to medium risk. In some cases we looked at, children at significant risk were assessed as suitable for NAIRA despite clear warning markers, credible intelligence, and multi-agency information and plans being taken account of during the risk categorisation process. It is our assessment that the application of the NAIRA policy for these children did not fully consider the contextual risks they face, and instead focused too much on the circumstances of the immediate missing episode. This had potentially left the risks that are well recognised across the partnership unmitigated and unmanaged.

Public Protection Notice (PPN) forms were mostly submitted promptly to SPOC. The quality of information recorded on the PPNs was variable and the outcome of the referral was often not recorded. The relevant contextual information and details of other children involved in an incident were not consistently recorded and wider risk was not always explored. Consequently, opportunities to engage, safeguard, build rapport, and intervene were not always taken. In most of the cases we looked at there were examples of PPNs not being submitted and shared with partners, including those subject to NAIRA, missing, low level crime, ASB, and stop and search. This results in partners not being able to make effective decisions based on all the available police information for a child.

In CCE cases, we saw little evidence that co-ordinated police disruption tactics were being used routinely to protect children. There was some reference to briefings being prepared but there was no evidence of formal tasking and coordination to disrupt perpetrators and gather intelligence. In addition, we did not see any evidence that response, trigger or disruption plans were being used to support frontline staff to identify individuals and locations and focus their efforts to find, engage and safeguard children as well as gather valuable intelligence.

People

Strengths

Practitioners across the partnership made significant efforts to engage with children. For example, our review identified how police officers engaged with children and their families and sought their views, their representations, and concerns on visits and prevention interviews. CSE minutes reflected the commitment, persistence and flexibility of the approaches used by staff to encourage young people's engagement.

In children's services teams have close links with the participation and engagement officer, with current work focusing on how paperwork can better capture the child's voice for children looked after. Over the pandemic, the participation officer led on the development of a digital platform to support young people's well-being and address loneliness.

We noted an Active Offer for those who wish to communicate in Welsh. This was seen across health and social care and in educational services. Welsh speakers were also located in the SPOC. In relation to health services we were told an active offer for those who wished to converse in Welsh was available, this was evident across the health board from GP services through to ED and school nurses.

The Youth Voices Conversation Project is a good example of a child-centered approach to engage with and seek the views of children about things they are concerned about relating to policing and community safety. During May and June 2021, 800 young people across the force provided feedback. Themes have been drawn together for each BCU and for NPT include knife and violent crime, drugs, and underage drinking and smoking. Young people presented their findings to the PCC, an Assistant Chief Constable (ACC) from SWP and the Children's Commissioner for Wales. Recommendations have been drawn up about how the police intend to improve services for children and young people.

The health board's Corporate Safeguarding Team supports SBUHB to implement its duties to safeguard children, young people and adults at risk within the statutory framework. The team addresses the most pertinent issues the health board may encounter regarding children and adults at risk, along with issues such as violence against women, modern slavery and Deprivation of Liberty Safeguards (DoLS). To monitor and manage incidences of safeguarding and any cause for concern, the team monitors all safeguarding alerts triggered via its electronic incident management system. This is positive as it allows the team to capture incidents that do not specifically require the submission of a safeguarding report or referral. This allows for the collation of information and to share learning in relation to safeguarding across teams.

Along with all health boards in Wales, SBUHB is required to complete an annual Safeguarding Maturity Matrix (self-assessment tool), to evaluate its quality of care, to identify improvements, and to review compliance against agreed standards of care. It is positive to note that actions have been completed by the Health Board following the last assessment. We were told any learning or actions are disseminated across the relevant healthcare teams throughout the Health Board. This is a positive action to help improve practice overall in relation to safeguarding, the protection of vulnerable children and those at risk of exploitation or harm.

SBUHB has undertaken bi-annual audits to monitor if the CSERQ tool has been used appropriately. We saw evidence of compliance with this process. We were told all published Child Practice Reviews are presented to the Safeguarding Committee, and any learning points or recommendations are included in the Health Board Practice Review Action Plan. For shared learning, action plans are disseminated as appropriate to the relevant service groups, and progress related to this is monitored by the Safeguarding Committee. Evidence of audits on children who attend ED was noted. The audit included key information to establish: if the child was a persistent attender, if details of accompanying individual had been obtained, if a CPR check had been undertaken, and if a CSERQ form had been completed with all relevant information. This demonstrated SBUHB had appropriate checks and balances in place.

Each SBUHB service related to children has relevant safeguarding leads. We found good processes in place to feed in to appropriate governance channels such as departmental, directorate and corporate safeguarding meetings, and committees. To support staff in their day to day work, and where immediate advice is required, the Health Board has a dedicated intranet safeguarding page easily accessible to staff.

The paediatric wards and other departments (such as ED), which provide services to children, take the views of children and young people into account when consulting with them. CLA Nurses attempted to engage the child and to capture their voice within the Statutory Health Assessment process.

The children's services senior management group work coherently and were visible across the workforce. This means practitioners feel 'safe', with sharing risk decisions. We met with highly committed and motivated professionals who demonstrated a good understanding of the nature of work in relation to children and families who are at risk or are experiencing exploitation. We recognised the complex nature of this work. The social work workforce is stable and the position in relation to recruitment and retention is positive. Work-load is on the whole manageable, this is significant as it allows practitioners the opportunity to be reflective in working with complex circumstances.

There was innovative thinking across the children's services senior management group, they were willing to test new ways of working, for example, changes in relation to contextual safeguarding. The local authority is forward thinking in terms of being engaged in several projects working with academia.

The local authority gives regard to the rights of children to be offered formal advocacy. From the information provided, we found evidence children were offered access to advocacy services; the offer was not always accepted.

Evidence from children's services case files demonstrated consistency of supervision, opportunities for case consultation and management oversight of good quality. Practitioners valued the approachability and experience of managers; they told us they felt well supported, enjoyed working for the local authority and there was a supportive culture.

In SPOC, the quality of threshold decision-making was mainly consistent and the context to decision-making was evidenced in the manager's comments and at sign off points. In review of records we noted the local authority's quality assurance systems identified a file

had been prematurely closed and was subsequently re-opened for further assessment and exploration of potential risk.

Learning and development for local authority staff has continued through the pandemic, with consultant social workers supporting a culture of development across the service. Staff reported the quality of exploitation on-line training was good.

Work has been undertaken to develop a toolkit to support decision-makers to respond effectively and consistently to harm outside of the family home. It is meant as a guide/checklist to help inform existing mechanisms for decision, assessment and planning. It is still being piloted and so was not well known to all staff, nor partners, and the intention is to evaluate its usefulness through the Quality & Performance Management Group.

There was strong leadership from the local authority officers who strategically and operationally actively promoted an effective safeguarding culture across all schools. The Education Safeguarding lead officer is skilled and knowledgeable, and her professional advice and support was valued by all schools.

There was strong evidence of beneficial collaboration across teams in the Education service to promote effective sharing of information, a culture of reflection and challenge to consistently seek to improve the quality of support available to schools. Head-teachers said education lead officers were approachable, and their views were listened to.

The local authority has a secure overview of safeguarding practices in all schools with clear structures and processes in place to quality assure practice. All schools complete a detailed safeguarding audit on an annual basis. This helps them identify their strengths and areas for improvement. Nearly all schools adopted the local authority model Child Protection policy. This includes all the elements you would expect to see in such a policy. From the sample scrutinised, all were appropriate and reviewed on an annual basis, for example to include changes in legislation or schools' protocols.

Every three years schools are subject to a peer review of safeguarding which further identifies their strengths and areas for improvement. This work includes how well schools reduce the risk of child exploitation. Where the local authority identifies shortcomings, these are then followed up with subsequent meetings and assessments. However, due to the pandemic the peer review initiative has been temporarily halted. To help mitigate the risks, the local authority will be scrutinising all schools' safeguarding audits in the autumn term and will address any concerns with schools directly.

A robust high-quality training and development programme was in place for schools delivered by the local authority. It included training on how to recognise and deal with potential CCE and CSE. This effectively supports schools to recognise early indicators of exploitation as well as enhanced training in exploitation for school staff who educate and support highly challenging young people who are already known to be at risk.

Leadership and management of safeguarding in schools was strong with identified designated safeguarding teachers having a thorough knowledge and understanding of effective safeguarding practices. In nearly all schools, staff recognised the signs if a pupil was involved in exploitation. Secondary schools in particular had strong pastoral programmes for pupils at risk of becoming involved with CCE and CSE.

Across education services there was a strong commitment to delivery of support services through the medium of Welsh. Education services could provide Welsh speakers to support young people and their families where this was identified as a need. There were sufficient Welsh language speakers throughout every team in the local authority to meet the demands from Welsh-medium schools, for example for counselling services and support from the education welfare service. Many pupils who attend a Welsh-medium school, however, request that support is delivered through the medium of English. This is particularly apparent if they come from non-Welsh speaking homes.

Ysgol Hendrefelin provides specialist support for young people, some of whom are known to be at risk of exploitation. Staff across the school have received ongoing training on the trauma informed approach, and training with Junior Smart which looked at exploitation. In addition, St Giles' Trust, the school police liaison officer and staff from the Wellbeing Team have worked closely with the school. In one case we reviewed a young person transitioning to Ysgol Hendrefelin was supported by school staff who had visited the current placement to meet with him to build a working relationship. The Cynnydd team will provide additional support. The emphasis on gaining the young person's involvement in education is crucial to distract him from potential further exposure to exploitation.

School representatives were invited to most key strategic meetings involving their pupils. They said their voices were heard and they play a key role in decision making. They often challenged the views and decisions of other professionals. A shortcoming was quite often meeting notifications were at short notice which makes it difficult to organise attendance.

The local authority has shared their framework for Person Centred Practice with all schools and have a programme to train all school staff on its implementation. They are also rolling out Rights Respecting Schools' work to all schools. Young people were consulted on a number of fronts across the local authority. For example, when the specialist unit at Dwr-y-Felin School was being planned, officers met with children to consult on how it should be established. There is a new draft policy on the participation of young people in decision making which the local authority will share with young people during the consultation process. Established in 2019, the Junior Safeguarding Board has provided valuable opportunities for children and young people to have a voice and to influence the decisions made within the local authority.

The Youth Service was one of the first in Wales to achieve the Children in Wales Participation standards. The Youth Council has won a National Youth Excellence Award for their work around children's rights. The local authority is one of very few to have an elected Youth Mayor.

The local authority run youth clubs for lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ+) and Welsh speaking pupils. There was strong representation from these groups on the Youth Council. Youth council meetings were chaired by the council leader which further strengthens the importance the local authority places on the voice of young people. LGBTQ+ young people were also part of the relationships and sex education (RSE) working group that promoted changes to RSE lessons to better reflect LGBTQ+ issues.

The Vulnerable Learners' service has provided beneficial support for pupils who have English as an Additional Language (EAL). This service has capacity to respond flexibly to the needs of schools. They have seven bilingual teaching assistants who reflect the main languages within the local authority. The team were very proud of the strong academic outcomes pupils with EAL have achieved within the local authority over recent years. The Vulnerable Learner service also works with the Gypsy, Roma and Traveller communities. Staff recognised the vulnerabilities of pupils within these groups places them at risk of exploitation and work closely with the two Traveller sites to support children and their families. There was strong multi-agency working with the sites to ensure these pupils are safe and have sufficient medicine and food.

YOS staff presented as enthusiastic and showed commitment to helping children and young people. They recognised the importance of developing strong working relationships to constructively achieve positive change. This is significant as positive relationships with children and families creates trust and encourages children to disclose issues that worry them. A young person we interviewed said he had previously been allocated numerous social workers, but his current social worker, YOS worker and Cynnydd worker all listened to him and treated him with respect. Similarly, a foster carer interviewed said she felt very well supported by her supervising social worker, the child's social worker and Cynnydd worker. She expressed great trust in them and said they were respectful and easy to access.

YOS staff have all received training in recognising and responding to child exploitation. The training was delivered remotely by Barnardo's and we were provided with copies of the training material which was comprehensive. Workloads were appropriate and this enabled practitioners to provide a good quality service to children.

A finding of the 2019 inspection was the YOS management board did not understand the needs of children or the service. This position has substantially improved, and management board members have close contact with staff. The service has recently begun to invite young people supervised by the YOS to board meetings.

Areas for Development

While we found resilient social work practice in seeking the views of children and young people, there was variation in the quality and content of written records. It was positive children were seen and seen alone but the good social work practice we heard about to elicit the child's wishes and feelings was not consistently well reflected in the content of assessments and some were too adult focused. Inconsistency in recording the voice of the child was also evident in police records.

We found What Matters conversations recorded in social services records, but these could be improved with greater clarity about what needs to happen to achieve personal outcomes. It was positive workers see themselves as advocates for the children they work with but it was less clear there was a shared understanding of the added value and function of independent advocacy. This is an area that needs to be refreshed to ensure it is promoted more robustly. Working with a new provider, National Youth Advocacy Service could provide this opportunity.

During interviews social services staff were able to describe the significance of strength based outcome focused work but the 'lived experience' of the child was not always apparent in records. Whilst the local authority works with an outcomes focused ethos we found further development and embedding of a strengths based approach to practice was needed. Many examples of record keeping were not clearly outcome focused, were often overly descriptive and lacked a clear indication of children's strengths, what professionals were concerned about and what is expected from children, carers and professionals to ensure safety and to achieve desired outcomes.

Children's services assessments often did not sufficiently include a sense of the child in the context of the wider family. It was particularly noted the significance of the children's relationship with their siblings and the extended family was not always explored. Identification of risks was not always sufficiently robust or outcome focused to support the child and family to understand the required focus of change.

We did not see consistent evidence of the shared implementation and review of safety plans. In some cases, there was lack of clarity about which agencies were responsible for addressing which aspects of safety and well-being concerns. Professionals, children and families alike can also be overwhelmed by the lack of coordination in terms of the delivery of multi-agency services. We heard due to the pandemic, assessments were not always shared with families although social workers spent time going through the assessment with them.

Safeguarding supervision and support is an essential component of clinical governance, ensuring continuous improvement in the delivery of high quality care to service users in accordance with the All Wales Safeguarding Best Practice Supervision Guidance. We were told that the health board uses a variety of models for safeguarding supervision, however, through our staff interviews we found that safeguarding supervision was inconsistent across the health board with some staff telling us this frequently takes place, whilst others told us there were no systems in place for safeguarding supervision. Nonetheless, all staff we spoke with told us there were good relationships, communication and support from the safeguarding leads in the health boards. The health board should therefore ensure that the provision of safeguarding supervision is consistent with all relevant staff across the health board.

Following a training needs analysis in 2019/20, SBUHB identified as a minimum, all staff groups are required to complete Level 2 Safeguarding Adult and Children Training. This training is available via eLearning and needs to become part of the SBUHB Board wide mandatory training monitoring requirements. SBUHB must promptly prioritise staff access and study time to complete this training.

In the absence of multi-agency face to face exploitation training during the pandemic, SBUHB ensured some exploitation content was included in their Level 3 training. Full day face to face exploitation training is scheduled to resume in the near future.

SBUHB staff spoken with generally had a good level of knowledge and understanding in relation to exploitation, however, there were mixed reports on the training staff had received, this was consistent with the SBUHB decision to pause training for exploitation in

response to the pandemic. When the training recommences this will also be available to staff in primary care, such as GP practices.

There were some gaps in training for the police, for example role specific training for referral unit officers. We also saw individual officers were not demonstrating a comprehensive recognition or knowledge about child exploitation issues, which indicates further work needs to be done to ensure officers and staff are fully aware of what is expected of them.

In the YOS's desire to improve the quality of their service they have developed multiple service improvement plans. Monitoring progress across these plans is complex and time consuming and they were considering how these processes could be rationalised to make them more manageable. A wide range of meetings and forums, both internal to the YOS and through partnership arrangements, have been developed in response to the needs and risk factors associated with specific children. Practitioners described meeting congestion occurring where multiple meetings with overlapping purpose were held on the same child in quick succession. Some of the YOS initiatives were in the early days of development and there was not always an awareness of them among across the partnership. It will be important to ensure these are evaluated.

We found the perceptions of probation managers and staff about the service's ability to focus on safeguarding differed. For example, managers viewed the temporary measure of a 'doorstep visit' as providing some safeguarding assurance where there are children in an adult offender's home. Practitioners were more cautious stating because they often relied on colleagues to make these visits they felt there were limitations on the extent to which they could be relied upon. There are significant issues to resolve as new processes and structures start to take effect.

Probation staff described their workloads as being high although this is an issue throughout the probation service. Training for probation on general child safeguarding was evident but there was no specific training on exploitation. There was a general lack of knowledge about the NRM. There was lack of knowledge regarding safeguarding procedures and sharing of information processes (particularly between probation and YOS).

Partnerships and Integration

Strengths

We found partners identified risks to children and reported safeguarding issues promptly. As an example, the police have a system to monitor referrals over the weekend allowing response to urgent issues. SPOC benefit from timely and efficient initial processes in relation to referrals. Early prioritisation means children at risk of significant harm are quickly identified and receive immediate attention. We noted some agencies had beneficial access to each other's systems, namely YOS and social services, with SBUHB having access to the CPR on the local authority system.

There was a clear and well-understood process for professionals to refer concerns about children to the SPOC, initially by phone and through the completion of an integrated referral form or in the case of the police, PPN forms. The Integrated Referral form promoted consistency and was jointly developed by multi-agency partners, with time additionally

spent on training in its completion. This has been time well spent, with the quality of referrals having reportedly improved. The form clearly guides the referrer through the provision of information to ensure this assists the decision-making process. The quality of the referrals was generally satisfactory to enable the SPOC to make next step decisions. Issues of consent were mainly addressed and SPOC staff routinely undertook proportionate agency checks as part of the screening process.

Strong relationships and close working together were evident between key partners in SPOC and effective information sharing and decision-making was evident. For example, the Police Referrals Unit has been embedded in the SPOC team since November 2019. This has resulted in increased levels of contact and shared understanding. This similarly applied to the health professional aligned to SPOC.

The probation 'front door' is at court and also when child-safeguarding issues emerge in cases. Making links between risky adults and vulnerable children can be complex because they often have different surnames and addresses. There are systems in place to exchange information and these were mostly effective in the cases reviewed.

A further example of inter-agency co-operation was health visitors sharing important information with primary schools when children start nursery education. As most health visitors know children very well, this helps school staff address pupils' needs at the earliest opportunity. Communication between children's services and special schools was particularly strong.

There was strong evidence of multi-agency approaches to assessing and analysing intelligence to inform safety planning. For example, children's services and Cwm Brombil School have trialled local triangulation meetings with partners. These provide a valuable opportunity to discuss young people and identify links involving the police and YOS to map important connections between individuals, potential perpetrators, and community locations. Currently the local authority is developing terms of reference for this approach to be rolled out across the local authority.

Children and families benefit from a well-developed early intervention offer, available through the SPOC and YOS. The multi-agency early intervention panel provided additional management oversight of thresholds, constructive challenge and access to appropriate services and resources. There were good joint working arrangements identified, for example the Police Community Support Officer (PCSO) embedded in the Team Around the Family (TAF), was a member of the Early Intervention Panel and attended home visits with TAF workers. This allows any policing concerns to be identified and addressed at an early stage and supports positive relationships and a multi-agency ethos of early identification and prevention.

These arrangements help improved understanding of professional roles and more flexible management of service thresholds supporting the council's ambition that people be directed more easily between social services and early intervention services. We saw examples of information, advice and assistance (IAA) being easily accessible with people signposted to preventative services.

Organisations within the partnership invest in an extensive range of support and therapeutic services, including from the third sector used in both the preventive environment and to

support children, young people and their parents/carers to achieve positive outcomes from statutory interventions.

Schools have access to an effective range of internal support interventions in consultation with other agencies. The Education Safeguarding lead officer provided valuable support and guidance for all schools and has a pivotal role in working across agencies. The Cynnydd workers, as part of the Well-being Team, worked across all secondary schools and the college. They consistently develop positive and strong working relationships with identified pupils.

We found partner agencies provided support to detained children in police custody suites. These include Dyfodol referral workers from the Kaleidoscope project and health care professionals. This means children have access to support relevant to their health and vulnerabilities, with signposting and interventions put in place.

We were told about a pilot project starting imminently between local authorities, SWP, Gwent Police, Dyfed Powys Police and the Welsh Government regarding the provision of an alternative accommodation bed for children detained in police custody post-charge. This is a positive development as detaining a child in a police station for longer than necessary, except in very rare circumstances, is not in their best interests.

The local authority contextual risk panel met regularly to discuss young people at risk of exploitation. This multi-agency team plan actions and support to young people affected by extra-familial exploitation. Where agencies have identified serious issues within a local community, agencies worked closely with schools to discuss concerns and to agree actions to support young people and to provide guidance within the school.

Health services worked well to ensure prompt sharing of information. GPs demonstrated good partnership working with evidence of engagement with school counsellors and YOS services. GPs indicated although they do not attend strategy meetings, they 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.

We saw evidence of GPs and schools working collaboratively with children to ensure there was input from a school counsellor when services from CAMHS were not available. In addition, school counselling services were also proactive in engaging with GPs when intervention from CAMHS was required. This demonstrated key partnership working to ensure children were having access to the services they required.

All staff across SBUHB had good knowledge and understanding of the DTR processes. CLA healthcare assessments were completed within the statutory time limitations and were comprehensive and contained all relevant information. GPs told us when undertaking assessments and attending to children’s medical needs in Hillside, they would often have delays in medical information being available from the transferring authority, particularly for children coming from England. This meant key information could potentially be missed when providing medical treatment to children.

Areas for Development

The approach to CCE is as at an early stage of development. There is no multi-agency CCE protocol or agreed risk assessment. Whilst the police have a team dedicated to tackling Organised Crime and County Lines with a focus on vulnerability, there is no CCE team who 'own' the children, with the associated long-term intervention, safeguarding and disruption function. Some work is ongoing in this area, for example, YOS staff have access to partner agencies such as Better Futures, who provide advice on criminal exploitation in individual cases.

Although overall there was positive communication and healthy interaction recognised, there was evidence in two cases of professional differences about the implementation of safety planning at an operational level with no record these issues were resolved or escalated. This is an area the partnership needs to review to ensure timely care and support planning is in place.

Where a child presents with multiple areas of need, their case may be discussed at various meetings attended by different partners and this has potential for confusion. Partners need to ensure actions and planning is consistent and clear.

Some professionals said they did not receive invites to child protection meetings or received late notice. The local authority, however, was able to demonstrate the efforts it has made to ensure invites are consistently circulated to key professionals. This is an area that requires clarity and communication to ensure all relevant professionals can contribute in key conversations about safety for children.

We found further development is needed to embed the strengths based approach practiced and led by the local authority. For example, care and support plans were not routinely co-produced with children and families. Some children and families felt overwhelmed by lack of co-ordination of the many different professionals and support services offered. We did not see consistent evidence of the shared implementation and/or review of safety plans nor were safety plans shared with children and families.

We were told it is often difficult to obtain updates from the local authority on the outcomes of referrals made. The local authority and partners should consider reviewing and amending policies and procedures to ensure updates are provided to staff in a timely manner.

SPOC staff valued access to a weekly consultation meeting with a CAMHS worker, although this support had recently been reduced. This partnership supports SPOC and TAF workers in their intervention with families and builds a bridge with CAMHS. Children's services staff told us about the deficit in emotional wellbeing resources and waiting lists, for example for Barnardo's Blue Yonder project. This is compounded by the increased demand due to the pandemic and means children do not always get the help and support they need at the right time. The local authority has worked hard to develop and coordinate its own in house therapy service for CLA. Services include an in house therapy team and the MAPS team, both include psychologists and consultant social workers and work to support placement stability and permanence.

We found good examples of prompt referrals to CAMHS services. However, we were told by numerous GPs and others in the health partnership, that there were often long delays in

obtaining a CAMHS assessment for children. This means there could be delays in children receiving timely interventions to address their mental health needs.

Across all schools there was a similar concern about a lengthy waiting list to access CAMHS support. Schools have increased their internal capacity to help support pupils through additional training and the introduction of different initiatives, however, specialist provision is still lacking. SBUHB must review its process for CAMHS assessment, to achieve timely care and support, in order to maintain child safety and minimise the risk of mental health crisis.

Some GPs reported if a child does not attend an arranged CAMHS appoint, a re-referral is required which results in further delays. SBUHB has a 'Was not Brought Protocol for Children, Young People and Adults where there are Safeguarding Concerns or have Care and Support Needs' in place. This highlights the procedures to follow up on non-attendance. Our review has identified issues with delayed CAMHS assessments, which may increase the risk of harm to a child. SBUHB should consider the process in place to audit non-attendance and where children have been referred back to the referrer, when 'Not Brought' for an appointment. In addition, any audit should consider whether a re-referral was required, and the effect this may have had on the child.

School Health Nurses were redeployed at the start of the pandemic and this has impacted on health professional representation at statutory safeguarding meetings. For example, for one file we noted there was no representative from SBUHB at the Initial Child Protection Conference. Whilst we were informed most School Health Nurses have now returned to their substantive posts, the health board should consider its strategy to ensure adequate staff resources are available to attend all relevant statutory safeguarding meetings in the future, or that appropriate measures are in place consistently, to mitigate the absence and any correspondence documented within the case records accordingly.

We observed and were informed of some examples where communication between health staff had not been effective nor timely. For example, when a child ceased to be looked after, this change in circumstances was not communicated to the GP or the School Health Nurse. We were informed this task is usually performed by an administrative support worker, but due to the CLA Team having no administrative support for over a year, this had not happened. SBUHB should ensure adequate resource is in place to support timely communications relating to CLA.

There are concerns schools 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 the local authority, but also when a pupil moves mid-phase from one school to another, both from within the local authority and from a different authority.

Prevention

Strengths

The local authority works within a person-centred ethos that promotes children and young people being looked after within their own family wherever this is in the best interests of their well-being and safety. Where children are unable to live at home, sustaining contact with parents and siblings and wider family members is prioritised. We saw evidence of

imaginative and innovative use of the services such as the Family Action Support Team (FAST) as well as third sector services such as Barnardo's and West Glamorgan Council on Alcohol & Drug Abuse (WGCADA) in supporting a family focused approach. The local authority has embraced the view some families need ongoing engagement.

We found regular scrutiny and quality assurance processes across agencies. Themes and trends of concern, and individual learning were identified and fed back to practitioners and supervisors. We saw evidence of effective challenge across agencies, for example in police systems and children's services records, and appropriate communication and challenge between partners leading to effective decision making.

There were well established governance processes at police BCU and force level where issues surrounding children at risk were analysed. In addition, performance metrics were available through the business intelligence dashboard. There were also dip sampling assurance processes across several policing areas to analyse the qualitative response to concerns about children at risk. These include the Public Protection Unit (PPU), PSC and custody. This regular regime of oversight and governance provides the opportunity for senior officers to test the nature and quality of decision making and outcomes for children.

In advance of this inspection, in December 2020, SWP conducted an internal review of its response to child exploitation. This included reviews of investigations and missing persons cases and holding focus groups with police professionals. This review made eight recommendations. We were pleased to find during the inspection the recommendations made had been completed or work was underway to complete them. This has included holding three continuous professional development days attended by Inspectors and Sergeants with an intention to hold a further three for neighbourhood and response teams and PCSOs, focusing on the response to children at risk of exploitation. A new flowchart has also been created to make it easier to understand how NRM referrals should be dealt with from an intelligence, safeguarding and investigation perspective.

Quality assurance has a high profile across children and family services, with managers and staff engaged in this process. This is positive in contributing to the dissemination of learning across the service. Staff described a learning culture and were positive about the expansion of consultant social workers and the input they can provide to peer learning and reflective practice. The YOS conducts regular audits focusing on a specific aspect of practice. Recent audits have included girls in the system and serious violence. Regular reports on safeguarding are produced and discussed at the management board.

There was a shared early intervention and outcome focused ethos across the partnership. Children and families benefit from a well-developed early intervention offer, available through the SPOC and YOS. The multi-agency early intervention panel provided additional manager oversight of thresholds, constructive challenge and access to appropriate services and resources. It was noted some early intervention services had waiting lists due to reduced face-to-face activity during the pandemic

We saw good early intervention assessments by TAF that were co-produced with families. The complexity of some cases held by the TAF was recognised, inspectors were assured staff were confident in their safeguarding responsibilities and felt well supported. Evidence was seen that when needs or risks increased, cases were 'stepped up' from early intervention to children's social services and also stepped down as appropriate. The weekly

transfer meetings involving principal officers and managers from across teams supported shared oversight and opportunities for professional discussion regarding progress of cases.

Although no formal mechanisms were identified, we were assured families referred to early intervention who did not then engage were not automatically closed to the service until SPOC had reviewed this to ensure the right response had been made regarding potential vulnerability. We considered this as an essential feedback loop to ensure threshold decisions are not based on simply a family's willingness to engage.

The local authority has relatively stable numbers for the CLA population. Senior managers and officers have a good understanding and knowledge of the profile of CLA. They are strongly committed to the preventative agenda, and to the safe reduction of the number of children who are looked after. It was evident from talking to staff the needs of the child were clearly acknowledged and accepted to be the priority in relation to permanency and contingency planning.

A quality assurance process was introduced in SBUHB in June 2021 to ensure consistency of the quality of CLA Statutory Health Assessments, in line with National Standards developed in 2020.

The local authority has worked hard to protect children placed by other authorities in their area and mitigate the shortfalls caused due to the lack of proper notification by some placing authorities. It was noted the consultant social worker in SPOC now had the role of chairing CSE strategy meetings for these children.

The YOS offers voluntary contact as a preventative and safeguarding measure. The emphasis is on diversion away from the criminal justice system and retaining an 'open door' when cases are closed so children can access support as and when required. The importance of diversion strategies was recognised by the YOS in providing constructive activities building on the child's interests and protective factors including education as a desistance factor. There was evidence of good risk awareness and a growing understanding of local patterns of drug distribution and how children are exploited within these networks.

There was a strong emphasis on trying to maintain children in school where they are safe. Partner agencies including the police and YOS worked with schools to address patterns of concern. One secondary school was taking part in a pilot initiative working with a PCSO in the evening to identify children in the community who were getting involved in anti-social behaviour.

The local authority has supported schools to follow safeguarding procedures swiftly and effectively using SPOC. In many cases, a chronology of school events was well documented to support the SPOC process. The education safeguarding officer has full access to all SPOC intelligence. This enables her to provide schools with additional information and support following a referral, including whether the threshold to proceed with an assessment was met. Schools found this support very effective. They had a process in place where they could raise concerns if they did not agree with an outcome from a SPOC referral or the advice offered. These concerns could be raised with senior managers and at the fortnightly safeguarding group where information is also shared, and emerging issues considered.

Prompt alerts from Operation Encompass provided schools with daily early notifications of young people involved in domestic abuse incidents involving the police. This early alert system effectively allows a school to strategically plan for the young person prior to their arrival at school at the start of the day. Schools can ensure the appropriate support is available and staff are aware and can identify when the young person may require additional time to talk about their worries. Schools reported this allowed the young person to feel safe at school where they can access a trusted member of staff if necessary. Schools also received PPNs daily, helping them to be proactive in providing necessary support.

Senior leaders in schools appeared to work diligently to avoid the unnecessary exclusion of vulnerable pupils as they understand the risks involved in this. One school has funded a successful off-site provision for pupils who need to be excluded from their class to help avoid a formal fixed-term exclusion. Where young people are at risk of permanent exclusion and are known to be at risk of exploitation, the social worker, school, and any other professional involved with the young person were required to look at packages of support to avoid the exclusion occurring. The Wellbeing team manager discussed school plans to reduce the exclusion figures with senior leaders in schools. Currently specific training for school governors on exclusions and the impact on young people is being developed and will be launched in the autumn term.

Each governing body had a dedicated governor with responsibility for safeguarding. The local authority provided regular ongoing safeguarding training to governors as part of the termly governor training programme. Safeguarding was a standing item on termly governing body meeting agendas. This included headline information on the number of cases referred to social services, number of physical interventions used, updates on safeguarding training provided to staff and any bullying and exclusion incidents.

The Education Welfare Service had effective systems in place to track pupil attendance. They worked proactively with schools to address attendance issues as early indicators of those pupils who are at risk of disengagement from education. The service worked with school practitioners to share information and contribute to planning meetings to target support for individual pupils and their families where attendance figures were a concern.

The local authority was highly committed to early intervention work to support children and young people. There was an increased emphasis on training and support for school staff on the impact of substance misuse and mental health issues that children and young people are enduring. Across the school based counselling service, staff emphasise the development of personal and social education programmes and support for teachers to deliver these programmes in school settings. A directory of local resources, seminars and services about healthy relationships was available for all schools. There was a wide range of support and advice to help ensure pupils understand about substance misuse, emotional and mental health issues and how to make important choices.

The RADS service operated in a number of community settings, including youth clubs and colleges throughout the county addressing the target age range of 14-25 years. RADS youth practitioners are highly trained members of staff that deal with a range of young people’s issues including safe relationships, contraception, pregnancy, abortion, sexually transmitted infections, LGBTQ+ and many others. They also provided barrier contraception,

pregnancy testing, advice and support to access secondary sexual health and other health services. Additionally, the RADS service offered support, guidance and workshops to all secondary schools within the locality to support the Relationship and Sexuality Education (RSE) programme.

Areas for Development

It was evident practitioners and managers in children's services were committed to supporting children and families and respecting their wishes and feelings following a strength based approach to practice. However, we found in some cases workers were overly optimistic about engaging with children and families who had a history of dis-engagement. For these circumstances it is particularly important contingency planning is considered should engagement not go according to plan. Contingency planning in YOS was similarly not always sufficiently robust and could lack structure.

For one young person residing in a children's home there was limited evidence of multi-agency planning for the young person's imminent move on. The care and support plan required more detail, elements of which were not agreed across agencies with no indication this was being resolved.

Whilst the partnership is committed to early intervention, there are some waiting lists and demand outstrips supply. This means opportunities to address and mitigate risk at the earliest stage may be missed.

Next steps

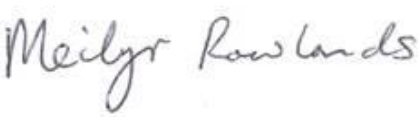
The local authority should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the Probation Service, Youth Justice Service, Swansea Bay University Health Board and South Wales Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.

The head of service for children's services should send the written statement of action to CIWLocalAuthority@gov.wales by 18 September. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely,

Gillian Baranski
Chief Inspector
Care Inspectorate Wales

Alun Jones
Interim Chief Executive
Healthcare Inspectorate Wales



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