Rapid review of child protection arrangements

Full report

September 2023

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Estyn

agic hiw | Arolygiaeth Gofal Iechyd Cymru
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Background

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.

The purpose of this review is to determine to what extent the current structures and processes in Wales ensure children's names are appropriately placed on, and removed from, the child protection register (CPR) when sufficient evidence indicates it is safe to do.

Working alongside Healthcare Inspectorate Wales and Estyn, we published our interim findings in June 2023 to share learning and promote best practice at the earliest possible opportunity. The initial findings were shaped with feedback from peers in education, children's services, police, health and regional safeguarding boards, as well as talking directly to children and young people who are, or have recently been on, the child protection register. Further consultation with additional stakeholders and a detailed analysis of various sources of information continued after the publication of the interim findings.

It is important to note this piece of work relates specifically to the safeguarding process and does not address in detail children's experiences prior to them being named on the CPR, or when their names have been removed.

Foreword

There were 3670 children placed on the child protection register in Wales during 2021/22.[1] Ensuring there is a robust and consistent approach to adding and removing children's names from the child protection register is imperative in order to keep children safe.

This review has provided an important opportunity for our three inspectorates to work together, alongside partners and practitioners, to consider the strengths and areas for improvement in this critical aspect of safeguarding children at risk of harm or abuse. We would like to take this opportunity to thank everyone for their invaluable contributions.

Following on from the publication of the child practice review into the tragic death of 'Child T' and the findings of other child practice reviews, Deputy Minister for Social Services, Julie Morgan addressed the Senedd where she stated, 'the time for action is now'. The calls to action outlined in this review should be carefully considered and actively taken forward by the relevant organisations across Wales.

Multi-agency practitioners involved in safeguarding children work incredibly hard and are committed to ensuring children's safety. Their contribution must be acknowledged and appreciated.

However, it is impossible to ignore the significant challenges we are facing in providing care and support for children in Wales.

Children and families' needs are increasingly complex. Fragility across the workforce and limited resources across all sectors have inevitably led to delays in support for children and families. These challenges also impact on how well the current child protection structures and processes work in practice. As a result, children and families do not consistently receive the same service wherever they live in Wales.[2]

Children's safety is everyone's responsibility. Collectively, we are committed to raising standards and delivering positive outcomes for the children and young people most at risk across Wales.

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Symbols used in this document


Multi-agency


Education


Police


Health


Children's Services


Regional Safeguarding Board


National Independent Safeguarding Board Wales

Welsh Government

Key terms used in this document

Wales Safeguarding Procedures (WSP)

These support individuals and agencies across Wales to understand their roles and responsibilities in keeping children and adults safe.

Section 47 enquiry

The purpose of the Section 47 enquiry is to establish whether a child is suffering or is likely to suffer significant harm and requires intervention to safeguard and promote their well-being. Social services have lead responsibility for the enquiries. Other practitioners, such as the police, health, education and other relevant partners have a duty to co-operate and help social services undertake its enquiries.

Initial child protection conference (ICPC)

The initial child protection conference follows the Section 47 enquiry where there are concerns of continuing risk of harm to a child or children. The conference brings together family members (and the child where appropriate), with the supporters, advocates and practitioners most involved with the child and family, to make decisions about the child's future safety and whether they should be subject to a care and support protection plan (CSPP).

Review child protection conference (RCPC)

When a child is subject to a care and support protection plan, a review conference must be held within three months of the initial conference. Its purpose is to decide whether the child is still suffering or likely to suffer significant harm.

Core group

All members of the core group have equal ownership of and responsibility for the detailed care and support protection plan and should co-operate to achieve its aims. Core group members have a responsibility to challenge and report concerns where they believe the plan is not protecting the child from the risk of abuse, neglect or other forms of harm.

A full glossary of terms can be found in Appendix 8

Key line of enquiry 1

Thresholds and information sharing

We looked at whether children receive the right help and protection because of the application of appropriate thresholds and effective information sharing.

Findings

Thresholds

Managers in children's services consider risks appropriately, with timely progression to the right service for children and families, including a rationale for intervention.

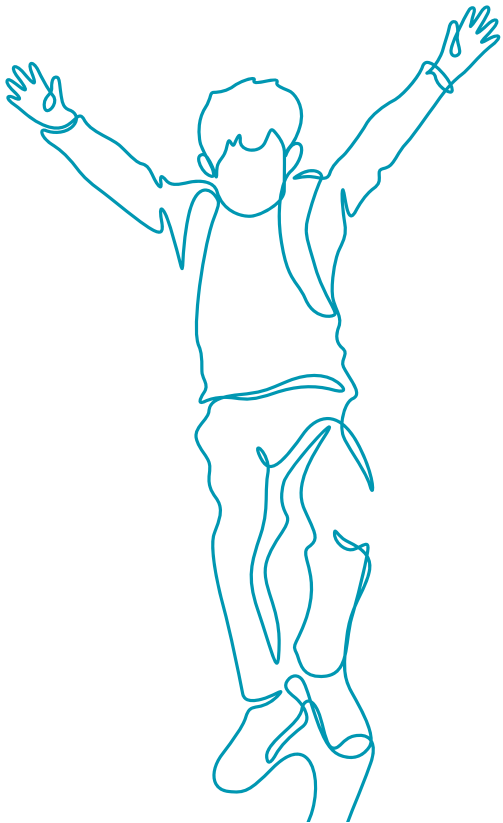
This was specifically evident through the initial stages of the intervention; the assessment and decision to proceed to undertake section 47 enquiries and to initial child protection conferences.

Practitioner's understanding of the risk of significant harm to children is variable.

This is linked to the high turnover of children service's practitioners which means families have to build trust with new practitioners time and time again. Inexperienced practitioners are also not as familiar with the concept of significant harm, which means they are reliant on experienced staff to provide guidance. This also places greater demand on the induction and training process.

The availability of shared guidance about thresholds and information sharing protocols are inconsistently available and applied across Wales.

Health board representatives commented that threshold guidance was helpful in analysing risk and submitting a referral or duty to report. Some professionals expressed preference for a local or regional document. This can bring challenges given the varying structures and governance arrangements across local authorities in each region. This is already managed in some areas. For example, the Mid and West Wales Regional Safeguarding Board area, which covers four local authorities and two health board areas, has guidance for the region.



Thresholds and information sharing

In some situations, the Child Protection Register (CPR) is being inappropriately used as a means to secure limited services.

This means that some children's names remain on a CPR, not necessarily because the threshold of significant harm is met, but because they may not receive relevant support when they are removed from the register. This rationale is misplaced as the focus of any care and support protection plan should be to address harm. Partner agencies are subsequently anxious and reluctant on occasions for a child's name to be removed from a CPR.

> "Children on the register will get allocated a social worker so they are seen as a higher priority but if they aren't on the register this can be more challenging *(Conference Chair)*"

A shared understanding about how to respond to harm is not consistently clear across partner agencies.

We saw examples of duty to report not being responded to and the lack of a shared understanding about decision making and rationale.

Children's social care records are, at times, being closed abruptly without ongoing consideration of care and support needs.

Whilst acknowledging the provision of care and support services requires parental consent, there are examples where children and their families would have benefitted from continued support when removed from the CPR.

Welsh medium schools can face challenges in making reports and accessing and receiving professional support in Welsh.

This means that Welsh first language schools have to rely on their personal translation skills to accurately reflect the issues they wish to report. This may mean important points are not given the gravity they require or expressed clearly enough.

Information sharing

The quality of information sharing is an area for development across multi-agency practice.

There are examples of good information sharing between agencies resulting in appropriate reports being made to children's services, and relevant information being shared as part of section 47 enquiries, and initial child protection conferences.

However, in the latter stages of the child protection process information sharing across Wales can be untimely and poor. In some instances, the lack of information sharing could have resulted in a child being harmed, or the risk of harm increased. For example, a police force did not share information about a partner's serious convictions in a timely manner. Agencies have different systems for recording, and the disconnected systems are limiting information sharing.

Sharing information about self-harm incidents and children's mental health issues with schools is often inadequate.

This can leave the school unsighted when it should be risk assessing individual pupils and arranging for bespoke safeguarding measures to be in place. However, in the most effective examples, multi-agency collaboration ensures children receive the support they need.

A Child and Adolescent Mental Health (CAMHS) worker shared their risk assessment and safety plan with the child's GP, school and social worker. As CAMHS staff are likely to have an in-depth insight into the child's mental health and any presenting risks, this sharing of information with professionals working with the child is key to their protection.

Response from a parent whose child is on the Child Protection Register when asked 'How could professionals respond in a better way, for you and your family?'

> "There needs to be better professional communication systems to stop oversights and speed up outcomes."

Thresholds and information sharing

Current arrangements used by schools to share information about child protection concerns are inconsistent.

School's internal systems for monitoring and reviewing intelligence do not identify important themes and trends relating to pupil's experiences in schools. This raises the risk of overlooking crucial insights and themes regarding the pupil's wellbeing. Multiple systems across schools and local authorities also makes the transfer of information more difficult, especially at the transition points of primary to secondary school, and with other moves between schools.

Many school leaders expressed the need for a national system that can be used by all professionals across all local authorities in Wales. Currently, the systems used across Wales vary from school to school and local authority to local authority. This does not allow the easy transfer of sensitive and confidential information should pupils move from one school to another. These systems rely on individuals to prepare reports and send them to the new school or local authority.

Very few local authorities, schools, and other education provision, such as youth justice, youth support service, pupil referral units (PRU) and education other than at schools (EOTAS), have appropriate access to social services records.

Where access is available, authorised staff keep up to date with issues arising for children whose names are on the child protection register (CPR). This access to records helps providers monitor progress against action plans and see improvements in the pupil's home and community life. They can also use this to track the impact of any multi agency referral forms they have raised. This access gives providers the important understanding necessary to consider personalised risk assessments and put individual safeguarding processes in place for identified children.

Monmouthshire education department has access to social service records which enables them to securely obtain up to date information about a child whose name is on the CPR, and are able to support accordingly.

Expertise is appropriately shared across schools, and other education provision such as youth justice, youth support service, pupil referral units and education other than at schools.

This effective partnership working plays a vital role in facilitating effective collaboration across various service areas within local authority education services, thereby enabling the local authority to fulfil its obligations to children whose names are on the child protection register and their families. There are shared agreements among partners to actively engage in collaborative efforts, recognising the importance of working together to ensure the well-being and protection of children and their families.

Information about child protection incidents are not always shared with partners in a timely or detailed manner.

Partner agencies do not always know the concerns leading to child protection conferences (CPC), although there are examples of good practice.

In Blaenau Gwent invitations to child protection conferences include an outline of the reason for the conference and the conclusion of the section 47 enquiry. Health board staff reported finding this useful in ensuring professionals, parents and the wider family understand the concerns and risks prior to the conference.

Communication between healthcare and children's service practitioners across Wales is inconsistent.

GPs are not routinely invited to child protection conferences (CPC) and do not always receive minutes. This is a missed opportunity as they may hold relevant information about both the child and key family and household members. Some GP records have nothing recorded to indicate a child is named on the child protection register (CPR).

The Wales Safeguarding Procedures are clear that GPs must always receive an invitation to CPC and provide a written, evidenced-based, relevant and child-focused report.

Although a child had only recently been registered at a GP practice in Wales, the GP reviewed the child's records going back several years prior to writing their report for an initial child protection conference (ICPC). Their thoroughness ensured practitioners attending the ICPC were made aware of the child's historic involvement with child and adolescent mental health service and children's services in England.

There is no statutory requirement for children on the CPR to undergo a comprehensive health assessment in the same way as children who are in the care of a local authority.

Whilst in some cases a child will have undergone a child protection medical assessment and, in general, health visitors provide a detailed overview of the health needs of pre-school children to aid decision making at CPC, such an assessment is largely absent for school aged children in some health boards. This means the physical and mental health needs of school aged children might not be identified and considered to the same extent as those of younger children.

We understand the National Safeguarding Service will be developing quality principles for health professionals which will outline how children's health needs may be more robustly identified and addressed.

Communication and information sharing between health professionals working with a child is variable.

This presents a risk of some health professionals being unaware of child protection concerns or of any safety or protection plans in place to protect the child. This is compounded by staff working to different recording systems within the same health board and by the use of handwritten records in some areas of practice. Additionally, some hand written records were found to be illegible with basic information omitted.

Recommendations

1.1 Children's services must communicate information about duty to report outcomes in a timely manner to the person who made the initial report. In line with Wales Safeguarding Procedures, if the report-maker has not received an acknowledgement and a confirmation of the outcome from children's services within seven working days, they must contact children's services again.

1.2 A child's eligible needs for care and support, once their name is removed from a child protection register, must be clear and explicitly recorded in the minutes of review child protection conferences (RCPC). There should also be a record of a proposed contingency plan in case circumstances change and the risk of significant harm increases for a child.

1.3 Partner agencies and members of the public must be able to make referrals / reports and receive support in the Welsh language. The 'active offer' of providing a service in the Welsh language at the front door must be made to comply with the *More Than Just Words* strategy.

1.4 In line with Wales Safeguarding Procedures, GPs and other relevant health professionals must be invited to CPC. A copy of the outline plan and a summary of the decisions made at the CPC should be circulated to all those invited to the conference, irrespective of whether they attend.

1.5 A national drive is required to improve a shared understanding and awareness of thresholds and relevant guidance. This should focus on multi-agency understanding and consistent decision making when assessing risk.

Recommendations

1.6 Welsh Government should work alongside health boards to commission a centralised, accessible IT system that is able to capture all health information relating to children, including the location of any non-digitalised records. Any handwritten records must be legible with robust quality assurance processes in place to evidence this.

1.7 Health professionals must ensure every child has a robust assessment of their health needs, including emerging and potential health needs where there are child protection concerns. Where this cannot be fully achieved prior to the initial child protection conference (ICPC), an action to complete the health assessment should be recorded at the ICPC. Any unmet health needs should be addressed via the care and support protection plan.

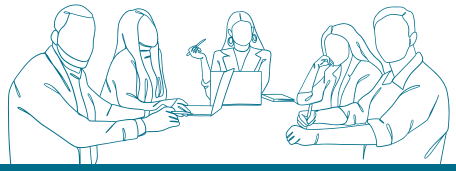
1.8 GP practices hold key information in relation to children and their families. In line with Wales Safeguarding Procedures, they must provide a written report for all child protection conferences.

1.9 Welsh Government should work with local authority education services to commission a suitable national IT-based system for education that enhances monitoring and information sharing. This system would enable consistent recording of pupil-level data, encompass various factors affecting their well-being, and facilitate seamless and timely exchange of sensitive information.

Key line of enquiry 2

Multi-agency arrangements

We looked at whether children are protected through effective multi-agency arrangements.

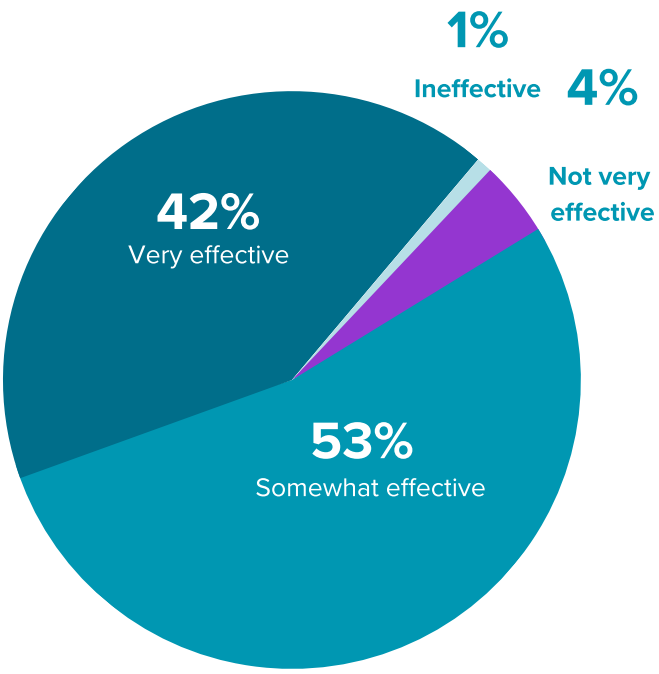


Findings

Multi-agency arrangements work well in many areas of practice, although some key areas could be strengthened.

Initial child protection conferences (ICPC) are well attended by partner agencies. This is an opportunity for all agencies to share information and contribute to decision making as to whether a child is experiencing, or is at risk of experiencing, significant harm. This ultimately informs a decision as to whether a child's name is to be added to a child protection register.

How effective are multi-agency meetings for sharing information? Practitioner responses



However, partner agency attendance at review child protection conferences (RCPC) and core groups is inconsistent. This can impact the quality of conversations, information sharing and the effectiveness of a care and support protection plan.

Partner agencies highlight the benefits of having co-located front door arrangements in order to support information sharing and timely decision making.

There is an appetite for more integration and co-location, and it is suggested this would support the understanding of roles and responsibilities, and improve the application of consistent thresholds. The benefits of being co-located improving safeguarding working have been highlighted previously. [3]

The general approach across police force areas in Wales is for the police to attend ICPC, but not RCPC.

Whilst it may not be appropriate for police officers to attend all RCPC, at times their absence can be significant. For example, where there may be concerns about contextual safeguarding, continued domestic violence and discussions required around the content of a Claire's Law disclosure.

South Wales Police have targeted additional resource and are piloting attendance at RCPC where most appropriate. This development is to be commended.

Multi-agency arrangements

Initial strategy meetings / discussions are routinely held between police and children's services only.

Whilst this may be the most appropriate approach to take in urgent circumstances, digital communication could enable other relevant agencies to also contribute.

Involving all relevant agencies at strategy discussion / meeting is a clear stipulation in the Wales Safeguarding Procedures. At minimum the police and children's services should attend with contributions from other agencies as required. This would better facilitate a multi-agency approach to safety planning between the time of a strategy meeting / discussion and the initial child protection conference. Whilst there are some areas of good practice, this is an area for improvement in order to enhance communication and better understand the risks for children.

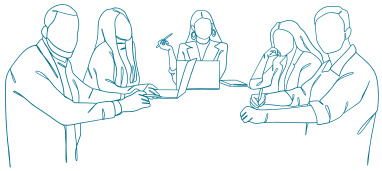
Some partner agencies are not always clear on which models of practice are implemented in certain local authorities.

There are examples of models of practice being successfully applied. These support all agencies and families to have a shared understanding of safeguarding practice and the identification and management of risk.

Models and practice frameworks such as *Effective Child Protection (ECP) Practice* and *Signs of Safety* provide focus on the risks of significant harm to a child and when the threshold of a child suffering or likely to suffer significant harm is met or no longer met. The models provide focus on what needs to change to keep a child safe as well as any strengths such as how the family and wider community can assist to keep children safe and what can reduce the risk of harm. Collaborative communication and motivational interviewing is utilised in these models, ensuring a strengths-based approach to communicating with families.

In Blaenau Gwent, a member of the Health Board's safeguarding team is present at strategy discussions and meetings. This results in the inclusion of relevant health information in decision making.

Gwynedd children's services utilise the ECP model incorporating the Risk Model. The ECP model provides clear practice guidance for practitioners to include, but not limited to, what is meant by significant harm, when the threshold of significant harm has been reached, and what needs to change, with the availability of visual tools to support parents to see what change is required. The Risk model provides a framework for practitioners to assess whether children are experiencing or at risk of experiencing significant harm, and provides clear guidance on what practitioners should consider and equally important, why. This ensures consistency of practice. It is noted that other local authorities in North Wales are considering adopting the ECP model.



Multi-agency arrangements

Multi-agency training for practitioners working with children who are at risk of, or are experiencing significant harm, is inconsistent across Wales.

There is an appetite for such training, as well as multi-agency support for delivery. However there are challenges for some professionals to attend due to staff capacity.

Training for education representatives is usually generic and often delivered online, which hinders inter-disciplinary discussions and information exchange.

Multi-agency, in person training, emphasising that safeguarding is everyone's responsibility, would provide opportunities for agencies to work together and focus on collaborative working. Training should focus on child protection processes and should be routinely held on an ongoing basis to ensure skills and knowledge are sufficiently maintained, mitigating the risks of a changing workforce.

The National Safeguarding Training, Learning and Development Framework will be available in autumn 2023. A key objective will be to ensure a consistent national approach to training, learning and development. Regional Safeguarding Boards are already engaged in developing this new framework and it will be important they make this a priority.

40%

Police force representatives stated they have not received training on the risk of significant harm

In line with the Wales Safeguarding Procedures (WSP), partner agencies must strengthen their contribution in core groups.

It is important that all core group members attend to ensure multi-agency responsibility in the development and delivery of the care and support protection plan.

The WSP clearly highlight that the chairing and minuting of these meetings is a joint responsibility and can be undertaken by different agencies supporting children and families. This is important as it promotes shared responsibility, but this rarely happens in practice.

On occasion, children's services are not consistently able to meet their statutory responsibilities in responding in a timely way to safeguarding matters.

Relevant meetings or visits are not always convened in line with the expectations of the WSP. Sometimes, records of visits or meetings are not made or are significantly delayed. This means up to date records are not made available to the core group of professionals working with the family and accountability can be unclear.

Recommendations

2.1 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.

2.2 All agencies should ensure representation at strategy meetings, review child protection conferences and core groups. Regional safeguarding boards should have oversight of these arrangements and must seek assurance that action has been taken if the contribution of wider partners limits opportunities for protecting and supporting children and their families.

2.3 All agencies should work together to deliver specific multi-agency training on statutory child protection processes including their responsibilities as core group members and collaborative working. This should include a focus on the monitoring and development of the care and support protection plan and healthy challenge. Regional safeguarding boards should have oversight of these arrangements.

Key line of enquiry 3

The child's individual needs

We looked at whether professionals ensure that children's lived experiences and individual needs (including linguistic needs and rights to advocacy) are understood and included in decision-making about safety.

Findings

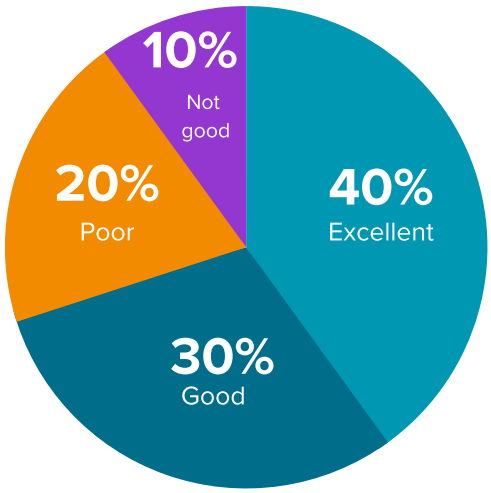
Children and their parents / carers can experience many changes in social workers which impacts on the quality of their relationships. [4]

This impedes the development of trusting working relationships and the sharing of sensitive information. Frequent changes in social worker is also a key factor in why children's wishes and what their daily life is like, is frequently under-represented in assessments and care and support protection planning. On occasions, different duty social workers undertake statutory visits to see children and chair core groups.

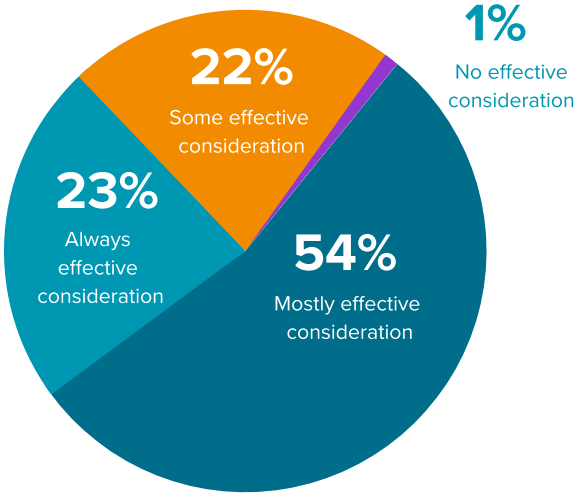
The importance of a consistent social worker for children is not to be underestimated. Relational practice is key to developing trusting relationships and practitioners require protected time to achieve this. The best examples of child centred and direct work evidenced creativity in the way social workers and social care practitioners communicate with children and young people, enhancing their individual voice. Practitioners should be supported to ensure consistency for children and their families is prioritised.

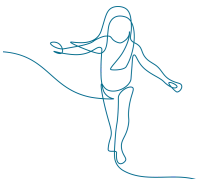
> I've had so many social workers I can't event count them. Some I've only seen for one day or maybe a week. I'm wondering when this social worker is going to leave (15 year old young person).

'How good is your social worker? (children's response)



Are professionals you work with effective at ensuring the lived experience of children are considered when making decisions about their safety? (parents / carers)





The child's individual needs

Children are seen and seen alone but this is not always consistent across Wales.

This means children are not always given the opportunity to have a voice, share opinions and explain what daily life is like for them. Children's direct contributions are essential to support decision making as to whether they are experiencing, or at risk of experiencing, significant harm.

There are examples where children are not being seen by social workers, or there are no records of such visits / meetings. This is often a consequence of limited capacity, work pressures or practitioner vacancies. Robust contingency arrangements must be in place to ensure children's safety.

It was not always clear if children have been seen alone outside of the family home by children's social workers / social care practitioners and / or police.

Where appropriate children must be afforded an opportunity to speak alone without fear of a household member listening to what is said. Records need to be clearer in relation to this.

39%
Parents/carers said they do not get support when they need it

37%
Parents/carers said social workers speak to their child alone

61%
Children said they are seen alone by their social worker

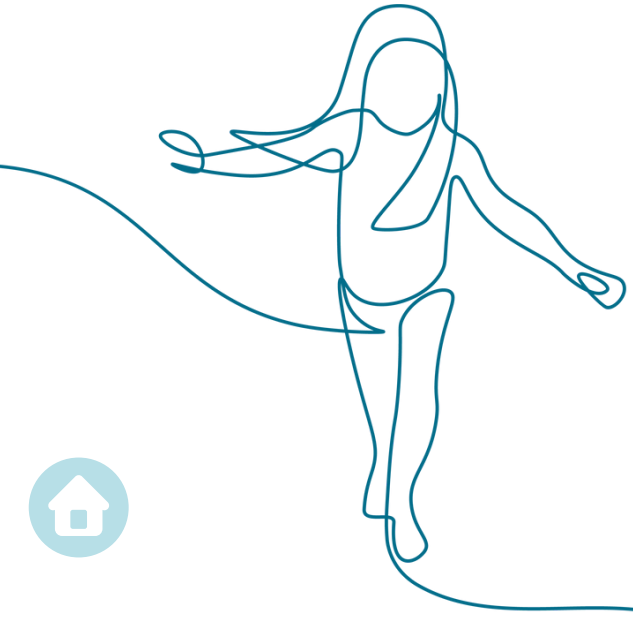
48%
Children had seen their care & support protection plan

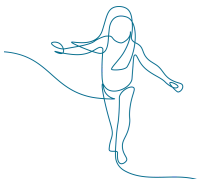
70%
Children knew why their name was on the child protection register

27%
Children said their care & support protection plan has made things worse

25%
Parents / carers said that professionals don't understand their child

42%
Children said they are invited to child protection meetings





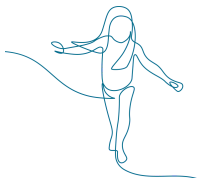
Children's voices, wishes and feelings are being promoted at conferences by social workers, advocates and representatives of partner agencies, but rarely through children's direct contribution to the conference.

More needs to be done to ensure children have a genuine understanding of the child protection process. Older children express their desire to attend conferences, listen to the discussions, and contribute to the decisions concerning their own wellbeing. They often describe a lack of clarity and misunderstanding regarding the implications of care and support protection plans (CSPP). One young person (aged 15) did not know that their name was on a child protection register until they took part in this review.

It is crucial to prioritise the child's voice and actively involve them in decision making processes as appropriate, ensuring they comprehend the significance of plans and feel empowered to contribute. Subject to their age and development, children and young people would benefit from having a more active role in their CSPP. The plan should include a specific focus on what steps they could take if they were to feel unsafe.

School staff deliver an essential role in supporting children named on the child protection register and can be an important conduit between parent and children's services.

Children generally feel safe, and are able to learn, play and be with friends at school. They have teachers they trust and feel able to talk to. In the most effective examples, pupils who need additional support are also given the time and opportunity to engage with programmes which address their specific needs.



The offer and provision of a formal advocate varies across Wales.

> When my children were placed on a child protection register nothing was clearly explained to me about any of the process - I felt I was not supported and was not checked in on by professionals and not informed a new social worker had been appointed (Parent / carer).

In contrast a parent, supported by an advocate from NYAS Cymru, benefitted from being able to share their views through writing a letter to conference members.

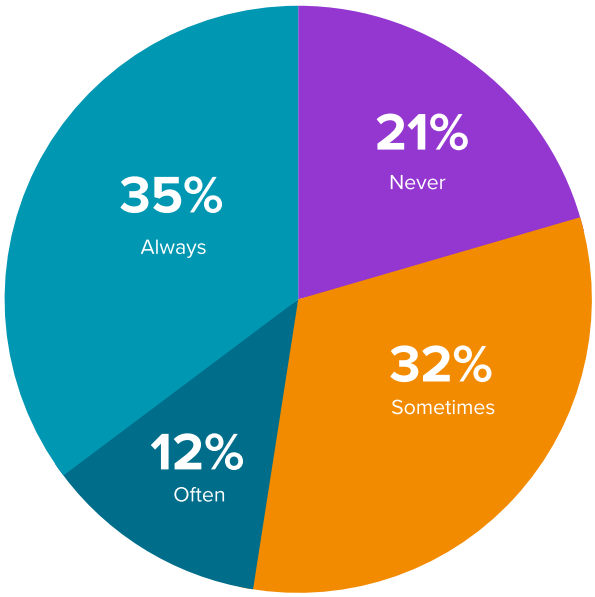
There is evidence children benefit from different forms of advocacy to include informal advocacy, formal advocacy and independent professional advocacy, but this is inconsistent.

In Flintshire children who are ten years of age and above are offered a conference buddy. This is someone independent from the child's social worker and as well as relaying their wishes and feelings at conference they also relay the outcome of conference to the child in a sensitive manner.

There are good examples of parents benefitting from formal parental advocates although this support is not routinely available across Wales.

It is noted that Welsh Government has awarded a grant to NYAS Cymru to run a programme of parental advocacy 'Pan Gwent' with one of its main objectives being to support a reduction in numbers of children entering care in Wales and reduced involvement with the child protection system. A final research report is expected next year.

Do you feel listened to?
Parent's / carers response



The focus on the role of extended families and parents living outside the family home is inconsistent.

There are positive efforts to involve parents living outside the family home in decision making about their children. However, there are also examples where there is no clear understanding of who household members are, and a lack of knowledge about the roles of family members. This important information can enhance safety planning. In line with the Wales Safeguarding Procedures, parents / carers must always be actively encouraged to attend child protection conferences, and to be part of assessments as they could promote the wellbeing of the child. (These findings are also highlighted in 'A Thematic Analysis of Child Practice Reviews in Wales')

The individual voice of a child is often missed when they are part of a large sibling group.

Out of 95 parents who completed the SHOUT survey, only 29% felt that professionals understood all the children's needs. One parent stated:

> "Listen to what we need as a family rather than focusing on the one child... listen to what we are saying with regard to the concerns we have about the other children being kept safe."

In contrast,practitioner's views of how well children's lived experience are taken into account is mostly good with just over 75% of practitioners stating that there is 'always' or 'mostly' effective consideration of children's lived experience when making decisions about their safety. Equally over 60% noted that they feel they know all of the children's needs well.

The quality of professional and parental relationships is variable.

Parents referenced how they feel the impact of having to re-tell their story and not feeling well supported due to numerous changes in social workers.

There is often evidence that practitioners know children and families well, but this is not always reflected clearly in records.

We saw good evidence of children and family's culture and linguistic needs being identified.

A child in Swansea benefitted from a social worker undertaking good quality, direct work with them in their first language (Welsh), ensuring the active offer was implemented in practice.

86%

Parents said they understood why their child's name was on a child protection register.

Recommendations

3.1 All meetings held in line with child protection processes should start with the child's story. The child's individual voice, including children of large sibling groups, should consistently feature in all relevant key documentation.

3.2 Children, subject to their age and level of understanding, must be invited and supported to take part in meetings, or part of meetings, held in line with Wales Safeguarding Procedures. This will help children understand their circumstances and enhance their care and support protection planning.

3.3 Assessments must always consider the role of partners, all household members, parents living outside the family home and extended family members in terms of potential risks but equally, potential safeguards for children.

Key line of enquiry 4

Leaders and managers

We looked at whether leaders and managers understand the experiences of children and families who need help and protection.

Findings

Overall, there are good mechanisms for overseeing front line practice across Wales but there is variability across local authorities, police force areas, health boards and regional safeguarding boards.

There are few multi-agency audits to oversee multi-disciplinary front-line practice. The benefits of multi-disciplinary audits have previously been highlighted in terms of assisting practitioners to develop their writing, assessment and risk assessment skills.[5] Audits can be linked to regional safeguarding board's regional priorities, care and support protection plans, local intelligence and performance information.

The remit for the regional safeguarding boards is broad. Current demand and limited resource is impacting on their safeguarding functions.

There are gaps in the governance and structures of sub-groups in some regional safeguarding boards which impacts on the focus of their work and the strategies for overseeing front line practice. As with local authorities, the strategies which some regional safeguarding boards have for overseeing and monitoring front line practice vary and do not allow for details about performance across Wales.

Children's services across Wales have different approaches to quality assurance.

As part of their quality assurance system, Blaenau Gwent look at the social care records of children who have remained on the child protection register (CPR) after the second review conference to identify the obstacles for reducing risk and implementing further measures.

Swansea local authority convene a practice discussion about all children who's names are removed from the CPR at the first review conference. This enables reflective discussions with partner agencies as to whether the threshold for significant harm has been met, and whether there is sufficient evidence of change and improvements.

80%

Practitioners noted that quality assurance systems were somewhat effective or very effective

Children's services have made concerted efforts to address the workforce shortfall through different strategies targeting recruitment and retention of practitioners, often supported through Welsh Government funding and grants.

Leaders told us they also recognise the challenge for experienced practitioners and managers in supporting newly appointed and newly qualified staff.

A focus on staff well-being continues to be important across local authorities, particularly in the context of responding to increasing demand and complexity.

The role of agency workers has been critical in addressing gaps in service areas, but temporary staff can often result in inconsistency of staff working with children and families.

Looking ahead, some managers in children's services expressed there is an appetite for a national pay scale for social workers to promote workforce stability across Wales. Under the Rebalancing Care and Support Programme a pay and progression framework is under consultation.

Systems are in place across health boards to ensure staff working with children and their families where there are safeguarding concerns, are well supported by experienced and knowledgeable staff.

The safeguarding teams are well-established and are valued by staff. As well as providing timely advice and support during normal working hours, they lead on ensuring staff have access to up to date, relevant safeguarding training, formal supervision, support when professional differences arise and in some teams, they provide a significant quality assurance role.

Recommendation

4.1 The national independent safeguarding board and the regional safeguarding boards should continue to work together to develop and agree a consistent approach to multi-agency safeguarding performance reporting. Clear mechanisms for regular data sharing are required.

Key line of enquiry 5

Decision making

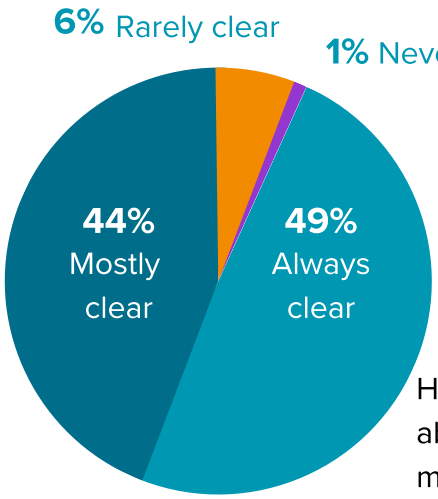
We looked at whether decision making about registration or deregistration of children's names is clear and evidence based.

Findings

On the whole, children's names are appropriately placed on the child protection register (CPR) and removed when there is sufficient evidence for doing so.

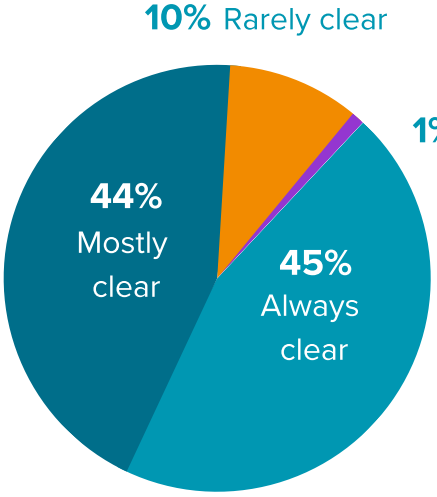
A high percentage of practitioners feel they are clear as to why children's names are added to or removed from the CPR.

However, there are occasions when it is unclear why children's names remain on the CPR with limited focus on the risk of significant harm, and partner agencies favouring continued registration as a means of enabling continued access to care and support. Parents / carers are not always well informed of, or involved in, the process, and on occasions remain unclear why their children's names remain or have been removed from a CPR.



How clear are you about the decision making that leads to a child's name being put on the register?

Mid and West Regional Safeguarding Board subgroup review re-referrals as well as professional differences about whether a child's name should or should not be on a CPR. This multi-agency management group provides challenge and reflection.



How clear are you about the decision making that leads to a child's name being removed from the register?

Decision making

Overall, the social worker report for initial and review child protection conferences are shared with parents prior to conference in a timely manner.

However, this is not always the case in relation to reports provided by partner agencies. This means parents / carers and other professionals do not have appropriate time to reflect and understand professional concerns.

Similarly, conference minutes and care and support protection plans (CSPP) are not always distributed to relevant parties in a timely manner. This is concerning as this is where details about what is expected of parent / carers and partner agencies are outlined.

Greater clarity is also required in formulating distinct CSPP that do not become merged amongst other documents such as conference minutes. This is essential in ensuring group members can be accountable and progress can be more effectively measured. CSPP should be available as up to date working documents and should be distributed in line with the expectations of the Wales Safeguarding Procedures.

> “There was a delay since the incident in July 2022 and the social services becoming involved in my life in October 2022. Since then they've been very kind and helpful. I'm grateful for the support and kindness offered. (Response from a parent whose child is on the Child Protection Register).”

The format of safeguarding meetings varies following the COVID pandemic.

Meetings may be virtual (all members in attendance are accessing the meeting virtually), hybrid (some members are accessing virtually, and others are present in person) and face to face (all members are physically present in a meeting together). There are benefits to people being able to join meetings virtually and stakeholders told us this had led to improved attendance.

However, there are examples of parents and professionals accessing meetings from unsuitable locations that do not provide privacy. This suggests there is a lack of consideration for the sensitivity and significance of these meetings, creating uncertainty as to whether confidentiality is being maintained.

Accessing IT support for parents attending meetings virtually has also been highlighted as an obstacle to communication. During observation of a hybrid conference a parent had difficulties accessing the meeting and had to resort to using a mobile phone speaker. Concerns have been consistently expressed about missed opportunities to observe and assess relevant body language and for professionals to support accordingly when meetings are not held in person.

Conference chairs do not always meet parents before virtual conferences.

Parental advocates report how helpful it is for parents to meet chairs face to face prior to conferences. This gives them the opportunity to be heard.

Practitioners and managers express different opinions as to how future meetings should be convened. There are clear benefits to face to face meetings, whilst equally acknowledging some professionals would not welcome returning to the pre-pandemic pattern of attending every meeting in person, especially given that some partner agencies cover several local authority footprints.

One local authority issued a survey to parents and families to ask how they would prefer conferences to be held. Responses indicated they would prefer face to face meetings so the local authority has returned to holding all meetings in person.

Virtual meetings can be more of a challenge for parents who have a learning difficulty or disability. A Welsh Government report has previously highlighted the importance of parents being provided with in person support when online communication is unavoidable to assist in preparation for, engaging in and debriefing following such meetings. [6]

Conference chairs are highly regarded in leading and facilitating conferences, providing structure and leadership in the child protection process.

They ensure the focus remains on the risk of significant harm to children and the child's voice. Children and families largely benefit from consistent, experienced, and professional conference chairs who talk with parents prior to conferences as well as providing an opportunity to de-brief post conference. Conference chairs are often trained in collaborative communication and ensure the family's perspective is considered. Consistent conference chairs also provide continuity of support to families and decision making for practitioners.

Some conference chairs convene a mid-point review process between conferences to check on the progress of the care and support protection plan to ensure children's safety. This mirrors the arrangement that is in place for many Independent Reviewing Officers who chair the looked after children review meetings.

Decision making

Overall partner agencies report being confident in challenging others when they disagree with decisions.

Positive local relationships mean this can mostly be addressed informally, with formal escalation policy rarely utilised. Conference chairs utilise their roles in conference to ensure robust and healthy discussions take place, but evidence of professional challenge is not always recorded in child protection conferences and core group minutes. This was further corroborated by an advocate who stated conference members tend to 'follow others lead'. Although it is important to recognise the benefits of strong inter-agency local relationships, there is potential for such relationships to become overly familiar with a risk of complacency if channels for healthy challenge are not utilised.

There are examples when decisions about children do not accurately reflect the degree of harm experienced by children and challenge may have provided opportunity to re-evaluate. However, there are examples when health practitioners are confident in challenging partners around decision making at child protection conference and are able to clearly articulate their rationale.

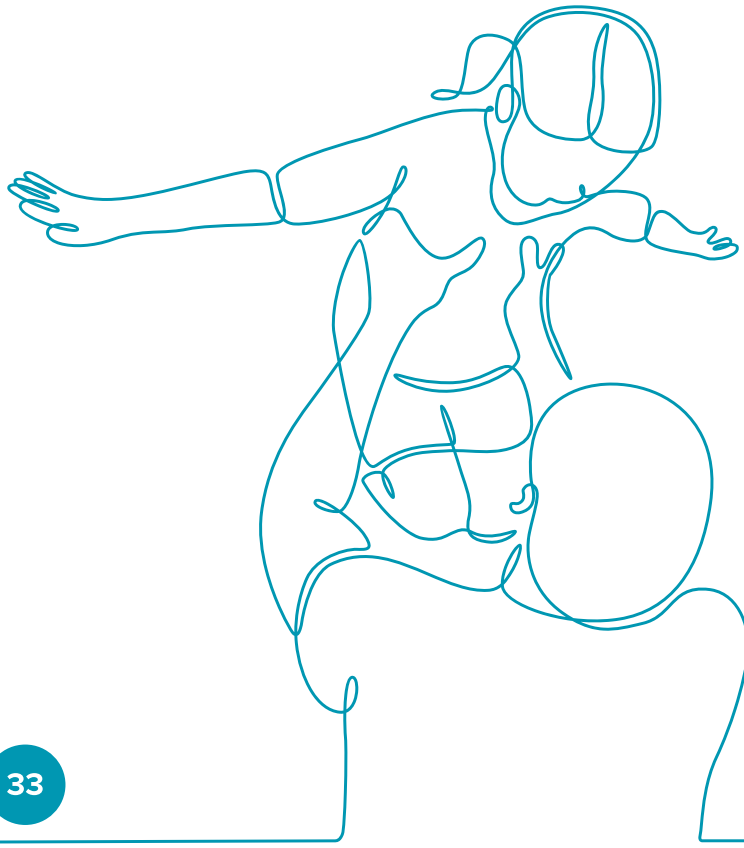
When core group members do not jointly own the care and support protection plan and are passive in challenge, the plans are less effective with the same issues repeatedly discussed. Focus on harm can diminish and progress falters. In these circumstances it can be difficult to help families progress.

47%

Practitioners told us individuals are open to challenge

63%

Practitioners told us there are appropriate systems to escalate to senior management



Recommendations

5.1 Records must clearly reflect progress made in review conference and core group minutes, as well as the risk of children suffering significant harm in the future.

5.2 All agencies should ensure that, as part of quality assurance reporting, they evaluate how well escalation and challenge is utilised in practice. Regional safeguarding boards should monitor these arrangements and ensure appropriate action is taken.

Key line of enquiry 6

Establishing whether or not a child is at risk

We looked at whether practitioners establish if a child is at risk and / or has experienced significant harm and remain focused on assessing whether there are changes, whilst supporting a child and their family.

Findings

Practitioners' focus on the risk of significant harm to children, and how well this is assessed, varies in practice.

There are excellent examples of practitioners working together to understand the impact of abuse and neglect. Sometimes, however, the focus on harm can be overlooked.

It is not routinely the case that assessments are reviewed or that re-assessments are undertaken.

Whilst acknowledging that types of assessments can be found in different reports by different agencies they are often not consolidated, and the evidence is fragmented meaning that it can be difficult to pinpoint risks, strengths, barriers, and progress made.

The Code of Practice (part 3) on assessing the needs of individuals clearly states that a local authority must review assessments where there has been a change in identified personal outcomes, or a significant change in the individual's or family's needs or circumstances.

The judgement on whether the change is significant should be made with reference to the five elements of the assessment (outlined in the Code of Practice - part 3). This can include a new barrier, a new risk or the loss of a resource. Such assessments should contain essential information to help evaluate progress, but too often the information is not consolidated in a clear autonomous assessment.

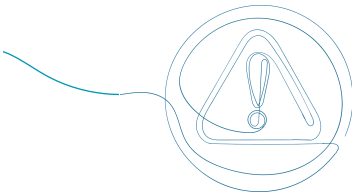
In some conference reports the focus on the risk of significant harm needs to be more consistent and clearer.

Some reports submitted for conference contain relevant information but there needs to be stronger analysis and an improved focus on the risk of significant harm.

Subsequent decision making at conference can also lose focus and specificity (the ability to be clear and exact in relation to harm). This means there can be misplaced professional optimism, limited professional curiosity and insufficient reference to the evidence of progress made. Shared documents such as core group minutes also require improved focus on the risk of significant harm.

However, there are examples of good practice:

CPC reports and minutes in Pembrokeshire provide a proportionate level of information, written in plain language. The best examples of analysis provide clarity and insight into complex family situations, what the risks are and how safety is promoted. Harm statements develop clarity and specificity about risk. Equally, minutes and decision letters contain analysis of the risks to children as well as what is working well. It is clear what actions would be taken if no progress is achieved.



Establishing whether or not a child is at risk

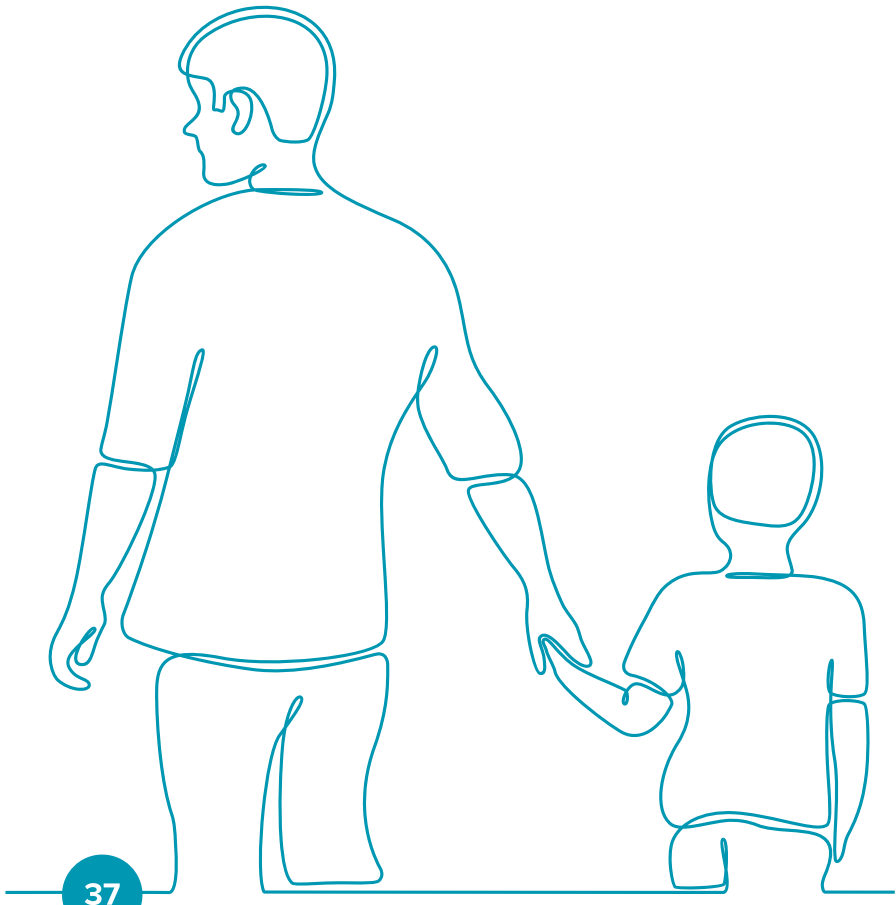
Care and support protection plans can be overly focused on delivery of services rather than elements of the plan that focus on safety and what needs to change to reduce risk.

This is significant as the emphasis on change provides greater assurance about safety. This is not to say services working with families do not provide essential support, rather there needs to be improved connection between what services can provide and how they will contribute to safety and reduce risk.

Children and young people (subject to their age and level of understanding), parents and carers and partner agencies must be made aware of the implications if progress is not made or sustained in mitigating risks to the child.

In many cases there is minimal safeguarding activity between the conclusion of a Section 47 enquiry and the convening of the initial child protection conference (ICPC). This should be a critical time to work collaboratively with parents / carers.

This means by the time the ICPC is convened, limited work has been undertaken with parents / carers to help them understand what professionals are worried about and how children's safety can be reassured.



Recommendations

6.1 Children's services should ensure a consolidated assessment is completed following the completion of a section 47 enquiry. This assessment must be reviewed when there is a significant change.

6.2 All relevant partners must ensure they contribute to a robust and active safety plan between the time a decision is made to convene a child protection conference and the actual date of the conference being held. Regional safeguarding boards should have oversight of these arrangements.

Appendices

Multi-agency recommendations

1.1 Children's services must communicate information about duty to report outcomes in a timely manner to the person who made the initial report. In line with Wales Safeguarding Procedures, if the report-maker has not received an acknowledgement and a confirmation of the outcome from children's services within seven working days, they must contact children's services again.

2.2 All agencies should ensure representation at strategy meetings, review child protection conferences and core groups. Regional safeguarding boards should have oversight of these arrangements and must seek assurance that action has been taken if the contribution of wider partners limits opportunities for protecting and supporting children and their families.

2.3 All agencies should work together to deliver specific multi-agency training on statutory child protection processes including their responsibilities as core group members and collaborative working. This should include a focus on the monitoring and development of the care and support protection plan and healthy challenge. Regional safeguarding boards should have oversight of these arrangements.

3.1 All meetings held in line with child protection processes should start with the child's story. The child's individual voice, including children of large sibling groups, should consistently feature in all relevant key documentation.

3.2 Children, subject to their age and level of understanding, must be invited and supported to take part in meetings, or part of meetings, held in line with Wales Safeguarding Procedures. This will help children understand their circumstances and enhance their care and support protection planning.

3.3 Assessments must always consider the role of partners, all household members, parents living outside the family home and extended family members in terms of potential risks but equally, potential safeguards for children.

5.1 Records must clearly reflect progress made in review conference and core group minutes, as well as the risk of children suffering significant harm in the future.

5.2 All agencies should ensure that, as part of quality assurance reporting, they evaluate how well escalation and challenge is utilised in practice. Regional safeguarding boards should monitor these arrangements and ensure appropriate action is taken.

6.2 All relevant partners must ensure they contribute to a robust and active safety plan between the time a decision is made to convene a child protection conference and the actual date of the conference being held. Regional safeguarding boards should have oversight of these arrangements.

Children's services recommendations

1.2 A child's eligible needs for care and support, once their name is removed from a child protection register, must be clear and explicitly recorded in the minutes of review child protection conferences (RCPC). There should also be a record of a proposed contingency plan in case circumstances change and the risk of significant harm increases for a child.

1.3 Partner agencies and members of the public must be able to make referrals / reports and receive support in the Welsh language. The 'active offer' of providing a service in the Welsh language at the front door must be made to comply with the *More Than Just Words* strategy.

1.4 In line with Wales Safeguarding Procedures, GPs and other relevant health professionals must be invited to CPC. A copy of the outline plan and a summary of the decisions made at the CPC should be circulated to all those invited to the conference, irrespective of whether they attend.

2.1 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.

6.1 Children's services should ensure a consolidated assessment is completed following the completion of a section 47 enquiry. This assessment must be reviewed when there is a significant change.

Regional safeguarding board recommendations

1.5 A national drive is required to improve a shared understanding and awareness of thresholds and relevant guidance. This should focus on multi-agency understanding and consistent decision making when assessing risk.

2.2 All agencies should ensure representation at strategy meetings, review child protection conferences and core groups. Regional safeguarding boards should have oversight of these arrangements and must seek assurance that action has been taken if the contribution of wider partners limits opportunities for protecting and supporting children and their families.

2.3 All agencies should work together to deliver specific multi-agency training on statutory child protection processes including their responsibilities as core group members and collaborative working. This should include a focus on the monitoring and development of the care and support protection plan and healthy challenge. Regional safeguarding boards should have oversight of these arrangements.

4.1 The national independent safeguarding board and the regional safeguarding boards should continue to work together to develop and agree a consistent approach to multi-agency safeguarding performance reporting. Clear mechanisms for regular data sharing are required.

5.2 All agencies should ensure that, as part of quality assurance reporting, they evaluate how well escalation and challenge is utilised in practice. Regional safeguarding boards should monitor these arrangements and ensure appropriate action is taken.

6.2 All relevant partners must ensure they contribute to a robust and active safety plan between the time a decision is made to convene a child protection conference and the actual date of the conference being held. Regional safeguarding boards should have oversight of these arrangements.

National Independent Safeguarding Board recommendations

1.5 A national drive is required to improve a shared understanding and awareness of thresholds and relevant guidance. This should focus on multi-agency understanding and consistent decision making when assessing risk.

4.1 The national independent safeguarding board and the regional safeguarding boards should continue to work together to develop and agree a consistent approach to multi-agency safeguarding performance reporting. Clear mechanisms for regular data sharing are required.

Welsh Government recommendations

1.6 Welsh Government should work alongside health boards to commission a centralised, accessible IT system that is able to capture all health information relating to children, including the location of any non-digitalised records. Any handwritten records must be legible with robust quality assurance processes in place to evidence this.

1.9 Welsh government should work with local authority education services to commission a suitable national IT-based system for education that enhances monitoring and information sharing. This system would enable consistent recording of pupil-level data, encompass various factors affecting their well-being, and facilitate seamless and timely exchange of sensitive information.

Health recommendations

1.6 Welsh Government should work alongside health boards to commission a centralised, accessible IT system that is able to capture all health information relating to children, including the location of any non-digitalised records. Any handwritten records must be legible with robust quality assurance processes in place to evidence this.

1.7 Health professionals must ensure every child has a robust assessment of their health needs, including emerging and potential health needs where there are child protection concerns. Where this cannot be fully achieved prior to the initial child protection conference (ICPC), an action to complete the health assessment should be recorded at the ICPC. Any unmet health needs should be addressed via the care and support protection plan.

1.8 GP practices hold key information in relation to children and their families. In line with Wales Safeguarding Procedures, they must provide a written report for all child protection conferences.

Education recommendations

1.9 Welsh Government should work with local authority education services to commission a suitable national IT-based system for education that enhances monitoring and information sharing. This system would enable consistent recording of pupil-level data, encompass various factors affecting their well-being, and facilitate seamless and timely exchange of sensitive information.

Footnotes

1 Social Services activity: April 2021 to March 2022- Information on assessment and safeguarding activity of local authority social services for April 2021 to March 2022

2 If not now, then when? Radical reform for care experienced children and young people - May 2023

3 Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales: What does good look like?

4 If not now, then when? Radical reform for care experienced children and young people - May 2023

5 Evaluation of Integrated Multi-Agency Operational Safeguarding Arrangements in Wales

6 Guidance for social workers for families where the parent has a learning disability

Glossary (A-H)

The Association of Directors of Education in Wales (ADEW)

The professional group of local authority officers accountable for statutory education functions in each of the Local Authorities in Wales.

Care Inspectorate Wales (CIW)

The body which regulates and inspects social care and childcare services in Wales.

Care and Support Protection Plan (CSPP)

A child becomes the subject of a care and support protection plan if they suffered and are at risk of continuing to suffer from abuse or harm in the future. The plan contains details of the actions required to meet the child's needs and by whom. Once a child becomes the subject of a care and support protection plan, their plan should be reviewed within the first three months and then at intervals of not more than six months.

Child Protection Register (CPR)

The child protection register lists all children in a local authority area who are suffering or likely to suffer significant harm and who are currently the subject of a care and support protection plan. The child's name is placed on the register in order to:

- alert all practitioners working with a child to their risk of harm
- confirm that a care and support protection plan for the protection of the child is in place and must be complied with
- that a social worker and a core group of practitioners are working with the child and family/ carers.

Conference Chair

The primary role of the conference chair is to ensure that the conference is child-centred and the care and support protection needs of the child/ren are identified and addressed at conference.

Core Group

All members of the core group have equal ownership of and responsibility for the detailed care and support protection plan and should co-operate to achieve its aims. Core group members have a responsibility to challenge and report concerns where they believe the plan is not protecting the child from the risk of abuse, neglect or other forms of harm.

Effective Child Protection Model

Aims to ensure child protection practice is effective, with a focus on removing significant harm or the likelihood of significant harm and ensures that the care provided to a child is 'good enough.' There is a focus on the need for change that is required to prevent harm to a child. Equally, there is a focus on collaborative communication with families which aims to develop positive working relationships and collaboration. This includes encouraging families to take ownership of the changes through collaborative discussions about what they feel needs to change can encourage ownership of change, and it can lessen barriers to engagement. This is then more likely to result in the changes being maintained into the future.

Estyn

The inspectorate of education and training in Wales.

Five elements of assessments

The Social Services and Well Being Act (2014) and its associated regulations introduce assessment and eligibility criteria based on a comprehensive analysis of five inter-related elements to ensure that a local authority considers the person's circumstances in the round. Guidance on the Five Elements of Assessments can be found here part-3-code-of-practice-assessing-the-needs-of-individuals.pdf (gov.wales)

Front Door

The 'front door' in a social care context is the arrangement that local authorities have in place to respond to an initial contact from a professional or member of the public who is concerned about a child. At the front door, local authorities provide advice and make decisions about how they will act on information about the health, well-being and safety of children.

Healthcare Inspectorate Wales (HIW)

The independent inspectorate and regulator of healthcare in Wales.

Glossary (I-W)

Initial Child Protection Conference (ICPC)
The initial child protection conference follows the section 47 enquiry where there are concerns of continuing risk of harm to a child/ren. The conference brings together family members (and the child where appropriate), with the supporters, advocates and practitioners most involved with the child and family, to make decisions about the child's future safety and whether they should be subject to a CSPP.

Practitioners
Professionals who are involved in supporting children who are experiencing or are at risk of significant harm. These include children's services practitioners such as social workers and social care practitioners, teachers, health visitors, school nurses , General Practitioners (GP's), paediatricians and police.

Regional Safeguarding Boards (RSB)
These are the six multi-agency strategic boards of relevant partner agencies set up across Wales designed to protect children at risk of abuse or neglect and to prevent those children from becoming at risk of abuse or neglect. Members of the board include but not limited to representatives from local authorities, police force and health board.

Review Child Protection Conference (RCPC)
The purpose of a Child Protection Review Conference is to review whether the child is continuing to suffer, or is likely to suffer, significant harm, and review developmental progress against care and support protection plan outcomes and to consider whether the plan should continue or should be changed.

Risk Model
The Risk Model provides a framework for managing decisions about risk of significant harm. Such a framework provides practitioners and organisations with a risk management system.

Section 47 Enquiry
The purpose of the Section 47 enquiry is to establish whether a child is suffering or is likely to suffer significant harm and requires intervention to safeguard and promote their well-being. Social services have lead responsibility for the enquiries. Other practitioners, such as the police, health, education and other relevant partners have a duty to co-operate and help Social Services undertake its enquiries.

Signs of Safety Model
The Signs of Safety approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.

Statutory duty to report
The duty to report to the local authority will be taken to mean a referral to children's services who, alongside the police, have statutory powers to investigate suspected abuse or neglect.

Threshold
The term threshold is not referenced in the Wales Safeguarding Procedures (WSP). However, it is a term widely used in practice and is referenced in some local and regional documentation across Wales to support practitioners, managers and partner agencies in their decision making. When we refer in this report to whether a threshold has been met, we are referring to when professionals decide whether or not to implement the WSP, which subsequently triggers a series of processes.

Wales Safeguarding Procedures (WSP)
The 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.

This chart summarises the process of protecting a child from risk. You can view the full review process in the Welsh Government's 'Handling Individual Cases to Protect Children at Risk' here

1. Practitioner makes a report of suspected abuse, neglect or harm to the local authority.

2. **If abuse, neglect or harm is suspected a strategy meeting is convened.** The local authority and the police should be involved in any strategy meeting. Practitioners from health and education would also be expected to attend if they have worked with the child.

3. If concerns are substantiated and a child is judged to be experiencing or at risk of abuse, harm or neglect, the local authority convenes a **child protection conference** within 15 working days. The child is registered and subject to a **Care and Support Protection Plan.**

4. A **Core group** is convened within 10 working days of child protection conference. A a care and support protection plan is developed by Lead Coordinator including child and their family, together with core group members.

5. Core Group members provide / commission the necessary interventions and services for the child and / or family.

6. A review conference is held within 3 months of initial child protection conference. If the child is at risk of continued harm the child remains registered and the care and support protection plan must be revised and recorded. If a child is not at continued risk of harm they are deregistered.

Methodology

STRATEGIC REVIEW GROUP
CIW
HIW
Estyn

FOCUS GROUPS
Health
Police
Schools and Local Authority Education Services
Third sector
Children's services

FACE TO FACE REVIEWS
Health
Schools and Local Authority Education Services
Children's services

NATIONAL SURVEY
Health
Police
Schools and Local Authority Education Services
Children's services

SHOUT SURVEY
Children and young people
Parents / carers
Practitioners

DESKTOP REVIEW
Child protection conference minutes
Core group minutes

This was a rapid, national review involving activity of varying scope and scale. To facilitate the review, an appreciative inquiry style was adopted, emphasising reflection and shared learning about effective strategies and areas for improvement in current child protection practices. Close collaboration with Regional Safeguarding Boards (RSBs) and various professionals from different fields was central to this review. This work included:

Specific activity in local authority and health board areas

CIW led engagement with local authorities and their relevant partners, undertaking in-depth review activity in the following five local authorities; Cyngor Gwynedd, Pembrokeshire County Council, Merthyr Tydfil County Borough Council, Swansea Council, and Blaenau Gwent County Borough Council. This included a review of a sample of children's social care records in each local authority and interviews/ focus groups with staff, managers and practitioners from partner agencies, and young people, parents and carers.

Estyn evaluated partnership working and safeguarding practices in education departments and schools, including primary and secondary schools, as well as a Welsh medium all-age school. Activity took place in six schools in three local authority areas:

- Monmouthshire County Council
- Flintshire County Council
- Pembrokeshire County Council

During school visits inspectors talked with pupils whose name were on the child protection register and their families, as well as key members of staff. Interviews were held with headteachers from each local authority and the local authority designated officers for safeguarding.

Evaluation focused on corporate level partnership working, cross-education department collaborative working, and input from headteachers and designated safeguarding persons through focus groups.

HIW engaged with four health boards:

- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Swansea Bay University Health Board
- Aneurin Bevan University Health Board

This in-depth engagement activity included:

- The review of a sample of children’s health records
- Interviews with health board safeguarding leads
- Multi-agency focus groups with practitioners (facilitated by HIW and CIW)
- A review of relevant safeguarding quality assurance audits.

National survey

All local authority children's services, education departments, police forces and health boards across Wales were invited to complete a national survey. You can view all the national survey results here.

SHOUT survey

Children and their families were a key stakeholder in this review. 'Mind Of My Own' was commissioned to design specific confidential surveys for children and young people, their families and carers, and practitioners from all agencies. The responses received have been analysed for this report.

National thematic analysis of child protection conference / core group minutes

Child protection conference and core group records were analysed from 11 children's services departments.

Observation of child protection conferences

A total of five child protection conferences were observed.

Other stakeholders we consulted with:

- National Independent Safeguarding Board Wales
- Gwent Safeguarding Board
- Cwm Taf Morgannwg Safeguarding Board
- Cardiff and the Vale Safeguarding Board
- Mid and West Wales Safeguarding Board
- North Wales Safeguarding Board
- West Glamorgan Safeguarding Board
- National Youth Advocacy Service Cymru
- Voices from Care Cymru
- Tros Gynnal Plant Cymru
- Association for Fostering, Kinship and Adoption Cymru:
  - Welsh Medical Advisors
  - Welsh Legal Advisors
  - Foster and Adoption Panel Chairs and Vice chairs
  - Conference chairs
- Children's Commissioner for Wales
- His Majesty's Inspectorate of Probation
- Association of Directors of Education Wales

Survey response rate

SHOUT survey responses

36
children and young people*

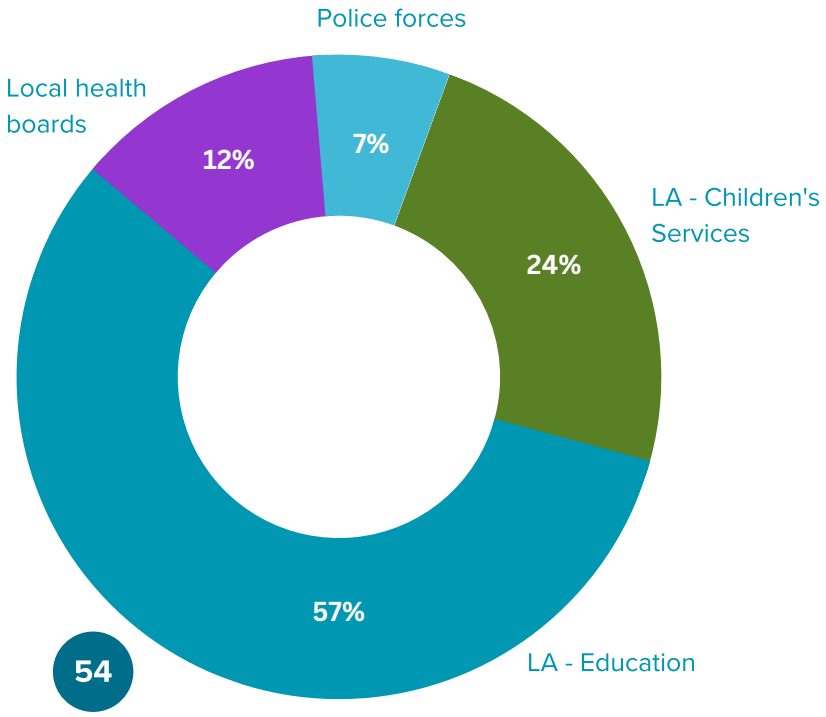
136
parents and carers

574
practitioners

*This number relates to the completed SHOUT surveys we received from children and young people after they were distributed by local authority teams and other relevant partners. Despite a drive from all agencies to gather the views of a larger sample of children and young people with experience of being on the CPC, we are mindful that this sample is relatively low and therefore could have limited statistical significance.

National survey responses

We received 72 responses, as follows:



Have you ever seen your Care and Support Protection Plan?		Y/DK/N
Are you always invited to your Child Protection meetings?		Never, Sometimes, Most of the time, All the time
Are you listened to when important decisions are made about keeping you safe?		• Not at all • Only a little bit • Quite a lot • All the time
Since you've had a Care and Support Protection Plan, how has your life changed?		• I don't think I have got a plan • It has made things worse • It has made no difference • It has made life better • It has made life a lot better
Which of the following best describes your social worker? Please select more than one	• They are honest • They ask me questions • They don't take sides • They support me • They are patient • They make me feel good • They are kind • They don't interrupt me • They make me feel good	• They ignore me • We don't get on • They tell me off • They make me worry about the future • I don't know my social worker • They make me feel sad • They are late • They are boring • They embarrass me
What does your social worker do with you when they visit?		• They don't visit • They ignore me • Talk to adults • Gets my wishes • See my bedroom • Talks to me alone • Talks to other important people in my life • Supports my parents
Do you understand why your name is included on the child protection register?		Y / N
How good is your social worker?		Poor, Not good, Good, Excellent
If you felt unsafe, do you have someone you could tell?		There is no one to talk to, Parents, Aunt / Uncle, Grandparents, Friends, Teachers Social worker, Doctor / Nurse, Police, Other
How could you be supported in a better way?		

Do you get the right support at the right time?	• I do not get the support when I need it • I get the right the support but not at the right time • Support comes quickly but it is not the right support • I get the right support at the right time
What does your child social worker do when they visit?	• They don't visit • They ignore me • Talk to me alone • Get my wishes • See my child's bedroom • Talk to my child alone • Talk to other important people in my child's life • Support my child
Are you invited, listened to and helped to understand meetings about you and your family?	• Never • Sometimes • Often • Always
How well do professionals understand your child's needs?	• They do not try to understand • They do not understand • They try to understand • They fully understand
Are professionals aware of the role of significant people in your child's life?	• No, they are not interested • They are not aware • They are aware • Yes, they are always interested
How well do professionals understand the strengths and risks in your family?	• They do not try to understand • They do not understand • They try to understand • They fully understand
If you have more than one child, do professionals understand their individual needs?	• I only have one child • They do not try to understand • They do not understand • They mostly understand • They fully understand everyone
Do you understand why your child's name is on the child protection register?	Yes / No
Since your child or the child you care for have had a Care and Support Protection Plan, how has your life changed?	• I don't think I have got a plan • It has made things worse • It has made no difference • It has made life better • It has made life a lot better
How could professionals respond in a better way, for you and your family?	

Do children receive the right help and protection because of the application of appropriate thresholds and effective information-sharing?	• They do not get the support when they need it • They get the right the support but not at the right time • Support comes quickly but it is not the right support • They get the right support at the right time
How often are professionals making appropriate referrals in line with Wales Safeguarding procedures?	• Rarely • Sometimes • Mostly • Always
How effective are the following agencies in a multi-agency context? Social workers, Education / schools, The Police, Health, Other:	• Ineffective • Not very effective • Somewhat effective • Very effective
How effective are multi -agency meetings in the following ways? Information sharing, Planning, Decision-making, Monitoring safety	• Ineffective • Not very effective • somewhat effective • Very effective
How effective are the following processes at capturing the voice of the child? Strategy discussions, Strategy meetings, Section 47 Enquiries, Child protection conferences, Statutory visits, Core groups	• Ineffective • Not very effective • Somewhat effective • Very effective
How clear are you about the decision making that leads to a child being put on the register?	• Never clear • Rarely clear • Mostly clear • Always clear
How clear are you about the decision making that leads to a child being removed from the register?	• Never clear • Rarely clear • Mostly clear • Always clear
How effective are practitioners at evidencing whether a child is at risk or has experienced significant harm?	• Ineffective • Not very effective • Somewhat effective • Very effective

Which of the following is true when there is professional difference about risk and safety? Please select multiple	• Individuals are open to challenge • Decisions in meetings can be challenged • There are appropriate systems to escalate to senior management • Challenge is usually healthy & constructive • Decision making is clearly evidenced or recorded • Individuals are not open to challenge • It is difficult to challenge in meetings • Unclear systems to escalate to senior management • Challenge is not constructive • Decision making is not clearly evidenced or recorded
How effective are leaders and managers at understanding the experiences of children and families in the following ways: • Supporting staff • Offering appropriate training • Challenging practice • Quality assurance • Promoting a learning culture	• Ineffective • Not very effective • Somewhat effective • Very effective
Are significant adults in the child's life appropriately supported?	• They are not supported at all • Support is not effective • Support is somewhat effective • Support is very effective
Are professionals you work with effective at ensuring the lived experience of children is considered when making decisions about their safety?	• There is no effective consideration of lived experience • There is some effective consideration of lived experience • There is mostly effective consideration of lived experience • There is always effective consideration of lived experience
If there is more than one child in the family, do professionals understand their individual needs?	• They do not try to understand • They do not understand • They mostly understand • They fully understand everyone
How effective is the conference process in promoting children's safety and well-being?	• Ineffective • Not very effective • Somewhat effective • Very effective
How effective are core groups at developing and reviewing the care and support plan?	• Ineffective • Not very effective • Somewhat effective • Very effective

Have you ever seen your Care and Support Protection Plan?		
Answer Choice	Response %	Response total
No	48.4%	15
Yes	41.9%	13
Don't know	9.7%	3
	Answered	31
	Skipped	5

Are you always invited to you child protection meetings?		
Answer Choice	Response %	Response total
All the time	41.9%	13
Never	22.6%	7
Sometimes	19.4%	6
Most of the time	16.1%	5
	Answered	31
	Skipped	5

Are you listened to when important decisions are made about keeping you safe?		
Answer choice	Response %	Response total
Quite a lot	36.7%	11
All the time	36.7%	11
Not at all	13.3%	4
Only a little bit	13.3%	4
	Answered	30
	Skipped	6

Do you understand why your name is included on the child protection register?		
Answer choice	Response %	Response total
Yes	71.4%	20
No	28.6%	8
	Answered	28
	Skipped	8

Since you have had a care and support protection plan, how has your life changed?		
Answer choice	Response %	Response total
made life better	30%	9
Made things worse	26.7%	8
Made life a lot better	26.7%	8
made no difference	13.3%	4
I don't think I have a plan	3.3%	
	Answered	30
	Skipped	6

How good is your social worker?		
Answer choice	Response %	Response total
Excellent	40%	12
Good	30%	9
Poor	20%	6
Not good	10%	3
	Answered	30
	Skipped	6

What does your social workers do with you when they visit?		
Answer choice	Response %	Response total
Talk to me alone	61.3%	19
See my bedroom	58.1%	18
Gets my wishes	45.2%	14
Talks to adults	41.9%	13
Talks to other important people in my life	41.9%	13
Supports my parents	41.9%	13
They don't visit	9.7%	3
They ignore me	9.7%	3
	Answered	31
	Skipped	5

If you felt unsafe, do you have someone you could tell?		
Answer choice	Response %	Response total
Parents	58.6%	17
Social Worker	58.6%	17
Friends	44.8%	13
Teachers	37.9%	11
Aunt/Uncle	31.0%	9
Police	31.0%	9
Grandparents	27.6%	8
Doctor / nurse	10.3%	3
Other	10.3%	3
There is nobody to talk to	6.9%	2
	Answered	31
	Skipped	5

Which Local Authority do you live in?		
Blaenau Gwent	39.3%	11
Rhondda Cynon Taf	21.4%`	6
Vale of Glamorgan	14.3%	4
Gwynedd	7.1%	2
Swansea	7.1%	2
Carmarthenshire	3.6%	1
Anglesey	3.6%	1
Torfaen	3.6%	1
Bridgend	nil	nil
Caerphilly	nil	nil
Cardiff	nil	nil
Ceredigion	nil	nil
Conwy	nil	nil
Denbighshire	nil	nil
Flintshire	nil	nil
Merthyr	nil	nil
Monmouthshire	nil	nil
Neath Port Talbot	nil	nil
Newport	nil	nil
Pembrokeshire	nil	nil
Powys	nil	nil
Wrexham	nil	nil

Do you get the right support at the right time?		
I do not get the support when I need it	38.8%	45
I get the right support at the right time	37.1%	43
I get the right the support but not at the right time	18.1%	21
Support comes quickly but it is not the right support	6%	7
	Answered	116
	skipped	17

What does your child social worker do when they visit?		
Talk to me alone	42.7%	50
See my child's bedroom	42.7%	50
Support my child	39.3%	46
Talk to my child alone	36.8%	43
Talk to other important people in my child's life	29.9%	35
Get my wishes	24.8%	29
They don't visit	16.2%	19
They ignore me	12.8%	15
Another choice	23.9%	28
	Answered	116
	skipped	17

Are you invited, listened to and helped to understand meetings about you and your family?					
Answer choice	**Never**	**Sometimes**	**Often**	**Always**	**Response total**
Invited	7	33	16	68	124
Listened to	25	39	15	43	122
Helped to understand	22	36	22	42	122
TOTALS	54	108	53	153	
				Answered	124
				Skipped	9

How well do professionals understand your child's needs?		
They try to understand	34.1%	42
They fully understand	31.7%	39
They do not understand	25.2%	31
They do not try to understand	8.9%	11
	Answered	123
	skipped	10

Are professionals aware of the role of significant people in your child's life?		
They are aware	42.3%	52
Yes, they are interested	30.9%	38
No, they are not interested	15.4%	19
They are not aware	11.4%	14
	Answered	123
	skipped	10

How well do professionals understand the strengths and risks in your family?		
They fully understand	36.9%	45
They try to understand	31.1%	38
They do not understand	18.0%	22
They do not try to understand	13.9%	17
	Answered	122
	skipped	11

If you have more than one child, do professionals understand their individual needs?		
They mostly understand	28.2%	35
I only have one child	23.4%	29
They fully understand everyone	22.6%	28
They do not understand	17.7%	22
They do not try to understand	8.1%	10
	Answered	124
	skipped	9

Do you understand why your child's name is on the Child Protection Register?		
YES	86.4%	108
NO	13.4%	17
	Answered	125
	skipped	8

Since your child or the child you care for have had a Care and Support Protection Plan, how has your life changed?		
It has made life better	28.2%	35
It has made things worse	26.6%	33
It has made no difference	24.2%	30
It has made life a lot better	16.9%	21
I don't think I have got a plan	4%	5
	Answered	124
	skipped	9

How could professionals respond in a better way, for you and your family?		
Negative responses	74%	58
Positive responses	17%	13
Neutral / NA	9%	7
	Answered	78
	skipped	55

Do children receive the right help and protection because of the application of appropriate thresholds and effective information-sharing?		
They get the right support but not at the right time	37.0%	206
They get the right support at the right time	27.8%	155
Support comes quickly but it is not the right support	19.2%	107
They do not get the support when they need it	16.0%	89
	Answered	557
	skipped	18

How often are professionals making appropriate referrals in line with Wales Safeguarding procedures?		
Mostly	61.1%	345
Always	24.8%	140
Sometimes	12.6%	71
Rarely	1.6%	9
	Answered	565
	skipped	9

How effective are the following agencies in a multi-agency context?					
Answer choice	**Ineffecitve**	**Not very effective**	**Somwhat effective**	**Very effective**	**Response total**
Social Workers	26	46	339	160	571
Education / Schools	6	51	339	174	570
Police	19	83	359	105	566
Health	45	84	354	118	570
TOTAL	65	264	1391	557	
				Answered	573
				Skipped	1

How effective are multi-agency meetings in the following ways?					
Answer choice	**Ineffecitve**	**Not very effective**	**Somwhat effective**	**Very effective**	**Response total**
Information sharing	5	24	304	238	571
Planning	3	75	335	157	570
Decision making	5	53	326	186	570
Monitoring safety	9	66	322	171	568
TOTAL	22	218	1287	752	
				Answered	571
				Skipped	3

How effective are the following processes at capturing the voice of the child?					
Answer choice	**Ineffecitve**	**Not very effective**	**Somwhat effective**	**Very effective**	**Response total**
Strategy discussions	77	185	251	44	557
Strategy meetings	73	184	256	47	560
Section 47 Enquiry	21	68	330	133	552
Child Protection Conference	17	103	315	125	560
Statutory visits	10	50	335	156	551
Core groups	25	142	323	65	555
TOTAL	223	732	1810	570	
				Answered	564
				Skipped	10

How clear are you about the decision making that leads to a child being put on the register?		
Always clear	48.8%	277
Mostly clear	43.7%	248
Rarely clear	6.7%	38
Never clear	0.9%	5
	Answered	568
	skipped	6

How clear are you about the decision making that leads to a child being removed from the register?		
Always clear	45.4%	259
Mostly clear	43.8%	250
Rarely clear	9.8%	56
Never clear	1.1%	6
	Answered	571
	skipped	3

How effective are practitioners at evidencing whether a child is at risk or has experienced significant harm?		
Somewhat effective	60.6%	347
Very effective	30.4%	174
Not very effective	8.6%	49
Ineffective	0.5%	3
	Answered	573
	skipped	1

Which of the following is true when there is professional difference about risk and safety?		
There are appropriate systems to escalate to senior management	63.1%	354
Decisions in meetings can be challenged	62.6%	351
Challenge is usually healthy & constructive	56.1%	315
Decision making is clearly evidenced or recorded	56.0%	314
Individuals are open to challenge	46.9%	263
It is difficult to challenge in meetings	24.2%	136
Individuals are not open to challenge	19.6%	110
Unclear systems to escalate to senior management	17.8%	100
Decision making is not clearly evidenced or recorded	17.5%	98
Challenge is not constructive	14.3%	80
	Answered	561
	skipped	13

Are significant adults in the child's life appropriately supported?		
Support is somewhat effective	69.0%	388
Support is not effective	17.6%	99
Support is very effective	11.7%	66
They are not supported at all	1.6%	9
	Answered	562
	skipped	12

How effective are leaders and managers at understanding the experiences of children and families in the following ways:					
Answer choice	**Ineffecitve**	**Not very effective**	**Somwhat effective**	**Very effective**	**Response total**
Supporting staff	15	65	295	190	565
Offering appropriate training	9	64	304	187	564
Challenging practice	15	97	308	144	564
Quality assurance	15	95	300	152	562
Promoting a learning culture	20	95	273	172	560
TOTAL	74	416	1480	845	
				Answered	566
				Skipped	8

Are professionals you work with effective at ensuring the lived experience of children is considered when making decisions about their safety?		
There is mostly effective consideration of lived experience	54.4%	308
There is always effective consideration of lived experience	22.6%	128
There is some effective consideration of lived experience	21.7%	123
There is no effective consideration of lived experience	1.2%	7
	Answered	566
	skipped	8

If there is more than one child in the family, do professionals understand their individual needs?		
They mostly understand	69.4%	390
They fully understand everyone	18.7%	105
They do not understand	10.9%	61
They do not try to understand	1.1%	6
	Answered	562
	skipped	12

How effective is the conference process in promoting children's safety and well-being?		
Somewhat effective	59.3%	334
Very effective	33.6%	189
Not very effective	6.4%	36
Ineffective	0.7%	4
	Answered	563
	skipped	11

How effective are core groups at developing and reviewing the care and support plan?		
Somewhat effective	66.9%	374
Very effective	20.8%	116
Not very effective	11.6%	65
Ineffective	0.7%	4
	Answered	559
	skipped	15

Which of the following agencies do you work with or for?		
Local Authority Children Services	53.4%	287
Local Authority Education Department	23.8%	128
Local Health Board	17.9%	96
Police Force	4.8%	26
	Answered	537
	skipped	37

Which Local Authority Children Services do you work with or for?		
Bridgend	10.3%	54
Blaenau Gwent	8.9%	47
Wrexham	8.2%	43
Denbighshire	7.0%	37
Powys	6.5%	34
Swansea	5.9%	31
Caerphilly	5.7%	30
Newport	5.7%	30
Anglesey	5.1%	27
Pembrokeshire	4.8%	25
Carmarthenshire	4.6%	24
Rhondda Cynon Taf	4.6%	24
Neath Port Talbot	3.6%	19
Flintshire	3.2%	17
Monmouthshire	3.0%	16
Conwy	1.9%	14
Cardiff	1.9%	10
Ceredigion	1.9%	10
Torfaen	1.7%	9
Gwynedd	1.5%	8
Vale of Glamorgan	1.3%	7
Merthyr Tydfil	0.8%	4

What Local Authority Children Services you work with or for?			
Answer Choice		Response Percent	Response Total
1	Blaenau Gwent	6.9%	5
2	Bridgend	2.8%	2
3	Caerphilly	5.6%	4
4	Cardiff	6.9%	5
5	Carmarthenshire	5.6%	4
6	Ceredigion	16.7%	12
7	Conwy	4.2%	3
8	Denbighshire	2.8%	2
9	Flintshire	4.2%	3
10	Gwynedd	4.2%	3
11	Isle of Anglesey	1.4%	1
12	Merthyr Tydfil	5.6%	4
13	Monmouthshire	4.2%	3
14	Neath Port Talbot	4.2%	3
15	Newport	5.6%	4
16	Pembrokeshire	8.3%	6
17	Powys	6.9%	5
18	Rhondda Cynon Taf	4.2%	3
19	Swansea	6.9%	5
20	Torfaen	4.2%	3
21	Vale of Glamorgan	18.1%	13
22	Wrexham	2.8%	2
answered			72
skipped			0

How clear is decision making about child protection registration?			
Answer Choice		Response Percent	Response Total
1	Never clear	0.0%	0
2	Rarely clear	2.8%	2
3	Mostly clear	52.8%	38
4	Always clear	44.4%	32
		answered	72
		skipped	0

How clear is decision making about child protection deregistration?			
Answer Choice		Response Percent	Response Total
1	Never clear	0.0%	0
2	Rarely clear	2.8%	2
3	Mostly clear	56.9%	41
4	Always clear	40.3%	29
		answered	72
		skipped	0

If there is more than one child in the family, do professionals understand their individual needs?			
Answer Choice		Response Percent	Response Total
1	They do not try to understand	1.4%	1
2	They do not understand	2.8%	2
3	They mostly understand	62.5%	45
4	They fully understand everyone	33.3%	24
		answered	72
		skipped	0

How effective are the multiagency discussions in the case conference in promoting children's safety?			
Answer Choice		Response Percent	Response Total
1	Ineffective	0.0%	0
2	Not effective	0.0%	0
3	Somewhat effective	41.7%	30
4	Very effective	58.3%	42
		answered	72
		skipped	0

What are your current arrangements for convening initial case conference? Please select all that apply			
Answer Choice		Response Percent	Response Total
1	Face to face	43.1%	31
2	Virtual	43.1%	31
3	Hybrid	61.1%	44
		answered	72
		skipped	0

What are your current arrangements for convening review case conferences? Please select all that apply			
Answer Choice		Response Percent	Response Total
1	Face to face	38.9%	28
2	Virtual	52.8%	38
3	Hybrid	59.7%	43
		answered	72
		skipped	0

How effective are core groups at developing and reviewing the care and support protection plan?			
Answer Choice		Response Percent	Response Total
1	Ineffective	1.4%	1
2	Somewhat ineffective	2.8%	2
3	Somewhat effective	72.2%	52
4	Very effective	23.6%	17
answered			72
skipped			0

How effective are practitioners at establishing whether a child is at risk and/or has experienced significant harm?			
Answer Choice		Response Percent	Response Total
1	Ineffective	0.0%	0
2	Somewhat ineffective	1.4%	1
3	Somewhat effective	40.3%	29
4	Very effective	58.3%	42
answered			72
skipped			0

Do you have a methodology for assessing risk of significant harm?			
Answer Choice		Response Percent	Response Total
1	Yes	80.6%	58
2	No	19.4%	14
answered			72
skipped			0

Do practitioners receive specific training on risk of significant harm?			
Answer Choice		Response Percent	Response Total
1	Yes	86.1%	62
2	No	13.9%	10
answered			72
skipped			0

How well do leaders and managers provide appropriate support, training and challenge to practitioners so that effective practice can flourish?						
Answer Choice		Ineffective	Not very effective	Somewhat effective	Very effective	Response Total
1	Supporting staff	0	1	22	49	72
2	Offering appropriate training	1	2	22	47	72
3	Challenging practice	0	3	28	41	72
4	Quality assurance	0	5	31	36	72
5	Promoting a learning culture	1	1	24	46	72
answered						72
skipped						0

How effective are leaders in the regional safeguarding board, through the multi-agency safeguarding arrangements, at monitor and evaluating the work of statutory partners?			
Answer Choice		Response Percent	Response Total
1	Ineffective	1.4%	1
2	Somewhat ineffective	2.8%	2
3	Somewhat effective	56.9%	41
4	Very effective	38.9%	28
	answered		72
	skipped		0

How effective is the regional safeguarding board at promoting multi-agency learning about the identification, assessment and response to initial need and risk?			
Answer Choice		Response Percent	Response Total
1	Ineffective	0.0%	0
2	Somewhat ineffective	2.8%	2
3	Somewhat effective	55.6%	40
4	Very effective	41.7%	30
	answered		72
	skipped		0

How effective are professionals at ensuring children's lived experiences and individual needs are understood and included in decision making about safety?			
Answer Choice		Response Percent	Response Total
1	Ineffective	0.0%	0
2	Somewhat ineffective	8.3%	6
3	Somewhat effective	38.9%	28
4	Very effective	52.8%	38
	answered		72
	skipped		0

How effective are leaders and managers in understanding the experiences of children and families that need help and protection?			
Answer Choice		Response Percent	Response Total
1	Ineffective	0.0%	0
2	Somewhat ineffective	4.2%	3
3	Somewhat effective	47.2%	34
4	Very effective	48.6%	35
answered			72
skipped			0

Partnerships and Integration How often do professionals make appropriate referrals in line with Wales Safeguarding Procedures?			
Answer Choice		Response Percent	Response Total
1	Rarely	0.0%	0
2	Sometimes	9.7%	7
3	Mostly	48.6%	35
4	Always	41.7%	30
	answered		72
	skipped		0

How well is healthy challenge evident, including opportunity to escalate when there is professional difference about risk and safety?Please select multiple choices			
Answer Choice		Response Percent	Response Total
1	Individuals are open to challenge	79.2%	57
2	Decisions in meetings can be challenged	90.3%	65
3	There are appropriate systems to escalate to senior management	81.9%	59
4	Challenge is usually healthy & constructive	84.7%	61
5	Decision making is clearly evidenced or recorded	76.4%	55
6	Individuals are not open to challenge	4.2%	3
7	It is difficult to challenge in meetings	1.4%	1
8	Unclear systems to escalate to senior management	6.9%	5
9	Challenge is not constructive	1.4%	1
10	Decision making is not clearly evidenced or recorded	6.9%	5
		answered	72
		skipped	0

How effective are multi-agency arrangements in reducing risk of significant harm for children?			
Answer Choice		Response Percent	Response Total
1	Ineffective	1.4%	1
2	Not effective	1.4%	1
3	Somewhat effective	56.9%	41
4	Very effective	40.3%	29
answered			72
skipped			0

Do children receive the right help and protection because of the application of appropriate thresholds and effective and timely information-sharing?			
Answer Choice		Response Percent	Response Total
1	They do not get the support when they need it	6.9%	5
2	They get the right the support but not at the right time	31.9%	23
3	Support comes quickly but it is not the right support	11.1%	8
4	They get the right support at the right time	50.0%	36
		answered	72
		skipped	0

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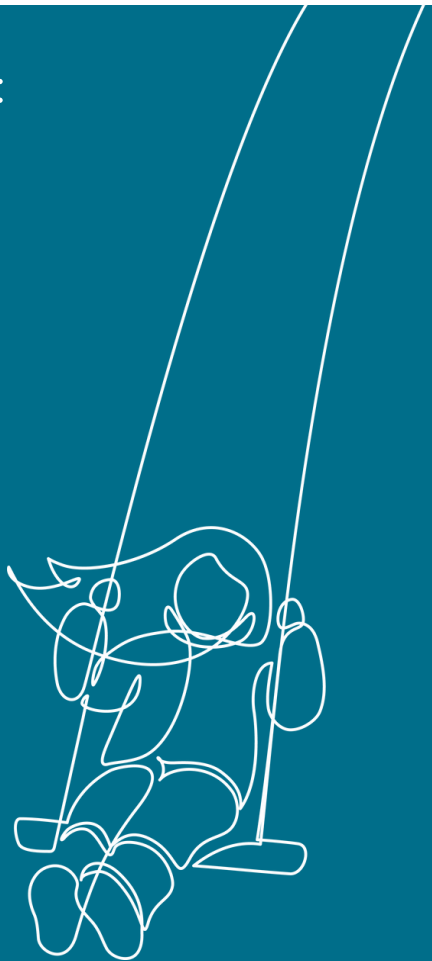

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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