Bridgend County Borough Council, Cwm Taf Morgannwg University Health Board, South Wales Police

Report of Joint Inspection Review of Child Protection Arrangements

June 2023

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

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Introduction

Between 12 and 16 June 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in Bridgend.

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

Scope of the inspection

The Joint Inspectorate Review of Child Protection Arrangements (JICPA) reviewed:

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

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

- BCBC or LA - Bridgend County Borough Council or Local Authority
- CAMHS - Child and Adolescent Mental Health Services
- CASPP - Care and Support Protection Plan
- CPRs - Child Practice Reviews
- CRISP - Concerns Regarding Inter-Agency Safeguarding Practice Protocol
- CTMSB - Cwm Taf Morgannwg Safeguarding Board is a statutory partnership made up of the agencies that are responsible for safeguarding children and adults at risk in the Cwm Taf Morgannwg area.
- CTMUHB - Cwm Taf Morgannwg University Health Board
- DBS - Disclosure and Barring Service
- DSL - Designated Safeguarding Lead is the person appointed to take lead responsibility for child protection issues in schools.
- DVPN - Domestic Violence Prevention Notices
- EET - Education Engagement Team
- ED - Emergency Department
- ELSA - Emotional Literacy Support Assistant is a social and emotional intervention programme delivered by trained staff in primary and secondary schools.
- ESR - Electronic Staff Record in the health board
- FCR - Force Control Room (Police)
- IAA - Information, Advice and Assistance

- IDVA - Independent Domestic Violence Advisers providing help and support to victims of domestic violence.
- IRO - Independent Reviewing Officers
- MARAC - MARACs are Multi Agency Risk Assessment Conferences. They are regular meetings of professionals who discuss how to help individuals who are most at risk of serious harm due to domestic violence and abuse.
- MASH- Multi-Agency Safeguarding Hub
- MIU - Minor Injuries Unit
- Operation Encompass - Operation Encompass is a partnership between police and schools, a school can only join if the local police force has already joined Operation Encompass. One of the principles of Operation Encompass is that all incidents of domestic abuse are shared with schools, not just those where an offence can be identified.
- PPN - Public Protection Notices
- PSC - Public Service Centre is the police force's control room.
- PRU - Pupil referral unit where pupils with social, emotional and/or behavioural difficulties attend for short periods of normally up to 12 weeks. They receive support to regulate their emotions/behaviour and to re-integrate to mainstream education.
- PRUDIC - Procedural Response to Unexpected Death in Childhood.
- SWP - South Wales Police
- RSB - Regional Safeguarding Board
- Section 47 (S47) - Under section 47 Children Act 1989, a local authority has a duty to investigate if it appears to them that a child in its area is suffering or is at risk of suffering significant harm.
- SoS - 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.
- TAS - Team around the School (TAS) model aims to support schools to identify and support families earlier when the needs arise by collaboration with key partners
- THRIVE - Threat, harm, risk, investigation, vulnerability, and engagement. A model used to assess the right initial police response to a call for service.
- WSP - Wales Safeguarding Procedures detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect.

1. Summary

In common with many areas across Wales, recruitment and retention of key staff is impacting on children's safeguarding arrangements. This is exacerbated by high levels of demand and increasing complexity of children's and families' needs. The workforce position within social services remains fragile. Deficits in the number of social workers and a competitive market has resulted in an increased reliance on agency social workers.

Despite this context, overall, systems and relationships are in place to facilitate effective partnership working where a child is at risk of abuse and neglect. Partners are working to a shared ethos of safeguarding children at different levels of vulnerability. Senior leaders in the local authority, police force and health board articulate a shared vision with a positive approach to regional safeguarding arrangements. Managers and leaders provide a positive working together culture. The local authority has taken action to instigate learning following recent critical incidents. The subsequent improvement and joint action plans are overseen by the Cwm Taf Morgannwg Regional Safeguarding Board (CTMSB).

From the sample of records viewed as part of the inspection we found no concerns for the safety of children. Actions generally happen within timescales with support and protection in place to meet needs. There are, however, areas of child protection which are inconsistent and require attention. Professionals make appropriate referrals but partner agencies, such as police and health, are struggling to resource the increase in child protection activity. Challenges remain in sharing information between agencies in the Multi-Agency Safeguarding Hub (MASH). It is envisaged a new IT platform will address this.

Immediate actions are taken to promote children's safety but there can be gaps following a Section 47 enquiry (S47). Post enquiry feedback (including single agency enquiries often undertaken via children's services) generally involves social services and police, is routinely via email communication, and does not include relevant partners who were involved in the initial strategy discussion. This may represent a missed opportunity to share essential information and discuss the outcome of the enquiry. The quality of care and support protection plans (CASPP) is too variable. Plans are adult, rather than child focused, and without clear outcomes for the child identified. There are gaps in recording and in supervision which need to be addressed by managerial oversight and a focus on the quality of practice.

Schools across Bridgend work well with a wide range of services to support children and families. There is good multi-agency attendance and participation in child protection meetings arranged under the Wales Safeguarding Procedures (WSP). This includes initial and review child protection case conference and core groups. The MASH facilitates adherence to the WSP and encourages close partnership

working. Multi- agency contribution is evident in addressing the child's safety through the care and support protection plan.

2. Key findings and evidence

2.1 Well-being

Partnership Arrangements
The best examples of child protection practice in Bridgend happen when there is a shared understanding of significant harm. A clear link is evidenced between this harm and the impact on the child. Actual and potential risks are identified well with proportionate actions taken to protect children. These child protection records demonstrate a clear strengths-based approach whilst ensuring the CASPP makes an explicit link between risk and safety.

Professionals identify children in need of help and protection and report their concerns accordingly. This is significant as it enables prompt and accurate early decision-making. Referrals from partners to children's services generally provide relevant detail but measures are being taken to improve their quality. There is a focus in the MASH on collecting good quality information from referrers to enable robust decision-making.

Strategy meetings and child protection conferences are effective forums for information-sharing, planning and decision-making. These are well attended by multi-agency groups. Conferences are well structured and facilitated through collaborative conversations with parents/carers whilst maintaining a focus on risk and safety.

There are examples of the local authority and partners responding promptly and effectively to meet the needs of children, especially where acute need and risk is identified. For example, we saw agencies arranging strategy meetings and visits to children at short notice to ensure their welfare. The subsequent planning was generally focused and based on a good exchange of information across agencies.

Practitioners who report safeguarding concerns are not consistently notified of the outcome of their referral and the reasons for subsequent decisions. There are delays in sharing strategy meeting minutes, although relevant actions are communicated immediately. This is an area to develop to align with the expectations set out in the Wales Safeguarding Procedures (WSP).

Sufficiency of resources across partner agencies needs strengthening to ensure safeguarding responsibilities are consistently met and to promote staff well-being. The local authority has responded to unprecedented demand by investing in additional agency workers over its funded establishment to meet statutory duties. Whilst this additional resource is currently needed, it is impacting on the ability of

other agencies to respond consistently and effectively to activity, for example the increase in strategy meetings.

Strengths

Cwm Taf Morgannwg University Health Board

There is good communication between members of the health board's safeguarding team and staff working directly with children. Public protection nurses based in the MASH provide advice to Cwm Taf Morgannwg (CTM) staff to support a consistent threshold for referrals. All referrals from health staff are copied to the safeguarding team for information and quality assurance. A safeguarding champion model is in the early stages of development. It is anticipated that champions, who will undertake additional safeguarding training and act as a first point of contact within departments, will provide an additional layer of support and advice for staff across the health board. This is particularly the case out of hours when the safeguarding team is not available. The child protection reports seen as part of this inspection were timely and appropriate.

Public protection nurses co-ordinate the collation of health information, invite relevant health professionals and facilitate attendance at strategy meetings.

Where concerns relate to a suspected non-accidental injury, a paediatrician or safeguarding clinical nurse specialist will also attend. The safeguarding hub provides access to child protection medical examinations for children over the age of one, in normal working hours, in a child centred environment. Child protection medical reports are generally produced in a timely way, shared with appropriate professionals, and provide a clear narrative as to whether injuries are believed to be inflicted. It is positive that reports outline additional areas of harm children may be experiencing, such as neglect and emotional abuse. Monthly peer review meetings are well attended and provide a supportive and reflective learning space for paediatricians across the health board to discuss child protection medicals.

The welfare of staff is a prime consideration, and the health board has a well-being service in place. This includes Independent Domestic Violence Advisers (IDVA) who can provide support to staff members who are victims of domestic abuse. There is also support via the third sector when staff are invited to attend Procedural Response to Unexpected Death in Childhood (PRUDIC) meetings. A blended model of group supervisions and 1:1 supervision is in place. Some staff groups, such as children and adolescent mental health services (CAMHS) do not have access to regular formal supervision but access to ad-hoc supervision is readily available for complex situations.

Education

The local authority's education service promotes a strong safeguarding culture in its schools and in the pupil referral unit (PRU). Senior leaders support school leaders well to ensure that they prioritise pupils' emotional development and well-being. The local authority provides schools with regular, comprehensive, and relevant support and guidance in safeguarding matters. This includes a model safeguarding policy and support for managing challenging behaviour. There are regular and beneficial opportunities for designated safeguarding leads (DSL) to meet at a forum to discuss issues, listen to speakers, and share learning and good practice with colleagues. Education officers have recently introduced an authority-wide strategy to improve attendance across all its schools. Attendance rates in Bridgend are currently lower than at the time before the COVID-19 pandemic, especially the attendance of specific vulnerable groups of learners. This reflects the national picture. Schools have played an active role in supporting the local authority's strategy and a pupil-led film highlighting the importance of good attendance is being shared widely from September.

Schools have a very high regard for pupil well-being and safety. Teachers plan helpful activities to teach pupils about the importance of healthy and safe relationships, including how to stay safe online. In all schools visited, pupils felt happy, well cared for, safe and listened to. They all gave relevant examples of how school staff keep them safe and develop their understanding of positive emotional and mental health.

Schools say they receive valuable support and advice from MASH when referring new concerns. School staff feel listened to and able to challenge decisions. Many schools report that relevant agencies within the local authority are forthcoming in sharing information with them when it is necessary. Schools are well represented in a wide range of multi- agency meetings.

Local authority education officers support schools well by providing a broad range of training to staff. As a result, many schools provide effective interventions and approaches to support the needs of vulnerable pupils, including those at risk of harm and subject to a care and support protection plans. These include emotional health interventions such as the Emotional Literacy Support Assistant intervention (ELSA), mindfulness sessions and adopting whole-school trauma-informed strategies for pupils who have experienced adverse childhood experiences. School leaders place a considerable focus on establishing positive and supportive relationships with vulnerable families. Many schools employ their own well-being practitioners or family liaison officers to support this aspect.

South Wales Police

The force has good processes to identify crimes in referrals and record these on their systems so they can be allocated for investigation. There is consistent use of flags and warning markers to highlight vulnerable children on child protection plans.

Call handlers in the Public Service Centre use these flags and markers to identify vulnerable children quickly and assess the level of risk using the THRIVE risk assessment tool to inform the type of response to an incident. They have immediate access to the latest information held on force systems. This not only supports their decision making but provides front line staff with the necessary information to support their response.

Referrals are promptly discussed between police and social services with appropriate outcomes recorded. Initial actions are taken immediately, with risks to linked children not actually present at the incident considered. Police are active partners in strategy meetings and initial child protection conferences. In general, we saw evidence of responsive services to address risk. This includes joint visits and follow up strategy meetings when new information comes to light.

Officers attending incidents sometimes speak with children and record the voice of the child. They share information with the local authority appropriately using Public Protection Notices (PPN). The force also shares information as part of Operation Encompass, to alert safeguarding partners of children witnessing domestic abuse. We saw this happening even when a child was not physically present at the incident which we consider good practice.

Children's Services

Children's services mostly meet statutory duties in line with the requirements of the WSP. We saw effective information sharing in the IAA service and MASH. Additional agency workers assist with screening referrals in a timely manner and actioning immediate safeguarding. Positively, during the screening process there is consideration of people's rights by obtaining consent and evidence of consent being followed up.

Signs of specific risks to individual children are recognised and consideration is given at initial strategy meeting to whether single or joint S47 enquiries are required. S47 enquiries include consideration of siblings or other children who may have contact with people who present a risk to them.

Children are seen by their workers as often as needed in line with their level of need or risk. At an individual level, workers are seeking children's wishes and feelings through the positive use of tools for child centred practice. In the best examples, the outcome of this work informs the quality of the analysis of risk, and the factors within the child's family and community which can help keep them safe. These practices are positively impacting on outcomes for children and families.

For children on the child protection register, statutory visits are mostly undertaken at intervals in line with the WSP. Where children are visited, there is evidence they are seen alone or, if not, a rationale is recorded, and evidence of practitioners observing

their behaviour and interactions with family members informs analysis of their circumstances.

What needs to improve

Cwm Taf Morgannwg University Health Board

With the significant rise in the volume of referrals and strategy meetings and a lack of public protection nursing resource to meet this increased demand, some strategy meetings are held without health information or relevant health professionals present. However, further meetings to share information are arranged where necessary. Access to timely advice can be challenging because of demand.

Whilst the management of suspected non-accidental injuries is generally consistent within normal working hours, staff voiced less confidence in multi-agency processes out of hours. The response from out of hours social work teams did not always support timely decision making. Although we saw some instances where GPs were asked by social workers to see children with suspected non-accidental injuries, we were informed that this is not a common occurrence and GPs are usually confident in challenging such requests.

The child protection component of the paediatric form used for all children attending the health board's emergency department (ED) at Princess of Wales Hospital was not always completed, meaning a child's social worker may not be notified of a child's attendance at ED. Furthermore, across the health board, there is no access to the child protection register. Staff make enquiries but report that at times they do not get a response and due to workload pressures, they do not always persist. Measures are underway to address this by the local authority providing named health board staff with access to their computer recording system, but currently this is not in line with the WSP.

The school nursing service customarily withdraws from child protection processes following an initial child protection conference if there are no apparent health needs. However, we found that the determination of health needs is usually based on a review of health information recorded on health board computer systems and often does not involve any consultation with the child and their parent/carer. The school nursing service needs to seek opportunities to ensure the child or young person's voice is heard throughout the child protection process.

Education

The distribution of support services across schools, such as the education welfare service, does not always reflect the level of need or context of individual schools. In addition, although the provision of support through area early help hubs to schools is strong, this arrangement does not suit providers whose pupils live across the whole of the authority. This is because staff may have to engage with too many different

professionals. However, the local authority is beginning to plan more strategically to identify specific needs and allocate resource and services accordingly.

South Wales Police
The MASH teams are under-resourced with multiple vacancies. This has adversely impacted on some joint working such as the screening of referrals. The police computer systems within MASH have significant issues with connectivity at times.

Child neglect and abuse offences are not always investigated by specialists which may mean some cases are dealt with by inexperienced officers. We saw some examples of the impact of this, with poor responses from calls involving children, resulting in them being closed as being resolved without deployment.

The force's recording of ethnicity details remains poor and inconsistent. The force knows about this problem but hasn't addressed it. This represents a missed opportunity on an individual level to understand the child's identity and strategically to collate information which may inform service delivery. The recording of ethnicity is also an area for improvement in social services.

When responding to families at risk from domestic abuse, we saw officers considering issuing offenders with domestic violence prevention notices (DVPN). These orders are a positive act to safeguard vulnerable families. However, the domestic violence disclosure scheme (also known as Clare's Law) is not always fully understood or progressed in a timely manner, meaning that victims and children are not receiving the right information, when necessary.

Children's Services
Improvement is required in recording the strengths and protective factors in children's lives. At the time of the inspection, we did not see the impact of the recently launched recording policy in records we viewed. There is insufficient evidence measuring progress in the care and support protection plans. Some records include genograms and chronologies, but not all chronologies are up to-date. As in CIW's performance evaluation inspection dated May 2022, care must be taken when individual children are part of sibling groups to ensure their individual voice and lived experience is not lost. The quality of practice and recording remains too variable across teams. The local authority is in the early stages of implementing the model of Signs of Safety (SoS). This includes back to basics training to improve the consistency of practice and support practitioners' confidence.

2.2 People

Partnership arrangements
There is a positive approach to learning and development in relation to child protection across agencies. A programme of multi-agency face to face and virtual

training is being progressed across CTMSB footprint in line with recommendations following published child practice reviews.

There is a positive healthy culture of challenge between agencies, at times utilising the CRISP policy to support practitioners in finding a resolution when they have a professional disagreement in relation to safeguarding practice.

Leaders and managers understand the prevalence of need and risk in their area. They have a good understanding of the experiences of children and families who need help and work together to plan strategically for this. A child-centred approach is evident at an operational level particularly when children are in school.

Strengths

Cwm Taf Morgannwg University Health Board

In paediatric consultations and health visitor records there is evidence of professionals seeking the views of the child. Health services work closely with parents and carers to effect positive change for children. Feedback obtained from children and their families is used to shape services, including in CAMHS and the Safeguarding Hub.

The health board's safeguarding team is a valued resource, offering support, advice, supervision, and training to staff. The team is proactive in ensuring learning from reviews is shared via the development of 7-minute briefings and the revision of training to capture key messages. Further resource would enable the team to expand their services to more staff groups, such as offering formal safeguarding supervision sessions to CAMHS staff and the delivery of more Level 3 safeguarding training sessions to improve mandatory training compliance.

Education

There is strong leadership of safeguarding in schools which is well supported by the Education Engagement Team (EET). The work of the EET is exemplary and is highly valued by school leaders and well-being staff. The Corporate Director of Education and Family Support has a clear and ambitious vision to ensure that schools are safe, supportive, and nurturing learning environments for the children and young people of Bridgend. Together with the head of education and group managers of relevant services, the Corporate Director places a significant focus on the safety and well-being of all pupils. They work together effectively and with determination to fulfil well-considered strategic plans. Leadership and management roles are distributed effectively and sensibly across the service. Leaders at all levels understand their responsibilities in keeping learners safe and are passionate about their work.
The Education and Family Directorate considers national priorities accordingly and have identified important areas for development. It has put in place appropriate policies and strategies to support improvement, for example improving attendance, reducing exclusions, and tackling the impact of poverty and deprivation on pupil progress and well-being.

In all cases evidenced during the inspection, schools robustly support children at risk of harm and those who have suffered significant harm and provide beneficial and relevant interventions for them (and often their families). In most cases, schools are fully informed of incidences and developments, but there is too much variability in timeliness of information from PPNs. In a few cases, important developments are not shared directly with schools.

When appropriate, children are included and invited to meetings that affect them. Pupil voice in schools is strong and children say staff involve them in decision making and listen well to their views. The local authority provides linguistic support in meetings for pupils and their families for which English is not their first language and also translate key documentation.

Schools have access to regular and relevant safeguarding training at all levels, delivered by the local authority. This training complies with statutory requirements for training of education staff at all levels on safeguarding and child protection. As part of the learning from a recently published child practice review, schools have had further advice on how to investigate and respond to non-accidental injuries. There are regular and useful other professional learning opportunities organised by the local authority in relevant safeguarding matters. Although school staff are trained to an appropriate level to enable them to fulfil their role in safeguarding children, there is variation in how many school governors undertake safeguarding training.

South Wales Police

The vulnerability of people is a clear focus for the force. At a strategic level, the force has structured governance for vulnerability, which includes child protection. A fortnightly force vulnerability improvement board is chaired by the assistant chief constable (ACC) and is attended by strategic leads from departments across the force. In addition, a structure also exists with partners to review performance and take learning to improve practice.

There is strong visibility at chief officer level. For example, the chief constable has a road show where they and other senior officers discuss topics such as child exploitation, the early help pathway and well-being support. The force also has in place well-being and support avenues available to all staff.

Where police officers are concerned for the welfare of children, they record this on force systems. Specialist staff check these reports and add relevant information before sharing with children's services. We saw timely and frequent supervisory oversight of investigations, which, at times, has included senior managers.

We saw some good examples of officers attending incidents and engaging with the public to make sure they are safeguarded. PPNs show officers capturing the voice of the child. Children are often seen and spoken to, but the force knows that this

remains inconsistent. The quality of the recording of children's lived experience needs to be improved so the response to their needs can be individual and tailored.

Children's Services

Leaders and senior managers in Bridgend maintain a strong focus on improving children's services. The Chief Executive continues to chair the Improving Outcomes for Children Board, which was set up in March 2022. The Board has made a positive impact through enhanced oversight of children's services and early help services, ensuring there is sufficient information about, and scrutiny of, performance.

Practitioners spoke positively about the support offered to each other and the ethos of a team approach. We heard about excellent peer support, informal and formal supervision, and approachable and available managers. Management oversight of files is consistent, but not always sufficiently effective in terms of the recording of challenge and quality control of decision making. This can result in a missed opportunity to improve the variable quality of assessments and plans. Practitioners welcome the reduction in caseload numbers to support improvements in practice in IAA.

Advocacy is being provided to meet the needs of individual children. The local authority reports a steep rise in advocacy referrals compared with 2021/22. There is good overall communication between practitioners and third sector providers. Children we spoke to said they know their social worker and understand that they kept them safe. They all had support from an advocate to express their views and appreciated this support. Where children and families' voices are prominent in plans, it assists to ensure people receive the right support.

Practitioners are generally positive in relation to training, development, and opportunities to share learning in the local authority. It is too soon to assess the impact of Signs of Safety, but it is certainly welcomed by the workforce. Some practitioners in MASH expressed the view that they would benefit from more bespoke training on particular topics to confidently oversee their broad range of work.

We saw evidence of the Active Offer of Welsh language and people's language preference was seen in key documents. Whilst we did not review any records in Welsh, we could see where it was recorded as the preferred language.

What needs to improve

Cwm Taf Morgannwg University Health Board

Governance arrangements need to be strengthened, with clearer oversight and improved quality assurance monitoring. There is no safeguarding strategy in place and the ongoing health board restructuring has led to some uncertainty as to where

scrutiny and oversight should be managed. The health board's safeguarding executive group meetings are well attended by representatives from across departments.

Compliance with level 3 safeguarding training amongst some key staff groups is poor and is a long-standing identified risk. Compounding factors include the impact of the COVID-19 pandemic on the completion of training, some staff groups not having access to the electronic staff record system (ESR), accuracy of recording on the ESR, and a lack of multi-agency training opportunities. There are limited resources within the health board's safeguarding team to develop, coordinate and deliver training. Compliance with violence against women, domestic abuse, and sexual violence training is also low.

The health board has a high percentage of staff who do not have a Disclosure and Barring Service check (DBS) recorded on their ESR. This is a concern and one which needs to be rectified with urgency.

Safeguarding activity is clearly being prioritised by health board staff despite the competing pressures. However, increased demand has impacted service delivery in some areas. This includes compliance with statutory timescales for children looked after (CLA) health assessments, and the timeliness of the response of public protection nurses to staff seeking advice about child protection referrals.

The number of computer recording systems used across the health board hinders the gathering of information staff for strategy meetings and child protection conferences. It also presents a significant risk that some pertinent information may be missed.

South Wales Police

Analysts complete strategic assessments and problem profiles to help the force understand the extent of risk, threat, and harm in its priority areas, such as criminal exploitation. It is unclear whether this approach is used to drive an overall child protection strategy. For example, the force has information about individuals who are exploiting children criminally or sexually, but there is not an understanding of dynamic risk and harm posed to the children. It means the force is not properly assessing the information it holds about children's vulnerability, who they are, or those who are a risk to them.

Compliance with safeguarding training should be improved. The force delivers vulnerability training to staff, although not all the staff in vulnerability-focused roles have completed the accredited training.

The force response to children with missing episodes, particularly care-experienced children, needs to improve. A jointly formulated multi-agency risk management plan would make it more effective and in line with partnership working. We saw some

examples where cases were allocated to patrol officers rather than more experienced specialist investigators.

Children's Services

Whilst the local authority continues to take substantial action to address the challenges of recruitment and retention, this remains a significant pressure. At the time of the inspection, agency staff are depended upon to deliver key statutory functions. A high level of anxiety exists across the permanent workforce about the exit plan for agency workers. We acknowledge recent successes in appointing to managerial posts permanently. However, an unstable workforce inhibits children's ability to form stable, trusting, and significant relationships with a consistent worker. We found both informal and formal supervision takes place frequently across the teams. Staff reported receiving regular and good quality supervision, however, this was not well evidenced in a sample of supervision notes. Supervision lacks critical analysis, reflection and a focus on individual staff's learning and development needs. In recent months, the local authority has launched a new supervision policy, some staff and managers are unaware of this policy which indicates it has not been embedded in teams.

Further strengthening of practitioners' responsibilities to parents, including parents who may be estranged or who may not be actively involved in their child's life, is required. For instance, we saw an example where a father was not invited to core group meetings and had not been sent the minutes of the initial child protection conference. This missed an opportunity to involve and update significant family members. CTMSB has issued a practice reminder in relation to 'professional responsibility to absent parents' which must be routinely followed.

The local authority's ambition to drive forward a range of improvement plans is positive. A challenge is ensuring this is carefully managed with a focus on key priorities to reduce the potential risk of staff feeling overwhelmed. Concise and targeted communication to staff is required to enhance consistency in some key areas. Time is now required to consolidate and digest the messages about practice.

2.3 Partnership and Integration

Partnership Arrangements

There is good support from the Regional Safeguarding Board where relationships are established and consistent. Leaders in the local partnership, through the multi-agency safeguarding arrangements (MASA), actively monitor and evaluate the work of statutory partners. They provide partnership-based governance, scrutiny, and assurance about the effectiveness of services. A Joint Operational Group at manager level provides further regular opportunity for constructive challenge and continuous improvement between partners.

Opportunities for partnership working are positively exploited at an operational and strategic level. Professionals in the MASH are co-located, helping promote

partnership working. MASH team managers meet regularly to highlight any issues or share good practice. We noted good representation from key partners at strategy discussions/ meetings and case conferences. Forty-five practitioners responded to CIW's anonymous survey with most rating partnership working as excellent or good (60%) with 38% recording this as adequate.

There has been investment in a regional information sharing system – referred to as GOSS (Ground Operational Support Services) for use by partner agencies. There has been consultation with key stakeholders as part of development of this work, which is intended to enhance multi-agency communication.

As noted in CIW's recent inspection activity, there is continued oversight of performance across different levels of the local authority. Quality assurance by both an external provider and children's services provides an accurate picture of the quality of practice, both by using compliance information and children's experiences. These messages are shared with partners for consideration.

Ensuring a joint understanding of the threshold for significant harm is an area which requires strengthening. Positive steps are being taken to address the consistency of decision-making including awareness raising by social services managers in schools. We understand a joint training programme is being progressed along with a threshold policy. There is a need for professionals working together to have a clear understanding of each other's roles and responsibility. This is particularly the case where new legislation impacts on child protection practice such as the Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020.

Strengths

Cwm Taf Morgannwg University Health Board

In many of the records it is evident that health staff, including GPs, generally communicate well and work productively with multi-agency partners. GPs know which children are being looked after by the local authority or named on the child protection register. There is evidence of good multi agency working and communication along with attendance at safeguarding meetings being prioritised by health visitors. Engagement in safeguarding meetings is consistently good.

Healthcare staff are confident in challenging partners and escalation processes are in use. They can escalate through the corporate safeguarding team if needed. A multi-agency case discussion forum is in place, providing a safe space for partners to discuss and professionally challenge cases where differences arise. Paediatricians have developed bespoke training for partner agencies on roles and responsibilities when a child requires a child protection medical to ensure partners are aware of the correct pathways and process.

Education
There are strong working practices between schools/PRU and other agencies such as health and children's services who work effectively in partnership to plan, implement and review provision for vulnerable children in Bridgend. This is supported through Team Around the School (TAS) meetings and close working with the Education Engagement Team, MASH, and the area 'early help' hubs.
The local authority requires all schools to submit an annual safeguarding audit which is then scrutinised by the local authority's Education Engagement Team (EET). The EET provides strong challenge to schools through this process. Overall, these audits are comprehensive, purposeful and enable schools to identify clear strengths and areas for development. EET link workers conduct termly visits to all schools to review progress and this helps maintain, a strong focus on improvement.

Schools attend and contribute fully to child protection conferences and reviews. Data on the child's attendance, punctuality and attainment are shared in school reports. Schools know children well and often offer additional support through breakfast club provision, establishing a trusted adult for children to have access to and facilitating rooms for social worker visits. There is good evidence of schools working supportively with parents whilst remaining totally focused on the child's well-being. Parents' contact with schools provides useful intelligence that supports the care and support planning.

The local authority has robust and timely processes to manage any professional concerns under Section 5 of WSP.

South Wales Police
There are many examples of positive partnership working including pro-actively sharing information and contributing to decision-making forums. Repeat strategy meetings are held when new information comes to light, supported with good record keeping including clear actions.
In some cases, officers attending incidents engage well with people to ensure they are safeguarded. In these cases, decision-making includes obtaining the views of people involved to ensure situations can be managed safely.

Partners work well together to initiate and progress child protection procedures to ensure the child is safe from harm and abuse. Information reports for case conferences were thorough and shared with all agencies. They were also easily available on police systems.

Children's Services
As in previous CIW inspections, opportunities to work in partnership across agencies are positively taken up. Case recordings and interviews demonstrate excellent working relationships between families and professionals. We saw a particularly

positive example of school assisting a mother with budgeting and advice around healthy eating.
Despite hearing about the negative impact of frequent social work changes on working in partnership with children, we also heard from parents about the positive impact when it works well. One parent told us '*my child's social worker now is amazing. He keeps me in touch and informed really gets on well with * and * really likes him. I just hope he will stay*'.

We found in general effective partnerships are in place to commission and deliver good quality support to children and families in Bridgend. For example, the local authority has invested in the third sector to develop and grow family group meetings. Positive examples were shared of the good outcomes of this work. Third sector partners are clear and confident in their roles. They make a significant contribution to building resilience within families and supporting people's well-being. Some third sector partners are not time limited when undertaking work with children, and families appreciate the flexibility this affords.

What needs to improve
Cwm Taf Morgannwg University Health Board
It is not clear that there is a smooth pathway for the transition of care between health services, for example midwife to health visitor, or health visitor to school nurse, in the files seen. There was also no evidence of care and support protection plans being revisited or actions updated as part of the health professional's contact.
Despite some good examples of joint visits between health and social services and good communication supporting practice, attendance at key child protection meetings could be improved. Contribution to core group meetings and review child protection conferences for school aged children could also be improved. This represents a missed opportunity to be involved in multi-agency child protection arrangements.

From a health survey undertaken as part of this review, of 71 respondents across CTMUHB, 60% said that IT systems did not support the effective communication/information sharing regarding safeguarding. Some 50% of respondents said information sharing between relevant agencies regarding child safeguarding is not effective.

As previously mentioned, safeguarding training compliance is varied across the health board, with poor compliance in some areas. This is acknowledged by the health board as an area for improvement. There is confusion regarding thresholds and further work and training around thresholds and professional curiosity is required.

South Wales Police
As mentioned earlier in the report, there are occasions when PPNs are not shared in a timely manner with schools. This means some children may not receive support quickly enough.

Despite some positive examples of engaging with children in the records reviewed, we also saw some language of frustration between the force and partners, highlighting disagreements as to which agency is responsible for safeguarding a child. These tensions indicate that agencies are not always working together effectively. Attitude and activity are not always child focused.

Children's Services
Records of child protection meetings such as conferences and core group minutes are not consistently shared with key partners. This means agencies may not receive key information to enable them to safeguard and support children and families.

Gaps in children's records mean that it is challenging to obtain an accurate understanding of children's circumstances. Management oversight is good at the front door but weakened when it moves to the safeguarding hubs where in the recent past social work practice has been adversely impacted by staff turnover and high caseloads.

There is evidence of reviews occurring but limited evidence of how children are involved in reviews of their care and support plan. Only a relatively small number of children and young people attend their meeting and the reasons for this need to be understood by the local authority. We saw an example where the child was recorded as too young when they were of sufficient age to participate.

Independent Reviewing Officers (IRO) have a critical role in overseeing the quality of practice and provide a valuable contribution in challenging delays where necessary. Due to their current volume of work, they cannot always prioritise visits to children prior to CLA reviews. They consult parents in all cases prior to initial and review conferences. The local authority must ensure children consistently have their views sought, and they are provided with opportunities to participate in decisions which affect them.

Some plans are adult rather than child focused with a lack of measurable outcomes. These plans are written in generic language with limited specific detail of what needs to change and how progress is monitored. Broad statements make it challenging to evidence progress against identified needs and risks. Core groups should have a greater focus on progress against the child protection plan. Discussions with practitioners also highlighted there is variance across teams in understanding which records are shared with children and families as part of the child protection processes.

2.4 Prevention

Partnership Arrangements

In the current context of increased demand, it is a challenge to prioritise the preventative agenda in a way which reduces the need for more formal care and support. It is positive the local authority has commissioned an independent review of children's services to evaluate its operating models. Early help and edge of care services are included in this review to maximise the use of all available resources to prevent escalation of need.

Early help is co-located in the locality safeguarding teams with a representative also based in MASH. A wide range of early help and preventative support is being provided to children and families including the Comets and Rockets programme for children, IDVA, ELSA support via school and many programmes providing parenting support. There has been a recent focus on reducing referral pathways and improving information sharing.

Despite a range of preventative services, we heard mixed accounts about their effectiveness. These were reflected in our anonymous social services staff survey with one respondent commenting **'**early help is a good source of support, and the staff have a good knowledge base'. Social services staff told us waiting lists can delay support for families beginning but also prevent families stepping down to lower levels of support. Schools provided a more positive account of early help services.

Practitioners from different agencies reflected the view that arrangements for stepping up and stepping down support to children and families could be clearer and more streamlined. Whilst we were informed there is a clear written transfer protocol in place, which includes joint visits, it appears not all staff are aware of this protocol. There should be a clear and consistent approach to accessing assessments and preventative services to improve outcomes for children.

For some children who have experienced long-term neglect, planning can be ineffective across agencies, with insufficient focus on the impact of interventions and what is changing for children. Recordings are descriptive and do not evidence what progress is made, or why improvements have not been made. We saw examples where children may have benefitted from earlier intervention to avoid an escalation of need.

Strengths

Cwm Taf Morgannwg University Health Board

During the inspection health staff informed us they welcome the introduction of the Signs of Safety approach and there were positive examples of referrals to preventative services. We saw holistic health assessments in children looked after

records which identified emotional and physical health needs as well as wishes and feelings.

Education

The local authority has consolidated its wide range of support services available to schools and vulnerable families into a purposeful, well-managed and integrated 'Early Help' provision. Early help consists of a team of professionals distributed equally across three hubs covering the whole of the local authority who support the work of schools and children's services. Overall, schools say the Early Help Hub system works very well, and staff provide a high level of support for individual families. They also run bespoke sessions in schools for common concerns, for example dealing with behavioural issues.

Primary schools and the special school offer a wide range of preventative activities and interventions to pupils, including lessons on healthy relationships and staying safe online as well as running anti-bullying campaigns. However, the provision for relationships and sexuality education (RSE) is variable across schools, which reflects the current national picture. The youth service and other services such as youth justice and the communications and relationships (CART) service provide beneficial support to schools and individual pupils. They deliver assemblies and share resources with schools with a clear focus on preventative and proactive strategies to boost pupil engagement and reduce the risk of offending.

Children's Services

Children's services do not have waiting lists across teams and despite the context of increasing volume and complexity, staff express positivity about improvements made by the authority over the last eighteen months. This commitment to improve systems, processes and practice is an area of strength in BCBC. As in CIW's previous improvement check the local authority continues to respond effectively to meet the needs of children, especially where acute need and risk is identified. We saw examples where safe care arrangements are discussed and implemented with parents while further enquiries are underway.

Despite the demands on the service performance indicators in relation to statutory duties such as timely child protection conferences and visits are generally good. There is still room for improvement so the local authority must maintain focus and scrutiny on ensuring compliance with all statutory responsibilities.

What needs to improve

Cwm Taf Morgannwg University Health Board

Some home monitoring visits by health staff do not capture progress against the child's CASPP. Timescales are often vague, for example recorded as 'asap' or 'ongoing'. In some cases, there could have been an improvement in the engagement of school nurses, as at times it was unclear what involvement they had.

South Wales Police

There are examples of good service delivery by the force at the point of attending incidents with a focus on safeguarding, as well as within the MASH. However, the force response to missing children has some gaps. Risk assessments do not fully reflect the circumstances of the information provided, meaning some children are left at risk for longer periods when they should not be.

There is inconsistent awareness and understanding of Operation Encompass, the process, and its purpose. Useful information is not being shared with schools so vulnerability in children is not identified in their education setting.

Children's Services

We heard there can be uncertainty around the progress of referrals to the early help service and limited opportunities for transition from one team to another. Practitioners are not always aware of when support will commence which can result in re-referrals. Children's early help and preventative assessments identify needs well, but subsequent plans are not always informed by sufficient or clear management direction. A prudent approach to resource allocation is required to ensure the right help is available at the right time.

Next Steps

On behalf of the partnership, the local authority should prepare a written statement of proposed action responding to the findings outlined in this report. This should be a multi-agency response involving Cwm Taf Morgannwg University Health Board and South Wales Police. The response should set out the actions for the partnership and, where appropriate, individual agencies. The head of service for children's services should send the written statement of action to CIWLocalAuthority@gov.wales by (date to be confirmed as will be 6 weeks after report publication). This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Methodology

Fieldwork

Most inspection evidence was gathered by reviewing the experiences of people through sampling agency records and file tracking children's care and support arrangements. We case sampled ten files and tracked six.

Tracking a child's record includes having conversations with the child where appropriate, their family or carers, key worker, the key worker's manager, and other professionals involved.

We held focus groups with staff and two professional groups focused on the working arrangements and outcomes for two of the tracked files.

We visited a small sample of primary schools and the special school where we conducted meetings with the headteacher, the designated safeguarding lead and small groups of children.

We interviewed a range of employees across different agencies.

We interviewed a range of partner organisations, representing both statutory and third sector.

We reviewed supporting documentation sent to the inspectorates for the purpose of the inspection.

We administered surveys to children's services staff, third sector organisations and children and family members.

We observed child protection conferences and practice as part of our inspection activity.

We conducted a pre-inspection headteacher survey and visited a small sample of primary schools during the inspection week.

We evaluated samples of health and well-being schemes of work and looked at samples of pupils' work. This included holding a 'listening to learner' sessions in all schools visited.

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