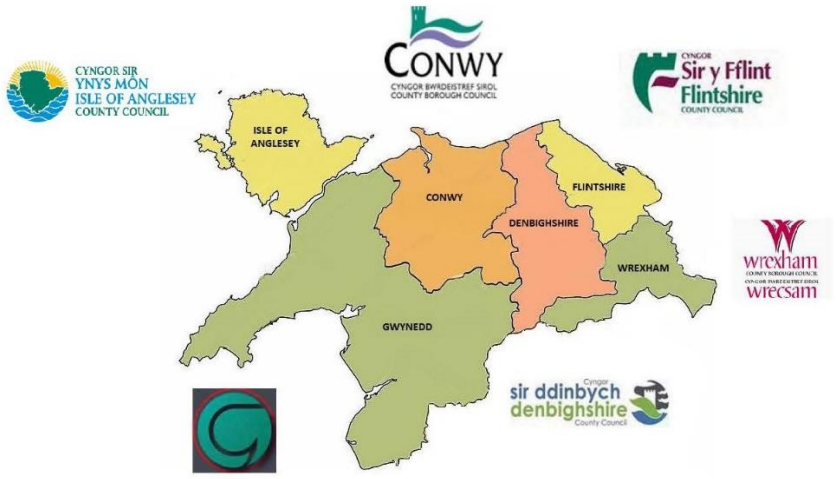
Appendix 1

NORTH WALES SAFEGUARDING BOARD

Annual Report 2023 – 2024



See Something – Say Something

SAFEGUARDING IS EVERYONES BUSINESS!

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Introduction by the Chairs of the Adults & Children's Boards:

It gives us pleasure to jointly present the North Wales Safeguarding Board Annual Report.

This Annual Report outlines the progress we have made against the outcomes set by NWSAB and NWSCB as part of our joint Annual Strategic Plan for the year 2023-4.

The resolve and resilience as accountable public agencies has been, and continues to be tested to the limits, in the most challenging and complex circumstances. As a region, we have been able to recognise and value the strength and benefits of a collaborative response through excellent partnership working.

Recruitment and Retention of staff has continued to impact all agencies in the region a number of experienced safeguarding staff have made the decision to move away from frontline safeguarding practice.

Safeguarding Practitioners continue to highlight the complexity of cases that are being referred into all agencies. These unprecedented challenges have demonstrated the paramount importance of the Regional Safeguarding Boards in ensuring a multi-agency response to challenges in the safeguarding of children and adults at risk.

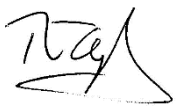
In the coming year, we remain committed to continuing to work together to meet the needs of the most vulnerable in our communities, and to learn any lessons to aid the future delivery of high quality, resilient and effective multi-agency safeguarding services.

Finally, we would not only like to thank the members of the North Wales Safeguarding Boards and sub-groups for their engagement, commitment and progress made in the last year but most importantly the whole safeguarding workforce across the region.

As we proceed to publication, it should be noted that we will be losing our Safeguarding Adults Board Chair, Neil Ayling, who is retiring from his role as Chair and as Chief Officer within Flintshire County Council in June 2024.

Board members would like to extend their thanks to Neil, for his hard work and dedication in carrying the role for the past eight years, during which time there have been many highs and lows within the adult safeguarding arena . With his guidance and support, adult safeguarding in North Wales has continued on its journey to ensuring the citizens of the region and their protection from abuse and harm, remains a priority. The Board would like to take this opportunity to wish Neil well on his retirement, he will be greatly missed.

Jenny Williams
Chair North Wales Safeguarding Children's Board



Neil Ayling
Chair North Wales Safeguarding Adults Board

Objectives of the Safeguarding Boards

The North Wales Safeguarding Boards serve the citizens and diverse communities of the North Wales region which encompasses six Local Authority areas this does not come without significant challenges. The Board and its' members however continue to be proud of the strong ethos of collaboration and partnership working that has been established at a senior executive board and subgroup level. We look forward to the year ahead and continuing to build upon the strong foundations established in the preceding five years to deliver against our objectives and our aspiration to achieve excellence in Safeguarding Work, Professional Practice, and within the services we provide to our communities.

Protecting and preventing children and adults at risk from experiencing harm and promoting the wellbeing of the people of North Wales enabling them to achieve better outcomes remains central to the Board's work.

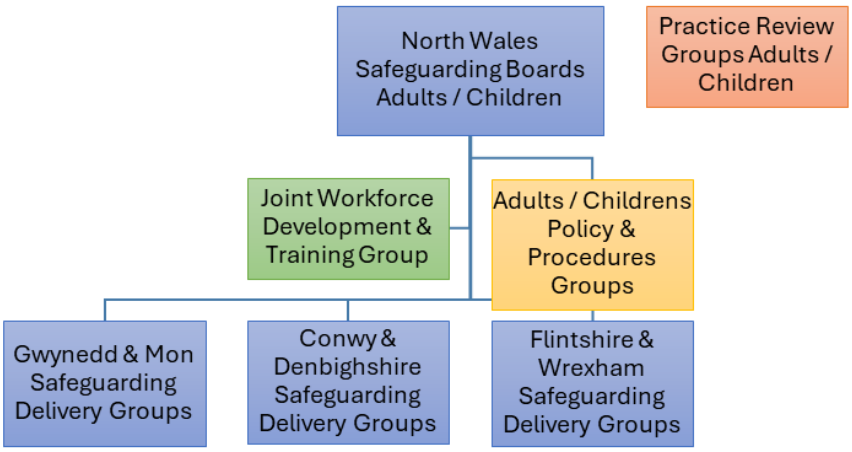
Areas have been identified for continuing improvement and will enable the Board and its members to fulfil their statutory responsibilities as outlined in Part 7 of the Social Services and Well-being Act (Wales) 2014 to protect and prevent children and adults at risk in the region from experiencing abuse and neglect and other kinds of harm.

1.0 About the North Wales Safeguarding Boards

Structure & Membership:

The North Wales Safeguarding Boards currently meet three times per year and jointly once a year. In addition, there is also a joint Business Development Day held annually to set the priorities for the coming year and self-assess the progress of the Boards.

The Board's Practice Delivery Groups and the Children's Policies and Procedures Group currently meet on a quarterly basis. The Practice Review Groups, the Adults Policies and Procedures Group and the Joint Workforce and Training Group meet every two months. Meetings are held mainly virtually but the Boards are partially returning to face-to-face meetings.



Structure: The Adult and Children's Safeguarding Boards have identical structures and subgroups.

North Wales Safeguarding Adults Board Membership

Chair: Neil Ayling, Chief Officer Social Services, Flintshire County Council.

Vice Chair: Michelle Denwood, Director of Safeguarding & Public Protection Betsi Cadwaladr University Health Board BCUHB)

Isle of Anglesey Council: Director of Social Services & Head of Adults Service.

Public Health Wales: Designated Nurse National Safeguarding Team

Conwy County Borough Council: Director of Social Care and Education, & Head of Children, Family & Safeguarding Services

North Wales Fire & Rescue Service: Business Education and Arson Reduction Team Manager

National Probation Service: Head of Probation Delivery Unit, North Wales

North Wales Police: Detective Superintendent, Protecting Vulnerable People Unit

Age Cymru: Head of Safeguarding and Advocacy, Hope Project

Denbighshire County Council: Corporate Director Communities & Head of Community Support Services

Cyngor Gwynedd: Corporate Director &Head of Adult Health and Wellbeing Services

Flintshire County Council: Chief Officer Social Services & Senior Manager Safeguarding and Commissioning

National Independent Safeguarding Board Member

Wrexham County Borough Council: Director Social Services / Head of Adult Social Care

Care Forum Wales: Chief Executive

Betsi Cadwaladr University Health Board: Director of Nursing Mental Health & Learning Disabilities

HMP Berwyn: Deputy Governor / Head of Public Protection

Welsh Ambulance Service Trust: Safeguarding Specialist Quality, Safety & Patient Experience Directorate

NWSSIC: Head of Regional Collaboration.

North Wales Safeguarding Children's Board Membership

Chair: Jenny Williams, Director of Social Care and Education, Conwy County Borough Council.

Vice Chair: Jacqueline Downes, Detective Superintendent, Protecting Vulnerable People Unit, North Wales Police.

National Independent Safeguarding Board Member

Wrexham County Borough Council: Chief Officer, Social Services & Head of children's Services. Chief Officer Education & Early Intervention

Flintshire County Council: Director of Social Services. Head of Children's Services. Chief Officer for Education & Youth

National Probation Service: Head of Probation Delivery Unit, North Wales

NSPCC: Wales Hub Relationship Manager

Barnardo's: Assistant Director Children's Services

Isle of Anglesey Council: Director of Social Services, Head of Children and Family Services, Director of Education, Skills, and Young people

Denbighshire County Council: Corporate Director Communities, Joint Head of Service for Education and Children's

Youth Justice Service: Head of Prevention and Support, Education & Early Intervention Services, Senior Manager, Service Manager

Cyngor Gwynedd: Head of Children & Support Families, Head of Education

Public Health Wales: Designated Nurse National Safeguarding Team

Betsi Cadwaladr University Health Board: Director of Safeguarding and Public Protection & Named Doctor Children's Safeguarding.

Welsh Ambulance Service Trust: Head of Safeguarding, Safeguarding Specialist.

NWSSIC: Head of Regional Collaboration

2.0 Action the Safeguarding Boards Have Taken to Achieve Particular Outcomes

2.1 Risk Register

The Board continues to monitor its risk register and escalate concerns to Welsh Government or relevant agencies where action is required.

During 23/ 24 the Board has a number of areas / practice concerns where risk has increased.

The following areas has been highlighted:

Section 5 guidance:
The local delivery groups have all highlighted concerns around Section 5 Guidance.

- Key issues are the increase in Section 5 referrals across the region, this is increasing demands on the relevant Local Authority Designated Officers.
- Quality of Section 5 referrals
- The interface between Section 3 of the Wales Safeguarding Procedures and Section 5.
- The section on outcomes from Section 5 strategy meetings need further work.
- The need for national training on Section 5, so to try to ensure consistency of Practice.

In response, the Board have escalated concerns to the Wales Safeguarding Procedures National Project Board. We have highlighted to the other Regional Boards, once Section 5 is updated that we need to jointly commission national training.

Single Unified Safeguarding Review process:
The Board would like to acknowledge the good work undertaken by Mid Wales

Safeguarding Board on the SUSR training materials that are currently being developed. In relation to the draft guidance, Board members still have concerns around the interface between SUSR guidance and the Home Office quality assurance panel where reviews have a domestic homicide element. We have concerns around the increase demands on Board members and the Business Unit in identifying chairs and reviewers. In 2.2, we highlighted steps undertaken in relation to demand on Child Practice reviews.

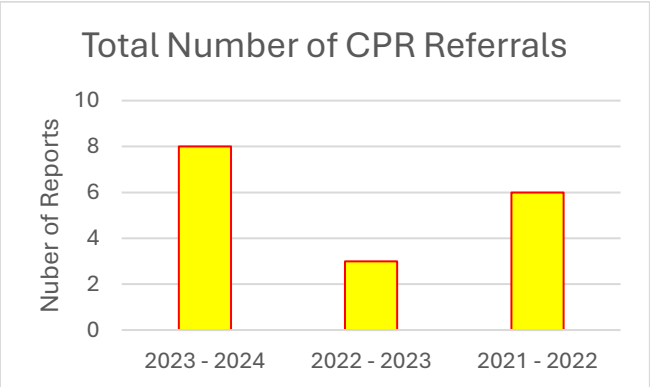
We continue to contribute to the work undertaken by the Single Unified Review team in Welsh Government.

Staff Recruitment and Retention:
Board members have highlighted the challenges around the recruitment and retention of safeguarding staff. Looking at the Staffing Profile across the region, we have a number of inexperience / newly qualified staff.

In response a Board we have identified the need to deliver more multi agency Section 47 training workshops for newly qualified staff and the need to develop a multi-agency Adult Safeguarding training.

2.2 Responding to the increase activity in Child Practice Reviews

During this 12-month period we have seen an increase in child practice referrals.



Due to the increase in referrals, the North Wales Safeguarding Board has had to increase expenditure in relation to commissioning external reviewers. The outcome that the Board has achieved, is that child practice reviews within the region have been allocated and are underway.

The Board has continued to seek expressions of interest from in-house reviewers and during the last quarter of 23-24 a number of Board partners have identified officers to undertake the Chairing and Reviewing role.

2.3 Responding to emerging practice issues identified during the practice review process.

One of the panel members at a Child Practice review escalated concerns in relation to the management of the review process and the need to develop practice in relation to Cultural Diversity. In response to the concerns, the Board commissioned BASWSO to deliver Cultural Diversity and Harmful Practices Training.

The outcome that the Board was seeking was greater insight from practitioners in working with Black Minority Ethnic communities but also that family within this review process felt supported and contributed to the review process. This was evident within the review process and noted when the report was approved by the board.

2.4 Responding to Regulatory Inspections where multi-agency safeguarding issues are identified.

The Board has requested that members escalate to the Chair and Business unit recommendations from Regulatory Inspections where improvements need to be made regarding Multi agency practice.

During 23-24, the Board received a presentation from Care Inspectorate Wales which identified the following issues:

Thresholds and Information Sharing:
CIW highlighted the need for improvement within the region around the management of risk when the threshold for significant harm is reached and what needs to change. Good Practice was identified within Gwynedd Children Services around the Effective child Practice Model.
The practice model is based on four principles:

- Conversations – effective communication through practicing 'collaborative conversations.
- Thresholds – consistent decision making when assessing risk.
- Change – a clear focus on the change that is needed to prevent harm.
- Measure – measuring our progress towards outcomes.

In response to the recommendations to the Board from CIW, all six local authorities across the region are adopting this practice framework.

The Board, in line with the Wales accord for sharing personal information, have developed a regional information sharing protocol for all Board partners to adhere to.

3.0 The extent to which the Safeguarding Board has implemented its most recent Annual Plan.

3.1 Strategic Priority 1 – To respond effectively to the learning identified from Regional Adult / Child Practice reviews, Regional Multi-agency professional's forum and the National and UK safeguarding reviews.

As a Board, there are still significant challenges around the recruitment of in-house reviewers. Key pressure point has been in relation to Child Practice reviews. However, in relation to completed reviews and investigations undertaken across Wales and England, progress in sharing and embedding learning is evidenced within the partner agency reports.

Anglesey: Use a variety of sources and methods to establish the evidence base about the quality of practice within the service including learning from regular audits as well as the APR's. The learning and recommendations from CPR's are cascaded throughout the service through internal learning circles and reflective supervision.

Betsi Cadwaladr University Health Board: The Health Board Safeguarding and Public Protection Team has developed a Quality Assurance Group covering Child Practice Reviews (CPR), Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR) and Multi-Agency Professional Forum's. The group monitors review activity across North Wales to ensure that BCUHB are able to offer assurances in terms of identified learning.

Conwy: Conwy's Children's Safeguarding Forums continues to be held, however now at quarterly intervals; this being due

to manager's capacity as well as introducing a Practitioner Safeguarding Forum. The practitioner safeguarding forum has been established to provide an opportunity for all social care staff, from varying positions, to attend and be directly updated of the information that was previously expected to be disseminated to them from their managers.

Denbighshire: APRs are shared with operational teams and used as learning and reflective opportunities for practitioners. Multi Agency Practice Forums have been completed and a few key themes identified from CPR's includes parental cannabis use and professional curiosity.

Flintshire: Flintshire initiated an internal audit around learning from reviews, and the scope was to: Ensure Practice Review outcomes (APR and CPR) are dealt with in accordance with Legislation. Examine Practice Review outcomes in accordance with the reviewing framework and to ensure they are being implemented in accordance with policies and procedure. Ensure action plans are completed and learning embedded and that they are making a difference. Have effective management information and management reporting processes in place.

Regional learning opportunities are promoted to staff on a regular basis who are encouraged to attend.

Cyngor Gwynedd: APRs continue to be cascaded to staff and are discussed at the quarterly Adult Safeguarding Meeting. A colleague from Flintshire County Council attended the Gwynedd a Môn Adult Safeguarding Board to share the lessons learnt from an APR. Following this meeting, it was decided that Cyngor Gwynedd would invite colleagues from across the region to present their APRs at the quarterly Adult Safeguarding meetings.

North Wales Police: There is an established process within NWP whereby recommendations are escalated internally and reflected in tactical action plans. The plans are monitored regularly to ensure that progression is made, and processes amended accordingly.

Wrexham: Adult Social Care embraces a supportive learning culture across its service areas and ensures that all national and UK safeguarding updates are disseminated through the quarterly Corporate Safeguarding Newsletter, which is distributed across the Council. Additionally full discussion and reflective learning sessions are held monthly within the Adult Safeguarding and DOLS Team.

Regional and national CPRs are reviewed by the children's safeguarding team, and key learning is pulled from the reports and shared within our senior leadership team and within the performance, practice quality (PPQ) quarterly meetings. Where it is shared with all managers and added to our PPQ action plan. As a key partner of the local delivery board, we ensure that learning shared in the board are then shared through the organisation.

3.2 Strategic Priority 2 – Effective engagement and communication: To improve engagement and consultation with children and adults at risk, vulnerable groups, professionals, and partnerships.

Evidence of improved communication with Children and Adults at Risk was evidenced in the Annual Partner Agency Reports. For example, the Isle of

Anglesey Council's Children and Families Services are embarking on a transformative programme by adopting a Collaborative Communication approach at all levels in the organisations. Denbighshire Therapeutic Service have also invested heavily in Collaborative Communication.

There is a clear increase in the involvement of advocacy support within strategy meetings and via regular audits, it has been identified that consideration is given to the voice and involvement of the individual within strategy meetings and adults case conferences. In Conwy, attendance by the Adult Safeguarding Lead at weekly provider calls initiated by the Quality Standards and Commissioning Service raised concerns as to the lack of engagement with the provider sector outside the direct Adult at Risk reporting processes. There was also the added concern that on some calls, the attendance by providers was low and key safeguarding messages and awareness were not being shared widely and effectively. It was agreed, therefore, that a Conwy Safeguarding Provider Newsletter would be produced and in December 2022 the first edition was shared with all providers across Conwy. A regular newsletter is produced on a 6 monthly basis.

With regards to the boards, there is still a challenge in engaging with children and adults at risk directly. Additional membership on the NWSAB to include a representative from |Age Cymru's Hope Project has been created and it is hoped that there can be some collaboration with them on engaging with adults at risk.

Communication with other strategic partnerships: Highlight reports and key issues are identified and provided to the Vulnerability & Exploitation Board with a joint meeting held between both boards in September of each year.

Reports are also provided to the Chair of Chairs meeting & Annual Update to Regional Partnership Board.

There is continued collaboration between other regional teams, including the Regional Commissioning team and the Children and Young People's work streams.

3.3 Strategic Priority 3 – To support the implementation of new legalisation in 2022 including End Physical Punishment and Liberty of Protection Safeguards alongside responding to national action plans on Child Sexual Abuse and prevent of abuse of older people.

The Serious Violence Strategy has been developed and work is underway. Regular updates are received, and more formal discussion takes place at the Joint Board in September.

Though LPS is still on hold currently, agencies continue to develop their workforce in preparation for this. Additional training around Mental Capacity is something that has been taking place across the region. Work is continuing to reduce waiting lists for DoLS authorisations, with some agencies able to employ additional assessors to undertake the work.

Rapid Review of Safeguarding Practice in Wales - Joint Inspectorate Review of Child Protection Arrangements:

Presentation and discussions have taken place at the NWSCB meetings regarding

the rapid review findings, with CIW attending to present.

National Action Plan to Prevent the Abuse of Older People:

At the time of writing, the plan has only recently been published. The North Wales Safeguarding Board are aligning the actions to the areas of work already undertaken in the region.

4.0 How have the safeguarding boards collaborated with other persons or bodies engaged in activities relating to the board's objectives?

North Wales Vulnerability & Exploitation Board:

Regular highlight reports are provided to the V & E Board in relation to cross cutting themes and issues. Chairs of both safeguarding boards are members. Joint meeting held annually where the V & E Board Chair presents his annual highlight report. The agenda for the last meeting was focused on exploitation and vulnerability including Modern Slavery within Care Homes, County Lines, CSE, Serious Violence Duty and presentation and discussion around Right Care, Right Person.

Cheshire & Cheshire West Safeguarding Boards:

Meetings are scheduled and take place annually. The Board received notification from Cheshire West Partnership regarding the Thirlwall inquiry and has requested to be kept updated.

Safeguarding Boards across Wales:

Regular meetings with colleagues from across the Safeguarding Boards in Wales take place on a quarterly basis. The Business Managers communicate and share information, resources, and knowledge on a regular basis.

Welsh Government:

Meetings with Welsh Government and the National Independent Safeguarding Board take place with the Chairs of Safeguarding Boards every few months. Quarterly meetings also take place with the safeguarding boards Business Managers, Welsh Government, and the National Independent Safeguarding Board to discuss themes and issues arising, and progress on national work streams.

North Wales Coroner's Office:

Chairs of both Boards and members of the Business Unit attend bi-annual meetings held with the North Wales Coroners, to discuss key issues and themes coming out of practice reviews and anything highlighted within the local practice delivery groups that are deemed to be in the realm of the coroner.

Care Inspectorate Wales (CIW):

Regular communication between the Boards and CIW takes place. Issues and themes are discussed, together with

progress on how agencies are responding to the Rapid Reviews that have been undertaken, following CIW's attendance at the North Wales Children's Board to present their findings.

North Wales Regional Commissioning Board & the North Wales Partnership Board:

A number of Safeguarding Board members also attend the Regional Commissioning Board and the North Wales Partnership Board. Collaboration has taken place between the Boards in relation to the review of the North Wales Escalating Concerns Process to ensure reference to safeguarding procedures, protocols and guidance were in place. Further collaboration is taking place in relation to the work streams that have potential cross-over with safeguarding.

5.0 Any requests the Safeguarding Board has made to qualifying persons under section 137(1) of the Act for specified information, and whether the requests were complied with.

Neither board has felt it necessary to make any requests under section 137(1) of the act. All information has been supplied as part as usual board business.

6.0 Achievements of the Safeguarding Boards during the year.

6.1 Completion and Publication of Guidance

The following guidance has been developed and completed:

Sudden Death of an Adult at Risk Protocol:

The circumstances in which an unexpected death of an Adult at Risk takes place, where there is a suspicion or it is known that abuse or neglect was involved, can be challenging and complex to navigate with partner agencies having different roles and responsibilities in response to the death.
The adult death protocol provides a framework for establishing an agreed standard between partners to:

- Ensure an effective and consistent multi-agency response that will support agencies of the NWRSB to meet the requirements of legislation, national and local guidance and practice standards around appropriate responses to unexpected adult deaths involving abuse and neglect.
- Ensure clarity and consistency of procedures across organisations of the NWRSB.
- Develop arrangements that support efficiency in partnership working to identify potential criminal offences or when there is a need to conduct investigations into unexpected adult deaths.

Safer Bathing for Babies and Young Children:

A leaflet has been designed to promote the messages around safer bathing for babies and young children, a theme that has been highlighted in several child practice reviews.

What to Expect at an Adult Protection Case Conferences:

An information leaflet has been produced with information for Adults, their Carers, Family and Advocates around what to expect at an Adult Protection Case Conference.

North Wales Safeguarding Adults at Risk Report Form:

The report form has been reviewed and updated to include gender identification.

Delegated Enquiries and Outcome Form:

This has been developed by BCUHB in agreement with partners in order to assist with information requirements of delegated S126 enquiries.

Updated Joint Protocol between the North Wales Safeguarding Board and the North Wales Area Planning Board

The North Wales Safeguarding Children and Adults Boards and the North Wales Area Planning Board are committed to effective joint working. The aim of this document is to:

- Support collaborative and joint working, where sensible and practical to do so.
- Establish robust and clear communication between the Area Planning Board and the Regional Safeguarding Board.
- Help avoid unnecessary duplication and ensure any lessons learned are shared widely across multi-agency partnerships and respective review processes.

Practice Guides in Progress:

The current practice guides are in the consultation phase:

- Cuckooing Practice Guidance: A guide to working with adults at risk of exploitation – cuckooing.
- Lived Experience of the Adult Practice Guidance: This document is being developed by partners to enable practitioners to consider the adult's experience and ensure that the adult's lived experience remains central to any action taken to safeguard the adult at risk.
- Single Unified Safeguarding Reviews – Complaints Process.
- Was Not Brought" Principles for: Children, Adults at Risk and Adults who may have care and support needs.
- Transitional Safeguarding: This practice guide sets out the arrangements for young people aged 17.5 years to 25 years, whose circumstances may mean that the Wales Safeguarding Adults procedures would apply when they are 18.

6.2 National Safeguarding Week

During National Safeguarding Week, the following events were commissioned, and events were open to all agencies and third sector organisations:

Understanding so called 'honour' based abuse: Facilitator: (Stori Cymru). Session to aid understanding of so-called 'honour-based abuse' (also referred to as harmful practices) in order to recognise and respond to the whole family. The course aimed to increase the confidence of individuals to identify and respond to disclosures of or situations of suspected so called "honour" based abuse.

CSA – Managing Risk & Trauma after online sexual offending: Facilitator: Natasha Sabin. Practice Improvement Advisor, Centre of expertise on CSA. Hundreds of families find out a parent or carer has accessed child sexual abuse material each month. The session highlighted the research evidence on this type of offending and provided practical advice for professionals on how to safeguard and support families at a time of great emotional distress.

HSB - Centre of expertise on CSA: Facilitator: Lorraine Myles. The session discussed some of the work undertaken and new resources that have been published by the Centre of expertise. Recognising Abuse of Older People: Facilitator: Stori Cymru. This workshop aimed to raise understanding of the dynamics of abuse. Family dynamics and the impacts on abuse, and how age can impact the experience of abuse.

Fluctuating Capacity in the Context of the Mental Capacity Act 2005: Facilitator: Dr Laura Pritchard Jones). The event looked at the legal framework in situations where it appears a person's mental capacity to make decisions may 'fluctuate'. Case studies were presented, and included a consideration of the different ways in which a person's mental capacity might fluctuate, as well as what legally and ethically literate practice looks like in such situations, using the relevant legal framework, its statutory guidance, and associated case law from the Court of Protection.

CSA Signs & Indicators: Facilitator: Nici Evans. The session highlighted some of the work undertaken and new resources that have been published by the Centre of expertise on CSA.

Cultural Diversity & Harmful Practices Training: Facilitator: BASWSO. Following on from recommendations and learning from a Child Practice Review, this session was commissioned to cover Culture, Diversity, Equality the do's and don'ts of working with BME communities and harmful practices.

SP-OT Suicide Prevention – Overview Tutorial: Facilitator: PAPYRUS Young Suicide Prevention. The key objectives were to understand the prevalence and impact of suicide. To explore the language, and the challenges, when talking openly about suicide. To recognise the 'signs' that may indicate someone is having thoughts of suicide.

Engaging with Fathers in the Safeguarding Arena including child practice reviews: Facilitator: Paul Jones. A workshop for practitioners to gain a greater knowledge of learning from practice reviews concerning engagement with fathers. Attendees also gained good practice tips for when working with father's/ father figures.

Hourglass – Supporting victims of Elder Abuse: Awareness raising session about the charity and services they offer, the types of calls and cases they deal with. Including some case studies/examples.

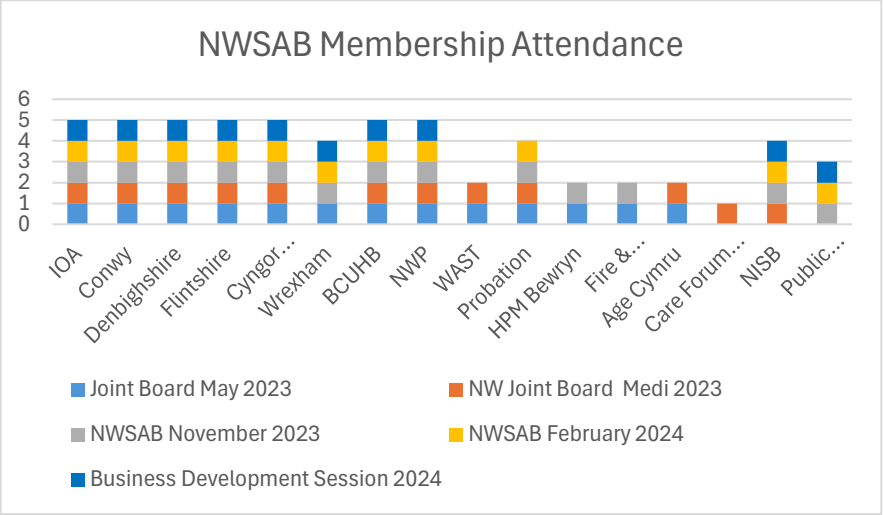
Professional Curiosity: Facilitator: Paul Jones. Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. The workshop referred to learning from practice reviews and also looked at the NWSCB Professional Curiosity Guidance.

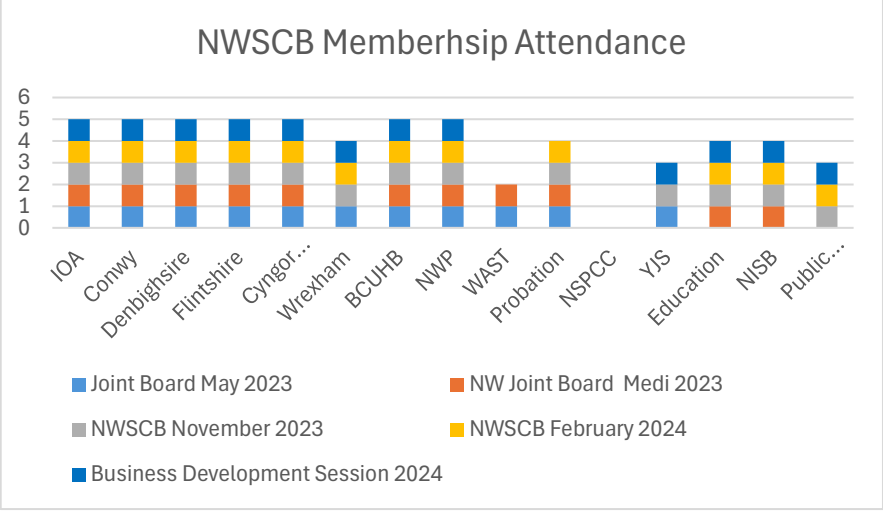
7.0 The extent to which each member of the safeguarding board contributed to the board's effectiveness.

7.1 Board Attendance & Business Development Session:

Board attendance was discussed at the Business Development Session held on 7th March 2024. It had been identified that there was a lack of attendance at Board by some agencies, and this was addressed following the session. The NWSB Risk Register was updated to reflect current risk .

The Board's priorities were discussed for the coming year ahead of publication of the Boards Annual Business Plan, together with agreement on the budget and level of partner contributions. Also discussed was the SUSR implementation plan for North Wales and possible board restructure.

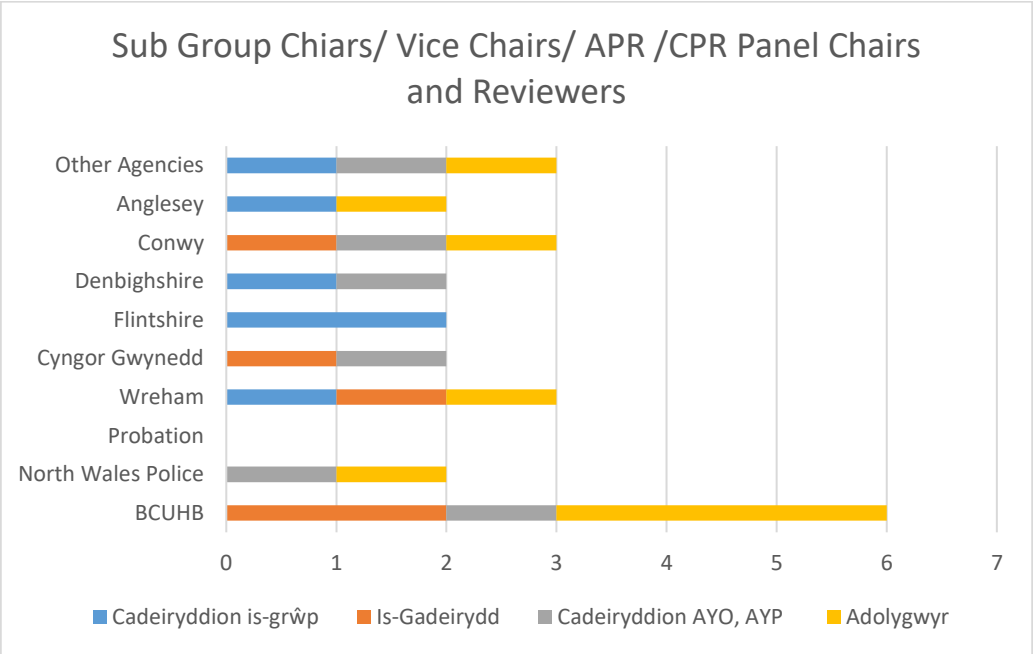




7.2 Partner Agency Work Contribution

The graphic below shows each agencies contributions to the work of the Boards. Details include attendance on behalf of the Board in relation to national pieces of work, Chair arrangements of the sub-groups and contributions to Adult and Child Practice Reviews as either a Panel Chair or a Reviewer.

Sub Group and Review Chair Participation:



7.3 Challenges in relation to Child and Adult Practice Reviews and the Single Unified Safeguarding Review:

As previously mentioned, the increase in the numbers of referrals into the Child Practice Review Group, and subsequently the increase in those referrals that are taken forward, has created challenges in sourcing Panel Chairs and Reviewers. With the implementation of the Single Unified Safeguarding Review imminent, it is highlighted, by the Board, as a risk area with the Board becoming responsible for the Domestic Homicide Reviews, Mental Health Homicide Reviews, and the Offensive Weapons Homicide Reviews together with the Child and Adult Practice Reviews. Although there will be a register of approved reviewers and chairs, there may still be issues in attaining Chairs and Reviewers with the required area of expertise, to undertake these processes.

Further challenges identified are around embedding learning into practice, duplication of themes and lessons coming out of the reviews and some issues in relation to the preparedness of agency staff in undertaking the roles of panel members and lack of communication between panel members and their staff nominated to attend the learning events. It is hoped that the scheduled SUSR training will help to reinforce and explain further the responsibilities of Chairs, Reviewers and Panel Members.

7.4 Partner Agency Reports:

Partner Agency Reports are produced and received annually to provide information and assurance around work undertaken in relation to the Board's priorities, each agency is asked to present their report and a critical friend is assigned to ask questions or seek further information.

This practice ensures that the Boards are aware of any emerging issues or themes and highlighting good practice. Some of these themes will assist to inform the Board's priorities for the coming year.

Themes and Issues identified during 2023 / 2024:

Conwy County Borough Council:

Adults

- Rise in Financial Abuse.
- Increase number of AAR Reports.
- Section5 - lack of clarity and training.

Children:

- Increase in children being returned to the safeguarding conference arena following a period of child protection de-registration within 12 months period.
- Pressure from an overall increase in family complexities.
- Risks are not able to be reduced, by means of a care and support protection plan, resulting in complex older children requiring a placements outside of their immediate and extended families.
- Management of safeguarding and well-being needs specifically in relation to extra familial harm.
- Recruitment and retention of Social Worker's continues to impact on service delivery, use of agency social workers at high costs.

Betsi Cadwaladr University Health Board:

Adults

- The Section 5 process remains a key challenge.
- NHS Wales plan to move to a single Digital Report System that will incorporate the digital reporting of Safeguarding concerns.
- There are a high number of AAR Reports completed by the Health Board staff that relate to concerns raised at independent care provider services. Immediate action is taken to support individuals and services with full engagement with partner agencies and the AAR process.

Children:

- Increase of Child at Risk Reports.
- Section 5 process.
- Number of Child Practice Reviews across North Wales. This presents as a challenge in terms of capacity to engage in the reviews within the varying roles i.e. Chair, Reviewer and Panel Member.

Flintshire County Council:

Adults

- Adult Safeguarding reports increase and complexity.
- Staffing issues across Adult Social Care has created challenge.
- Lack of effective communication in relation to working with other teams and being informed of key staff changes.
- The biggest challenge continues to be staff recruitment.

Children:

- Defined Practice Model.
- Enhancing partnership working.
- Recruitment & retention and agency exit strategy.
- Dissemination of learning and development of practice.

North Wales Police:

Adults

- The Force's problem profile for Adults at Risk is to be refreshed with the assistance of partners. The document will allow for a more detailed understanding of what future demands look like and impact on policing.

Children:

- Capturing the 'Voice of the Child'.
- Absence of MASH facilities across the Force.

HM Prison and Probation Service

Joint

- End of Custody Supervised Licence

  (ECSL), established to ease the capacity pressure in prisons.

Isle of Anglesey Council:

Adults

- Section 5 requires more clarity.
- High volume of complex safeguarding concerns as well as complex concerns around self-neglect and hoarding individuals that need specialist support.
- Develop a greater understanding between agencies around the self-neglect and hoarding protocol and agencies need to understand their roles as lead co-ordinators.
- Increase in the number of requests for DOLS assessments, including CoPDoL.

Children:

- Number of placements available for adolescents who are not able to remain living with their birth family.
- High rate of school exclusions (fixed term and permanent).
- Section 5 of the Wales Safeguarding Procedures.

Denbighshire County Council:

Adults

- Section 5 process still proves to be a challenge in many areas, but specifically in relation to the operational element of this process i.e. poor practice verses abuse/neglect etc.
- Deprivation of liberty safeguards waiting list has fluctuated over the past 12 months and continue to prove to be a challenge.
- BIA training remains on the agenda as there is no provision to deliver this through local HEI's.

Children:

- Recruitment - Whilst progress on recruitment has been made the recruitment of experienced social workers remains a challenge in the key areas of Child Protection and Court.
- Placement sufficiency – both in house and external, remains a significant concern, with the availability of all placement types impacted.

- Unaccompanied Asylum-Seeking Children – we continue to receive placements via the mandated National Transfer Scheme – placed out of county - increases their vulnerability and lessens LA ability to effectively support.

Wrexham County Borough Council:

Adults

- S.126 Enquiries undertaken by other agencies – time delay.
- Housing and Tenancy for those who are deemed to lack capacity.

Children:

- Challenges in relation to the recruitment and retention of staff.
- Budget constraints.
- Mental health lead responsibility challenge
- There is an increasing number of children who have Mental Health problems where the support and service available from health partners is limited.

Cyngor Gwynedd:

Adults:

- Police lack of resources - This impacts on ability to arrange timely meetings.
- Self-neglect / capacity.
- Section 5.

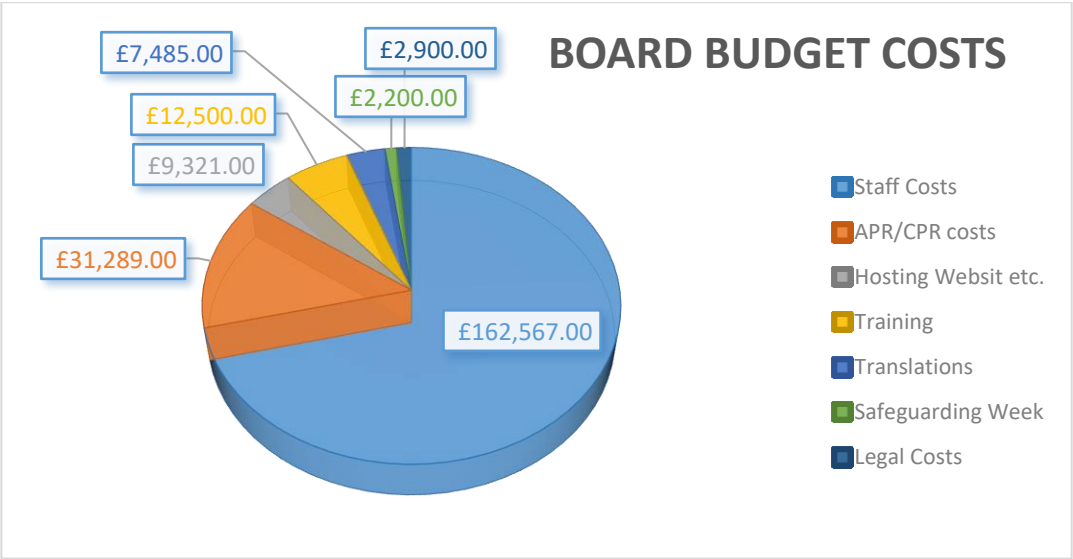
Children:

- Difficulties in recruiting to posts where there is a need for considerable experience and language skills.
- Safe placement challenges.
- Unplanned demand increases – Probation checks.

8. An assessment of how the Safeguarding Boards used its resources in exercising its functions or achieving its outcomes.

8.1 Board's Budget:

The table below illustrates the spend against the safeguarding board's budget:



8.2 Child & Adult Practice Reviews/Single Unified Safeguarding Review:

As the number of referrals into the Child Practice Review group has continued to increase, the capacity of staff to undertake the roles of Panel Chairs and Reviewers has diminished. This has resulted in the commissioning of Chairs and Reviewers to undertake these reviews. This has come at great financial cost and has also created a delay in commencement of the process due to going through the commissioning processes required.

Presentations have been given at Safer Communities Board / North Wales Safeguarding Board / Regional Partnership Board and regular meetings have been help with CSP Business Managers. NWSB and CSP Business Manager attended the pilot SUSR Panel Member and Chair and Reviewer training in February and have fed back comments and observations.

The North Wales Safeguarding Board have produced an SUSR Implementation Plan in order to provide a smooth transition to the Single Unified Safeguarding Review. Discussions are underway with regards to

moving to a joint Board and what the structure of that board's sub-groups will look like. ToR for the SUSR Case Review Group is being drafted and the proposed membership is being considered.

A trainer has been identified in order to continue the role out of SUSR training once the guidance has been finalised and published. The Board aims to have a rolling a programme of training available to all agencies.

SUSR resources will be uploaded to the NWSB website once they are available for easy access.

8.3 Training and Awareness Raising:

During 2023/24, in addition to commissioning training, we have utilised Board members and their agencies staff from across the region to deliver workshops, webinars and training around issues that have had an impact on their own organisations and to share learning from and their experience of Practice Reviews. These have included:

Modern Slavery in Care Homes:

This session was delivered by the adult Safeguarding Lead for Conwy, following on from a reported and investigated Modern Day Slavery case within the county.

Self-neglect – Embedding learning into practice / Learning from and Adult Practice Review:

The organisational and personal learning from an Adult Practice Review was presented and discussed via the Regional Safeguarding Adults Delivery Groups across the region by the Older People's Team Manager in Flintshire. The sessions were open to third sector staff as well as local authorities, and blue light service staff.

Cost of Living Crisis:

The Age Cymru member of the North Wales Safeguarding Adults Board, presented a bite-sized, lunchtime session. This was open to all agencies across the region and raised awareness of the impact of the cost-of-living crisis on the older population in the region and the signs to look out for.

Child & Adult Practice Reviews – Roles & Responsibilities:

The Safeguarding Board Business Coordinators presented to North Wales Police Officers, an overview of what is expected from panel members, chairs, and reviewers. Also presented were themes and case studies on published practice reviews and the learning generated from those.

Improving the safeguarding process around dog bites in children:

Delivered by Betsi Cadwaladr University Health Board colleagues to multi-agency practitioners.
The session highlighted awareness around:

- ❖ new risk assessment across BCU.
- ❖ reducing variation in practice across sites
- ❖ improving partnership working across health , social care, and police.
- ❖ sharing good practice.
- ❖ improve the quality of care.

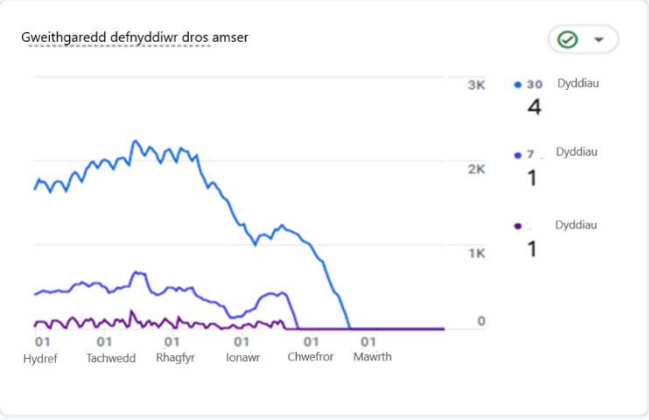
County Lines Awareness Session:

Facilitated by North West Regional Organised Crime Unit, the session provided a brief overview of the County Lines model of drug supply, including a summary of the local picture, examples and typical indicators of exploitation, and some signposting to available resources for professionals.

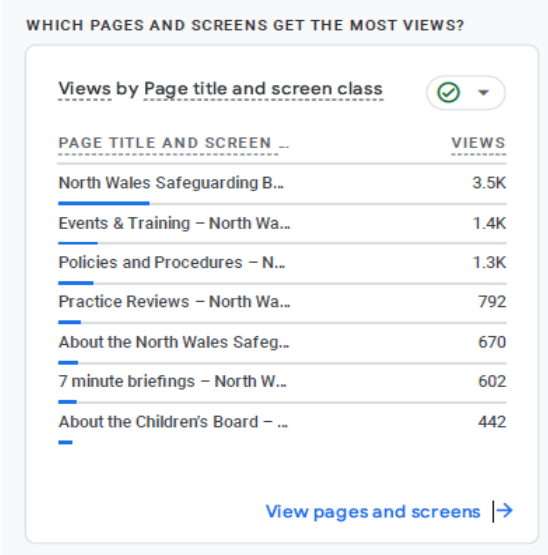
North Wales Safeguarding Board Website:

During the course of 2023 – 2024, the NWSB website has undergone a transformation. The aim of the new site it to make access clearer with direct links to the most popular resources.

Website Stats:



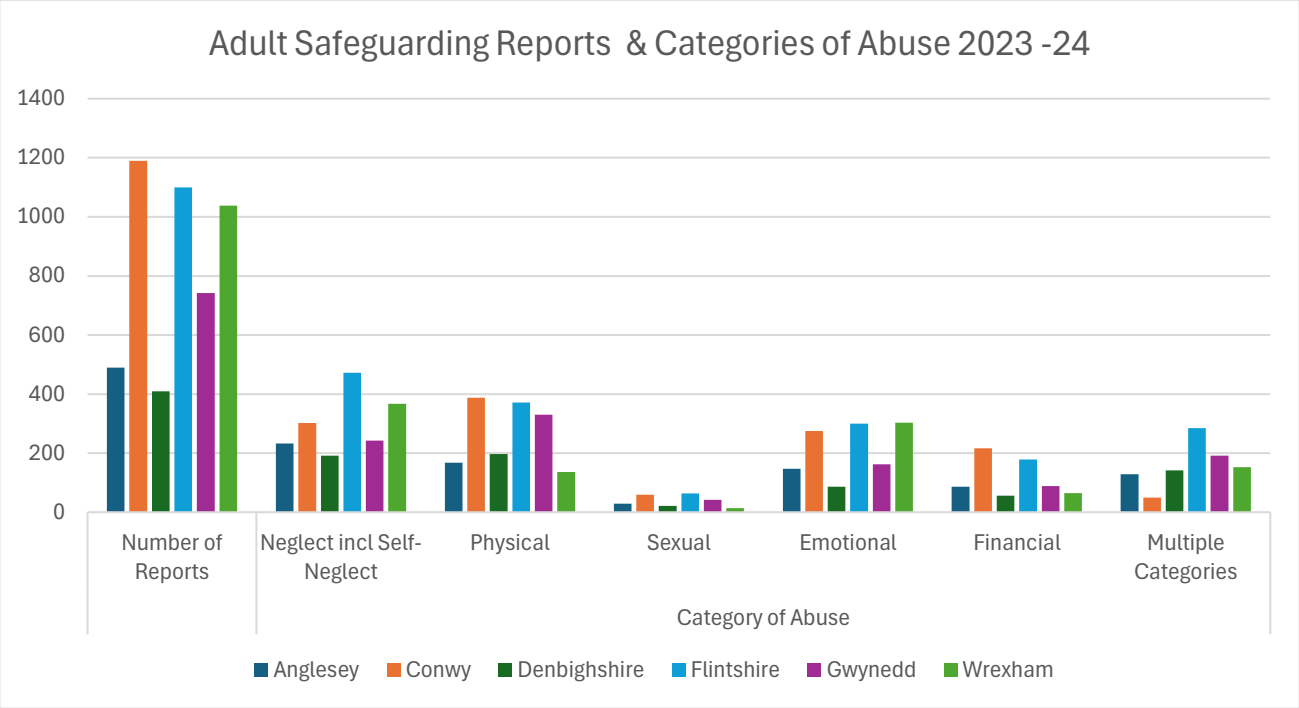
Please note that a transition from the old website to the new one took place at the end of January 2024.



9.0 Any underlying themes in the way the safeguarding boards exercised its functions as shown by an analysis of cases it has dealt with, and any changes it has put into practice as a result.

9.1 Adults

Volume of Safeguarding Reports 2023 / 2024 & Categories of Abuse Reported:



As the table above illustrates, neglect continues to be the highest reported category of abuse, in particular self-neglect. As a consequence, the Board is undertaking a thematic review of 16 – 18 cases in order to identify:

a) Compliance with the North Wales Self-Neglect protocol.
b) Identify any gaps or any part of the protocol that needs further clarity.
c) To enable the North Wales Safeguarding Board to respond effectively to the Welsh Government's consultation of the National Self-Neglect Policy when it is published.

Financial abuse cases have also increased across the region, and in addition to developing the North Wales Financial Abuse Practice Guide last year, safeguarding leads across the region are now in regular contact with the Department for Works and Pensions. Connections with DWP were made following their attendance at the Safeguarding Adult Practice Delivery Groups, where local authority representatives highlighted the rise in reports of financial abuse.

The NWSAB continues to raise awareness of safeguarding adults at risk, including those at risk of abuse within the care home sector. The data received into the

boards sub-groups for discussion highlights the increase in reports coming from the care home sector. Risks highlighted are the homes dependency on agency staff and reports of modern slavery cases occurring within that sector. The Board has held awareness raising sessions to alert staff, commissioners and third sector organisations around the risks involved, in relation to l safe recruitment and due diligence around engaging agency workers. The sub-groups also continue to have regular updates and discussions with the Disclosure and Barring Service.

Section 5 – Position of Trust

Local Authorities are reporting a continued increase in Section 5 reports coming into their safeguarding teams. There is concern that due to lack of clarity and guidance within the Wales Safeguarding Procedures around Position of Trust, it poses a risk to them by way of opportunities for legal challenge. Section 5 was highlighted in the majority of Annual Partner Agency Reports as being an ongoing issue for their organisation.

More guidance is required to ensure a consistent and regional approach to the application of Section 5 and there needs to be more information for reporting agencies in relation to identifying what is poor practice versus abuse/neglect. In addition, there is a lack of understanding within both third sector and national organisations, around what should trigger a Section 5 report, and their legal duty to make those report.

The Board's Business Unit has been raising awareness with various organisations in order to assist them in understanding the requirements around Position of Trust, and it is anticipated that once the review of Section 5 is completed by the National Project Board, that more clarity will enable the roll out of training across the region.

9.2 Children

Partner Agency performance and highlight reports are submitted in order to give a complete overview of any themes and issues.

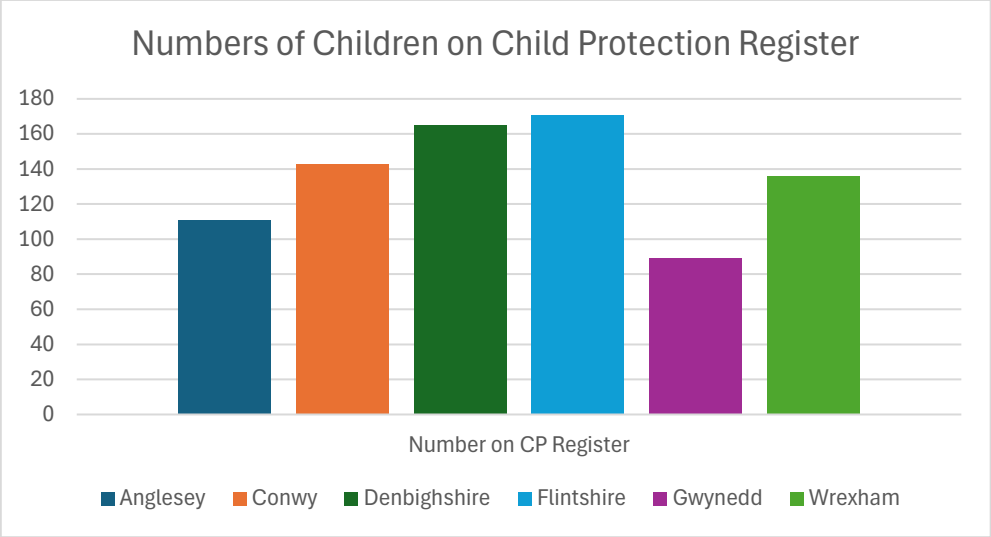
Identified themes / Issues:

Via the local delivery groups, it was reported an increase in the number of dog bites. In response the Health Board are developing a mandatory reporting system to police and a risk assessment on their ICT system. The Policy and Procedures group are developing guidance for practitioners around safeguarding Children and Adults around dangerous dogs. The primary aim of this guidance is to protect children and adults across North Wales from the serious injuries that can be inflicted by dogs that are prohibited, dangerous or poorly managed.

The local delivery groups have also highlighted themes around substance misuse. Both Youth Justice services and Police have reported concerns around the use of Ketamine and also the high rates of cannabis use. In response a briefing note was issued for practitioners around how Cannabis, alcohol other associated depressant substances affect the brain and potentially impact on an individual's ability to make wise decisions. Practitioners need to be mindful that although adults who use cannabis may have intrinsically good parenting skills– they may be unable to exercise them consistently.

Child Protection Register:

Data was received by the children's practice delivery sub-groups in relation to the number of children on the CP register during 2023 / 2024.



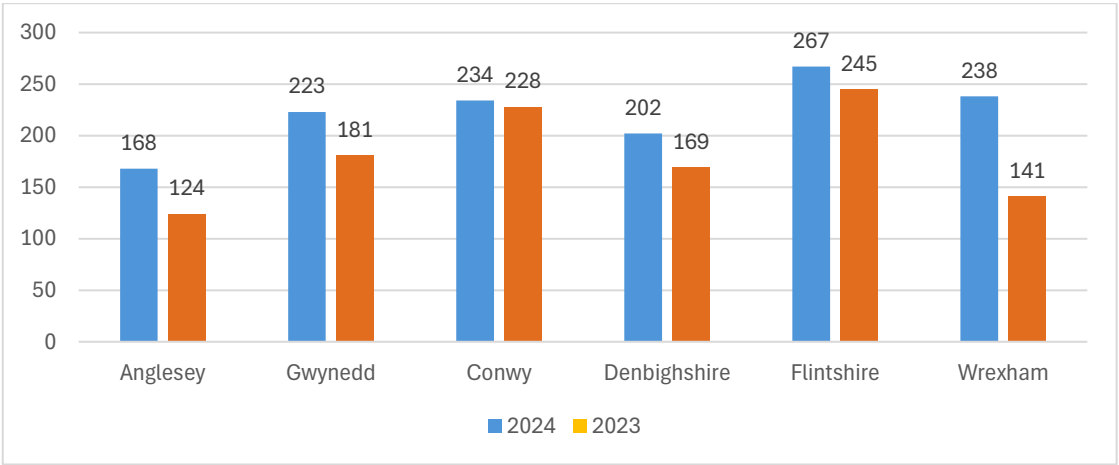
The primary category of abuse reported by each local authority is:

Anglesey/Conwy/Denbighshire/:	Emotional/ Psychological
Cyngor Gwynedd/ Wrexham :	Emotional
Flintshire:	Neglect / Emotional + Neglect

Rapid Review of Child Protection Arrangements:

Work is under way to consolidate the national recommendations made by the CIW Rapid Review of Child Protection Arrangements, IICSA recommendations and recommendations from the Child T practice review with the national recommendations made by the NISB Thematic Review of 22 Child Practice Reviews. The aim will be to develop an action plan that supports a cohesive national approach to addressing the recommendations from each, some of which overlap.

Electively Home Educated (EHE):



The increase of learners becoming Electively Home Educated (EHE) continues to rise. There are a large number of children not able to attend school due to Emotional Based School Avoidance (EBSA) relating to issues following the pandemic is considerable, with long waiting lists for children and young people to be seen, with very little movement in terms of how we address this issue to get them back into education.

There is also recognition that some families are struggling financially, so Education Services have signposted parents requiring support to debt management via parent pay.

10. The number of Adult Protection and Support Orders which were applied for in the Safeguarding Board area.

There have been no APSO's applied for in the North Wales Region between April 2023 and end of March 2024.

11. When and how children or adults exercised an opportunity to participate in the safeguarding board's work.

11.1 Adults

We continue to undertake work with Regional Advocacy services around engagement with Adults at Risk. We have also asked that draft Board practice guides are shared with adults in receipt of care and support services to comment on.

We are developing a specific practice guide on Lived experiences. This guidance has been developed by partners to enable practitioners to take into account the adult's experience and ensure that the adult's lived experience remains central to any action taken to safeguard the adult at risk.

This guidance is for use by all professionals (the term includes managers, staff, and volunteers) who have direct and indirect (i.e., may work with families/carers) contact with adults at risk; and who therefore have responsibilities for safeguarding and promoting their welfare.

The guidance highlight that case notes should reflect what is known about the lived experience of the adult, how this is considered during assessment, and the impact it has on decisions made. Always remember to update case records for others to see what work has been completed with the service user.

Remember:

- Use direct quotes where possible.
- Notes should focus on facts relevant to the case.
- Where professional opinion is required, it should be identified as such and justified.

We also ensure that practice audits undertaken, identify if the lived experiences of the adult at risk is evident.

11.2 Children

In relation to engagement with children and young people, we work with the other safeguarding partnerships in the region.

An example is the consultation work on the Regional Serious Violence Strategy. A Children and Young People North Wales Serious Violence Survey was conducted in 2023 to gather the views and experiences of children and young people relating to violence in North Wales.

The Partnership has also recently conducted a Children and Young People Survey, with 377 respondents. This survey helps to monitor children and young people's feelings of safety in North Wales, as well as identifying the prevalence of particular issues and thoughts on serious violence.

One of the questions in the survey asked about the participants' feelings of safety in their local community. The majority of respondents (81%) answered that they feel safe in their local community (at least most of the time), 14% said they feel safe sometimes, and 5% said they do not feel safe.

When asked whether they have ever been a victim or, witnessed or committed violence, 20% of respondents said they had been a victim, 29% said they had witnessed violence and 1% said they had carried out an act, or acts, of violence. Survey respondents gave a variety of views when asked what they thought the main causes of violence to be.

"I believe, in some cases, people will commit violence due to what they have experienced at a young age. Whether that was violence at home, r witnessing it at home or witnessing it online or in person. If they are taught incorrectly at young, then they may not understand non-violent ways of handling situations." – Survey Respondent.

"A lot of people act out this way, because of peer pressure, also home life" – Survey Respondent.

"Because they may be drunk or angry, maybe they need to talk to someone about their problems to avoid it. " _ Survey Respondent.

"Out of fear, needing to be 'popular', to fit in – peer pressure" – Survey Respondent.

12. Any information or learning the safeguarding board has disseminated or training it has recommended or provided.

Single Unified Safeguarding Review:

The updates and 7 Minute Briefings developed by the SUSR team are shared in all Regional Groups and placed on the website.

SUSR is a standing agenda item for the Boards, Practice Review Groups, Delivery Groups and the Safeguarding Workforce Development and Training Group.

National Safeguarding Training Standards:

In relation to the National Safeguarding Training Standards, the Regional Chair of the Workforce Development and Safeguarding Training sub group is part of National Steering Group and has led on the work in the region.

A number of workshops were held in the region to promote the national standards.

We have acknowledged that we have further work to do in relation to ensuring compliance with the standards and that we need to support organisations across the region to access more training opportunities for Level B and Level C.

We identified the gap in delivering Level C Multi agency Adult safeguarding Training.

In 24/25 we are hoping to launch Multi Agency Adult Safeguarding Training module which covers the following areas:

1. Understand the legal frameworks to support the process of a safeguarding enquiry.
2. Understand agency responsibilities in developing a multi-agency response, including effective methods of communication with other agencies and with the person at risk.
3. Understanding of the process of a Section 126 Enquiry and the roles & responsibilities of partner agencies.
4. Practice developing terms of reference for an Enquiry.
5. Explore the application of Person-Centered Practice (PCP) principles in an Enquiry and keeping the person central throughout.
6. Apply risk assessment/analysis, to support decision-making and in drawing conclusions.
7. Safeguarding Enquiries and Police investigations.
8. Deploy professional curiosity in the context of multi-agency safeguarding enquiry.

Recommendations from the IICSA Report:

During the year, the recommendations from the IICSA report have been presented at the Board and the Local Delivery Groups. Via the work with NISB and Manchester Metropolitan University around a National Performance Framework we hope to ensure that we are in a position to implement the recommendation around the collection of data on Child Sexual Abuse

Learning from Practice Reviews:

In response to the thematic analysis by Manchester Metropolitan University of national child practice reviews. The Board have created an action plan to respond to the key findings to the six themes identified. For example, in relation to Theme 2 Multi Agency Responses – we

highlighted the following actions that have been undertaken:

- Development of the Professional Curiosity Guidance and training Provided.
- Work done regionally on the lived experiences of the child but further work to be done.
- Current work on developing a practice guide around Transitional Safeguarding.

National Action Plan to Prevent the Abuse of Older People:

This plan sets out measures Welsh Government are taking across Government to ensure that older people are protected from all types of abuse, and to prevent them from being at risk of abuse. The plan is available on the NWSB website and has been included as an agenda item for Board and the local delivery groups.

Protection of Children Online, Research:

Information has been made available on the NWSB Website in relation to online harm. Ofcom have published three new research reports on online harms as part of their series on the protection of children online.

The reports cover: understanding pathways to online violent content amongst children; experiences of children encountering online content promoting eating disorders, self-harm and suicide; and key attributes and experiences of cyberbullying among children in the UK.

Don't Think 'What If I'm Wrong?', Think 'What If I'm Right?' – 'Make the Call'.

This Welsh Government campaign launched by the Deputy Minister for Social Services, Julie Morgan, urged anyone who is worried about a child or young person in their family or community, to contact social services in their area or call 101. It draws on learning from practice about when and how to report safeguarding concerns. Messages were shared via the website and social media. The Board's own safeguarding video 'See Something, Say Something' was also promoted and shared to re-enforce the message.

10 Step Guide to Sharing Information to Safeguard Children:

Welsh Government shared the resource from the ICO that assists in providing assurance to organisations and practitioners across Wales that data protection is not a barrier to information sharing. Shared via the Board and local safeguarding delivery groups the 10-step guide has a clear central message that where individuals are worried about the safety of children, they should share information to protect them. Discussions have continued with all agencies around the messages about the importance of information sharing to safeguard vulnerable children and adults.

Get Safe Online Campaign:

Messages from the campaign were shared via social media and the website and disseminated through the delivery groups to all agencies and 3rd sector organisations.

Welsh Government Consultations:

Consultations are shared across the region, and all are encouraged to respond individually as well as contributing to the response of the NWSB.

13. How the safeguarding board has implemented any guidance or advice given by the Welsh ministers or by the national board.

Publication of Elective Home Education Statutory Guidance:

The statutory guidance on Elective Home Education, has been developed to support local authorities in effectively discharging their duties in relation to home educated children. The statutory guidance helps to ensure that all children are supported to access the universal services and benefits normally available to children and young people in mainstream education.

The guidance was highlighted at the North Wales Safeguarding Children's Board and local delivery groups, ensuring that Education representatives were aware. Key messages and links to the document are highlighted on the Board's website.

Guidance on Reducing Restrictive Practices In Childcare, Education, Health And Social Care Settings:

Guidance was disseminated via the Board and local delivery groups, links to the guidance and key messages were also shared via the website and social media.

14. Other matters relevant to the work of the safeguarding boards.

Development of a Child Exploitation Tool – Covering Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE):

The proposed Welsh Government practice guidance around a specific tool kit on Child Exploitation has been paused. As a Regional Safeguarding Board, we would still prefer that we have a national agreement on a multi-agency toolkit rather than individual agencies / regions developing different toolkits. The Board would be keen for this work to take place during 24-25.

Management Information Systems:

Board members have highlighted potential risks facing Local Authorities around the need to identify a replacement for the current social care IT system (WCCIS). Four of the six local authorities in North Wales currently use WCCIS. When initial discussions took place regarding the implementation of WCCIS, one of the proposed drivers for this work was to support greater integration between Health and Social Care. It is evident from learning from Practice reviews that this has not been achieved.

Self-neglect and Hoarding:

Whilst still not wholly under the safeguarding agenda, more and more cases are reported and progressed via safeguarding when there is an impasse in cases and where agencies are concerned that partner agencies are not engaged in the process. It has been identified that self-neglect and hoarding are being regularly reported by agencies through adult at risk reports, often with very minimal information by the reporting agency.

This current practice results in the local authority taking the lead responsibility on all self-neglect and hoarding concerns. It has already been identified that there is a lack of understanding of the principles of the Mental Capacity Act 2005 and that agencies are not fully complying with WASPI guidance around sharing information.

15. Good Practice Case Studies

All agencies were asked to provide a good practice case study for inclusion in the Annual Report.

Isle of Anglesey Council:

Mr A is a 64-year-old man who resides alone in his own home, which is believed to be the family home. Mr A's parents resided there until they died. Practitioners believe that his parents may have had hoarding tendencies too. Mr A is described as an extremely intelligent man and there are no concerns in relation to his capacity. He understood the risks to himself and was happy to accept them. Mr A described himself as a 'recluse and a loner' and has shared that he does not enjoy the company of others. He relies on books for company and will often refer to books as his 'friends'.

The adult service practitioner has been working with Mr A for approximately 18 months. Initially, Mr A was reluctant to allow professionals into his home. The social worker arranged to meet with him at the GP surgery and after building a trustworthy relationship, she was eventually allowed into his home. Mr A was open under the self-neglect/ hoarding protocol. The Environmental Health and Fire Service were also involved but Environmental Health could not implement any powers at this time due to dry hoard only concerns.

When a practitioners' assessment was completed with Mr A in his home, it identified that all rooms were initially at level 7/8, with some believed to be scoring at level 9 on the hoarding scale. It was identified that Mr A's home was at high risk for fire as the hoard was mainly books, paper, and toys. Initially Mr A was reluctant to declutter. However, after many months of continuous support from the social worker, Mr A agreed to receive a service to support him to declutter his home. The turning point came after consideration of the risks to others, in particular the fire risk that could potentially result in harm to neighbours.

Mr A could not afford a cleaning service, but the social worker secured a grant for him to pay for a specialist support with decluttering. With the agreement of Mr A, the cleaning service was put in place for 2 weeks. During that time Mr A managed to declutter the house to the equivalent of 2 full skips. Following this another practitioner's assessment was completed which identified that all rooms within the property were now at level 1/2/3. Mr A's home conditions have improved significantly. All rooms apart from the bathroom were decluttered and cleaned. Mr A did not want the bathroom to be accessed and his wishes were respected. The social work team continues to support Mr A and has noted that 5 weeks following the declutter, the house is being maintained and is believed to be in a liveable condition.

Moving on, Mr A has agreed to work with support workers on budgeting, managing letters and paperwork. Information in relation to a cleaning service has been shared with Mr A. He is said to be considering this support. The practitioner that completed the declutter with Mr A remains in telephone contact. This practitioner who supported Mr A to declutter was able to provide specialist support during the decluttering process as she is a trained counsellor. It had been identified that the declutter process was very difficult for him but with specialist support he managed this successfully.

Mr A refused a formal CMHT referral, but this was offered several times by the social worker.

Mr A collected marvel figures and toys (duplicates) and wished for these to go to a good cause. With Mr A's consent, these were donated to a local hospital (children's ward) and a local cancer charity. Mr A does not wish to receive on going social work support but has agreed to an annual review. The service will remain in contact as per Mr A's wishes.

This case has highlighted good multi-disciplinary working. It demonstrates that practitioners need time to work with individuals who hoard and self-neglect to offer support through significant changes to their lives. It took 12 months for Mr A to agree to work with the social worker and it took many months for change to happen.

** Pictures below have been shared with Mr A's consent **






Betsi Cadwaladr University Health Board:

Safeguarding Quality Assurance for Reviews
The Health Board Safeguarding and Public Protection Team has developed a Quality Assurance Group covering Child Practice Reviews (CPR), Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR).

The group monitors review activity across North Wales to ensure that BCUHB are able to offer assurances in terms of identified learning.

The Quality Assurance Group meets monthly to:-

- Identify early learning for the Health Board and agree any necessary actions.
- Identify any challenges/drift within the process.
- Identify and share good practice to support learning.
- Capture key themes and trends to support future actions.
- Capture agreed data.
- Respond to any triggers for immediate internal escalation ensuring this activity follows internal Governance and Quality arrangements identified in the BCUHB Safeguarding Reporting Framework.

Key functions include:-

- Incorporating identified learning into relevant training packages.

- Developing relevant 7 Minute Briefings.
- Influencing internal and local policy, procedures, and guidance.
- Ensuring timely escalation and sharing of information.
- Communication of learning and information across the Health Board.
- Developing expertise in the engagement with and function of CPR/APR/DHR's.
- Working in collaboration with the Safeguarding Policies and Procedures Task Group to ensure learning is included in Health Board policies and procedures.
- Ensuring the Health Board Safeguarding webpage accurately reflects CPR/APR/DHR learning.

Through the above activity the Quality Assurance Group acts as an exemplar of multi-agency learning and embeds an effective foundation for learning.

Conwy County Borough Council:

Background

An 18-month child suffered a fall from her pram when cared for by her father who was heavily intoxicated at the time. He had the child as the mother too was heavily under the influence of substances. Police did consider a Police Protection Order [PPO] as neither of the parents were deemed to be in a fit state to care for their child when she was fit for discharge from hospital. Positively, the paternal grandmother was assessed as an alternative carer and the child was discharged to her care, while matters within the child protection process continued.

Intervention

The child was placed on Conwy's child protection under the category of neglect, with parents being provided with interventions from the strengthening family's team, substance misuse and domestic abuse services. Sadly, parents continued to utilise substances, with the risk of emotional abuse becoming more apparent due to them not being able to commit themselves to family time with their daughter. There were also concerns for disguised compliance in regard to the parental relationship, with parents refuting that they were still in a relationship, however, social media reports from the paternal grandmother informed otherwise. The matter progressed to Public Law Outline [PLO] to ensure that parents were fully informed by their retrospective solicitors as to what they needed to change and sustain in order for their child to return to either of her parent's care. Throughout this time, the child remained within the care of her paternal grandmother, with the extended family pulling together to assist in supporting the household and enable the paternal grandmother to continue her employment.

Outcome

An Interim Care Order was granted, as neither of the parents were able to be in a position to have their daughter to return to her care, nor were they exercising their parental responsibilities effectively. Positively, the paternal grandmother wanted to ensure that her granddaughter remained within the family, with her wanting to secure this relationship by means of a Special Guardianship Order. The mother recognised that she could not safeguarding her daughter and agreed that her daughter should have stability of care afforded by the paternal grandmother. Sadly, the child's father was unable to recognise that his situation remains poor. He was becoming outwardly verbally aggressive towards his mother, unable to accept that she was changing her life in order to prioritise and care for his child. This was a highly emotional and complex situation for the paternal grandmother; however she was commended by the Judge for

her commitment towards her grandchild and was subsequently granted a Special Guardianship Order.

Denbighshire County Council:

DBT Skills Groups

The Therapeutic Service have delivered a well-respected therapeutic intervention Dialectical Behaviour Therapy (DBT) for nearing six years. DBT is a skills-based experience that allows parents and carers to develop core life skills that help individuals regulate strong emotions, manage stressful situations, and experience a kinder relationship with themselves and others. The group covers four sets of skills; Mindfulness (increasing self-awareness to help a person cope); Interpersonal Effectiveness (feeling able to communicate with people more effectively); Emotion Regulation (learning how to understand emotions and how they affect behaviours) and Distress Tolerance (increasing ability to tolerate feelings of distress and to cope more effectively in a crisis). When brought together, these skills build towards a life worth living.

The Therapeutic Service has great success in working with men as fathers and carers and a male DBT Group is now part of the DBT offer.

Where parents and carers may struggle to attend the group, 1:1 DBT skills can be offered as a way of building confidence to join a future group as the messages from attendees highlights the powerful nature of being alongside others in validating progress and potential barriers to recognizing and celebrating personal strengths.

Flintshire County Council:

Flintshire's Youth Justice Services led a successful bid for grant funding to establish Action for Children's Side Step project in Flintshire. The project seeks to divert young people away from a life of serious organised crime. The service offers targeted support to 11 to 18-year-olds through intensive one-to-one support, peer mentoring, education, and employment training. The project uses 'peer mentors' as accessible role models for teenagers who have previously resisted other types of support.

Case study

Mark has previously been linked to know adults in the local area and in Merseyside who are criminally exploiting him to use and distribute drugs. Mark has complex needs which make him very trusting, easily influenced and erratic at times. These traits make him a target for criminal and or sexual exploitation.

Mark has extremely low self-esteem, being severely bullied and a victim of multiple assaults. He craves belonging and friendships again making him vulnerable to OCG exploitation due to the power imbalance.

Through Side Step Mark:

- has developed a positive relationship with his peer mentor

- attends 3 hours of alternative provision education
- attends regular Boxing sessions and the gym
- is engaging with his YJS/ CAMHS meetings and working on his life skills.

His peer mentor has attended a formulation with a psychologist who has determined that Mark has the social and mental ability of a child much younger and under 10 years old. This has informed how services engage with Mark needs to reflect his abilities, and this has been reflected in his service plan.

Mark is currently placed in a solo residential placement and Side Step liaise with staff to provide support via phone and face to face.

Cyngor Gwynedd:

Child A was open to DERWEN (Specialist Children Services), and sibling Child B was open to Children and Families Team. There were mounting concerns about parental capacity. Concerns included poor home conditions, lack of understanding around developmental needs, including health and educational needs. Overall, this indicated neglect.

It was clear in practice that there was compassion and an understanding about the competing needs of the two children; especially for Child A who had additional and complex needs. It was clear that a Care and Support Plan was insufficient to address the growing concerns. There had been considerable efforts already to support the family and help them to make changes.

The concerns met threshold and the children were discussed at an Initial Child Protection Case Conference. In keeping with the collaborative nature of conferences, agencies were able to have honest and robust discussions with the family about the concerns. It became clear at Conference that father had little awareness of how hard agencies had been trying to engage with the family. It also became apparent that the mother had been somewhat dishonest with workers, contributing to the level of assessed risk to the children.

The Conference worked collaboratively with the family to share information from each agency and establish the family's own view about the risks the children faced. In accordance with ECP, there was an agreement with the family about 'what needed to change.' This provided the foundation for the Child Protection Plan that was created in partnership with the family.

Working collaboratively across agencies and with the family establishes the working model that will hopefully promote change to keep the children safe.

Wrexham County Borough Council:

Through the links between Adult Safeguarding and Single Point of Access (Adults SPOA), the Safeguarding Team have been able to provide advice and support to an individual who had been living in a lifelong abusive relationship. This individual had suffered from coercive control and emotional abuse from the start of their relationship. Through the support offered by the Adult SPOA Team, the individual's confidence grew, and they were eventually able to reach out for

additional support. Emergency accommodation was identified, and the Adult Safeguarding Team became involved as this individual had no access to any of their finances or personal identification. Through links made at the North Wales Safeguarding Delivery Group, the Safeguarding Team were able to liaise with a representative from the Department for Work and Pensions, this individual was able to trace their joint bank account details, re-direct their personal pension away from the joint account and is now in receipt of their own money for the first time in over 60 years. Feedback from the individual was that through the support received, they felt as though the first night in their safe accommodation was the first them, they had felt safe in all their married years.

The good practice example serves as evidence of partnership working (both internally and externally), working collaboratively and dynamically, as well as drawing on resources and contacts to support positive outcomes for the most vulnerable.

North Wales Police:

Operation Makesafe. This is the education and training of local hotel staff regarding Child Sexual Exploitation. Positive outcomes at court demonstrate the Forces commitment to prosecuting those who cause the most harm in our communities.

The implementation of the multi-agency arrangements across the Force which enable the timely sharing of information which promotes proportionate decision making and timely intervention. NWP has recorded significant outcomes in terms of both sexual abuse and domestic abuse offences at court.

HM Prison & Probation Service:

Ar Brawf' or "On Probation" is a **Welsh language documentary** offering unprecedented access to the inner workings of the Caernarfon probation office in North Wales. Set against the backdrop of a predominantly Welsh-speaking community, the series provides an intimate look into the lives of both the probation staff and those under their supervision. With English subtitles for accessibility, the documentary delves into the complexities of rehabilitation, highlighting the efforts of probation staff to support individuals in their journey towards reintegration into society. The series can be viewed on **S4C** and **BBC iPlayer.**

Glossary

AMH	Adult Mental Health
APR	Adult Practice Review
AWCPP	All Wales Child Protection Procedures
BCUHB	Betsi Cadwaladr University Health Board
CAMHS	Children Adolescent Mental Health Service
CIW	Care Inspectorate Wales
CMHT	Community Mental Health Team
CCBC	Conwy County Borough Council
CHC	Continuing Health Care
CPR	Child Practice Review
CSE	Child Sexual Exploitation
DBT	Dialectical Behaviour Therapy
DCC	Denbighshire County Council
DoLS	Deprivation of Liberty Safeguards
DHR	Domestic Homicide Review
EAPR	Extended Adult Practice Review
ECPR	Extended Child Practice Review
FCC	Flintshire County Council
GC	Gwynedd Council
GP	General Practitioner
HASCAS	Health and Social Care Advisory Service
HSB	Harmful Sexual Behaviour
IICSA	Independent Inquiry into Child Sexual Abuse
IOAC	Isle of Anglesey Council
KPI	Key Performance Indicator
LA	Local Authority
LDG	Local Delivery Group
SMART	Specific, Measurable, Achievable, Realistic, Timely
LDU	Local Delivery Unit
LSCB	Local Safeguarding Children's Board
MAPF	Multi-Agency Professional Forum
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MHLD	Mental Health Learning Disabilities
NISB	National Independent Safeguarding Board
NPPS	National Probation & Prison Service
NSPCC	National Society for the Prevention of Cruelty to Children
NWP	North Wales Police
NWSB	North Wales Safeguarding Boards
NWSAB	North Wales Safeguarding Adults Board
NWSCB	North Wales Safeguarding Children's Board
OCG	Organised Crime Group
POVA	Protection of Vulnerable Adults
P & P	Policy & Procedure
PCC	Police Crime Commissioner

PHW	Public Health Wales
PLO	Public Law Outline
PPO	Police Protection Order
PRUDIC	Procedural Response to Unexpected Death in Childhood
PVPU	Protecting Vulnerable Persons Unit
SCWDP	Social Care Workforce Development Partnership
SERAF	Sexual Exploitation Risk Assessment Framework
SPOA	Single Point of Access
SUSR	Single Unified Safeguarding Review
WAST	Welsh Ambulance Service Trust
WCBC	Wrexham County Borough Council
WG	Welsh Government
YJS	Youth Justice Services
YN	Ynys Mon