









Annual Report 2023/2024





Bwrdd lechyd Prifysgol Cwm Taf Morgannwg University Health Board

















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Introduction and Foreword - Chair of the Regional Safeguarding Board

Welcome to the 2023-2024 Cwm Taf Morgannwg Safeguarding Board Annual Report.

In March 2023, the Board published a three year strategic <u>plan</u> and has recently published a <u>plan</u> setting out its key priorities for the coming year. These priorities stem from the lessons that we have learnt over previous years and an analysis of the prevalent and emerging safeguarding issues affecting the region. There remains a strong focus on developing our strategical approach to exploitation both in relation to children and adults at risk.

There was a strong focus this year on developing our strategic approach to exploitation, both in relation to children and adults at risk. Partner agencies have worked together to develop our governance arrangements and agreeing appropriate tools to support with the identification and assessment of all forms of exploitation. This work will continue into 2024-2025.

Recognising early intervention and prevention are crucial in meeting the needs of people we support; a key focus this year has been raising the profile of abuse and neglect. We have successfully worked in partnership with the NSPCC and other key stakeholders to raise and promote public awareness campaigns across the region, supporting communities to recognise signs of abuse and neglect and how to report concerns.

Finally, I would like to thank the staff who work tirelessly across the region to protect our most vulnerable people. Their wellbeing remains a priority for the Board and we continue to seek assurances from partner agencies that this is addressed.

If anyone is interested in finding out more about the Cwm Taf Morgannwg Safeguarding Board, or if you'd like to get involved in informing our priorities, please contact our Business Unit by e-mailing: ctmsafeguarding@rctcbc.gov.uk



Lisa Curtis-Jones
Chair of the Cwm Taf Morgannwg Safeguarding Board

1. Safeguarding in Cwm Taf Morgannwg

The region of Cwm Taf Morgannwg covers the local authority areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf with a combined population of approximately 428,000¹

The 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 Cwm Taf Morgannwg. The aim of the Board is to ensure that people of all ages are protected from abuse, neglect or other kinds of harm. This also involves preventing abuse, neglect or other kinds of harm from happening.

The two key **safeguarding** objectives of **protection** and **prevention** underpin the work of the Board and inform the priorities each year.

The responsibilities and functions of the Board are set out in the statutory guidance under Part 7 of the Social Services and Wellbeing (Wales) Act 2014. It has an overall responsibility for challenging relevant agencies so that:

- There are effective measures in place to protect children and adults at risk who are experiencing harm or who may be at risk as the result of abuse, neglect or other kinds of harm; and
- There is effective inter-agency co-operation in planning and delivering protection services and in sharing information.

Safeguarding Children

Section130 (4) of the Social Services and Well-being (Wales) Act 2014 defines a child at risk as a child who:

Is experiencing or is at risk of abuse, neglect or other kinds of harm;

a) Has needs for care and support (whether or not the authority is meeting any of those needs).



What do we mean by Harm?

Harm is defined as:

- ill treatment this includes sexual abuse, neglect, emotional abuse and psychological abuse
- the impairment of physical or mental health (including that suffered from seeing or hearing another person suffer ill treatment).
- the impairment of physical, intellectual, emotional, social or behavioural development (including that suffered from seeing or hearing another person suffer ill treatment).

Types of Harm

The following is a non-exhaustive list of examples for each of the categories of harm, abuse and neglect included in vol 5 Working Together to Safeguard People: Volume 5 – Handling Individual Cases to Protect Children at Risk:

¹ Source: Office for National Statistics (Census 2021)

- physical abuse hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions;
- emotional/psychological abuse threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks, witnessing abuse of others
- sexual abuse forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening, including: physical contact, including penetrative or non-penetrative acts; non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways;
- financial abuse this category will be less prevalent for a child but indicators could be:
 - not meeting their needs for care and support which are provided through direct payments;
 or
 - o complaints that personal property is missing.
- **neglect** failure to meet basic physical, emotional or psychological needs which is likely to result in impairment of health or development.

Safeguarding Adults

S126(1) of the Social Services and Well-being (Wales) Act 2014 defines an adult at risk as an adult who:

- a) is experiencing or is at risk of abuse or neglect,
- b) has needs for care and support (whether or not the authority is meeting any of those needs), and
- c) as a result of those needs is unable to protect himself or herself against abuse or neglect or the risk of it.



Abuse can be physical, sexual, psychological, emotional or financial (includes theft, fraud, pressure about money, misuse of money) and can take place in any setting, whether in a private dwelling, an institution or any other place.

Neglect describes a failure to meet a person's basic needs physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health). It can take place in a range of settings, such as a private dwelling, residential or day care provision.

CASE EXAMPLE: Rhondda Cynon Taf Children's Services



Magu, translated as "to raise and nurture," is RCT's pre-birth service offering support to parents from 10 weeks into pregnancy lasting, if required, until the child is one year old.

This intervention is targeted towards supporting families where there is likelihood of the child becoming involved in statutory child protection and public law outline procedures, and is at risk of separation from a parent, potentially entering the care system.

The overall aim of the Magu service, is to deliver better outcomes to children and families, decreasing the number of children entering the care system. This is a strengths-based intervention which relies on early relationship formation between the worker and the parent with the aim of building skills, knowledge, and resilience, ultimately reducing likelihood of future risk.

Background: Both Mother and Father to child A are care experienced having had significant involvement with children's services throughout their childhoods. Issues of concern

- Vulnerable to sexual exploitation.
- Use of substances.
- Both having engaged in risk taking behaviour.
- Extremely poor home conditions.
- Difficulties with unstable mental health.
- Lack of self-care and poorly developed independence skills.
- Non-attendance at ante natal appointments.
- Not accepting concerns raised and not engaging with the social worker.

Child protection procedures were initiated leading to a plan for the baby to be placed on the child protection register at birth, due to the extent of worry about parents' ability to care safely for their baby PLO was also invoked. At this stage, there was a very real possibility of care proceedings being initiated and potential of the plan for the expected baby to be one involving separation from parents.

What we did:

- Relationship building, spending time listening to parents differing experiences of children's services involvement in their lives.
- Hands on practical support to address very poor home environment, this included cleaning our debris and clutter, teaching about cleaning products and their use.
- Focus on healthy and safe lifestyle for themselves in order to create a safe environment for their baby.
- Delivery of parenting programmes at pace suitable for learning needs.
- Practical support to prepare for baby, teaching about feeding, bathing, sleeping.
- Assistance to attend ante natal classes and medical appointments, the parents have minimal support network and were at risk of disengagement with health services.

The pre-birth parenting assessment carried out by the social worker from the Intensive Intervention Team concluded that, whilst recognising strengths and significant progress in engagement, the risk of placing the expected baby directly into parents' care was still too high. A parent and child placement was identified as the post birth plan. Parents were highly anxious and needed much support over this period. Although the placement was outside of the local area the Magu worker visited regularly and continued to support parents to understand and work through the concerns identified in the parenting assessment. Magu staff supported the transition from the placement back into the community with a high level of visiting patterns until it was evidenced that risk was reducing.

Outcome: The transition has been completed. Parents are meeting the needs of their baby consistently to a good standard. They provide a warm, nurturing and loving environment. They were delighted when PLO ended with a positive post birth parenting assessment. They are now awaiting a review child protection conference whereby the plan is to remove the name of their baby from the child protection register.

They work well with all necessary services for themselves and their baby and are eager to continue with Magu support over the coming months.

In their words; We are both so happy with the help we have received from you. We hope that all future interactions are as positive, and we strongly believe they will be.

Multi Agency Safeguarding Hubs

In the Cwm Taf Morgannwg region there are two Multi Agency Safeguarding Hubs (MASH) that report to the Board:

The Cwm Taf (Merthyr Tydfil and Rhondda Cynon Taf) Multi Agency Safeguarding Hub (MASH) and the Bridgend Multi Agency Safeguarding Hub (MASH).

The purpose of the MASH is to act as the single point of contact for all professionals to report safeguarding concerns. MASH provides the opportunity for a higher standard of safeguarding by providing all professionals with more information on which to make better, more informed, and more timely decisions. This enables the effective sharing of information between agencies, helping to protect children and adults from abuse and neglect.

Although the concept of the MASH involves co-location, partner agencies have responded to the different ways of working over the past four years, including remote working, without compromising the need for prompt information sharing and actions to safeguard people. The MASH is modernising operational models, utilising new communication/information sharing technologies that support both in-person and remote working.

The collaboration of both Multi Agency Safeguarding Hubs continues to be a key focus of the Board to streamline multi-agency safeguarding across the Cwm Taf Morgannwg region. Recent collaborative projects include:

- A multi-agency working group established to agree a consistent approach to a modernised operational MASH model. Terms of Reference has been agreed and future meetings are being arranged.
- A multi-agency working group to develop a shared understanding of child protection threshold decision making across the three local authority areas in Cwm Taf Morganwwg.
- Ongoing work to establish clear pathways for signposting and referrals for professionals (for both Children and Adults).
- Contributing to the National Independent Safeguarding Board's development of the National Performance Framework. This will provide assurances to the Board on the efficacy of multi-agency safeguarding practice across the region.
- The successful implementation of a new MASH information sharing system that is fit for purpose for both Cwm Taf and Bridgend. The system is supported by dedicated online TEAMS channels, providing multi-agency online workspaces for real-time collaboration and decision making.

2. Members of the Safeguarding Board

The Lead Partner for the Board is Rhondda Cynon Taf County Borough Council and the membership complies with the statutory guidance issued under Part 7 of the Social Services and Well Being Act 2014.

The lead partner hosts the Board's Business Unit and holds the Board budget on behalf of the statutory partner agencies.

A list of Board members is attached as Appendix 1.

3. What did the Board do in 2023-2024 to meet its Outcomes?

Governance

The Safeguarding Board has a robust governance structure in place (Appendix 2) that enables it to carry out its functions and achieve positive outcomes for children and adults at risk in Cwm Taf Morgannwg.

Challenge and Scrutiny

The Board holds partner agencies to account in relation to their safeguarding activities through effective monitoring and challenge. This is carried out via the Board and Sub Group meetings, reviews, inspection reports and audit activity.

The Board encourages partner agencies to share individual inspections and reviews that relate to safeguarding. In 2023-2024, the Board received and reviewed the following reports and improvement plans from agencies:

- Review of Cwm Taf Morgannwg Region Community Safety Arrangements
- Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Heath Board
- Care Inspectorate Wales, Improvement Check Summary, Bridgend Children's Services
- NHS Wales Safeguarding Network Annual Report 2022 2023
- HMP Parc Prison Assurances on Safeguarding Practices
- BCBC, CTMUHB, SWP Report of Joint Inspection Review of Child Protection Arrangements

Performance

The Board has a performance framework in place to capture safeguarding data. This has been subject to further development this year, to ensure that we have a consistent, regional, multiagency framework. The Board has ensured representation at the National Independent Safeguarding Board workshops in relation to the development of a National Performance Framework for Children.

The Board has a Children's Quality Assurance and Performance Group (CQAP) and an Adult's Quality Assurance Group (AQAP) that receive and analyses multi-agency performance metrics, scrutinising, respectfully challenging data and reporting on key thematic sources of harm. Whilst previously there was also a MASH Quality Assurance Group, this has been reviewed in line with

the development of the National Performance Framework and moving into 2024/2025 these metrics will be considered respectively within the children's and adults' groups to ensure the triangulation of qualitative and quantitative data is analysed, focused on outcomes and the lived experience of the child and/or adult through the journey of their intervention.

Children's Safeguarding

In 2023-2024, there have been a continued increase in the demand at the front door across the region. This is reflective of the joint campaign with NSPCC on raising public awareness on signs of safeguarding and how to report safeguarding concerns.

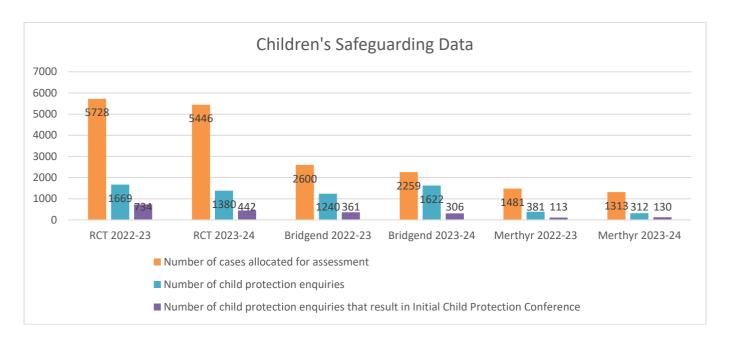
Bridgend has had the most significant increase in contacts at the front door compared to last year, although number of cases proceeding to assessment has remained relatively stable. A significant number of cases proceeding to assessment result child protection enquires, although the number that proceed to Initial Child Protection Conference is relatively low.

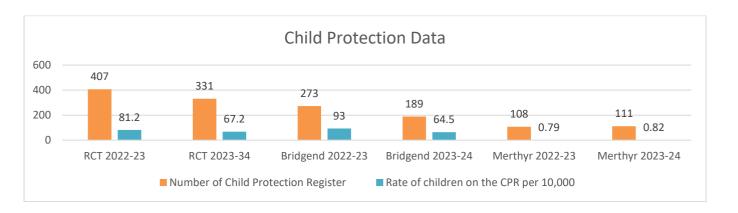
In Rhondda Cynon Taf, figures have remained relatively stable, with a steady decrease of cases under child protection enquires proceeding to Initial Child Protection Conferences. This is reflective of the internal quality assurance work that has been undertaken in relation to outcomes of child protection enquiries.

In Merthyr Tydfil, there has been a slight increase in demand at the front door, although number of cases proceeding to assessment has remained relatively stable. There has been a decrease in the number of cases allocated for assessment professing to child protection enquiries, although there has been an increase in those cases that proceed to Initial Child Protection Conference.

During 2023/24 we have identified harmful sexual behaviours in young people as being a potential thematic hotspot. In response, we have started an audit of young people identified as being charged with an offence. In developing the scope of the audit, we collaborated with Better Futures and have held multi-agency workshops. Whilst this work remains ongoing, early learning has indicated that early identification and prevention of inappropriate and problematic behaviours to reduce likelihood of abusive and violent behaviour is crucial to prevent escalation and criminalisation of children and young people. In response to this, practitioner guidance including resources will be created alongside consideration of future training needs.

With regards to the number of children on the Children Protection Register, Bridgend and Rhondda Cynon Taf saw a decrease over the course of 2023-2024, whilst Merthyr Tydfil remained relatively stable.





Case Example: Effective Partnership working to Safeguard children and young people at risk of exploitation.

In an effort to identify potential service links to exploitation among the children they work with, the Bridgend Youth Justice Service undertook a mapping exercise. The purpose of this exercise was to visually connect the different children they were currently assisting and determine if there were any direct associations or patterns that could indicate potential exploitation.

To conduct the mapping exercise, all team members gathered for a meeting. They utilised a large roll of paper to create a comprehensive list of all the children who were open to the service at that time. Each team member then began to establish links between the various children based on the information they had gathered throughout their interventions and interactions with the young individuals.

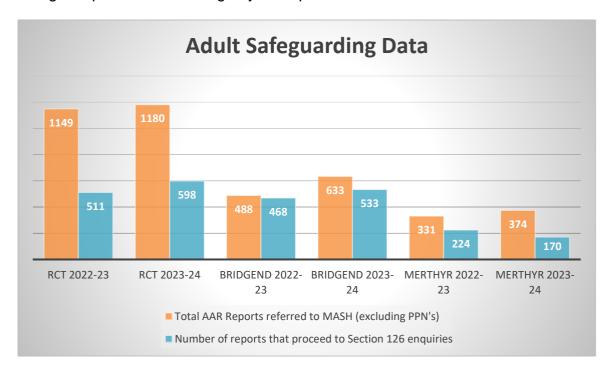
The result of this mapping exercise was a significant child mapping diagram that visually illustrated the connections and relationships between the children. The team observed clear links and identified similar concerning behaviours among the children included in the mapping exercise. Some of these behaviours included having unexplained amounts of money, frequently going missing, and absconding from school.

Recognising the importance of this information and its potential implications, the service shared the findings with relevant agencies involved in supporting these children. The information was specifically passed on to the child exploitation team, which has the necessary expertise and resources to further investigate and address potential exploitation cases.

By identifying these connections and concerning behaviours, the mapping exercise provided valuable insights for understanding the potential risks faced by the children in question. It allowed the team to take proactive steps in collaborating with other agencies and initiating investigations to safeguard the well-being of these vulnerable individuals. This exercise demonstrates the dedication of BYJS in identifying and addressing issues related to child exploitation within their jurisdiction.

Adult Safeguarding

Overall, there has been an increase in reports across the region with Bridgend having the most remarkable increase compared to 2022-2023. The percentage of reports proceeding to S126 continues to differ between the three local authorities. The overall percentage for Bridgend was 87%, whilst it was 45% for Merthyr and 50% for RCT. Whilst Bridgend and Merthyr seen a slight decrease compared to 2022-2023, RCT seen a slight increase. All 3 Local Authorities continue to improve on the national PI regarding S126 enquiries being completed in 7 working days compared with 22-23.



Escalating Concerns

Reports from Local Authority Commissioning Departments were received each quarter in relation to service providers in escalating concerns. There were 6 in total during 2023/2024.

Deprivation of Liberty Safeguards (DoLS)

In RCT and Merthyr, the number of DoLS assessments completed this year has slightly reduced compared to 2022-23. The Health Board had a 35% increase in the number of DoLS assessments completed in 2023-24.

Bridgend completed 443 assessments.

Overall, there has been a significant rise in the number on the DoLS waiting list across the region compared to 2022-23.

Adult Services Case Example

'Richard'

The case involved suspected financial abuse that was reported by a DoLS assessor. The man "Richard" is 57: he was in hospital for 20 months and then was discharged from hospital to a care home in April 2023. His placement is funded though NHS Continuing Health Care (CHC), which is where someone is assessed as having a primary health care need and the NHS funds all aspects of their care and treatment, including accommodation costs if the person is resident in a care home. Richard's situation was reported to Safeguarding when the DoLS assessment had taken place at the care home, as Richard does not have the mental capacity to consent to his care arrangements or to manage his money. Richard is aware that he has no money available to him and has said that he would like some money in his pocket. Since being in hospital and in the care home, Richard has had no access to money. The benefits that he previously had before going into hospital were managed by his aunt and uncle, but they have said that his benefits were stopped. His aunt was his appointee for the Department of Work and Pensions: his benefits were paid into her account, and she was responsible for his financial affairs. The DoLS assessor suspected that there might be financial abuse but had no evidence and there was no one who had the authority to investigate this matter. The DWP has been informed of the concerns. Richard's aunt and uncle were also suspected of financially abusing Richard's mother: she is also resident in a local care home and lacks capacity to manage her financial affairs.

Initially, the situation reached an impasse because the health board declined to take action to initiate a claim for benefit for Richard or to take on DWP appointeeship. At the same time, the Local Authority's view was that it was not responsible for safeguarding Richard's financial position because he is CHC funded.

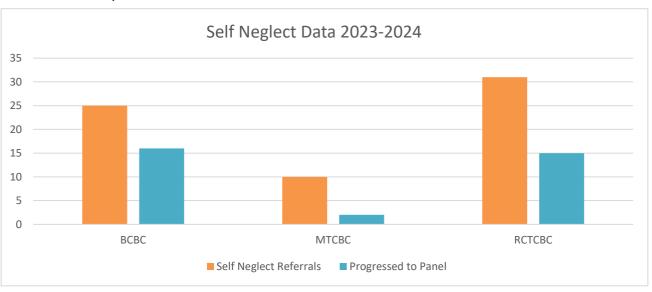
Meanwhile, Richard was not receiving income to which is entitled. His basic needs are being met but he has no money to fund any extras, which is a dignity and potentially an Article 3 Human Rights issue.

A best interest meeting was held, attended by the Safeguarding team, and it was agreed that a solicitor would take on appointeeship. This will enable Richard to access his benefit entitlement and safeguard him from risk of future financial abuse.

Self Neglect

A regional approach to managing cases of self-neglect in adults was introduced in October 2021. This has proved to be an effective mechanism in making a real difference to people experiencing severe self-neglect.

The Self-Neglect Partnership Panels are well-established, particularly in RCT and this is beginning to become embedded in the other local authority areas. There was a 35% increase in referrals compared to 2022-2023.



Professional Disagreements

The Board's <u>Concerns Regarding Interagency Safeguarding Practice</u> (CRISP) protocol supports practitioners in finding a resolution when they have a professional disagreement or concern in relation to another agency's safeguarding practice.

A review of the protocol was undertaken by the Policy and Procedures Group. There have been no cases escalated to the Board for resolution in Children's Services.

4. How did we implement our Annual Plan and what were our key achievements?

The Board published a Three Year Strategic Plan (2023/2026) on the 31st March 2023, setting out its priorities for safeguarding children and adults at risk in Year One, 2023/2024.

You can access the Annual Plan for Year One 2023/2024 by clicking here.

In relation to the Boards Strategic Priorities, a summary of the work is carried out below.

Strategic Priority 1: We will re-set and establish where we are and where we need to be

A key priority and continued focus for the Board is the prevention of abuse and/or neglect. We wanted to ensure that our communities were aware of early intervention and prevention services to support children, young people and adults, to prevent them becoming at risk of abuse or neglect.

To support this, we aimed to raise awareness within our communities of how to recognise and report safeguarding concerns. We have an established steering group, leading on the development and delivery of a public awareness campaign. We have collaborated closely with key stakeholders and the NSPCC to deliver this.

The NSPCC is delivering free 'Listen Up, Speak Up' workshops throughout the region as part of the Listen Up, Speak Up campaign. Theses workshops aim to raise awareness about child abuse and neglect while fostering open discussions within the community. These free workshops, delivered by NSPCC staff to community members 18+, are available both face-to-face and virtually, ensuring accessibility for all. A number of community organisations have already taken this up with future events planned.

In **RCT, Children's Services** have created a new public facing website for parents and carers and are currently in the process of developing an information platform for children and young people. As part of the development RCT have consulted with parents and carers and plans are in place to consult with children and young people regarding future content. The website contains information and resources on numerous topics including how and where to get support and how to report a concern. A media campaign is taking place over several various platforms to ensure communities are aware of the website.

RCT Adult's Services have continued to offer an 'Early Help' Service option for South Wales Police, via the Community Development Team. All residents referred via these routes receive a What Matters Conversation during the initial phone call, and the relevant support provided (supermarket or fuel voucher, non-statutory wellbeing assessment) and any ongoing signposting or referrals to supporting partners. South Wales Early Help referrals seek to support residents to overcome barriers and reduce the number of repeat calls to the Police.

Probation Services have embedded mandatory safeguarding enquires, which are completed both pre and post sentence. This ensures that any person on Probation who is living with, or has contact, with a child known to Children's Services is identified, safeguarding activities are timely, aligned and informed by close multi-agency working. The outcome of these checks inform risk assessments and risk management plans.

In **Bridgend**, Children's Services rolled out Members training to strengthen the referral process and safeguarding awareness to Councillors and Elected Members. Bridgend have also created and successfully recruited to two specialist exploitation senior social worker posts within Childrens Social Care.

Merthyr Tydfil Social Services has had a review of the safeguarding arrangements and structures have changed within Adult's and Children's to ensure robust safeguarding structures including signposting to early help and prevention. Children's Services has strengthened processes within their 'front door' with referrals being screened and actioned directly by social work teams. This has reduced delays in decision making and increased capacity within MASH to manage Information, Advice and Assistance.

Addressing vulnerability remains a priority for **South Wales Police**. An effective response to vulnerability, in all its forms, is essential in order to achieve both the mission and vision of SWP, as well as aspects of the Chief Constable's Delivery Plan. It remains a priority of South Wales Police to develop the understanding of the issues faced by our communities to provide the support they need, using the principles of early intervention and co-operation with partners to identify and help those who need it most. Operation Amdddiffyn ensured all officers in SWP were trained in the fundamentals of Safeguarding, promoting professional curiosity and a focus on those who abuse present a risk to vulnerable adults and children.

Strategic Priority 2: We will re-learn by reflecting on the past year and agreeing how what we learn as a Board can make a difference to safeguarding practice

In 2022/2023 we launched our Learning and Improvement Framework which sets out how we will identify, disseminate and implement learning to improve safeguarding practice, ensuring a continuous learning and improvement cycle. This continues to be a key priority for the Board. The Joint Review Group and Quality Assurance and Performance Groups continues to monitor the implementation and progress of learning and actions arising from reviews and other national work e.g., Rapid Review of Child Protection Arrangements.

In the **Health Board,** outcomes of reviews and audits are reflected in the health boards listening and learning events, training, safeguarding week and communications. The health board have strengthened their governance within the new organisational structure to ensure learning is effectively distributed throughout its services.

In **RCT**, **Education** has arranged a multi-agency safeguarding training morning to discuss pertinent issues facing schools in the current climate including lockdown procedures, managing allegations and Prevent.

In RCT, **Children's Services**, learning and good practice from reviews is valued and shared via management forums on a regular basis and cascaded throughout the organisation in a number of formats, including team meetings, inform and involve sessions, 7-minute briefings and newsletters. RCT also hold whole service mandatory summer safeguarding session to ensure key messages from reviews, audits and wider national work e.g., Rapid review of child protection arrangements enabling space for practitioners to reflect on good practice and learning.

In RCT, **Adult's Services** practitioner knowledge and practice has been enhanced through sharing of learning from complaints, by presentations from relevant organisations (e.g., DBS/SCW/Advocacy organisations). An area for future development for the Adult Safeguarding Team will be to draw upon examples of consultation and coproduction elsewhere in Adult Services, in promoting the inclusion and participation of the experiences of adults at risk and their families, in the work of the team.

In **Merthyr, Education and Social Services** have an established Corporate Safeguarding Reference Group that has attendance from all council areas. Learning from reviews, audits and other safeguarding issues that require reporting locally are escalated to this group and disseminated accordingly.

In **Bridgend**, they have worked in partnership with the Board and the Workforce Development Team to deliver a programme of safeguarding workshops with a focus on improving practice aligned with the learning and recommendations of practice reviews. They have also lead work on a the development of a regional 'Understanding Thresholds' Multi-Agency Guidance to support consistency in practice across the region.

The **Probation Service** in Wales remains committed to staff development in relation to safeguarding, the expectation being that all staff complete mandatory face-to-face classroom safeguarding training for both Child and Adult Safeguarding over the course of 2024. This serves to ensure all staff remain clear of the expectations of safeguarding being ingrained throughout our decision making and risk management. In addition to this, the 2024 'Think Child' campaign has been actively promoted across Wales, aimed at raising staff awareness of their unique role in supporting children whose lives are impacted by the behaviour of individuals we supervise and the decisions we make.

In **WAST**, an internal audit was published in relation to safeguarding children and young adults, with the learning identified being shared within a bespoke continuous professional development (CPD) webinar. There have been over 400 WAST colleagues complete this training package since its launch. A training package on Child Sexual Exploitation was also created and launched on Child Sexual Exploitation Day in March 2023. Colleague feedback states it raised their awareness, is a useful refresher on CSE indicators and re-enforced the importance of professional curiosity.

South Wales Police employ dedicated Review Managers, who engage with the Boards review sub groups, but also ensure learning from Adult and Child Practice Reviews, Domestic Homicide Reviews and Inspections, is translated into practice. There is strong governance, including a Protecting Vulnerable Persons Board, chaired by an Assistance Chief Constable that ensures the Safeguarding and Public Protection command are held to account for delivering against the priority of protecting the communities most vulnerable.

Strategic Priority 3: We will agree on how we can re-develop as a Board to maximise opportunities to improve how we safeguard people.

We have fully engaged and contributed to the development of the Single Unified Safeguarding Process (SUSR) to ensure a national approach to dissemination of learning is shared through the development of a national repository. This has included contribution at the pilot SUSR training and attendance at Offensive Weapon Homicide Review Training (OWHR). We will continue to support the implementation of the SUSR ensuring attendance at local and national workshops and ensure we contribute to the development and delivery of training resources to support the new process. Training dates for future Panel members, Reviews and Chairs are planned for 2024.

Another key priority for the Board is the development of the Regional Exploitation Strategy to achieve a consistent approach in managing and responding to all forms of exploitation. There are regular Exploitation Steering Group meetings held. Phase 1 of the Strategy is the development of Strategical

Exploitation Group, a multi-agency Prevention Panel, and referral pathways, practitioner guidance and resources including toolkits and safety planning for children and young people up to the age of 25 years old. The second phase of the strategy will be all adults. Whilst there have been some challenges in progressing the work due to demand and capacity throughout 2023-2024, this work is progressing, and it is envisaged that Phase 1 will be implemented in autumn 2024. The Board also has representatives who attend the Pan-Wales Exploitation Group, where there is regular attendance and contribution.

Assurances are provided to the Board via the Multi-Agency Exploitation Sub-group that children at risk of exploitation are being identified and each local authority has interim referral pathways and multi-agency meetings to appropriately consider the contextual safeguarding approach, implement safety planning and consider and utilise disruption tools where applicable.

There is also representation on the Pan-Wales Exploitation Group where local and national issues are discussed and reported back to the Steering Group.

In support of the Boards aims and priorities of South Wales Police, SWP have embedded dedicated Exploitation Investigation Teams across South Wales. Along with a significant restructure of the Public Protection command which ensures engagement by specialist officers at every level of board activity.

Other Board Priorities

Workforce and Wellbeing

Recruitment and Retention remains a key priority. All staff working across our partner agencies must feel valued and supported, in particular, at a time where there are continued pressures on our services. We continue to promote staff well-being through a range of different means and ask partner agencies to report to the Board on how they are ensuring that this priority is being addressed. Some examples are provided below:

In **RCT Children's Services**, whilst recruitment and retention continue to be a key issue, there is a workforce steering group with key actions that focus on retention of staff and staff wellbeing. Staff development and career opportunities is an integral part of the workforce plan and we have created the 'Grow Our own' pathway. Staff have access to a psychology led, reflective spaces fora, mental health self-service platforms as well as formal support through occupation health. Whilst there is some reliance on agency staffing due to vacancies, reassurances to the Board are provided. Despite some of the challenges, staff remain committed to safeguarding children, ensured children are protected and where early help is identified, preventative services in RCT offer an intervention focused on creating and building resilience.

South Wales Police recognise that its staff operate in a high risk and high threat environment and are exposed to traumatic incidents regularly, consequently SWP have embedded Trauma Risk Management (TRIM) as routine response for officers exposed to such incidents. South Wales Police are currently reviewing all its policies and procedures to ensure they adopt a trauma informed approach.

In **Bridgend**, Staff wellbeing has remained a priority. The Council Health and Wellbeing Group has meet every quarter. Employees can access a 24/7 employee assistance programme. Also provided is a range of wellbeing support resources and workshops. Additionally, the Directorate has made available bespoke wellbeing training and support for teams via SCDWP and also specialist trauma informed support for staff who require it. Staff have had access to individual coaching and mentoring and a bespoke leadership management and development programme has been established for managers in social care.

Suicide Prevention

The Board continues to work on a regional, cross-partnership basis to support the prevention of suicide and self harm agenda. A multi-agency Suicide Steering Group has continued to meet. This receives information in respect of suspected completed suicides managed under the Immediate Response Protocol, which allows us to identify themes, demographics and triggers that can support us in tackling this very important agenda. Further collaborative development of this cross-partnership work is planned for 2024/2025.

Protocols and Procedures

The Board has a Policy and Protocols Review Group (PPG) that has strong representation across the multiagency partnership. PPG, review and evaluate policies, procedures and guidance collaborating within task and finish groups to ensure multi agency contribution. Practitioner feedback is central to the review and evaluation process. PPG also ensures recommendations from practice reviews and multi-agency audits with regards to the review and/ or development of policy and practice guidance is developed to ensure practitioners have useful resources available to them to inform effective safeguarding practice.

The following Board protocols and guidance documents were reviewed and updated during 2023-2024:

- Deprivation of Liberty Safeguards (DoLS) Policy and Procedures
- School Safeguarding Policy
- Concerns Regarding Inter Agency Safeguarding Practice (CRISP)
- Professional Curiosity Resource Pack
- Coercive Control Guidance

Partner Agency Achievements

In addition to the joint work that is undertaken as a multi-agency Board, individual partner agencies also share their achievements in relation to safeguarding.

Bridgend Council Children's Services has created and appointed a Quality Assurance Officer and progressed the Quality Assurance Framework, facilitating workshops to fully embed learning and share effective practice examples. The introduction of a monthly exploitation panel which supports multi agency collaboration and solution focused practice for children and young people at risk of exploitation. The Signs of Safety Practice Model has supported practice, with an increase in compliments and decrease in complaints throughout 23-24.

Bridgend Council Adult's Services has worked in collaboration with Social Care Wales to develop a Strengths based/outcomes focused practice model within Adult Social Care and developed an escalation response which is activated by the Head of Adult Social Care to ensure critical care and support services are prioritised, where CTMUHB have declared Business Continuity Emergency status.

Merthyr Education and Social Services held a student focused conference that shared the Safeguarding Boards priorities with a focus on exploitation and supported the regional campaign to increase public awareness of how to recognise and report safeguarding concerns by developing and producing a short animation aimed at children and young people.

Rhondda Cynon Taf Children's Services has undertaken a review of its Information, Advice, and Assistance Service and from this developed the Right Help, Right Time, Right Place strategy, which seeks to deliver sustainable better access to the right help for vulnerable families whose needs are predicted to continue to increase. A central tenet of the strategy involves developing strong service delivery in

communities, developed with people and their communities that is focused on prevention, self-help, and early intervention, which can lead to more intensive support when needed.

Rhondda Cynon Taf Adult's Services Safeguarding Service Manager has lead on work within RCT to develop guidance for practitioners working with individuals who have No Recourse to Public Funds. A 'Lunch and Learn' session was held to launch the guidance, which is accompanied by a seven minute briefing.

Cwm Taf Morgannwg University Health Board, Utilising Welsh Government funding the health board has developed a Mental Capacity Act Team, who have raised awareness and provided both mandatory and bespoke training. This work will strengthen practitioners' practice in supporting those patients who lack capacity and are at an increased risk of safeguarding concerns.

Wales Ambulance Services Trust (WAST) hosted a Safeguarding Conference with a theme of 'Trauma Informed Workforce'. The conference included keynote speakers providing presentations on safeguarding all age groups and impactful survivor stories, and was attended by internal and external colleagues, many provided positive feedback stating the day was interesting, engaging, and informative.

Probation Services commenced chairing MARAC in 2023/24 illustrating their commitment to leading multi-agency collaboration and safeguarding victims of domestic abuse. Also, in collaboration with the CTM University Health Board they have promoted the use of sexual health kits to people on Probation and are exploring the implementation of follow up care from a sexual health nurse.

South Wales Police are an improving force according to His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in terms of tackling vulnerability, as recognised in the recent PEEL (police effectiveness, efficiency and legitimacy) Inspection. South Wales Police embrace the concept of continuous improvement and have introduced a Vulnerability App to assist officers in dealing with the complexity of multiple strands of vulnerability. A significant restructure has created a Public Protection and Safeguarding Command with a singular focus on delivering an effective response to vulnerability in all its forms, and whether in response to exploitation, missing children or sharing information with partner agencies, performance has improved with the acceptance there is still much to be done.

5. Safeguarding Themes

Audit Activity

Achieving improvement in safeguarding policy, systems, and practice is a core function of the Board. Audit work is carried out via task and finish groups set up by the Quality and Performance Sub Groups. Any recommendations made by case audits are monitored by these groups to identify how practice is adapted to reflect any learning. The key learning themes from four completed audits are summarised below:

AUDIT ACTIVITY	THEMES IDENTIFIED
Re-Registration (RCT)	Care and Support Protection Plans need to be jargon free, have clear outcomes that are co-produced with children, young people and parents/carers.

Although there were occasional delays with core groups, this was not a prominent feature in the audit and in most cases core groups and conferences were held consistently within timescales.

Core groups often took the form of updates from all in attendance as opposed to reviewing actions or outcomes from the plan. Attendance at core groups varied, however in cases where there was a named health visitor, there was evidence of regular attendance.

Review Child Protection Conferences evidenced that actions from plans are reviewed, as opposed to the outcomes wanted to be achieved. This was linked with findings that parents appeared to complete work, and so actions were marked as achieved, however, the attitudinal and behavioral changes expected were not achieved or sustained, resulting in further issues of the same nature and subsequent re-registration.

Domestic abuse and substance use featured in most cases.

De-registration in many cases occurred when the mother had completed work recommended but father/male partner had not completed any significant work. Those families reported that their relationship had ended, and as such, professionals felt the risk was no longer apparent. However, the couples resumed their relationship in some form in each case.

Parental engagement was inconsistent and there was evidence of disguised compliance.

Every case had input from extended family members, however, there was limited evidence of extended family participating in core groups. This resulted in situations were extended family did not have up to date information regarding the situations they were supporting.

The Management of Adult safeguarding Cases where the alleged perpetrator is a professional or a care home

In Merthyr, all A1 reports were evaluated on the same day. Where it was required there was evidence that immediate action was taken to safeguard at the time of the incident.

Only two of 7 cases identified an individual professionals however there was no evidence they had been considered under Section 5 Wales Safeguarding Procedures.

Lack of robust recording regarding decision and actions was a key theme.

Although there was some evidence that individuals were asked about their views wishes and feelings in relation to safeguarding, this was often felt generic without enough emphasis on their participation throughout the process.

In RCT, all reports were evaluated on the same day and immediate action to safeguard was taken by the referring home in all cases. Most cases of suspected abuse or neglect in care homes were instituitional in nature and no one professional was thought to be responsible. Most strategy discussions/meetings did not take place within 7 working days although Sec126 enquiries were completed within prescribed timescales.

There were no separate professional concerns meetings: the professionals who were the alleged perpetrators were dealt with within the AAR meeting. This was not satisfactory as there was no explicit

consideration of disciplinary requirements & referrals to professional bodies/DBS.

Family were mostly identified as providing support and advocacy to the AAR, although it was not always apparent how the family were involved. The offer of a case conference was not well documented and family supporters were not always offered a case conference even when the AAR was felt unable to participate.

Only 1 case had a formal review, yet there were actions for various parties from the strategy meeting. These did not appear to be followed up to check they were completed.

In Bridgend, all reports were evaluated on the same day and immediate action to safeguard was taken by the referring home in all cases. There were two cases that were not referred to the team immediately both of these were from learning disability providers. Both services had commenced their disciplinary processes prior to the referral and in one case the person had been dismissed for misconduct.

5 out of the 9 cases were medication errors, from slight medication errors that had no impact on the individual to medication errors that required staff to be retrained and reassessed to ensure they are competent to administer medication.

In all cases either the individual was spoken to or their family advocate to ensure their views and wishes were known in relation to the safeguarding process.

De-Registration at First Review (Re-audit)

In RCT, whilst there was evidence of improved practice further learning and recommendations were made to ensure consistent effective practice.

Some key themes included:

- Missing information from agencies at initial strategy meeting
- Lack of professional challenge when considering delays in referrals/PPNs
- No identified timescales against agreed actions at conclusion of strategy discussion
- Professional curiosity and utilising historical information (Chronologies)
- Missed opportunity for collaborative multi agency working throughout enquiries.
- Child's voice and lived experience was underrepresented.
- No offer of advocacy
- 33% of cases did not include fathers with 22% pf cases evidencing an over reliance on mothers' views and information taken at face value.
- Records of outcome strategy meetings did not evidence robust discussion on the actions set at the outset of the enquiries.
- Records of rational for decision making was only found in 45% of cases.
- At ICPC there was a clear lack of evidence base and analysis within practitioners' reports
- Where adults associated with the child had services, these agencies were underrepresented at conferences.
- The voice of the child and their lived experience was not always clearly recorded.

- Where there were sibling groups, there appeared to be a focus on a lead child than all children.
- Recommendations for advocacy were routinely missed from care and support plans.
- Core groups were inconsistently attended by members with an over reliance on the social worker to manage all core group functions
- Core groups tended to focus on 'updates' than specifically identifying the tasks and measuring the actions against the outcomes.
- Fathers were missing from core groups.
- Core groups lacked a focus on the voice and lived experience of the child and the impact planning had on improving and meeting their wellbeing outcomes.

In Bridgend, commissioned an independent reviewer to undertake the audit.

- 77% of referrals were judged to have an appropriate and proportionate response.
- Where physical harm was prevalent there was evidence that joint section 47 enquiries were initiated without delay
- There was evidence of management oversight allowing for clear and concise rational of decision making.
- In many cases, the screening record provides opportunity for a clear and concise history outlining the child and family's history.
- In many cases there was good evidence of multi-agency working
- There was evidence of good 'step up-step down' processes between statutory and early help services.

Reference to learning included:

- Parental consent
- Multi agency working and Professional Challenge including challenging the decision to or not to proceed to child protection medical assessment.
- Anonymous Referrals and Self Reports including over reliance on mother's voice and information taken at face value.
- The Lived Experience of the child.
- The inclusion of fathers, including practitioners over emphasising view of fathers through the 'lens of risk'

Adult Practice Reviews and Child Practice Reviews

In 2023-2024, the Board published 1 Child Practice Reviews and 1 Independent Safeguarding Review:

CPR CTMSB 08/20

CTMSB 07-2021 Independent Safeguarding Review

The learning from these Reviews were cascaded across all partner agencies and the action plans arising from the recommendations contained in these Reviews continue to be monitored. All partner agencies have demonstrated that they have shared the learning widely via a variety of different means. This includes 7-minute briefings, staff briefings, face- to-face

workshops and via web updates. Partner agencies have also assured the Board that the learning has informed training.

Both reviews have acted as reminder to all partner agencies on the importance of supervision and management oversight, good record keeping, the need for clear risk assessments and reanalysis of risks, including the impact of missed health appointments, professional curiosity, continuous information sharing including the use of chronologies and the challenges for professionals in recognising and responding to disguised compliance.

Some key actions have been undertaken in response to the learning, including:

- Bespoke training on domestic violence was delivered to mental health colleagues throughout CTMUHB. This included presentations from the Health IDVA and Drive Perpetrators Programme.
- ➤ Improvements to discharge planning within mental health including the development of a quality inpatient improvement board, with focus on process and practice around discharges. Subsequent review held in November 2023 by Health Inspectorate Wales noted significant improvements in these areas.
- ➤ The development of a multi-agency guidance on shared 'Understanding of Safeguarding Thresholds'
- ➤ The development of 'Section 47 joint enquiries by Social Services and Police
- > Training sessions held in Bridgend on Working with Complex Families
- Mandatory Training on Professional Curiosity for all social care staff in Bridgend.
- ➤ The adoption of a new Signs of Safety practice framework in Bridgend Children Services, which provides a strength-based, solution focused approach to safeguarding and child protection practice.
- Implemented a new information sharing platform for both MASH, supported by Teams channels. This will improve the timeliness of strategy discussions and record agency interventions all in one place.
- > Improvements to Quality Assurance and Learning Frameworks.
- Work has commenced to strengthen health representation at child protection conferences for school aged children. A standard operating procedure and pathway has been developed to support staff.

Complaints

The Board's <u>Complaints Procedure</u> provides families with the opportunity to make a complaint with regards to the multi-agency child protection conference process and procedures, and the multi-agency adult protection meetings process and procedures.

This year, there was one complaint received in relation to the child protection conference process and two in relation to adult protection meeting process. Of the 3 complaints received, the following outcomes were made by the Board's Independent Complaints Panel:

- 2 complaints were upheld
- > 1 complaint was not upheld

Any learning or recommendations from complaints is shared with the Quality Assurance and Performance groups and where required other relevant subgroups of the board, to ensure that practice improvements can be made.

6.Information Training and Learning

Board partner agencies are required to review the training needs of practitioners in the area and the Board ensure that there is a coordinated approach to safeguarding training, taking into account themes and learning arising from the delivery of the Boards functions. This work is monitored by the Board's Training and learning Subgroup.

Multi-Agency Safeguarding Training

The Local Authority Workforce Development teams (Cwm Taf and Bridgend) are the main source of reporting on safeguarding training, although all partner agencies ensure that adequate safeguarding training is delivered to staff.

On-line training has continued alongside face to face opportunities where it has been identified as being the best forum for learning.

During 2023/24 the Board delivered its first centrally co-ordinated bespoke regional multi-agency safeguarding training programme for partner agencies. This was following a recommendation within a Child Practice Review. It was recognised that there is a wealth of knowledge to be gained by professionals receiving training alongside multi-agency partners, which can lead to more collaborative working and better outcomes for people.

All courses were facilitated by external trainers / subject specialists. Marketing for the programme was via the Business Unit and partner agencies. There were sufficient applications received for all courses, however late cancellations and no-shows meant that some took place with lower-than-expected numbers. Courses evaluated positively, and some feedback provided is shown below.

What you found most useful:

'the application of learning to a case study throughout the training'

'it was a highly insightful session with lots of real-life examples the presenters were certainly highly knowledgeable about the content'

'this training is one of the most useful safeguarding training I have attended it made me reflect on my current practice and think carefully about what I ask other professionals excellent'

How do you intend to apply the learning in your job?

'Making sure that the whole process is centred around the child(ren) and that I make sure I take responsibility for my place around the table. The learning has given me more confidence to do so and challenge where applicable.'

'Be mindful of change of behaviours, audience and rescheduling of appointments'

'I now understand the role and responsibilities a childcare practitioner has with regards to conferences and core groups, as part of my role I will use this information to support other practitioner /settings when /if they need to attend these.'

National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The table below outlines Cwm Taf Morgannwg's progress regarding the VAWDASV National Training Framework in 2023-2024.

Group	Numbers completed
1 eLearning	1451
2 Ask and act	143
3 Ask and act champions	17
4 Specialist provider training	57
5 Specialist managers	2
6 Senior leaders	75+

Welsh Government Training Grant

The Board receives an annual grant from the Welsh Government to support additional safeguarding training activities. This year the grant enabled us to support additional training arising from the recommendations of our Practice Reviews. Training included (not exhaustive):

- Conference and Core groups (including capturing the lived experience and voice of child)
- Professional Curiosity
- A series of Coercive Control workshops
- Working with Hostile, Uncooperative or Resistant Families
- Working with Disguised or Non-Effective Compliance
- Hidden Men Working with Men in Child Protection
- Safeguarding and Personality Disorders
- Risk Positive Assessment of Personality and Suicidality
- Safeguarding and Self Neglect and Hoarding

Multi Agency Practitioner Events (MAPF) – Safeguarding Week

During Safeguarding Week, three online feedback events on child practice reviews were held practitioners in Cwm Taf Morgannwg. Each event was very well attended and helped to share the learning from the reviews.

Dissemination of Information

As part of developing a positive culture of learning, the Board uses a range of methods to disseminate best practice and learning within the workforce, including Multi-Agency Practitioner Forums, information within the Board's e-bulletin, Safeguarding Updates, use of Twitter, Facebook and the Safeguarding Board's website.

Safeguarding Updates

A section has been created on the Safeguarding Board's website called <u>'Safeguarding Updates'</u> and the information on this webpage is used to generate e-mails to the Board and partners, with encouragement for these updates to be shared widely. Such information includes:

- Recently published policies and protocols
- Recently published practice review reports
- Safeguarding campaigns
- New legislation
- Consultations

E-mails based on the updates that are uploaded to the Safeguarding Board's website are sent to partner agencies for dissemination to share the information and learning.

7. How have we collaborated with others?

Working in partnership with others is integral to the work of the Board. We do this in a number of ways, with individuals, agencies, partnerships and organisations both within and external to Cwm Taf Morgannwg. Regional partnership working across Cwm Taf Morgannwg has remained strong, whether it involves planning workforce needs and training requirements, safeguarding, integrating service provision or responding to region-wide challenges.

Public Service Board

The Public Services Board (PSB) acts as the principal strategic leadership forum for the planning, commissioning, and delivery of public services across organisational boundaries to achieve better outcomes for people. Members of the Safeguarding Board sit on the PSB to seek to understand the major issues faced by each partner organization in the region.

Community Safety Partnership

The Board works closely with the Community Safety Partnerships on common areas of interest, such as domestic violence, substance misuse, anti-social behaviour, preventing serious violence and domestic homicide reviews.

Together for Mental Health Partnership

Close working between the Board and the Together for Mental Health Partnership continues to address suicide and self-harm prevention.

Wales Safeguarding Procedures Project Board

Members of the Board participate in the Wales Safeguarding Procedures (WSP) Project Board to ensure that the WSP for children and adults, along with the accompanying practice guides, remain fit for purpose and are adopted appropriately.

Welsh Government

The Board works closely with the Safeguarding and Advocacy Division of the Welsh Government on matters including the Single Unified Safeguarding Reviews that includes Adult and Child Practice Reviews, Domestic Homicide Review and Offensive Weapon Homicide Review and safeguarding-related legislation and policies and as part of wider networks across Wales. This includes other Welsh Safeguarding Boards.

We also work closely with the Welsh Government's Regional Suicide and Self Harm Prevention Co-ordinator, who sits on the Board's suicide prevention groups and has worked alongside partner agencies to develop our strategic response.

National Independent Safeguarding Board (NISB)

A member of the NISB attends each Board meeting and provides advice and guidance in relation to safeguarding from a national, independent perspective.

Social Care Wales

The Board has contributed to the development of the National Training Framework, led by Social Care Wales.

Advocacy Providers

Advocacy providers sit on the Board's Adult Quality Assurance and Performance Sub Group to ensure that the voices of adults at risk are heard.

Third Sector

We continue to seek opportunities to work with the third sector to improve safeguarding approaches in the region. This has been particularly evident in our work to tackle suicides, through a third sector engagement group.

Department of Work and Pensions

This year we have engaged with the DWP to enhance our approaches to suicide prevention, with DWP officers attending the suicide prevention groups and feeding into our strategic response.

8. Participation and Involving

Children, young people or adults who are affected by the exercise of the Safeguarding Board's functions should be given the opportunity to participate in the work of the Board.

The information below highlights some of the work that has been carried out during 2023-2024.

Third sector and community engagement

The Safeguarding Board's Communication and Engagement Officer attended the Interlink's Children, Young People and Families Network to deliver a workshop on safeguarding and how the third sector and our communities can help to raise awareness of various safeguarding issues, to highlight the signs to look out for and what to do if people suspect that someone is at risk of harm.

The workshop was well received, with excellent discussion and suggestions from the group.

Safeguarding Week 2023

Safeguarding Week took place between 13th and 17th November. A multi-agency task group was set up to plan for the week and a programme of events was developed, which included awareness raising and training activities and events on various safeguarding issues. The activities were aimed at professionals, children and young people, parents and carers and the general community.

Safeguarding Animation

An animation (view here) on reporting safeguarding concerns has been created by members of the Merthyr Tydfil Youth Forum, Merthyr Tydfil's Education Department, Safer Merthyr Tydfil's Snakes and Ladders Project and the Cwm Taf Morgannwg Safeguarding Board.

The animation is targeted at children and young people, with the aim of empowering them to feel confident in knowing that they can report a safeguarding concern if they have one.

A resource pack is being developed to accompany this animation.

Merthyr Tydfil Children's Services and Education

Merthyr Tydfil Children's Services and Education facilitated a student conference, delivering a range of workshops across schools to raise pupil awareness of Exploitation.

Rhondda Cynon Taf Children's Services

RCTCBC's Children's Services Participation Officer has been working on 'Get Involved' conversations with parents, carers and families. The Graduate Officer for Participation and a representative from Children Services visited libraries and children and family centers to hear feedback on the content of the new information sharing platform, RCT Children's Service Website. Parents feedback was positive and notably, they like the content of information and found it helpful, they also liked that the website was split into service structures e.g., Early Help/Involved with Social Services. The website has also been shared by the Head Teacher for the Virtual School for Children Looked After with the designated leads for each school.

RCT plan to create a new children and young people section and further consultation with children and young people will be key to developing the content.

RCT has continued engagement with a cohort of young people from a local high school, they have participated in the partnership development of the Safe Spaces Pilot. This is a youth-focused location that provides an open access for young people within their local community. Supported by local business and organisations these spaces will demonstrate an inclusive coordinated multi agency commitment and approach to the creation and maintenance of a range of youth friendly spaces within the community.

Social Media

Throughout the year, information on a range of safeguarding issues for both the public and professionals was shared on the Board's Facebook page and its Twitter account, and posts from other organisations were also shared and retweeted, providing information and signposting to various support services.

9. Contributions of Board Members

Each Safeguarding Board partner has a responsibility to ensure that the Board is operating effectively. There are clearly defined Terms of Reference as well as role profiles for Board members.

The Board continues to review the effectiveness of measures taken by partners and other bodies in relation to safeguarding via quality assurance, audits, and performance management. All the required statutory partner agencies in Cwm Taf Morgannwg are represented on the Board, Operational Committees, and Subgroups, and attendance is monitored at these meetings.

Attendance at the Board and Joint Operational Committee meetings is presented in the table below:

AGENCY	ATTENDANCE AT BOARD (5 meetings)	ATTENDANCE AT OPERATIONAL COMMITTEE (4 meetings)
Director (RCT) Director (MT) Director (BCBC)	5 5 5	Not applicable
RCT Children Services	5	3
RCT Adult Services	5	4
RCT Public Protection	3	0
RCT Education	4	3
MT Children Services	4	2
MT Adult Services	4	1
MT Public Protection	2	1
MT Education	3	3
Cwm Taf Youth Justice Service	4	4
Bridgend Children Services	5	4
Bridgend Adult Services	4	3
Bridgend Public Protection	0	0
Bridgend Education	3	0
Bridgend Youth Justice Service	1	0
Cwm Taf Morgannwg University Health Board	5	3
Public Health Wales	4	N/A
South Wales Police	5	3
National Probation Service	5	3

Parc Prison	0	N/A
Welsh Ambulance Service Trust	3	0
South Wales Fire and Rescue	1	N/A
Third Sector	3	N/A

Partner agencies also provide the Board with an annual report demonstrating their contribution and commitment to safeguarding. This is summarised below.

Merthyr Tydfil County Borough Council (MTCBC)

Representatives from MTCBC are actively involved in all meetings and Subgroups of the Board, including the chairing of the Board, Executive Board, Strategic Suicide Group and until October 2023, the Protocols and Procedures Subgroup. MTCBC contributes to all other subgroups of the Board. MTCBC have participated in the pilot review of the Single Unified Safeguarding Review (SUSR) and have contributed fully to participating in Child and Adult Practice reviews.

The Education Department within Merthyr Tydfil has attended Board and relevant subgroup meetings throughout the year and contributed when required.

Bridgend County Borough Council (BCBC)

Representatives from BCBC are actively involved in all meetings and Subgroups of the Board. The Director acts as the vice chair of the Board and chairs the Exploitation Steering Group. Representatives have attended workshops, planning days and team meetings which have contributed to the setting of actions to meet the boards priorities for its annual plan.

BCBC has also contributed fully to participating in Child and Adult practice reviews, learning events and provided Panel members and Chairs where required. Representatives have participated and presented at Safeguarding Week and contribute to the Policy and Procedures Group, regional audit work and the facilitation of training to embed learning into practice.

Rhondda Cynon Taf County Borough Council (RCTCBC)

RCT Adult Services have representation on all of the Board's sub-groups and have an excellent track record in attendance. The Director chairs the Joint Operational Committee. During 2023-2024 the Service Manager for Safeguarding chaired the Adult Safeguarding Quality Assurance & Performance sub-group and the RCT Self-Neglect Panel and vice-chaired the Engagement, Participation & Communication sub-group. Adult Services have had a Panel member on all relevant Adult Practice, Domestic Homicide and Mental Health Homicide Reviews.

RCT Children Services continues to provide a high level of contribution to the work of the Board and all of the Subgroups to the Board. In 2023-2024 RCTCBC has chaired the Children's Quality Assurance Panel. Vice Chaired the Multi Agency Child Exploitation (MACE) sub-group alongside undertaking the lead role in the development of the Exploitation Strategy and practitioner guidance and tools. Chaired the Engagement, Participation and Communication Group. Chaired PPG in the absence of permanent chair/vice chair and contributed to the evaluation and revision of amended policies. Developed with RCT Adults Services, Section 5, Professional Concerns Training. Chaired the Suicide and Self Harm Review Group.

Contributed to Adult and Children Practice Reviews, Domestic Homicide Reviews and Offensive Weapons Homicide Review under the Single Unified Safeguarding Review (SUSR), MAPFs and other recommended audits. Provided a reviewer for a Child Safeguarding Review, and the review of Suspicious and Unexplained Injuries.

RCT have also been a representative on behalf of the CTMSB in relation to national work, e.g., National Performance framework, pan-Wales Exploitation Group.

The Education Department within RCT has attended and contributed to the Board and relevant subgroup meetings throughout the year. Information from the Board is routinely shared with schools via termly safeguarding meetings.

Cwm Taf Morgannwg University Health Board (CTMUHB)

CTMUHB are active participants in all of the Board and subgroup work. Both the Head and Deputy have undertaken chairing arrangements for the Joint Review Group and MASH QAP. Contributed to Adult and Children Practice Reviews, Domestic Homicide Reviews and Offensive Weapons Homicide Review under the Single Unified Safeguarding Review (SUSR), MAPFs and other recommended audits. Participated in the development and reviews of policies and procedures and co deliver multi-agency training with the local authorities. The Health Board were very active in this year's Safeguarding Week, promoting training and resources on a variety of safeguarding issues affecting both children and adults.

Probation Service

Probation Service are active participants in in all of the board and subgroup work. Contributed to Adult and Children Practice Reviews, Domestic Homicide Reviews and Offensive Weapons Homicide Review under the Single Unified Safeguarding Review (SUSR), MAPFs and other recommended audits and the review and development of policies and procedures.

Welsh Ambulance Service Trust (WAST)

During 2023-2024, WAST have attended and contributed to the Safeguarding Board. The WAST safeguarding team have attended and contributed to PRUDICs. They have also attended Joint Review Group and contributed to 2 Adult Practice Review, 1 Child Practice Review and a Domestic Homicide Review.

South Wales Police (SWP)

SWP are an active member of the board and commit senior management to actively participate in all board activity. South Wales Police Employ a dedicated review team who participate in every Child and Adult Practice Review and Domestic Homicide Review. SWP continue to chair a number of forums, including the Incident Response Group, PRUDIC's and MASH Executive meeting to name a few. South Wales Police have a mature set of data, which is shared in many Sub-Groups ensuring the Board are aware of developing concerns / trends. SWP remain committed to servicing both Multi-Agency Safeguarding and have dedicated Child and Adult Protection Officers present as well as Domestic Abuse Specialists who ensure the efficacy and delivery of the principles of MARAC.

10. Managing our Resources

The Cwm Taf Morgannwg Safeguarding Board uses the funding formula set out in the Social Services and Wellbeing (Wales) Act 2016 statutory guidance. This allows us to assess and identify annual financial contributions from statutory partner agencies.

This is calculated as follows:

Agency	% Split	% Split
Rhondda-Cynon-Taf CBC		55%
Bridgend CBC	60%	32%
Merthyr Tydfil CBC		13%
Cwm Taf Morgannwg UHB		25%
South Wales Police		10%
Probation Service		5%
Totals		100%

In 2023-2024 expenditure was as follows:

Staff	£368,199
Premises	£9,200
Other	£45, 611
WG Grant Income (SUSR)	-£ 30,000
Total	£393,010

Training costs are not included as this sits outside the Board budget.

Other Board Activities

Adult Protection and Support Orders (APSOs)

Adult Protection and Support Orders have been available since the 2016 implementation of the Social Services and Well-Being (Wales) Act 2014 but have been used rarely. There were no APSO applications APSOs in 2023-2024.

Guidance and Advice received from Welsh Ministers and/or National Board

The Board continues to work closely with Welsh Government and the National Board and responds promptly to requests for information. A good relationship has been established with the NISB member for the region, and support has been provided on a number of occasions when seeking to commission independent reviewers or to influence national processes and guidance.

Section 137(1) of the Act provides a Safeguarding Board with the power to request specified information from a qualifying person or body provided that the purpose of the request is to enable or assist the Board to perform its functions under the Act

In 2023-2024 the Board did not use its Section 137 powers to access information.

Are you Concerned about Someone?

If you suspect that a **child or young person** is being harmed or is at risk of being harmed then you have a duty to report it immediately. All calls concerning worries about children are treated seriously. Contact your local Safeguarding Team



In Rhondda Cynon Taf: 01443 425006 In Merthyr Tydfil: 01685 725000 In Bridgend: 01656 642320

Opening Hours:

Monday-Thursday 8.30 am – 5.00pm Friday 8.30 am – 4.30pm

If you suspect that an adult is being harmed or is at risk of being harmed then you have a duty to report it immediately. All calls concerning worries about vulnerable adults at risk are treated seriously. Contact your local Safeguarding Team



In Rhondda Cynon Taf: 01443 425003 In Merthyr Tydfil: 01685 725000 In Bridgend: 01656 642477

Opening Hours:

Monday-Thursday 8.30 am – 5.00pm Friday 8.30 am – 4.30pm

To contact Children or Adults Services outside office hours, at weekends and bank holidays, call:

Cwm Taf Morgannwg Emergency Duty Team On 01443 743665

If you suspect that a child, young person or an adult is at immediate risk of harm call 999 and speak to the Police.

If you would like to report a non-urgent incident, or have a problem or general query, you can call 101, the 24 hour non emergency number for the police.

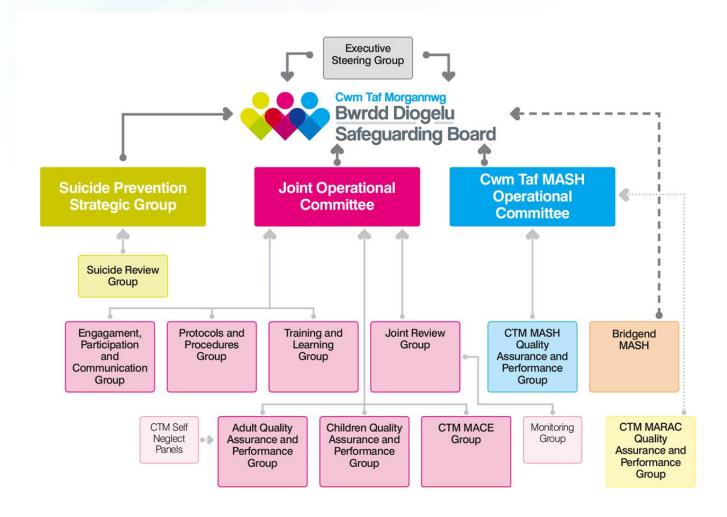
Use 101 when the incident is less urgent than 999.

APPENDIX 1 - BOARD MEMBERSHIP

TITLE	AGENCY
Director of Social Services (Chair)	Merthyr Tydfil County Borough Council
Director of Social Services and Wellbeing (Vice Chair)	Bridgend County Borough Council
Director of Social Services (Chair of the Joint Operational Committee)	Rhondda Cynon Taf County Borough Council
Head of Safeguarding, (Adults)	Rhondda Cynon Taf County Borough Council
Director, Public Health	Rhondda Cynon Taf County Borough Council
Head of Safeguarding (Children)	Rhondda Cynon Taf County Borough Council
Director of Education and Inclusion Services	Rhondda Cynon Taf County Borough Council
Service Director, Children Services	Rhondda Cynon Taf County Borough Council
Head of Legal - Community Care and Children	Rhondda Cynon Taf County Borough Council
Prison Director	Parc Prison
Head of Safeguarding	Cwm Taf Morgannwg University Health Board
Named Doctor	Cwm Taf Morgannwg University Health Board
Deputy Executive Nurse Director	Cwm Taf Morgannwg University Health Board
Head of Service	Cwm Taf Youth Justice Service
Head of Service	Youth Justice Service, Bridgend
Named Lead for Safeguarding	Public Health Wales
Designated Nurse (National Safeguarding Team)	Public Health Wales
Head of Probation	Probation Service
Director of Education	Merthyr Tydfil County Borough Council
Head of Public Protection	Merthyr Tydfil County Borough Council
Head of Adult Services	Merthyr Tydfil County Borough Council

Principal Safeguarding Manager	Merthyr Tydfil County Borough Council
Head of Children Services	Merthyr Tydfil County Borough Council
Head of Adult Social Care	Bridgend County Borough Council
Head of Children's Social Care	Bridgend County Borough Council
Head of Education and Family Services	Bridgend County Borough Council
Group Manager	Bridgend County Borough Council
Head of Public Protection	Bridgend County Borough Council
Head of Adult Safeguarding and Secure Estate	Bridgend County Borough Council
Superintendent	South Wales Police
Head of Protecting Vulnerable Persons	South Wales Police
Assistant Director Quality, Safety & Patient Experience	Welsh Ambulance Service Trust
NISB Member	National Independent Safeguarding Board
Safeguarding Lead Officer	South Wales Fire & Rescue Service

APPENDIX 2 – BOARD STRUCTURE



Glossary of Terms

Adult Practice Review

The Regional Safeguarding Board must commission an Adult Practice Review in cases where an adult at risk has died, sustained potentially life threatening injury or sustained serious and permanent impairment of health.

Child Practice Review

The Regional Safeguarding Board must commission a Child Practice Review in cases where a child has died, sustained potentially life threatening injury or sustained serious and permanent impairment of health.

Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them.

Children Looked After

A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

Community Safety Partnership

Statutory partnership to develop and implement strategies to tackle crime and disorder including anti-social and other behaviour adversely affecting the local environment.

Domestic Homicide Review

A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or,a member of the same household as himself or herself.

Exploitation

Exploitation is a type of abuse. Exploitation involves being groomed, forced or coerced into doing something that you don't want to do for someone else's gain.

Immediate Response Groups (IRG)

A group which is convened to provide a rapid, multi-agency response to managing the consequences of a critical incidents, such as the unexpected death of an adult and is led by the Police Superintendent (or a suitable deputy).

MARAC

A weekly risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan.

Modern Slavery

The illegal exploitation of people for personal or commercial gain. It covers a wide range of abuse and exploitation including sexual exploitation, domestic servitude, forced labour, criminal exploitation and organ harvesting.

Multi-Agency Practitioner Forum (MAPF)

Multi-agency professional forums are a mechanism for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep children safe. They utilise case information, findings from child protection audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice and to inform the Board's future audit and training priorities.

Public Protection Notice (PPN)

The forms have two main purposes. One is for police officers to make referrals to partner agencies when they have concerns about vulnerable people. The PPN is also used as a risk assessment tool for victims of domestic abuse and stalking and harassment (DASH).

Prevent

Prevent is about safeguarding and supporting those vulnerable to radicalisation

PRUDIC

This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

Quality Assurance and Performance Groups

Two separate groups for adults and children whose objectives are to monitor the effectiveness of agencies' practice within the processes of safeguarding and encourage high standards of practice by all those involved in safeguarding work, promoting agency and individual accountability through the monitoring and evaluation of performance.

Self Neglect

Self-neglect is a general term used to describe a vulnerable adult living in a way that puts his or her health, safety, or well-being at risk.

Social Services and Wellbeing (Wales) Act 2014

The Social Services and Well-being (Wales) Act is the law for improving the well-being of people who need care and support, and carers who need support.

Strategy Discussion/Meeting

A meeting for social workers and other professionals to plan what they are going to do next about a case.

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015 focusses on the prevention of these issues, the protection of victims and support for those affected by such issues.