Committee	Care Scrutiny Committee
Date of meeting	June 22nd 2023
Item title	Feedback from safeguarding review by Care Inspectorate Wales
Purpose	To present the feedback from Care Inspectorate Wales following a safeguarding review in children and families' services
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Cabinet member	Councillor Elin Walker-Jones

1.Background

1.1 Following the publication of a Child Practice Review in November 2022, the Deputy Minister for Social Services, Julie Morgan MS, requested that Care Inspectorate Wales (CIW) led a rapid review of decision making in relation to child protection.

1.2 The overarching objective was to determine to what extent the current structures and processes in Wales ensures that children are appropriately placed on,and removed from the Child Protection Register when sufficient evidence indicates that it is safe to do so.

1.3 The review focused on the requirements of the *Wales Safeguarding Procedures*; with the legislation Social Services and Wellbeing Act (Wales) 2014 and the statutory safeguarding guidance '*Working Together to Safeguard People'*.

1.4 It was stressed that this was an opportunity for shared learning and was not an inspection. There was an opportunity for a collaborative approach focused on reflection and shared learning about what works and where there is room for improvement in current approaches to ensure positive outcomes for children at risk of harm.

1.5 We were informed in February 2023 that we were one of five local authorities who had been selected to be subject of the review.

1.6 The review took place between March 26th and March 29th, 2023. Verbal feedback was shared with the Head of Service and Statutory Director of Social

Services on March 29th. There will not be a published individual authority report, but a national report will be published once the review period comes to an end.

2. The findings

2.1 Children in Gwynedd benefit from agencies sharing information effectively, and this is supported by a clear and understood model of practice. It was considered that children in Gwynedd are safeguarded effectively. However, two examples were seen where external agencies had not shared information with children's services in a timely manner.

2.2 There is a clear focus on assessing risk and specific attention is given to the threshold of a child having suffered or being likely to suffer significant harm, and of that threshold having been met.

2.3 Clear decisions were consistently made based on evidence when making the decision to place the child's name on the Child Protection Register and when deciding to remove the child's name from the Child Protection Register. At times professional optimism could be seen and it was noted that the recording of changes and developments could be improved.

2.4 It was reported that the level of compliance with the practice model could vary, but at the same time it was accepted that ensuring and creating change across the workforce is challenging. The view was that staff turnover had impacted on this along with the fact that the service had just begun to operate the new model shortly prior to the pandemic. Even so, the view was that there is a clear vision and a stable leadership within the service to ensure that practice expectations are consistent.

2.5 A comment was made that the level of understanding from external agencies of the model varies especially in relation to the threshold of significant harm and the definition of eligible needs for support under the arrangements for care and support for example. There is an enthusiasm for multi-agency training and it was recommended that the local authority considers a programme for training for this purpose.

2.6 It was recognised that there are national challenges in relation to recruitment and retention of social care staff in general, and within children's services in particular. There was recognition that children's services in Gwynedd had faced challenges in ensuring sufficiency within the workforce at times and that this challenge was present during the course of the review. The lack of sufficiency within the workforce inevitably affects practice. There was a possibility that a delay in one case in relation to timely meetings and visits in relation to the expectations of the Wales Safeguarding Procedures had been directly impacted by this situation. The inspectors made a comment that the pay scales in Gwynedd are a cause of concerns for practitioners in Gwynedd children's services and this was raised as a risk that could have an impact on the authority's ability to recruit and retain workers. It was suggested that the Council should review the terms and conditions of the service within the context of the national landscape and understand the risks posed.

2.7 Some examples were seen where the standard of care and support plans could be improved and some could benefit from being updated. As mentioned above, some meetings and visits were outside of expectations. However, it was recognised that the staffing issues and work pressures affected practitioners' ability to complete all of the tasks within timeframe.

2.8 It was noted that North Wales Police's policy is not to attend review child protection conferences. It was recognised that they provide a report to the meetings, but it was flet that this was a failure to participate in the discussion in relation to whether the child remained at risk of significant harm.

2.9 Overall, good practice was seen in the context of considering the voice and lived experiences of children, and that this was considered when making safeguarding decisions. Children were seen on their own during S47 investigations and this led to robust decisions being reached in relation to their protection. It was noted that further work was needed to ensure how the participation of children in their conferences could be developed and improved.

2.10 A comment was made that the social care worker role was invaluable within teams. In one case evidence was seen as to how this role ensured that the child had ample opportunity to share their views and to be listened to which in turn contributed to the overall picture of the daily life of the child. This provided assurance in relation to the safety of the child and that the threshold of significant harm had diminished.

2.11 Examples of clear communication with parents to explain why their child/ren were at risk of significant harm was seen. The support services available to parents are central in sharing these messages when it is deemed to be appropriate.

2.12 The role of the chairs of child protection conferences are critically important to remind attendees of the purpose of the meetings that are held in line with the Wales Safeguarding Procedures. This was evidenced as effective practice when the inspectors attended a conference to observe the discussion with the consent of the family. A comment was made that the consistency and stability of the chairs in Gwynedd was a clear strength. As a result, they, along with the extended workforce know families well, are committed and work hard to ensure that children are safeguarded.

Marian Hughes,
June 12th, 2023