Evaluation of Integrated Multi-Agency Operational Safeguarding Arrangements in Wales

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Contents

Tables

Figures

Executive Summary

The evaluation requirement set out two key elements to be achieved from the evaluation work:

1. A full UK/National literature review of multi-agency safeguarding arrangements of both adults and children (the 'Front Door' approach)
2. Ascertain the range of current arrangements operating in Wales and their key features.

The evaluation team made contact with 33 nominated safeguarding leads with assistance from NISB, with 29 included in the data analysis across all 22 Local Authorities within Wales. Due to the global pandemic of Covid-19, planned telephone interviews with each individual lead were also offered to be completed via an open survey, which could be returned via email in Welsh, or English. Data was transcribed and analysed using N-vivo for thematic analysis. Key themes identified are included in the table below.

Table 1. Key Themes and Sub-themes

THEMES	***Sub-themes***
1: AIMS	*Safeguarding* *Support and protect people* *Effective and coordinated system* *Informed decision making*
2: FRONT DOOR SYSTEM	*IAA and/or SPOA/SPOC* *Process* *Separate systems* *Leadership*
3: PARTNERSHIP ORGANISATION	*Multi-agency working* *Team structure* *Co-location* *Information sharing*
4: REFLECTION	*To MASH or not to MASH?* *COVID-19* *Working well* *Improvements*

In summary, the data highlighted some key areas:

- There is evidence of effective adoption of 'Front Door' services, with this seen as open and accessible to all (via various forms of communication: email, phone, to all users: general public through to specialist services/organisations).
- There is evidence of successful adoption of language and vision from the Social Services and Wellbeing Act (2014) and new All Wales Safeguarding Policy in terms of

being ‘person centred’, emphasising the individual and family at the heart of decision making processes.

- All 22 Local Authorities are engaged in multi-agency collaborative working, however, the way these operate vary significantly (see Table 7).
- It was clear when trying to identify relevant individuals to interview that children and adult services were often seen as separate. Initial plans were to interview 1 safeguarding lead from each LA, but on speaking to nominated leads they often had responsibility for one area, for example children safeguarding, and would therefore provide an additional name to follow-up with regarding adult safeguarding processes and provision.
    - Discussions with safeguarding leads furthered this issue with disagreement as to whether these should be more joined up, or distinctive, specialised and purposely separated.
- Some adult safeguarding nominated leads spoke extremely passionately about recent policy and legislative amendments with focus on adults having an equal statutory footing within safeguarding. However, frustrations from adult safeguarding leads still emphasised the need to use ‘duty to enquire’ to push for action, indicating that adult safeguarding still had much more work to be done to achieve similar level of response to children.
- Although ‘Front Door’ arrangements were said to be well established in all 22 LA’s, it is clear from the various arrangements (see Table 7) that these were not always co-located with safeguarding teams, with concerns about how processes and pathways across the whole system can be seen, shared, audited and importantly how learning can be taken forward. Those co-located (‘Front Door’ and safeguarding teams’) seemed to have better collaborative working, with talk of more support and learning coming from face to face conversations about cases as they come in.
- The above point was furthered in regards to difficulties with Information sharing systems that inhibit understanding data across services (children and adults, also for ‘Front Door’ to safeguarding), which then limits capacity to plan resources and conduct quality assurance (QA) processes.
    - All those that engaged with the study were asked for referral numbers to give estimation of size of demand across each service. However, some were able to give all parts of the system, for example, ‘Front Door’ through to safeguarding including adults and children, whereas others were only able to provide their service and could not access further data. This once again highlights issues with being able to see the whole system.

- There were different viewpoints and implementation of multi-agency arrangements between those using more virtual multi-agency arrangements compared to physical MASHs, particularly when these are in rural and urban areas.
    - Covid-19 restrictions have further emphasised variances within rural and urban safeguarding provisions. Rural areas seemed more prepared and functional with remote working, compared to urban areas stating concern about eroding relationships between organisations if remote working continued.
- There was evidence of effective engagement from key agencies in information sharing and decision making processes, with high levels of engagement with police, but issues with other organisations engaging as necessary. Education and CAMHS were often mentioned.
- Although not mentioned frequently, some safeguarding leads discussed issues regarding resourcing and turnover of staff. In addition, a couple mentioned their concerns in being able to adequately support their team dealing with vulnerable families, when they have lost their physical support (peer) network (due to covid-19 restrictions and remote working).
- Regarding the impact of Covid-19, there were concerns, around the pausing or reduction of early intervention and community level responses and support, with additional concerns around children that are not flagged as At Risk, or on child protection plans, with many vulnerable children not being seen by anyone outside their homes for months.
- Overall nominated safeguarding leads talked confidently about their safeguarding aims and how they were achieving these, with most acknowledging that there is still much work to be done.

Key recommendations: Phase 2

Key recommendations for future work to help continue to inform and improve effective multi-agency safeguarding have been extracted from the current study. These core questions should be asked for any follow-up study:

1. What are the views, perspectives and experiences of other safeguarding staff in regards to current safeguarding processes and asking them ‘what does good looks like?’ Further questions should probe further into exploring the added value in working together within safeguarding.
    a. Given the findings of the current study this should include those working within ‘Front Door’ Services, safeguarding teams, children and adult teams, and wider

services such as early help and other agencies that are part of these processes, and also cover those across rural and urban areas.

2. Who is contributing to information sharing, decision making and risk assessments? How are they contributing? Exploration of this question would help inform resourcing and functioning (co-located/remote) of arrangements going forward.
3. Can effective safeguarding processes and practice be identified in safeguarding data?
    a. Exploration of data sets through the safeguarding system. Again, choosing a selection of different arrangements identified in the current study (e.g., children/adult/joined up, urban/rural, remote/co-located) a deeper analysis of the data in exploring decision making, agency/interventions involvement, repeats, vulnerable characteristics, etc. This will enable understanding of crossover from initial contact to longer term support and what works well.
    b. Key questions would include: What factors are present in cases that do not come back into the system? And conversely, what factors are present in those repeat cases?
4. What has been the impact of covid-19 on practitioners and collaborative working? Exploring their experiences and perspectives in trying to extract good practice to be continued post covid-19, as well as where changes need to be made and additional support needed going forward.
5. What has been the impact of covid-19 on safeguarding practice to individuals and families (users)?
    a. Consideration in terms of the impact of covid-19 on those vulnerable families. Exploring what, if any, support they have had in lockdown and impact of experiences. Therefore, engagement with children, families and adults involved with safeguarding services regarding their view on what works well and what does not.
    b. The varying impact of lockdown, and possible continuous ‘mini’ lockdowns on children need to be understood. Consideration of how safeguarding professionals and schools can prepare for school returns and any further disruptions due to Covid-19, but also how best to support vulnerable children who may have experienced a range of adverse experiences over this time and may continue during self-isolation periods.
6. If/How is active live learning and feedback to practitioners being implemented and shared? Links to training, development, reflection and transparency – which were featured within the findings of this report. Is this linked to leadership and culture, and if so, how?

Literature Review

Introduction

Richardson (2014, p.118) defined safeguarding as the "protection of vulnerable groups from abuse and or neglect," with this being the responsibility for all individuals who work with such groups. Yet, despite the hard work of many professionals within the safeguarding sector in attempting to protect the young and most vulnerable in society, the task can seldom be done by one specific agency or team. In 2014, a report highlighting the findings of a Home Office project aimed at identifying multi-agency models carried out interviews with 37 local authorities in England. The report noted that "over two-thirds (26) of the local authorities that were interviewed said that they had multi-agency models in place at the time of interview (between January and April 2013) – around half of these used the term MASH (Multi-Agency Safeguarding Hub) to describe their model" (Home Office, 2014, p. 6). Shorrock, McManus, and Kirby (2019b) have observed that, "unlike previous safeguarding mechanisms, which have typically involved single decision-making processes, Multi-Agency Safeguarding Hubs aim to identify and manage risk at the earliest opportunity by promoting a collaborative approach to safeguarding" (p. 9).

Despite much agreement on the benefits of multi-agency, collaborative approaches in safeguarding, it is widely acknowledged that implementation of these models in practice vary greatly, with little evidence existing of their actual effectiveness (Shorrock, McManus & Kirby, 2019a). Questions are often raised as to which agencies should be involved, how should they be involved, with more difficult questions about governance, formalised structures, information sharing, funding and resources (Shorrock, McManus & Kirby, 2019b). The lack of national reviews on this have left many local authorities and agencies free to decide on a model that suits their own needs, which may not be supported by evidence, with decisions then based on resources and local opportunities and interest. Evidence of how best to set up, implement and sustain effective multi-agency safeguarding arrangements that takes into account the local differences (e.g., population data, service and crime data) is much needed to ensure the safeguarding of our most vulnerable.

The first section of this report sets out the existing literature exploring multi-agency safeguarding arrangements, highlighting relevant legislative developments in safeguarding, the theoretical benefits of collaborative working through to implementation, with focus on evidence of good practice and gaps in our understanding, particularly regarding the lack of research work undertaken on safeguarding within Wales.

Key milestones within Safeguarding Wales

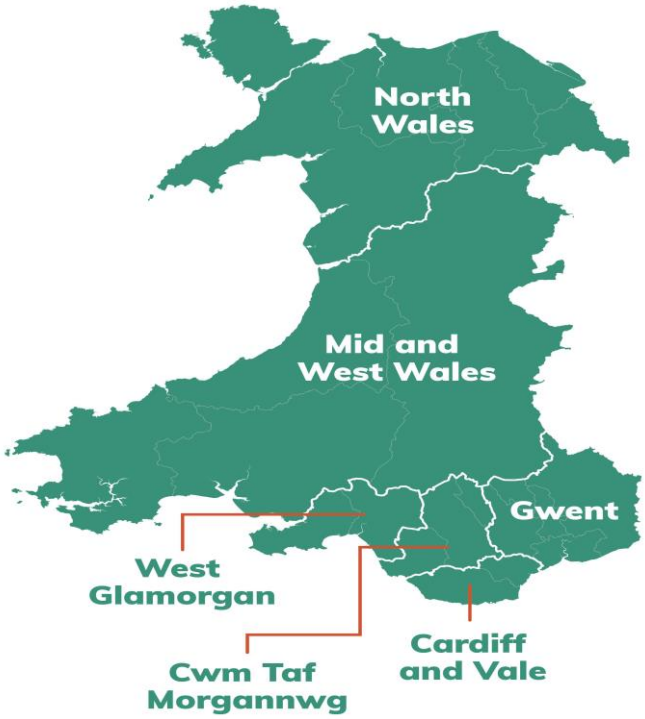
A number of key reports, legislation and guidance have been critical in the development of multi-agency working within safeguarding. The key milestones are outlined first.

The Children Act 1989 established the first statutory requirements for inter-agency collaboration and joint working. Specifically, what local authorities and other partner agencies do in terms of ensuring children are safeguarded. Although the Act focuses on the idea that children are primarily best cared for from within their respective families, other situations when families fail to fulfil the care role are considered. The Children Act 2004, as amended by the Children and Social Work Act 2017 within England, sought to strengthen this already important relationship by placing new duties on key agencies in a local area. Within Wales, the protective provisions of the Children Act 1989 continues to be in force and the remaining provisions of the Children Act 1989 co-exist with the Social Services and Well-being Act 2014 (Safeguarding Board Wales, 2020).

Victoria Climbie was aged 8 when she was murdered by her great aunt Marie-Thérèse Kouao and her boyfriend Carl Manning. The circumstances that led to Victoria's death resulted in a public inquiry that saw major recommendations in the UK's child protection policy: The Victoria Climbie Inquiry by Lord Laming (2003). These included a national agency for children and families which would focus on monitoring the effective performance of agencies including the police, health, and housing services; the formation of a children and families committee by each local authority that would include members of the police authority, council and health service trust; and, a single document outlining common language for all agencies that would give a step-by-step guide on managing a case. As this is relevant for England only, within Wales the Council's governance, remit and responsibility for children and families may vary in each Local Authority. Most councils have separate Cabinet portfolios for adults and children, with some having social services scrutiny committees which cover both.

The Welsh Assembly Government's One Wales Strategy (Health in Wales, 2020) reorganised the structure of NHS Wales creating single local health organisations responsible for delivering healthcare services within a geographical area, rather than the Trust and Local Health Board system. This resulted in 6 Health Boards and 3 NHS Trusts in Wales (Figure 1, below).

Figure 1. Six Welsh Health Boards



These 6 Local Health Boards (LHBs) have responsibility for the planning and delivering of healthcare services in their areas.

The Social Services and Well-Being (Wales) Act (2014) came into force on the 6th April 2016. The Act gave service users more control over the care and support they require as well as carers being allowed to have equal input around the type of support available for those they care for. The Act's foundations are embedded within the people in the system itself, but equally, with an emphasis on the creation of good effective partnership and collaboration. The Act was distinctive in its approach requiring the safeguarding of adults to have statutory equivalence with children. For example, it introduced a new power to enable Local Authorities to intervene and enforce access to an adult, including forced entry into the home of an adult under s.127 the Adult Protection and Support Order (Safeguarding Board Wales, 2020).

Focus of the Act is on the 'people approach', promoting people's independence to give them a stronger 'voice and control' (Safeguarding Board Wales, 2020). The intention with the Act in integrating and simplifying the law was to achieve greater consistency and clarity to those working with individuals who require all forms of care and support. With a focus on prevention and early intervention, the Act within its core principles states:

> "A key role of the information, advice and assistance service which must be secured by a local authority under Part 2 of the Act, will be to provide individuals with information about the range of advocacy services in their area and to assist them to

access it where required as part of achieving their well-being outcomes" (Welsh Government, 2019a, p.7)

In addition, the Social Services and Well-being (Wales) Act 2014 set up the National Independent Safeguarding Board (NISB). The NISB were set with 3 core primary duties:

1. To provide support and advice to Safeguarding Boards with a view to ensuring that they are effective
2. To report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales
3. To make recommendations to the Welsh Ministers as to how those arrangements could be improved (s.132 (2)).

Furthering this, the Well-Being of Future Generations Act (2015) focusses on adopting a more joined-up approach in working with people and communities, ensuring that the well-being of those living within Wales are at the forefront of decision making. When focussing on violence victimisation and the public sector response, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 developed a needs-based approach (not altering the criminal law) in the aim of promoting awareness, prevention and protection of those victims experiencing these types of crimes.

Risk and vulnerable groups

Over the last 30 years, there has been a recognition that certain risk factors can increase the likelihood that an individual will become a victim of crime. Such factors have become embedded in multi-agency risk management strategies (Shorrock, McManus & Kirby, 2019a/b). These have tended to focus on three specific vulnerability groups: (1) vulnerable children, (2) vulnerable adults, and (3) domestic abuse. As this report is interested in 'Front Door' safeguarding arrangements, focus will be in children and adults in this review.

Vulnerable children

The practice of safeguarding is often accredited to the protection of the youngest, most vulnerable in society, rather than adults, resulting in different definitions emerging. As a result, the safeguarding needs of these two groups (children and adults) can differ considerably (Shorrock, McManus & Kirby, 2019b). Historically, focus has been on developing separate policies and procedures for vulnerable children[1] and adults, with Wales leading the way in

their approach to ensure equal statutory footing for Children and Adults (as described above) and within the Wales Safeguarding procedures (Safeguarding Wales, 2020). In regard to children[2], the last four decades has seen substantial progress in the understanding of child safety. Sidebotham (2001) has noted that this understanding has "been based within two scientific paradigms: the psychodynamic and sociological models. More recently, both strands have been incorporated into a more comprehensive ecological paradigm" (p. 97). The ecological approach focuses predominantly on risk existing in the neighbourhood.

Ansley-Green and Hall (2009) note that in terms of preventative approaches to child abuse[3], safeguarding practices can be divided into three levels, the individual or family, the local area or school and the community as a whole. This three-pronged framework as Shorrock (2017) has observed: "supports the notion that risk management is no longer the sole responsibility of the state, but the responsibility of various social and economic actors" (p. 42). The question of responsibility, however, becomes a pertinent one since research has suggested that the safeguarding of children has, in the past, often been shouldered by social services with regular alterations to policy which has added to the confusion around the actual roles and responsibility of partner agencies (Horwath and Morrison, 2007; Munro, 2011; Shorrock, 2017). This has resulted in a loss of focus by practitioners, from what is the primary responsibility of addressing the needs of vulnerable children to becoming overwhelmed by the application of new policy. With such loss in focus, concerns have emerged over actual safeguarding being neglected, since the strains placed upon safeguarding professionals are increased.

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[1] In defining child vulnerability, the umbrella term of 'child abuse' is often used by professionals when describing adult behaviour that intentionally or unintentionally causes harm to a child (Marsh, Cochrane, and Melville, 2004). Moreover, Kempe and Kempe (1978), proposed that there were four types of child abuse; physical violence, physical and emotional neglect, emotional abuse and sexual abuse. However, recently, these categories have evolved into physical abuse, sexual abuse, and neglect. For this review, the term child abuse will be used.

[2] Within UK law, the age of a child is not defined (NSPCC, 2015). The government of the United Kingdom (UK) has thus, has used the definition set out in the UN Convention on the Rights of the Child. That is, 'every human being below the age of eighteen years' (UNICEF, 1989). The House of Commons (2008) defines a vulnerable child as an individual that is 'unlikely to achieve or maintain ... a reasonable standard of health or development without the provision ... of social care services.'

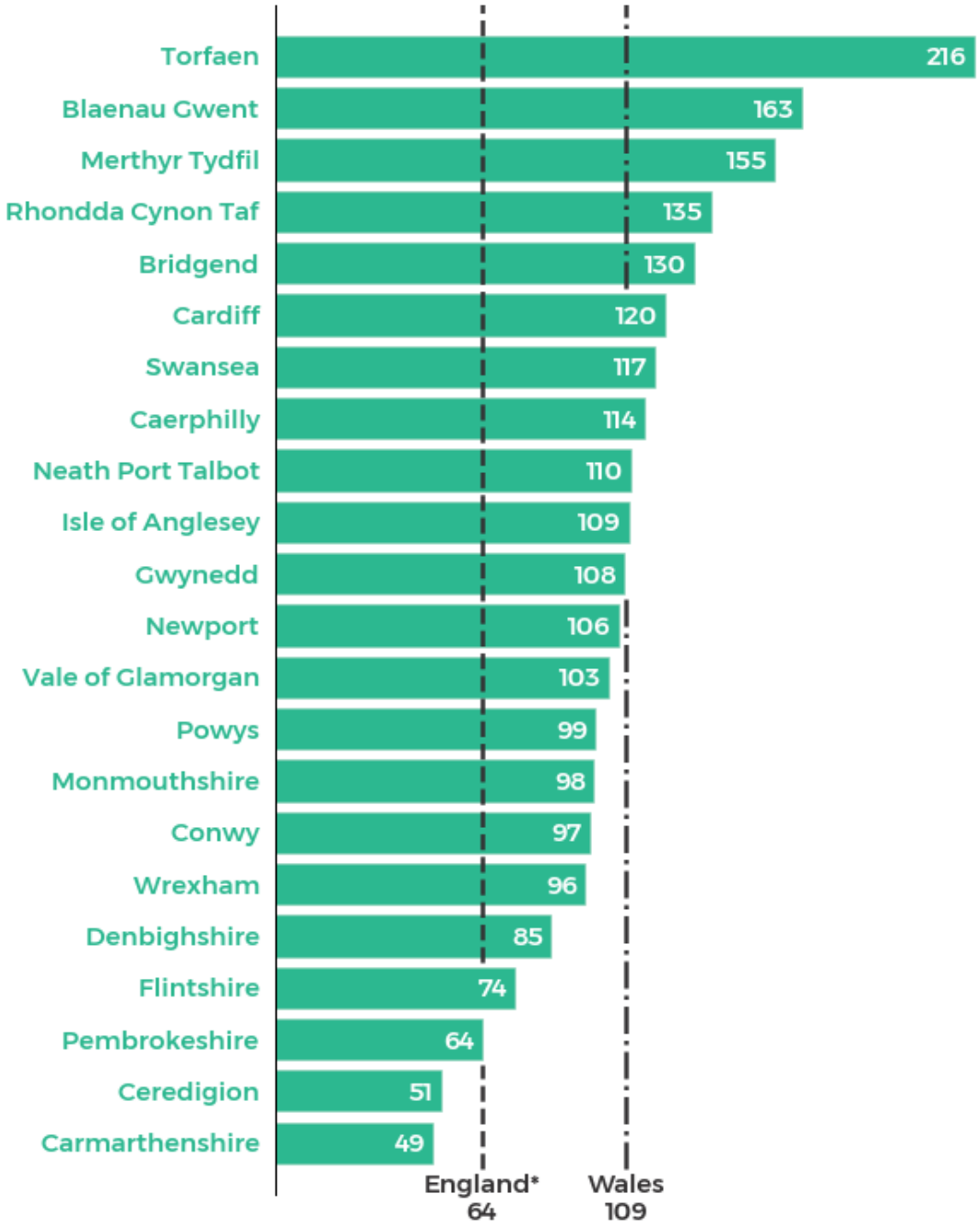
[3] Despite the relatively broad range of programmes existing within these three levels, MacMillan, Wathen, Barlow, Fergusson, Leventhal, and Taussig (2008) have commented that the effectiveness of such interventions remains unknown, although MacMillan et al. (2008) have observed two specific home-visiting programmes, the Nurse-Family Partnership (best evidence) and Early Start as being effective interventions for preventing child maltreatment and associated outcomes such as injuries.

Despite the full extent of child abuse in the UK being unknown, the latest updated information from across Wales (Welsh Government, 2019b) indicates that the number of looked after children (aged under 18 years) on 31st March 2019 was 6,846, with this being an increase of 7% from the previous year. Data also indicated that there were slightly more males (3,697, 54%) than females (3,149, 46%), with the proportion being stable over recent years. Regarding age profile of looked after children, 10 to 15 year olds were the most common age range to be LAC, with under 1's also a prominent age grouping:

- Under 1: 31%
- 1-4 years: 19%
- 5-9 years: 23%
- 10-15 years: 37%
- 16 and over: 15%

However, there were significant variations in the number of children aged under 18 that are looked after when comparing figures per 10,000 population across each Local Authority.

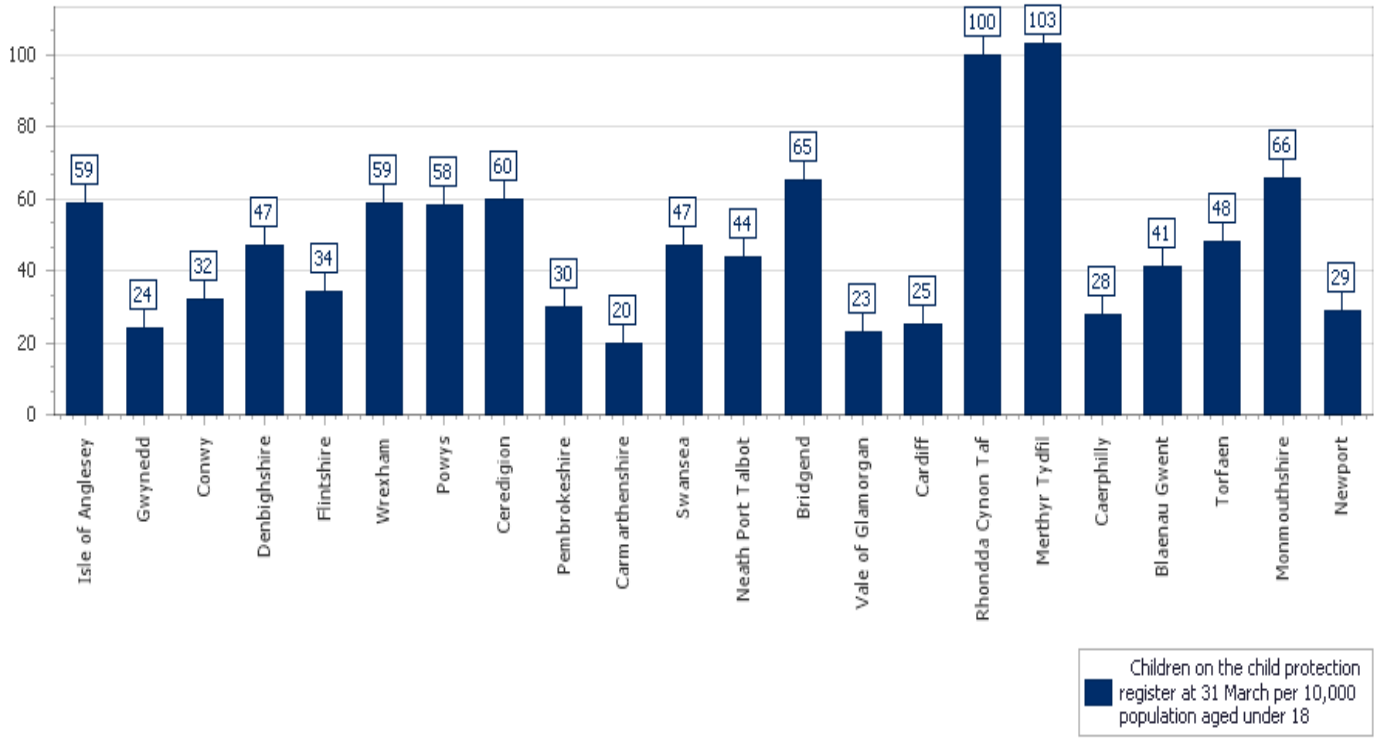
Figure 2. Children Looked After (31 March 2019) per 10,000 by Local Authority (source: StatsWales, 2020)



These numbers slightly differed when taking the number of children across Wales on the child protection register per 10,000 population, with Rhondda Cynon Taf and Merthyr Tydfil seeing a higher numbers than other local authorities. However, it must be noted that there is significant effort across Wales to better understand and respond to looked after children and those on child protection plans through their introductions and mandated requirements on information,

advice and assistance (IAA) to try and prevent escalation to crisis point, but also early intervention and prevention.

Figure 3. Children on the Child Protection Register (31 March 2019) per 10,000 by Local Authority (source: StatsWales, 2020)



Data released by the ONS (2020) estimated that one in five adults ages 18-74 years has experienced at least one form of sexual abuse or witnessing domestic violence or abuse before the age of 16 years (8.5 million). Furthermore, 481,000 adults reported experiencing physical neglect with 3.1million disclosing that they were victims of sexual abuse before the age of 16 years. Around 44% of adults reported experiencing multiple forms of abuse. This data is not broken down to indicate numbers across Wales and England separately.

Vulnerable adults

Safeguarding is not just about the welfare of children and young people, but also those deemed of being of adult age. The previous interim Protection of Vulnerable Adults (POVA) policies and procedures in Wales are now replaced within the All Wales Safeguarding procedures, which were launched in November 2019. This describes an adult at risk as:

> Anyone over 18 years of age who is experiencing or is at risk of abuse or neglect and has needs for care and support (whether or not the authority is meeting any of those needs), and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (S 126 of the Social Services and Well-being Act 2014)

Within these procedures, safeguarding practice principles are outlined that underpin the legislation, guidance and procedures. Specifically, a focus on a person-centred approach is emphasised, which considers the rights and respects the dignity of the individual alongside keeping their best interests at heart. Safeguarding procedures also accentuate the needs of the individual with focus on personal outcomes and communication with the 'effective safeguarding system' guidance. Additional resources detail definitions of adults at risk, safeguarding processes, including prevention and early help (Safeguarding Wales, 2020). It should be noted that the Wales Safeguarding procedures do not replace any of the statutory guidance previously highlighted, but seek to strengthen and clarify the responsibilities of professionals.

Data from StatsWales (2020b) shows the number of reports of adults suspected of being at risk during 2018-19 across Wales as 20,472, with those then proceeding to an enquiry recorded as 10,789. Again, these figures differed across the Local Authorities:

Table 2. Data showing no. adults at risk reported across Wales and each Local Authority (year ending March 2019: Source StatsWales, 2020b)

Area	Number of reports of an adult suspected of being at risk received during the year	Number of reports received during the year that proceeded to an enquiry
Wales	**20472**	**10789**
Blaenau Gwent	491	448
Bridgend	275	261
Caerphilly	996	378
Cardiff	1235	452
Carmarthenshire	1198	1198
Ceredigion	812	544
Conwy	686	113
Denbighshire	595	582
Flintshire	642	567
Gwynedd	468	452
Isle of Anglesey	269	165
Merthyr Tydfil	866	184
Monmouthshire	714	629
Neath Port Talbot	828	702
Newport	929	929
Pembrokeshire	906	332
Powys	789	448
Rhondda Cynon Taf	4699	419
Swansea	1185	372
Torfaen	637	573
Vale of Glamorgan	425	425
Wrexham	827	616

Data from StatsWales (2020b) also indicated that from the 10,789 reports across Wales that proceeded to an enquiry. Of these, 59% (6,388) were determined as requiring action by the Local Authority. In addition, the source of first contact for the adult at risk report was most likely to come from a 'Provider agency' (5,224), Police (4,200) and Local Authority (3,397). Additionally, the place of alleged abuse was highest for 'own home' (2,699) followed closely by 'care home' setting (2,228), with 'community' and 'health' setting both recording figures below 1000.

Adopting multi-agency working in safeguarding practice:

Percy-Smith (2006) has observed the recognisable and clear assertion that regardless of all models and theories of multi-agency approaches, collaborative working will bring a wider range of benefits over working in the absence of partnership. From this perspective, Fox and Butler (2004, p. 38) offer four substantive advantages that multi-agency partnership can

deliver that can be applied to any potential collaborative working framework but especially within the safeguarding sector:

1. Holistic approaches to tackling social and economic issues across the spheres of influence of a number of organisations.
2. Improving service delivery, particularly through the delivery of more seamless services.
3. Devolving solution development, often through the promotion of local problem solving, based on some form of local needs analysis.
4. Increasing involvement of service users and wider communities.

Adding to this, there is the idea that partnerships can remove conflicting tensions between policies, programmes or interventions, something that is particularly pertinent in safeguarding. This can result in a vastly improved deployment of resources (for example, better value for money, or overhead sharing). Safeguarding partnerships can result in more efficient delivery of services through improved integration, the involvement of the community and importantly the service-users themselves (this latter aspect, being widely reflected in the Social Services and Well-being (Wales) Act, 2014) together with the coupling of individual partners (financial resources, skills training, information and people). Partnership working can also build capability to resolve outstanding questions surrounding policy (increased flow of ideas or through stakeholder cooperation). Moreover, other benefits can include a better understanding and building of trust between agencies leading to a readiness to take calculated risks, improve potential for originality and enhance end results. Taken together, both Fox and Butler (2004 and Percy-Smith (2006) have identified two overriding areas of benefit in multi-agency working: (1) improved/more effective service delivery and (2) joint problem solving.

Impact of multi-agency framework

In considering the impact of a multi-agency framework, the literature points to three areas of enquiry, these are the impact on:

1. Professionals
2. Service users
3. Agencies themselves

In the first instance, Atkinson et al. (2007, p. 30) found impact on the professionals to be on four levels; *personal wellbeing* (professionals found multi-agency working to be rewarding, stimulating and enjoyable), *professional development* (increased knowledge and understanding of the roles and responsibilities of partner agencies, personal networking and

increased opportunities for further training), *professional identities* (increased accountability, confusion over roles and professional identities, uncertainty over professional status) and *working practice*s (improved communication between agencies/services, improved interaction amongst professionals, increased accessibility of other agencies, improved accessibility to information from other agencies, greater opportunities for information sharing and problem solving, increased workload on individual professionals, potential for duplication).

Examining impact on service users, two levels were identified; *improved services for service users* (easier/quicker access to services, referral to appropriate agencies, increased focus on prevention/early intervention and reduced need to access specialist services, reduced stigma attached to accessing services) and *Improved lives* (improved support and guidance). Finally, impact on the agencies themselves (increased demand placed on services/agencies, increased positive inter-agency relationships, improved communication between agencies, improved data sharing and efficiency in savings).

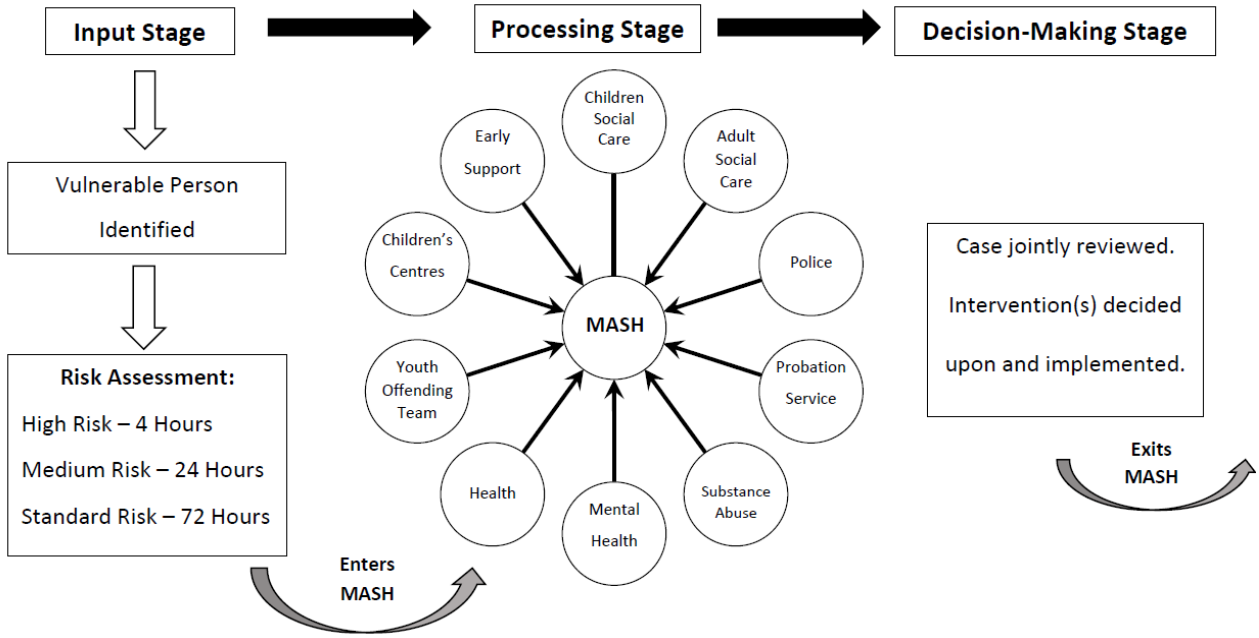
Identifying effective practices for MASH frameworks: What does good look like?

The introduction of MASH as more formal arrangements for operational safeguarding, which is accredited to Nigel Boulton (Golden et al., 2011), is a recent example of multi-agency practitioners taking a shared responsibility to identify and manage vulnerability at the earliest opportunity. By co-locating safeguarding agencies, MASH aimed to move towards a more collaborative approach, increasing the likelihood of safeguarding decisions being holistic, effective, and more proactive (Cullinan, 2013; Hanson et al., 2015).

Since 2010, many local authorities in Wales and England have embedded a MASH framework into their safeguarding practices, allowing the gaps within traditional silo approaches to be acknowledged and rectified. While a legal definition of MASH does not exist, the Home Office (2014) recognises that most MASH frameworks are based upon three core elements:

1. Information sharing;
2. Joint decision making
3. Co-ordinated interventions

Figure 4. Example of MASH process (source: Shorrock, McManus & Kirby, 2019a)



However, it has been acknowledged that without any legal/statutory definition, or guidance on the set up, or processes within these more formal operating safeguarding arrangements, local authorities and police forces have varied in their approaches within their area and also across the UK (Shorrock, McManus, Kirby, 2019a, 2019b). Transferring the recommendations of Acts, policies and guidelines into everyday practices has never been an easy task, since multi-agency partnerships are complex forms of social interaction, requiring the "re-negotiation of power, control and authority which can cross different professional boundaries" (Harris and Allen, 2011, p. 406). Morrison (1996) warned that whilst partnerships and collaborations are necessary, they are not the solution to conflict-free safeguarding processes.

Yet, despite the emphasis that has been placed on these three core elements, various models and features of multi-agency partnerships have emerged, with academics and agencies unable to agree upon a single framework. Watson et al. (2002) proposed that there are three broad types of multi-agency co-operation. The first was multidisciplinary working, which was defined as a single agency rarely co-ordinating with other agencies, choosing instead to focus upon their own priorities. Conversely, interdisciplinary working involved individual agencies assessing the needs of an individual and then meeting with other agencies to discuss findings and set goals. Finally, transdisciplinary working was based upon professionals, from different agencies, working together to share aims, information and responsibilities.

Similarly, Cheminais (2009) refers to the five degrees of multi-agency partnership working. In this model, terms such as co-existence, co-ordination and co-ownership were used to describe

a continuum of multi-agency interactions. Therefore, Cheminais argued that partnerships could range from just clarifying the role and responsibilities of an agency (coexistence), through to agencies committing themselves to a common goal and adapting their practices to achieve this goal (co-ownership). A final model of multi-agency partnership is Wilcox's Ladder of Participation (Wilcox, 1994), which was influenced by Arnstein's Ladder of Citizen Participation (Arnstein, 1969). Like the other models mentioned, Wilcox's ladder acknowledged the various levels of participation. Stage one, 'information stage', was deemed to be the lowest level of participation and control, whilst stage five, 'supporting stage,' had the highest degree of participation and control.

Consequently, the range of multi-agency models is vast, reflecting why academics and professionals find it difficult to agree upon one framework of collaboration. However, all the models mentioned here, and those that were overlooked (Cameron & Lart 2003, Atkinson et al., 2002), recognised that partnerships can vary from a simple association, to a more complex relationship. Thus, it can be argued that if a multi-agency partnership is to be successfully established, certain features need to be present. Subsequently, Miller and McNicholl (2003) proposed that the core features needed for effective collaboration include:

- Unified management systems
- Pooled funds
- Multi-agency common governance
- Shared training and integrated information sharing systems

According to Dunn et al. (2000), unified management systems represent an essential component of interagency partnerships, with working relationships needing to be built upon trust and mutual respect. Moreover, interagency partnerships need to clarify roles and responsibilities within the partnership, as well as identify levels of authority and accountability. To achieve this, partnerships need to appoint leaders with specific attributes (Atkinson et al., 2007), draft an agreed timetable for implementing change (Sloper, 2004), as well as holding case meetings on a regular basis (Salmon and Rapport, 2005). Furthermore, Convery (1998) argued that if a partnership was to advance, individuals need the support of others to enable constructive and self-critical reflection. This not only eradicates past mistakes, but also creates an opportunity to learn from them. Therefore, Abbott and colleagues (2005) concluded that effective and efficient collaborations required professionals to work across their traditional boundaries, modifying their role and responsibilities to meet the demands of integrated working. However, Feng and colleagues (2010) argued that whilst it is easy for professionals to have defined roles, it is harder to motivate individuals to function as an effective team.

Moreover, Ehrle and colleagues (2004) commented that such disagreements could result in the loss of partnership direction and commitment. Thus, if unified management systems are to become established, Crockett et al. (2013) argued that agency cultures must merge, albeit this creates major challenges. Principally, professional approaches to safeguarding vary, with agencies using different languages and terminology to describe similar problems and processes.

A key factor of influence is common governance. Shorrock, McManus and Kirby (2019b) noted that this is perhaps the easiest factor to achieve, since professionals working in the same environment usually strive for the same results. To achieve multi-agency common governance, Huxham and Vaugen (2000) recommended the introduction of collective performance indicators and shared goals, with Atkinson and colleagues (2002) finding that the development of shared goals and objectives reduced the likelihood of individual agency agendas remaining. Incidentally, Scott and Bruce (1994) concluded that staff, who believed in their agencies drive for innovation, were more likely to engage in multi-agency partnerships. Therefore, reaffirming the belief that common governance can be achieved through the implementation of shared goals and values.

A final important factor is the integration of information sharing systems, enabling effective and efficient communication to emerge (Atkinson et al., 2007; Salmon et al., 2005). Research by Miller and Ahmed (2000), coupled with Lord Laming's (2003) recommendations, acknowledged that the successfulness of any collaboration rested upon the introduction of a 'common language'. Similarly, Pinkney et al. (2008) found that one of the main strengths of multi-agency partnerships, according to social workers, was the ability to share information with other professionals. Therefore, the effectiveness of a multi-agency partnership depends upon adequate information sharing, particularly ICT systems, which allow agencies to access all relevant information quickly and easily. As Lewis (2006) argued, electronic methods of storing and exchanging information have the capacity to improve communication, whilst ensuring information remains secure and confidential. Thus, integrated information systems have the potential to help to bridge and aid the flow of communication, providing agencies the opportunity to move away from lone working, towards collective decision making.

By outlining the requirements of multi-agency partnerships, the complexity of implementing collaborative working practices has been demonstrated. This supports Van Eyk and Baum's (2002) statement that interagency collaboration does not occur automatically, but needs to be designed and imposed. Furthermore, Jones and Gallop (2003) argue that time constraints

impede the initiation and continuation of multi- agency partnerships, since there is too much to do and too little time to do it.

Therefore, whilst the principles of multi-agency partnerships may be attractive and theoretically beneficial, the practicalities of achieving interagency collaboration are fraught with challenges. However, policies and practitioners have not been deterred by the challenges surrounding the implementation of multi-agency partnerships. In fact, the most recent responses to vulnerability have been based upon the creation and implementation of Multi-Agency Safeguarding Hubs (MASHs). This implies that although partnership working can be complex and demanding, professionals are willing to collaborate to ensure the best possible outcome for vulnerable individuals.

Multi-Agency Safeguarding Arrangements: Other factors for consideration

Over the last decade, Multi-Agency Safeguarding Hubs (MASHs) have gained increased attention, with more Local Authorities either setting up, or considering plans for a MASH as part of their safeguarding practice. However, research examining how MASH has improved the identification and management of risk has been neglected. This has made it increasingly difficult to observe whether or not theoretical benefits of the MASH framework have been successfully transferred into safeguarding practices (Shorrock, McManus & Kirby, 2019a/b). This begs the question; what does 'good' actually look like within multi-agency safeguarding arrangements? This section of the review will consider multi-agency safeguarding arrangements and specifically MASH policy practice in relation to being an effective 'Front Door' approach, together with recent developments such as the General Data Protection Regulation (GDPR).

The making of a good 'Front Door' approach?

In discussing what makes an effective 'Front Door'[4], Ofsted's National Director of Social Care Eleanor Schooling (2017) has commented that social demographics can play a major part in shaping the most appropriate and effective response to risk and vulnerability. Schooling acknowledges that different models in different places can have different names such as MASH or 'contact referral service', but they are not always used to describe the same thing.

[4] Wales Audit Office (2019) state: "authorities need to have created a comprehensive 'front door' to social care; to have in place effective systems to provide those who contact them for help with appropriate and tailored information, advice and assistance – commonly called the 'IAA' service. An effective IAA service will direct people to preventative and community-based services, and also identify when someone needs an assessment or more specialist help" (p.6).

Moreover, what is seen to work in one location may not necessarily work in another. Thus, there is a need to examine locations in terms of local history, especially group/community biographies (Fraser, 2017). As Schooling (2017) further comments:

> Every area will have different challenges around multi-agency working and ensuring that children and their families get the right help at the right time. The best authorities will continue to develop ways of working that best meet these local challenges as they change over time (para. 4.).

Despite this pertinent diversity in 'Front Door' methods, one thing has become increasingly clear is that developing a multi-agency approach to safeguarding is critical towards effective practice. As Shorrock, McManus, and Kirby (2019b) comment:

> Serious case reviews have concluded that a lack of information sharing between agencies has resulted in vulnerable individuals being unnecessarily exposed to harmful or abusive situations (Preston-Shoot, 2017). In response to such criticisms, safeguarding policies and guidelines now advocate a need for safeguarding agencies to work more collaboratively, so that vulnerability can be identified and managed at the earliest opportunity (Care Act, 2014) (p. 9).

To achieve this, several features need to be implemented, including:

- A need for clarity about what information can and should be shared. Each agency and all professionals should have a clear understanding of their roles and responsibilities, both separately and to each other (Schooling, 2017).
- To address the above, a clear division of labour with a hierarchy of authority (a chain of coordination) should be implemented (Jaques, 2017). This should involve the joint agreement of rules and procedures which should be made clear at the onset to all practitioners. Ideally, this should be formalised through the production of hand/guidebooks or at the very least clear guidelines (Walter et al., 2015).
- Easier access for members of the public, this can be highlighted by Croydon MASH where members of the public can access a duty social worker through reception at the local council offices. Schooling (2017) has observed that the service is particularly well used by young people with accommodation issues. Croydon Mash has developed the Single Point of Contact (SPOC) made up of MASH staff and Easy Help with all children's referrals for emotional wellbeing and mental health support coordinated through the SPOC.
- Where child vulnerability is concerned, a child-centric culture should be established. Schooling (2017) suggests practitioners address questions such as: What is the experience of this child? What type of parental environment have they grown up

around? What is daily life like for this child? And what is the most tailored response that will meet this child's needs (e.g., ACEs framework)?

- Support for front line practitioners (the social workers). For this to be achieved, a culture of continued professional development should be nurtured. Schooling, (2017) makes the important observation that social workers operating at the 'Front Door' can become desensitised to the serious risks due to the volume of caseloads combined with the rapid decision-making process involved. This problem can be resolved by staff rotation with core members of staff who thrive well in the 'Front Door' environment. This latter approach is also a good way to introduce inexperienced staff into the system.

In summing up what makes an effective multi-agency 'Front Door' approach, Schooling (2017) asserts that "supporting front-door staff well is integral to a good front-door service … Looking after your staff and helping them to be skilled and confident in their decision-making is an important part of getting it right for children" (Para. 42).

General Data Protection Regulation (GDPR) and Implications for multi-agency safeguarding:

Safeguarding is about keeping people of all ages safe from harm. To do this requires the access and storage of a considerable amount of personal data. The introduction of the General Data Protection Regulation (GDPR) implemented on 18th May 2018 has meant that data storage has changed. The new regulations now not only mean that increased checks on how data is protected and maintained are required, but also makes it easier for an individual to either withdraw consent for their data to be used by an organisation, ask for it to be transferred to another provider or have it completely deleted from storage. So, what does this mean for multi-agency safeguarding arrangements and information sharing?

The non-statutory guide produced by Welsh Government (2019c) on Working Together to Safeguard People, details information sharing guidance to safeguard children using the Social Services and Well-Being (Wales) Act 2014. It comments heavily on GDPR principles, including a 'myth-busting guide'. The guide highlights the sharing of information between practitioners and organisations as:

> '…essential for effective identification, assessment, risk management and service provision. Fears about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children and young people at risk of abuse or neglect' (Welsh Government, 2019c, p.11).

The guidance document emphasises the use of professional judgement when making decisions about information sharing, following organisational procedures. Also considering a number of key principles such as whether sharing information is: necessary and proportionate, relevant, adequate, accurate, timely, secure and that it should be recorded (p. 9-10).

Summary

The section has sought to provide a review of the most relevant literature relating to safeguarding with particular emphasis on the operationalisation of Multi-Agency Safeguarding Arrangements. In doing so, the review has highlighted a number of issues and mechanisms that can be summarised into four key areas.

First, key milestones in terms of policy, legislation and guidance for safeguarding in Wales were outlined, considering recent developments under the New All Wales Safeguarding Procedures and focussing on the equal statutory treatment of vulnerable adults and children. It next highlights key research and statistics across Wales on vulnerable children and adults, extracting data across the Welsh Local Authorities. Further sections explore the realities of implementing a multi-agency safeguarding approach in practice, with focus on the MASH model and evidence existing (or lacking) of its effectiveness, asking ‘what does good look like?’ Finally, the impact of GDPR and information sharing within safeguarding is explored.

Methodology

Aims of the current study

As part of 'Phase 1', there are two key elements to be achieved from the evaluation work:

1. A full UK/National literature review of multi-agency safeguarding arrangements of both adults and children (the ''Front Door'' approach)
2. Ascertain the range of current arrangements operating in Wales and their key features.

In addition, the evaluation report seeks to:

- Identify the key features of effective multi-agency safeguarding arrangements, including comparisons with single agency activity when no co-location or jointly owned/managed arrangements exist, and effectiveness of arrangements in ensuring that adults and children are effectively protected
- Identify features which enable or inhibit effectiveness of arrangements or models in facilitating access by adults/children to wider 'step up' or 'step-down' services, ensuring protection is still achieved
- Provide evidence of what is known about MASH effectiveness and limits – including outcomes for children and adults
- Contextualise identified arrangements and scope for alternative approaches in terms of regional demographic, sparsity/density, geographic or other unique factors.

Design & data

In deciding how to identify appropriate safeguarding leads across the 22 Welsh Local Authorities, the NISB issued a letter with a briefing page on the evaluation to Directors of Social Services. Letters requested engagement and support of the evaluation and for information to be provided of an appropriate 'nominated safeguarding lead' for their area. This list was compiled by the NISB and sent across to the evaluation team. Each individual nominated safeguarding lead was then contacted via email offering the opportunity to engage with the evaluation via a telephone interview, attaching copies in Welsh and English of:

- Participant Information Sheet (detailing all aspects of the study)
- Consent form (for interview to be conducted and recorded)

Due to the timing of the evaluation with Covid-19 restrictions starting to come in force, participants were also offered the opportunity to return the interview questions via a word document on email. This was in recognition of the increased demand, role changes and

possible illness due to Covid-19 was likely to be having on key safeguarding services. Therefore, a document named 'Telephone survey in open survey format' was also made available on the initial email out to participants. Please see Appendices for further details.

Data:

At least one safeguarding lead from each Local Authority engaged with the study, therefore, each area of Wales was captured. However, due to the structure of safeguarding teams, a list of 33 names was collated from NISB. This was due to some Local Authorities providing separate names for both Adult and Children safeguarding lead.

Of the 33 'Front Door' teams approached, two were excluded from the main qualitative analysis as they were police leads and represented regional safeguarding arrangements[5]. Two nominated leads did not engage with the study, however, data from their Local Authority was still captured by other participants. This left 29 interviews and surveys in the data set: 22 (76%) were interviews, 6 (21%) were surveys and one return included both a survey and an interview. For 4 interviews, 2 or more individuals were present and were able to give viewpoints on various aspects of safeguarding (e.g., children and adults), which resulted in 36 safeguarding leads in total contributing to the data set. Interviews lasted between 34 minutes and 100 minutes with average interview lasting 53 minutes. Data was collected from 20th April 2020 with last interview held on the 4th June 2020.

Participants were all in a leadership role within the safeguarding services they represented. This sample was recruited to ascertain current safeguarding arrangements operating across Wales and, specifically, to capture key enabling and inhibiting features. A breakdown of participant identification numbers (IDs) and area represented is provided in Table 1 below to give context to the quotes used.

[5] Although their interview data was not subject to n-vivo thematic analysis, their responses helped inform the map of safeguarding arrangements and recommendations for Phase 2.

Table 3. Participant Context

Participant ID	LA	Service/Agency
P1	Rhondda Cynon Taf	Rhondda Cynon Taf Children Services
P2	Neath and Port Talbot/West Glamorgan RSB	Neath and Port Talbot Borough Council
P3	Caerphilly	Caerphilly Children Services
P5	Conwy	Family Support and Intervention Service Council
P6	Torfaen	Torfaen Children's Services
P7	Gwynedd	Gwynedd Adult Services
P8	Gwynedd	Gwynedd Children Services
P9	Bridgend	Children's Directorate
P10	Carmarthenshire	Children's Services Carmarthenshire
P11	Rhonda Cynon Taff	Rhondda Cynon Taf Adult Services
P12	Powys	Powys 'Front Door'
P13*	Swansea	Child and Family Services
P14	Blaenau-Gwent	Blaenau Gwent County Borough Council (children)
P15	Blaenau-Gwent	Blaenau Gwent County Borough Council (adults)
P16	Anglesey/Ynysmon	Service Manager (Safeguarding and Quality)
P17	Vale of Glamorgan	Vale of Glamorgan Children's Services
P18	Newport	Newport City Council
P19	Carmarthenshire	Department for Communities Carmarthenshire Council
P21	Ceredigion	Adults & Children Safeguarding, Ceredigion Council
P22	Pembrokeshire	Pembrokeshire Adult Safeguarding Team
P23	Pembrokeshire	Child Protection & Family Support, Pembrokeshire Council
P24	Powys	Assist and Adult Safeguarding, Powys County Council
P26	Flintshire	Safeguarding & Commissioning, Flintshire County Council
P28	Wrexham	Adult Social Care, Wrexham County Borough Council
P29	Merthyr	Merthyr Tydfil County Borough
P30*	Cardiff	Social Services, Cardiff Council
P31	Denbighshire	Community Support Services, Denbighshire Council
P32	Denbighshire	Safeguarding & Reviewing Unit, Denbighshire Council
P33	Monmouthshire	Monmouthshire Children's Services

The survey and interview responses were exported into Microsoft excel to code closed responses and were imported into NVivo Qualitative Data Analysis Software for qualitative analysis. The surveys were thematically analysed in both an *inductive* (being led by patterns than become apparent in the dataset) and *deductive* (looking for specific concepts previously identified in the relevant literature) way and this was conducted in a number of stages:

1. Reading the data and highlighting any quotes which were interesting, relevant and meaningful to the aims of the research;
2. Reviewing highlighted quotes to look for patterns across participants;
3. Categorising patterns in the data into themes and related sub-themes whereby quotes referring to the same concept, belief or idea are categorised together.

Ethical Considerations

Ethical approval was gained from LJMU (ref: 20/LAW/005). All participants were provided with participant information sheets, consent forms, with the offer of either engaging via a telephone interview, or Microsoft Teams video conference call that would be recorded, transcribed and analysed. All documents were available in welsh and English, with interviews also offered with a live welsh translator.

Results

Introduction

The qualitative analysis of the 29 interviews and surveys generated four main themes, each with a series of related sub-themes (see Table 2):

1. Aims of the initiative
2. 'Front Door' system
3. Partnership
4. Reflection.

Each of the themes and the related sub-themes will be discussed in turn. Figures will also be provided for each main theme to visualise how the sub-themes are connected.

Table 4. Themes and Sub-themes with Frequencies

THEMES	***Sub-themes***	**Participants[1]**	**Frequency[2]**
1: AIMS	*Safeguarding*	20 (69%)	23
	Support and protect people	14 (48%)	22
	Effective and coordinated system	18 (62%)	51
	Informed decision making	15 (52%)	36
2: FRONT DOOR SYSTEM	*IAA and/or SPOA/SPOC*	18 (62%)	28
	Process	29 (100%)	193
	Separate systems	18 (62%)	50
	Leadership	27 (93%)	85
3: PARTNERSHIP ORGANISATION	*Multi-agency working*	25 (86%)	85
	Team structure	24 (83%)	37
	Co-location	28 (97%)	52
	Information sharing	28 (97%)	65
4: REFLECTION	*To MASH or not to MASH?*	7 (24%)	15
	COVID-19	15 (52%)	31
	Working well	27 (93%)	82
	Improvements	27 (93%)	102

[1] Number and percentage of participants referring to the sub-theme.
[2] Number of references to the sub-theme

Theme 1: Aims of safeguarding arrangements

All participants were directly asked about the aims of their 'Front Door' safeguarding arrangements. Broadly these aims could be grouped as:

- Establishing and maintain an effective and coordinated system
- Safeguarding vulnerable people and prevent risk of harm
- Supporting people.

Unsurprising, the majority of the 29 respondents (*n* = 19, 66%) specifically referred to safeguarding and prevention of harm as being a core aim of their 'Front Door' arrangements. This included both preventing people from becoming at risk as well as safeguarding those already vulnerable, or who have experienced/are experiencing abuse, neglect or harm. De-escalation, or avoidance of escalation of risk of harm was discussed within this aim to safeguard. This aim related to "*statutory obligations*" (P18) to protect, feelings of personal "*duty and responsbility"* (P32) as well as an agreed organisational motto:

> *"Make me safe. That's our slogan"* (P28).

Alongside safeguarding people against harm, supporting them to live "*happy, healthy and safe lives*" (P13) was also discussed as an aim of the 'Front Door' (*n* = 14, 48%). This included supporting and developing people's resilience for any future crisis and focusing on improving outcomes for individuals. In nine (31%) returns, participants specifically discussed supporting individuals using a 'person centred' approach in which the adult, child or family is fully involved in the services and support they receive, enabling them to have "*the voice of control"* (P31) when this is safe to do so:

> *"Building resilient people and communities who are not reliant on services in the future" (P4);*
>
> *"The first port of call is the adult at risk. What is their view? Actually, you know, those discussions are so valuable. And when you can document that you've actually got the person's wishes and views on it. When people come in and audit and say, why did you make that decision? It is very clear why you made that decision, Because you've got it here in the person's own words, what they felt the risk was and how to manage it and whether or not they wanted us involved*" (P19).

In order to achieve safeguarding and support goals, 18 (62%) participants discussed the aim of having an effective and coordinated system as being crucial. An effective and coordinated response requires multi-agency collaboration (*n* = 12, 41%) with effective information sharing systems (*n* = 8, 28%) and a shared awareness of purpose (*n* = 6, 17%):

> "*We continually make sure that with our partners […] the referral process is known. That, you know, our access criteria is shared*" (P14);
>
> "*One of the first discussions that I had with my team when we started to evolve was you have got to understand what is the purpose of this team? You know, what is the purpose of our work? […] Because if we're not clear about what our purpose is, then how are other professionals going to know what our purpose is*" (P19).

This collaboration related to provision of information and advice to other agencies, sharing information across agencies and appropriate provision of services based on a truer assessment and understanding of need as well as support options across the partnership. Furthermore, as well as quality assurance processes like maintaining and analysing performance information, sharing good practice and serious case reviews, respect

for different agencies and the roles within them (P1) in order to build strong relationships were discussed as being a priority in supporting this aim:

> "*We're trying to achieve a consistent service. To be honest, a consistent service and good relationships with other agencies. That was the main aim because that really helps us in making decisions*" (P12).

Having and effective and coordinated system was hoped to generate decisions and risk assessments that are more informed and included a bigger picture, enabling more accurate and effective understanding of each case in context (*n* = 15, 52%*)*:

> *"To undertake lateral checks with partner agencies e.g health, education to inform decision making […] thorough analysis on referrals based on research and judgement, historical concerns to inform decision making as to whether there is a need for care and support, prevent or safeguarding immediate responses" (P3);*
>
> *"An ability for professionals to make the right decisions based on need for individuals and families to receive the support they need at that time, delivered by the people best placed to deliver it" (P4);*
>
> *"..to ensure the right decisions taken at the earliest opportunity" (P9);*
>
> *"…a consistent service and good relationships with other agencies. That was the main aim because that really helps us in making decisions" (P12).*

Informed and improved decisions included ensuring the right referral was made to the right service (*n* = 4, 14%*)* and that responses were made in a timely manner (within 24 hours) in order to reduce delays in the safeguarding pathway (*n* = 11, 38%*)*:

> *"…refer to the right service at the right time" (P3);*
>
> *"…make accurate decisions within one working day" (P8);*
>
> *"…making sure that that is a really timely and effective response to those concerns that come through the door" (P19);*
>
> *"Make them safe quickl.y" (P28).*

Theme 2: 'Front Door' System

All participants were asked to explain their current 'Front Door' safeguarding arrangements. The purpose of the 'Front Door' arrangement was described as the first contact for support and safeguarding services (P18). A breakdown of what support and safeguarding services were provided by the sample generally, can be found in Table 5.

Table 5. Support Service Provision[6]

Provision of support for:	No. of 'Front Door's providing this support	No. of 'Front Door's NOT providing this support	No. of 'Front Door's in which it is UNCLEAR if this support is provided
Safeguarding Children	21 (72%)	8 (28%)	0
Safeguarding Adults	17 (59%)	11 (38%)	0
Early Prevention	17 (59%)	0	11 (38%)
Domestic Abuse	21 (72%)	1 (3%)	6 (21%)
Missing Persons	4 (14%)	1 (3%)	23 (79%)

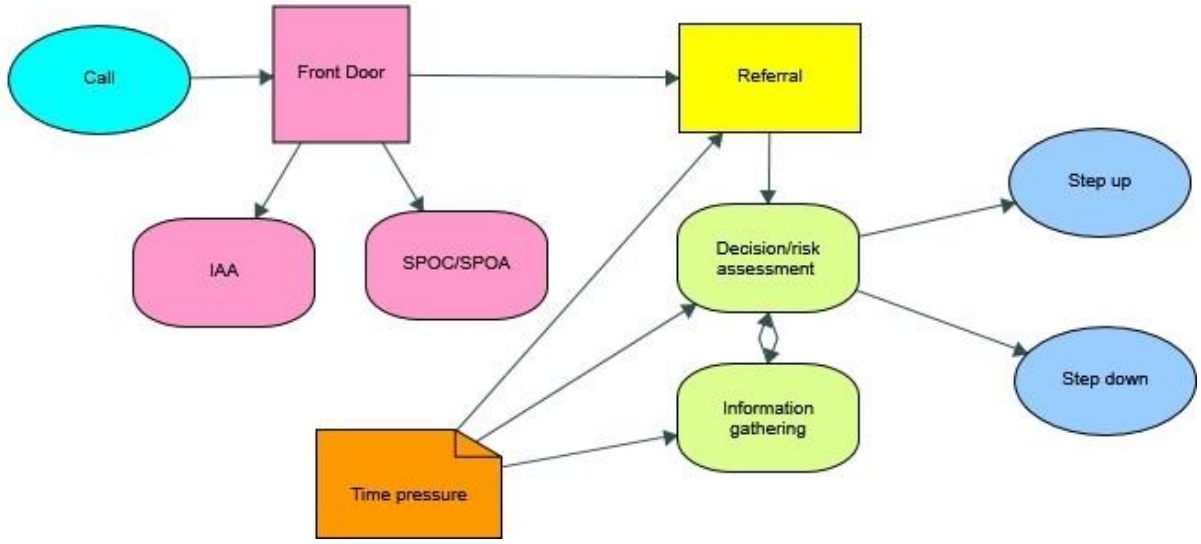
From the 'Front Door', an assessment regarding who and/or where the case should be referred to is made. Referrals, or contacts to the 'Front Door' were often described as able to "come from anywhere" (P23), such as members of the public, police, other agencies etc. However, descriptions of this arrangement seemed to differ across participants. For instance, participants seem to use the terms IAA (Information, Advice and Assistance), SPOA (Single Point of Access), SPOC (Single Point of Contact) and 'Front Door' interchangeably within their own responses and across participants. The majority of the sample (*n* = 18, 62%) indicated that there was some form of central system for all referrals, but it was not always clear if they were referring to the same or different process or system. Some participants stated that their 'Front Door' access was via their SPOC, which was also their IAA, within which assessment and referrals were made. Others clarified that their IAA was a separate service, providing information only, rather than actually conducting any assessments, or referrals.

In terms of the process underlying safeguarding arrangements, 19 described it as 'formal', two as 'informal', one as 'mixed' with seven unclear regarding this (see Figure 1 for conceptual flow chart depicting process). Responses describing the safeguarding process could be broadly grouped into descriptions of:

1. Referral (*n* = 27, 93%)
2. Risk assessment and decision making (*n* = 18, 62%)
3. Step-up and step-down processes (*n* = 18, 62%)

[6] Please note: not all participants gave a full list of services and this is likely to be updated.

Figure 5. Process flow



These referrals included written and verbal formats and ranged from information requests and court requests to public and professional referrals for both child and adult safeguarding concerns. They can come in the form of phone calls, email, an online referral, PPN (Public Protection Notification) or a MARF (Multi-Agency Referral Form). Once a referral is received, the information is entered into the data management system (exact system is dependent on each service – see Theme 3 for more information). Out of the 29 respondents, 11 were able to give an estimate number of referrals received by their 'Front Door' annually. This ranged from 520 to 16,800 referrals per year, averaging 6,617 referrals annually per 'Front Door' across the 11 participants who gave an estimate. P1 claimed that all referrals received feedback, apart from Police referrals due to the "significant volume" of these types of referrals.

The purpose of feedback is that the IAA and/or SPOC enables the referral to be sent to "*the right service at the right time based on an analysis of risk*" (P3). These services comprised of (i) early help/prevention services, (ii) support with consent, or (iii) safeguarding needed (P14). This would be based on the information received in the referral and information obtained from lateral enquiries, either with other agencies, or the person/family themselves where appropriate:

> *"if those assessments are required, then the social workers within the safeguarding hub will undertake those assessments. If at the end of those assessments, it's determined that there's a need for statutory social services involvement"* (P18).

Out of the 29 participants, 20 (69%) explicitly stated that that had a formalised 'step-up' and 'step-down' processes in place. This includes a "*weekly interface and weekly case*

discussions" (P1) and a joint assessment by Police and Social Workers (P4). One participant described the 'Signs of Safety' approach to support this assessment (P13): in this, resolution is sought at the lowest level firstly, and additional professional support is added where needed. 'Stepping up' a case refers to escalating the referral for additional professional and/or statutory support (i.e. where safeguarding concerns have been identified). In contrast, 'stepping down' a case would involve de-escalating a referral to Early Intervention Prevention (EIP)/Early Help services, community connectors or voluntary support (i.e. Supporting Family Change team). Early Help in particular was described (*n* = 8, 28%) as being critical to the offer, in that it can enable the person/family to develop their resilience and help support them with their situation at the earliest opportunity which in turn, prevents issues from escalating into requiring statutory support:

> *"It is about getting that early help offer right"* (P13);
>
> *"There's an early intervention hub then, which brings the agencies together to look at how best to support and promote early intervention and resilience. And that seems to be working really well"* (P16);
>
> *"Relationships between us and preventions are key"* (P18).

A specific type of situation for 'stepping up' a referral that was discussed within the sample was instances of Domestic Abuse (*n* = 15, 52%). In these cases, a referral would be made to the MARAC (Multi-Agency Risk Assessment Conference) co-ordinator (sometimes based within the 'Front Door', or within a MASH/safeguarding arrangements). For reports made relating to Domestic Abuse that did not come via a Police referral e.g., a PPN (i.e. assessed as being of a lower level risk), the case may be referred to other Domestic Abuse services (i.e. SafeLives). One participant discussed a pilot project called DARC (Domestic Abuse Referral Coordination) service in which there is a dedicated worker responsible for reviewing PPNs relating to Domestic Abuse who sits within the 'Front Door' team:

> *"…that has reduced the number that come to us. What we're finding is that there is a significant number where they are low [risk], but because nobody is doing anything, they would be repeated and then become an issue. So now then we can understand that pathway better, so if they do escalate and we have an understanding of how they got to that position and it could be that they had three referrals and it escalates sort of thing, that it could be that there six referrals but they were all around the same, time, there was a bereavement or something"* (P17).

Another indicated there was a dedicated Domestic Abuse Unit (DAU) and an Independent Domestic Violence Advocate service in which an advocate serves as a victim's primary contact to discuss a range of suitable options, develop safety plans and refer to appropriate services:

> *"The DAU have primacy for the safeguarding of domestic violence victims and their families throughout Bridgend County Borough and the Vale of Glamorgan. We receive an average of 20-40 reports of domestic violence every 24 hours, as well as external referrals from other agencies. The DAU are the on-going gatekeepers and maintainers*

of all domestic abuse safeguarding that has been implemented throughout the division, which means that they may still be maintaining and implementing safeguarding measures for years and years for some victims. DAU risk assess PPNs and external referrals and categorise them as High, Medium or Standard. This information is then shared with other agencies and the safeguarding measures appropriate to that particular level of risk are implemented" (P9).

Cases in which systems, team or processes were separate to that of the 'Front Door' arrangement was discussed by 18 (62%) participants. Eleven (38%) participants discussed having a separate team for safeguarding responsibilities to the 'Front Door' services. Safeguarding teams often involved higher risk cases and the teams included social workers:

> *"This is a different team […] we've got a specialist safeguarding social worker […] They go out a lot more" (P24);*
>
> *"That's a specialist team for the purpose of adult safeguarding and deprivation of liberty safeguards" (P28).*

It often meant that safeguarding staff members/team were not co-located within the 'Front Door' team. However, P17 was careful to state that this did not "take the safeguarding responsibility out of children and adults [services]". In some cases, this separate safeguarding team formed a MASH (*n* = 5, 17%) and this was described as a team for which calls with "immediate concerns for safety" (P30) are referred. In this sense, the MASH can be seen as a form of 'stepping up' a referral. One other area was in the process of piloting a MASH (P5). Having a MASH provision was generally considered a positive thing according to those participants who currently have one within their services:

> *"The MASH is a wonderful example of multi-agency working to share information and address risk at the earliest opportunity. There is no barrier to information sharing and working relationships flourish in our environment" (P9).*

But that this did not always work well and required work around developing "governance arrangements" "oversight on the data", "transparency" and good "relationships" (P30).

Other discussion of separate systems related to separations between 'Front Door' services for adults and children. This separation was described as being related to the different perceptions of risk associated with children compared to adults:

> *"I think we've still got a lot of work to do around getting people to understand that adult protection is all on the same statutory footing as child protection […] So when my team were actually asking, for example, a social worker to go out to visit, we were actually putting it on a statutory duty to enquire. Which made it very clear, under what duties we were asking them to do this and by what date we want the information back. And they've all started with; 'oh gosh we have had a statutory duty to enquire' and then go out. Because otherwise they were just seeing it as, you know; 'Yeah. Okay, when I have got a minute I will pop out and see this lady' (P19);*

Specifically, safeguarding adults often relies on understanding what the adult themselves want and 'what matters to them' (P31). Whilst some viewed this separation as positive in that it

allowed certain practitioners to become specialist experts within their area, others saw this separation as having a negative impact on the service they were able to provide as well as generating an environment which 'de-skills people" (P16):

> *"The reason we specialised is if you'd really look at the nuance of child protection procedures or POVA procedures as they were and the rules around looked after children and the regulation law and the role of an IRO. You can't get somebody who can do three of those roles equally as competently" (P8);*
>
> *"I would recommend specialisms. It works much better to have a specialist team" (P28).*

One participant emphasised their vision; "to join up that triage part that sits in the children's assessment and support team into that adult team" and that although there are differences across adults and in children; "it's safeguarding … and we have to be thinking about everybody's safeguarding" (P21).

All respondents were in leadership positions within their safeguarding provision. Leadership responsibilities discussed related to oversight of the information shared, decisions made and responses generated, quality assurance procedures and staff/team supervision:

> *"…coordinate all responses […] provide information and formal supervision to staff" (P1)*;
>
> *"…having oversight of safeguarding across the service" (P2).*

In terms of quality assurance activities in particular, 17 (59%) discussed this as an important part of the process in order to assess the safety and effectiveness of the 'Front Door' arrangement (P19), identify workload issues (P21), "*improve practice, but also to improve the quality of referrals coming in*" (P12). One participant (P13) actually discussed how their organisation was seeking to undertake a systems thinking review of their whole safeguarding arrangements.

Theme 3: Partnership

All participants discussed the organisation of the partnerships. Partnership organisation related to:

(i) Team structure
(ii) Multi-agency partnership working
(iii) Co-location arrangements
(iv) Information sharing.

The team structures varied across the locations. Nine respondents specified the number of members with the teams which ranged from 5.5 staff members to 27.5 with an average team

size of 15 staff members across the nine respondents. Teams involved team manager(s) support workers (i.e. contact officers, commissioning officer) and practitioners (i.e. qualified social workers, safeguarding officers, officers, district nurses etc.).

The vast majority of respondents (*n* = 25, 86%) indicated that their arrangements involved multi-agency partnership working. A breakdown of the core agencies specifically mentioned as involved in the partnership is provided in Table 4. Other agencies involved included: community based interventions, i.e. Community Connectors (n = 7, 24%), substance misuse services or rehabilitation centres (n = 7, 24%), mental health services (i.e. CAMHS: n = 5, 17%), Occupational Therapy (n = 4, 14%), family-based support services (i.e. Family First or Team Around the Family: n = 3, 10%) and carers support (n = 2, 7%). Other agencies (each with one reference only) included: sex offender management, Women's Aid, domestic abuse support (i.e. Assia Suite), Banardo's and the NSPCC.

Table 6. Multi-Agency Involvement[7]

Agency	**No. of Safeguarding arrangements in which agency was mentioned as involved**
Health	24 (83%)
Police	28 (97%)
Education	18 (62%)
Youth Offending Service	6 (21%)
Probation	6 (21%)
Housing	5 (17%)

All participants were asked about co-location within their safeguarding arrangements. Out of the 28 that responded, 25 indicated that there were at least some co-locating across the involved core agencies, whilst only two definitively stated there was no co-location (P3 and P10). Another participant discussed plans to co-locate, but in doing so, seemed to suggest that these plans were not yet in place (P5). The extent and organisation of the co-locating arrangements varied across the sample. There was a roughly balanced split between co-location arrangements that included IAA/SPOC 'Front Door' teams being physically co-located (before Covid-19) all together with safeguarding and/or MASH teams (n = 12), and arrangements in which IAA/SPOC were located separately to the safeguarding team(s), or children's teams were located separately to adult teams (n = 14).

[7] Note: participants were not asked to provide a list of agencies, therefore, agencies only include those that were mentioned.

> *"We used to sit in the same room as adults. But then they moved us. I don't know why. And we I think we were lucky because we worked with the adult side for so long that we we know them really well. So if something does come in in the adult door and they recognise that there's a child there they'll give us a call straight away. And we'll do the same. (P12)*

Reasons for separation included the physical layout and availability of the office spaces, also, confidentiality issues associated with large open plan office spaces when dealing with safeguarding issues:

> *"…confidentiality became a particular issue because the IAA had probably six or eight people within that front room […] The confidentiality was literally a social worker was like so-and-so's mother and I don't live in the area*" (P15).

One participant discussed being co-located, however, being able to work remotely based on where they may have meetings:

> *"We're very lucky that we've actually got a base where we are where they the based and we've got designated desks. But I guess what we've realised is that when you're working across the whole of the county, which we are, sometimes it makes more sense to base yourself in XX for the day if that's where you've got meetings […] You find that when you can hot desk, sometimes you end up sitting next to somebody that you wouldn't normally sit next to, surprising how your, you know what you're talking about. […] I just think it's a really good way of spreading information, really positive information, putting a face to a name as well*" (P31).

Teams were housed in police stations or local authority buildings. Some found co-locating in police stations to be problematic:

> *"It is unfortunate, we are in a police station […] it would be so nice if that wasn't in a police station. Because I think it's quite off-putting for people, really. And the station is not designed for public access to the offices. You know, it's not a welcoming building. You know, they go, people come in and they sit in the foyer and there's all sorts of people coming back and forth, they have to be brought up, a horrible set of back stairs. And, you know, it's just not a welcoming building at all"* (P11).

Co-locating team members tended to be all in the one, open-plan room which was said to enable 'verbal communication' across agencies (P1) and facilitate collaboration:

> *"Being co-located with adult services allows SPOC to link in with adult services more easily, thus parents' needs can be assessed in parallel allowing SW to focus on the child's needs i.e. parental mental health, disability (physical and learning) etc*." (P2);
>
> *"When we are co-located, they will be face to face discussions and other information from a wider group brought, you know, not just police and social services deciding what's going to happen. You will have that input from health, education, early help, so it will really assist the decision making*" (P13);
>
> *"We are quite fortunate in the Civic in as much as we're all based in almost like a circle, almost based together. So, in one of the rooms which has an entrance into the CP, the looked after children's teams and so on. You have the police officer. You have the social workers. The referral processors. And you also have a police researcher. We also have somebody now who works three days a week who reviews all the PPNs as part of EIP. But they're all based in one room and then the EIP workers and the prevention team will come up because there's like a hot desk system. So they'll come*

> *up and spend time. The GDAS worker and engage worker just sit through the door. But that's purely because of the size of the room available, because the safeguarding Hub has grown and grown over the last two years. So in terms of access, everyone has got easy access to each other*" (P18).

Information sharing across agencies was discussed as being integral to safeguarding functioning in order to:

> *"…provide a secure and confidential environment for professionals to share information and be in a better position to identify low-level, repeat referrals which taken in isolation may not appear concerning but combined may suggest a heightened risk to the individual" (P5).*

Effective information sharing helped highlight safeguarding concerns and trigger referrals and/or progressed responses (P1). If teams were co-located, verbal communication was a key method in sharing information with other agencies. Other means included using email, telephone or physical/virtual meetings as well as the specified information-sharing systems in place. In terms of information sharing systems, 20 (69%) currently used a dedicated information collation and/or sharing system. The most popular system was WICCIS (n = 9), followed by MHUB (n = 4), PARIS (n = 4), CareFirst (n = 4), EGRESS (n = 2) and WASPI (n = 1). Some arrangements used more than one system and one discussed moving from PARIS to WICCIS. These systems were used to access information from other agencies, share details and notify relevant partners during the assessment of a case. For instance, MHUB was used in the following way:

- Senior practitioner inputs reason for referral and service history into MHUB
- MHUB notified partner agencies
- Partner agencies research their information and inputs relevant intelligence back into MHUB.

Whilst having access to an information sharing system like this is positive in that it can enable practitioners to access information needed to base an informed decision on more readily than via email requests and phone call or meeting conversations alone, they were described as having related issues to their use. For instance, MHUB was described as "clunky" to use, "doesn't give you the data that you require" (P30) and is not internet hosted so required all staff to have police accounts in order to access the network for it (P11). PARIS was described as a system in which you have to "make your conversation fit the box" whereas, WICCIS allows the "system to fit the conversation" (P13), however this was also described as a "clunky" system (P17). Two respondents indicated a move to Microsoft Teams in the future as a result

of the need to use it during lockdown. P2 suggested that issues relating to information sharing tended to be in respect of individual practitioners, rather than agency wide problems.

Theme 4: Reflection

Lastly, all participants were asked to reflect on the running of their safeguarding arrangements with responses generally reflecting 4 areas:

(i) Utility of the MASH model
(ii) Impact of COVID-19 on working practice
(iii) What works well?
(iv) What improvements are needed?

These elements may inform both best practice sharing as well as evidence informed recommendations for change.

Seven (24%) participants reflected on the utility of the MASH model. In these reflections, the majority (n = 5) had a negative view on taking on a typical MASH model in their region. Some discussed the pressure felt to develop and use a MASH model in their region, however, could not "see what the [positive] outcomes were" in doing so (P13). Similarly, P16 described the results of a business case review exploring the adoption of MASH as "just not affordable". Others discussed the desire to implement a modified MASH model that fits with their regional needs (P12). In this, MASH was considered an "inner city" relevant model which would not typically work in a more rural and widespread area, and therefore taking the philosophy of multi-agency working into a "virtual MASH model" was suggested (P12). One participant indicated the need to understand the research evidence behind the MASH model before doing so (P29).

In light of COVID-19, 15 (52%) participants reflected on the impact that the virus and lockdown has had on their practice. In some cases, this generated potential for positive, and/or more efficient, practices. For instance, the use of virtual MASH arrangements (P12). Such a change (i.e. remote working and virtual meetings) was not only described as being useful during lockdown, but was also described as a positive change continuing out of lockdown due to the size of some authority areas:

> *"You can see the opportunity to stop the industry meetings and people seeing that as being the be all and end all of managing risk. And having meetings that go on for three hours and not focussed. This is the perfect opportunity to try and address some of these things. And we could if we could get some of the people to the technology" (P17);*

> *"It's forced us into some of the things that we've just resisted so long. You know, the technology is there and the means are there and we've just continued in a very old fashioned sort of way for, you know, many reasons as some are obvious. But actually what we're finding and you might find it, is having Skype Teams and all of this available to us, these meetings even though you are cramming them all in, they're far more productive. And the attendance, certainly for safeguarding strategy meetings. The attendance has gone through the roof because people are there, there's no excuses anymore, isn't it? Oh, I'm travelling or I'm stuck in traffic or I'm this. It's there. Yeah, I think any barriers about sharing information have disappeared now" (P19).*

In contrast, one participant discussed an "unwillingness" of police to engage with virtual platforms (i.e. Zoom) to facilitate distanced meetings (P17), with the specific force implementing a 'no-Zoom' policy, possibly due to concerns around confidentiality and privacy.

However, COVID-19 was also described as "hindering" the progress of the development of Early Help Hubs in some areas (P13), planned training (P15), as well as increasing the risk to social workers during visiting adults, children and/or families in the home or community (P14). Some mentioned that even established early interventions services had stopped since Covid-19, with some children safeguarding leads stating concerns around those children with lower level vulnerabilities:

> *"I really worry about those children that were maybe receiving lower level support and are not visible on, you know, just all of those kids coping with that. So it's really we're managing to work with those that we've RAG Rated Red, which is fine, but I'm more concerned with, the ones that we are not seeing, you know […] I've been beating the drum because we've got clubs open. But they only there for our vulnerable children or for children of key workers to allow them to work. I'm saying that's great. But what about the children that actually just need to come to school to get out of the stressful environment? You may not have RAG rated them red, Yeah, but you know, these are children where there is, let me say that a mental health issues and suddenly it's exacerbated my situation. And you know, these children's needs are not going away. And might be getting a lot greater, my view." (P14)*

When asked about what was working well within the multi-agency safeguarding arrangements, nine (31%) participants indicated that they felt that their current arrangements and processes were working well on the whole. Specifically, the elements that were considered as working well related to: (i) relationships between team members and agencies (n = 19, 66%), (ii) team stability and expertise (n = 9, 31%) and (iii) information sharing (n = 9, 31%). Other elements cited as working well were decision making and risk mitigation (n = 4, 14%), co-location (n = 3, 10%), leadership (n = 3, 10%), person centred approaches (n = 3, 10%), referral process and pathways (n = 3, 10%), and a strengths based approach (n = 2, 7%).

The relationships between the team members and partnership agencies were considered to be a strength by the majority of the participants within this sample (n = 19, 66%). As part of this strength, participants discussed that there was "trust" between the agencies and the team members (P11, P12, P17, P29). Participants discussed how the strong relationship was not always there, but instead is something that has been built up over time:

> *"Historically, it's there's been quite a poor relationship between social services and other agencies. And when I first started […] there was a real blame culture; you should be doing that, you should be. You know, that sort of thing. And we've worked hard to change that" (P12);*

> *"I've developed quite a good relationship with the police. So I think it's good. We have an open, transparent relationship. If they have concerns they raise them. If we have concerns we raise them […] I'd rather prefer a relationship like that than actually escalating things up to the director and then coming back down to me when I don't even know this was the concern. And that was happening quite a lot when I first started. But it doesn't happen anymore…we go to each other, you know, so that's that's a positive" (P30).*

Some attributed the strong relationships and levels of trust to team stability. In this, nine (31%) participants discussed how having permanent members of staff within the team and also within partnering agencies enabled mutual trust and the development of expertise, with others referring to their "stable work force" (P21):

> *"Because my team is really stable. So everyone has got to know who we are and how we work. So that's really helped" (12)*

Strong information sharing practices were also cited as something that was working well by nine (31%) participants – this was considered especially important in that it enabled timely and effective decisions and responses to be made (P11).

When asked about what was not working so well, or required improvement, responses across the sample varied. Predominantly most participants discussed challenges associated with joint working (n = 16, 55%), systems, i.e. information sharing platforms (n = 10, 34%), quality and volume of referrals (n = 8, 28%) and resourcing (n = 9, 31%). Other challenges or needed improvements related to: (i) practicalities, i.e. being based in a police station, geographical distance between meetings in rural areas etc., (n = 7), (ii) developing stronger adult provisions (n = 5), (iii) timing of case progression (n = 4), (iv) training, i.e. multi-agency training in particular (n = 4), (v) prioritising the person centred approach (n = 3) and defining and understanding what 'safeguarding' actual means (n = 3).

In terms of challenges associated with joint working, examples given were related to conflicting expectations regarding agency roles and working practices:

"Understanding and expectations of each agency's roles and managing competing demands this entails" (P1);

"You know, we do have little spats from time to time about who should be dealing with this. And, you know, is this for us? Why do you keep bothering us about these things?" (P11);

"There's still a bit of a poor understanding as to what we do as children services. Like there's this expectation we should be doing a lot more than we can" (P12);

"I think it's kind of that the ownership of risk, management of risk and understanding their roles and responsibilities really of social services and what powers we actually have to intervene so that I can be a bit of a challenge. I think that some agencies think that, you know, we can just intervene with families without significant grounds, which is a challenge" (P18).

In terms of inter-agency issues, access and engagement with health seemed to be a particular challenge for 4 participants and CAMHS and police to a lesser extent (P32 and P33 respectively):

"We've yet to managed to get health involved in any physical way [...] the issues with health remain a challenge" (P18).

Furthermore, joint working challenges not only related to joint working with other agencies, but also to the separation of children and adult teams (n = 2):

"I think the co-working with children's could be improved. I want to make an effort, you know, to because a lot of the issues are that there are families so that families have adults and children. And I find it a bit too separated" (P7).

In terms of systems, 10 participants discussed issues experienced, or improvements that were needed. These typically related to information sharing systems, processes and/or platforms. Again, systems such as MHUB and WICCIS were described as "clunky" (P11) and "frustrating" (P17). Instead, one participant described how there was a need for one ICT/information sharing system in place across all agencies and support provisions:

"ICT solutions. That is number 1. It needs to be one system right across the piece, all across, you know, from early help, all the way across. You know, that people can contribute, you know, that can contribute to, you know, to whatever chronologies, observations, whatever […] Without a good IT sharing system we're just adding more problems to, you know, to social work practise and, you know, the fluidity of work and how that can be reviewed and looked at from one from one end of service, right all the way through, you know, really something that works for absolutely everybody. Otherwise, we're just gonna be in this cycle" (P30).

Processes and systems in place for the purpose of information also had broader issues relating to GDPR concerns or poor practices:

"And I think a lot of agencies sometimes are concerned around the data protection etc. There's lots of; 'well I can't share you that because of, you know, it'll violate GDPR' etc. That is a constant issue I think for us" (P15);

"We've recently taken a piece of research with the PCC just looking at children exclusions and criminal exploitation. And what was really evident there was that there were lots of agencies involved, but the actions that each agency took has a significant impact on the other, but if we all talked, then the outcomes for the children to well-being would have been a lot better" (P18);

"There was that over sharing of information from an adults' perspective"(P19).

The demand generated from referrals as well as the generally poor quality of those referrals was discussed as a challenge in need of improvement by eight participants, coupled with the lack of adequate staff and resources to meet this demand (n = 9):

"Volume of PPNs from police essentially makes the haystack bigger and thus the needle more difficult to find. A high percentage (over 80%) of PPNs are NFA'd" (P2).

Word cloud data infographic

From the data collected, N-vivo was used to run content analysis on the key words taken from all 29 participants, with ‘safeguarding’ clearly being the most frequent word used, along with ‘team’.

Figure 6. Frequency word cloud using 'exact match' words

Results: High level Wales MASA arrangements

The table below gives an overview of the key information regarding the multi-agency safeguarding arrangements in place across each Local Authority in Wales.

Table 7. High level overview of multi-agency safeguarding arrangements across each LA in Wales

LA Area	Responsibility	'Front door'	Single Agency Co-location	Safeguarding	Single Agency Co-location	Early Intervention	Information sharing
Blaenau-Gwent	Children	IAA front door Children	No	Duty Team for children	No	Link with Early Action Together Team (within policing)	Egress
Blaenau-Gwent	Adult	IAA front door Adults	No	Adult Safeguarding Team	No	Community connectors along with other services	WCCIS
Newport	Children	Contact centre	Yes	Children's Safeguarding Hub	No	Early Intervention Project. Family first panel (preventions team)	WCCIS &WASPI
Newport	Adult	First Contact adult team (IAA)	No	Adult Safeguarding Hub (also have separate safeguarding team within hospital)	No	Community connectors	WCCIS &WASPI
Caerphilly	Whole area	IAA (SPOA)	Yes	Safeguarding team for Adults. Safeguarding team for Children	No	Supporting family change (children) and community connectors (adults).	TBC
Torfaen	Whole area	Call Torfaen (adults) & Children's MASH	Yes Call Torfaen, not in MASH	Children's Services MASH. Adult safeguarding Unit	MASH - No, But Adults Yes	Early help offers within Family First	WCCIS
Monmouthshire	Children	Early Help and assessment hub (Children)	Yes	Children's Duty Team / Adult safeguarding Duty Team	No	Early help prevention and early help panels	WCCIS

Merthyr	Whole area	IAA	No	MASH	yes	Early Help Hub	MHUB
Bridgend	Whole area	IAA	No	MASH and Adult safeguarding team	No	Early intervention offers	none yet
Cardiff	Whole area	Gateway	No	MASH	No	Early Help offer	MHUB & Carefirst
Vale of Glamorgan	Whole area	IAA	No	Adult safeguarding Team. Children Safeguarding Team	Yes	Flying Start & Families First	WCCIS.
RCT	Adults	IAA adults - SPOA	yes	MASH	No	lots of community prevention services linked in via MASH	MHUB
RCT	Children	Children Services IAA team	yes	MASH	No	Early prevention offer	MHUB
Swansea	Children and family	IAA - single point of access	yes	Integrated safeguarding hub	No	Early help hubs x5 (in community they cover)	WCCIS - migrating to PARIS
NPT	Children and adults	SPOC (children and adults)	No	Adult safeguarding within SPOC.	No	Early Intervention Prevention (EIP) Services	WCCIS
Carmarthenshire	Adults	Delta Wellbeing (IAA)	No	Safeguarding Team	Yes	delta link in to many prevention services in community	Care First
Carmarthenshire	Children	IAA	No	children's services referral team		Team Around the Family	Care First
Ceredigion	Children and adults	PORTH Gofal / Single point of Access (SPOA)	Yes	Duty team for adults and children	Yes	Community connectors	WCCIS
Pembrokeshire	Adults	First Contact Team	Yes	Adult Safeguarding Team	Yes	community connectors	Care First
Pembrokeshire	Children	Child Care Assessment Team (CCATS)	Yes	Duty Hub (with Children in Need team)	Yes	Team Around the Family	Care First
Powys	Adults	IAA	Yes	Adult Safeguarding Team	Yes	Community connectors	WCCIS
Powys	Children	Powys Front door	Yes	Assessment Team - Care and Support	Yes	Support for Families Team (early help)	WCCIS
Conwy	whole area	Front Door Assessment Team (within Family support	Yes	children, family and Safeguarding Service	No	Conwy's Early Intervention Family Centres.	WCCIS

		& Intervention Service FSI)		(will be moved to new MASH model)			
Flintshire	Children	SPOA adults. Children first contact (CFC) team	No - adults Yes - Children	Adult safeguarding team. Duty & Assessment team for children.		Early Help Hub	PARIS
Anglesey/Ynysmon	Whole area	Anglesey's family single point (SPOA)	Yes	MASH	No	Teulu Môn/Team aroundFamily	WCCIS
Wrexham	Adults	Single Point of Access (SPOA) children & SPOA for adults	Yes	Children Safeguarding (was MASH) & Adult Safeguarding Team	Yes for adults. Not clear for children	Community engagement	WCCIS
Gwynedd	Children	IAA children (SPOA)	yes	Intake Team	yes	team around family (early help route within police)	WCCIS
Gwynedd	Adults	Technically has 5 front doors (for 5 areas)	yes	Adult Safeguarding Hub	yes	within 5 areas provided locally adult community resource teams	WCCIS
Denbighshire	Adults	Ssingle point of access (SPOA)	Yes	Adult Safeguarding Team	Yes	Community Resource Teams (CRT)	PARIS
Denbighshire	Children	Children's Gateway (IAA)	Yes	intake and intervention team	Yes	EH has 2 provisions of service: children services and education services	PARIS

Discussion

Key findings

This report addresses Phase 1 of a series of planned work to explore, understand and improve multi-agency safeguarding arrangements in Wales. As part of this first phase, the study engaged with at least one nominated safeguarding lead from each Local Authority across Wales. Focus of the data collection was on describing their safeguarding arrangements, with particular focus on 'Front Door' arrangements, given the stipulations within Social Services and Well-being (2014) Act around the requirement to offer information, advice and assistance (part 2 of the Act). Data from interviews[8] (n = 22) and surveys (n = 6) were collected across all 22 Local Authorities, including 36 nominated safeguarding leads[9]. Key findings from the study are briefly outlined below.

First, although not captured in the data analysis, it was apparent that there were clear boundaries between services, even within Local Authorities, and therefore understanding in how and if cases can be seen along their full pathway by individuals dealing with safeguarding reports. As was established early on in the data collection phase, initially the plan was to interview one nominated safeguarding lead from each Local Authority, but it quickly became apparent that nominated leads were then recommending another lead from another part of the safeguarding services, e.g., their IAA, children, adult services, etc, as they did not feel comfortable or knowledgeable in answering questions posed. This requires further investigation within the next phase of the study to explore in more detail how some of those separated services are affected and what parts of the system are not shared or understood.

Key themes from the data collected

The qualitative thematic analysis of the 29 interviews and surveys generated four main themes, with a number of sub-themes (see Table 4). In summary, nominated safeguarding leads were common in their language regarding the aims of their safeguarding arrangements. They reflected on the key elements of the Social Services and Well-being (2014) Act, as well as recent updates within the All Wales Safeguarding policy (2020), referring specifically to these throughout. Person-centred approaches, building resilience and letting those they are

[8] One LA was interviewed and also returned a completed survey.

[9] 4 interviews had more than 1 nominated lead present, e.g., child and adult lead

engaging with have a ‘voice of control’ (P31) were all common themes represented across most LAs. Focus on timely and consistent decision making were key features when discussing collaborative working and information sharing, with a need to ‘refer to the right service at the right time’ (P3) and ‘make them safe quickly’ (P28).

With regards to the specific ‘Front Door’ arrangements, nominated leads consistently described referrals as being able to come in from anywhere, suggesting that ‘Front Door’ services across Wales are fully open and accessible to all. The functioning of these ‘Front Door’s in terms of processes, single agency/multi-agency, separate ‘Front Door’s for children and adults, staff expertise, co-location, and even the language used, all then seemed to vary across the LAs. Interchangeable terms such as IAA, SPOC, SPOA, ‘Front Door’, were all used (see Table 7) and often required clarifying as to their function. ‘Front Door’ services were described as more informal and thus very separate to more formalised safeguarding arrangements, with 62% specifically making reference to this separation between ‘Front Door’ and safeguarding. This was reflected in the staffing of ‘Front Door’s that often consisted of mainly contact officers, with maybe one or 2 qualified social workers within the team that were able to review information before final decision making. ‘Front Door’ services were less likely to go out of the office and worked mainly remotely collecting information from agencies.

A similar trend was seen when exploring adults and children safeguarding processes from ‘Front Door’ to safeguarding. Some safeguarding leads were quite strong in their view around the need for separation requiring distinctive expertise and specialised within these separate services, stating that is not possible to have someone complete all roles competently, whereas others saw safeguarding much wider, indicating a vision to move towards more joined up, co-located services and that it is about ‘everybody’s safeguarding’ (P21). This may also reflect recent movements in policy centred on adult safeguarding having equal statutory footing to children. Some adult safeguarding leads certainly indicated frustrations at having to put things on a duty to enquire in requiring follow-up and engagement from professionals when this would not be necessary within children services. Although still commented on as an issue, generally, it seemed as though this was improving, but that ‘there is still a lot of work to do’ (P19).

In terms of partnership working, 86% of the 29 nominated leads indicated there was multi-agency working in their arrangements. Key agencies that were mentioned as being part of decision making and collaborative working were mainly the police and health, although better relationships with health seemed to be apparent within adult services. Police were commented on contributing ‘significant volumes’ (P1) of referrals. Some participants referred to a lack of engagement with some services they sought as essential, for example CAMHS or education.

These findings reflect other similar work exploring practitioner perspectives in safeguarding practice (Shorrock et al., 2019b), with safeguarding seen as the core responsibility of social services, with a lack of understanding around practitioner roles and responsibilities (Howarth & Morrison, 2007, Munro, 2011). Again, further work is required to understand the levels of engagement in more detail across the various safeguarding arrangements at the 'Front Door' and within more formalised safeguarding arrangements.

Co-location was a key topic area with all but 2 nominated leads stating that there was some form of co-location within their safeguarding arrangements. Data indicated that 12 stated that their 'Front Door' team and more formalised safeguarding teams were co-located. However, 14 mentioned that their adult and children services were not co-located. Co-location could range from use of hot desks for agencies to use as and when needed; to one key agency, such as education being co-located on a part-time basis; to more formalised MASH set ups. Hot desking was seen as a great way of working for larger counties, with this also benefiting relationships by allowing people to engage with a variety of people and share practice more widely (P31). Co-location within police buildings was seen as problematic in terms of access for any visitors and the general 'welcoming' of the building. One respondent clearly stated the importance of the co-location building and presence of adult and children within them and how this benefits vulnerable families they are working with:

> *"Being co-located with adult services allows SPOC to link in with adult services more easily, thus parents' needs can be assessed in parallel allowing SW (social worker) to focus on the child's needs i.e. parental mental health, disability (physical and learning) etc*." (P2).

Again, this reflects back on the perceptions of adult and children services and how they are currently viewed by safeguarding leads as well as professionals sitting outside of this environment.

As expected, co-location was highlighted as being influenced by space available, with some stating that they used to be co-located (e.g, children and adults) but this recently changed, nonetheless the relationships with staff established have remained (P10). Others clearly discussed benefits of co-location in sharing information and having timely face to face conversations. However, others also emphasised that their virtual arrangements were working very well due to established relationships. Linked to this, MASHs were mentioned by a quarter of participants, with 5 indicating negative views on this as a framework and the pressure they felt in having to adopt this model. MASH was certainly seen as an 'inner city' model and consequently more rural areas deemed the MASH model to be more appropriate and effective as a virtual MASH model. This was further linked in terms of the current Covid-19 restrictions, which has taken current physical MASH models virtual.

Regardless of multi-agency arrangements being co-located or virtual, a key factor that was mentioned was relationships. 'Trust' was mentioned by leads, with some indicating that this has to be built up over time and was not always there. This is reflected in much previous research around the importance of professional relationships (Atkinson et al., 2007) and specifically trust (Dunn et al., (2000). Effective collaborative working was also attributed to stability of teams. Teams in more rural areas talked more confidently and consistently about the stability in their teams and thus being able to work remotely in their role, as people tended to stay in roles. Whereas there tended to be more comment on changing of staff in urban, co-located models such as MASHs, that required continuous work to ensure relationships and trust was maintained.

In terms of where safeguarding leads stated improvement was required, this was mainly focussed on the need for improved joint working, better information sharing systems and quality and volumes of referrals. Suggestions around an improved understanding across all professionals in terms of each agency's role, increased training and awareness to assist with this and ownership of risk were highlighted as pertinent. This was exemplified by some participants commenting that 'safeguarding teams' were often required to deal with all safeguarding concerns, whereas the key worker who was already engaged with the individual would be best placed to continue that relationship. In addition, problems with information sharing platforms was also linked to issues around data, performance reviews and quality assurance. When asked about referral data within interviews, often they could only give comment on their remit, with anything outside of this seen as problematic in gathering. Hence, being able to review safeguarding from the 'Front Door' through to safeguarding actions was seen as extremely difficult for most and hinders their ability to plan and resource accordingly.

Covid-19 has obviously impacted on services to vulnerable individuals and families, as well as working relationships and processes for safeguarding all over the world. As responses were captured within Covid-19, but were not specifically asked, safeguarding leads naturally reflected on things that were working well such as engagement with professionals that often struggled to contribute to information sharing and decision making on cases due to the virtual ease of communicating: 'attendance has gone through the roof' (P19). That this also allowed for more focussed virtual meetings and seemed to help 'stop the industry of meetings' (P17), with those in more rural areas seemingly more prepared for virtual working. In contrast, concerns centred on service delivery. Services such as Early Help and prevention were often paused in many areas due to this relying on many community helpers, with concern about the reduction in referrals received within lockdown and how they can engage with vulnerable

families without putting them at risk, whilst simultaneously ensuring families are safe. Additional concerns around those children not marked as high risk who might be experiencing 'stressful environments' (P14) at home, which may lead to a range of emotional and mental health issues as lockdown restrictions continue. Finally, some participants did reflect on their engagement with staff, with one individual particularly concerned about the ability to effectively support and supervise staff remotely. As mentioned by Schooling (2017) staff feeling supported and confident is integral in effective decision-making in safeguarding. Therefore, it is recommended that further work seeks to understand the impact of covid-19 remote working on safeguarding staff across services to ensure their experience is captured and can inform how to best support them in these social distanced, remote working environment going forward.

Limitations

There are a number of limitations that should be considered when taking into account the findings of the study. Due to data collection occurring at the same time as the global pandemic of Covid-19, it is likely that the arrangements discussed in many areas had fundamentally changed. Although all participants were asked about their arrangements prior to Covid-19, it is likely that the lockdown restrictions had certainly impacted on viewpoints. However, as this is likely to be a long-term issue going forward, it is hoped that by capturing data within the current pandemic that findings are reflective of practice that will be taken forward.

Those nominated leads interviewed were selected by Directors of Social Services, with these then leading to other names being given, who were then interviewed. Engagement with the study was problematic, no doubt due to the pandemic and demand this had on safeguarding leads. The study was due to be completed by end of May, with data completion only occurring in June. As the roles of those interviewed varied, with some having overriding responsibility for safeguarding in their area and able to comment on all aspects from 'Front Door' through to formalised safeguarding arrangements within children and adults, others were responsible for just one part of the service and therefore were unable to comment on anything beyond this. Therefore, further work needs to ensure all aspects of the safeguarding pathway are equally captured, as it might be that the data is slightly skewed by the representation of the nominated lead.

Conclusions

In summary, the data highlighted some key areas:

- There is evidence of effective adoption of 'Front Door' services, with this seen as open and accessible to all (via various forms of communication: email, phone, to all users: general public through to specialist services/organisations).
- There is evidence of successful adoption of language and vision from the Social Services and Wellbeing Act (2014) and new All Wales Safeguarding Policy in terms of being 'person centred', emphasising the individual and family at the heart of decision making processes.
- All 22 Local Authorities are engaged in multi-agency collaborative working, however, the way these operate vary significantly (see Table 7).
- It was clear when trying to identify relevant individuals to interview that children and adult services were often seen as separate. Initial plans were to interview 1 safeguarding lead from each LA, but on speaking to nominated leads they often had responsibility for one area, for example children safeguarding, and would therefore provide an additional name to follow-up with regarding adult safeguarding processes and provision.
    - Discussions with safeguarding leads furthered this issue with disagreement as to whether these should be more joined up, or distinctive, specialised and purposely separated.
- Some adult safeguarding nominated leads spoke extremely passionately about recent policy and legislative amendments with focus on adults having an equal statutory footing within safeguarding. However, frustrations from adult safeguarding leads still emphasised the need to use 'duty to enquire' to push for action, indicating that adult safeguarding still had much more work to be done to achieve similar level of response to children.
- Although 'Front Door' arrangements were said to be well established in all 22 LA's, it is clear from the various arrangements (see Table 7) that these were not always co-located with safeguarding teams, with concerns about how processes and pathways across the whole system can be seen, shared, audited and importantly how learning can be taken forward. Those co-located ('Front Door' and safeguarding teams') seemed to have better collaborative working, with talk of more support and learning coming from face to face conversations about cases as they come in.
- The above point was furthered in regards to difficulties with Information sharing systems that inhibit understanding data across services (children and adults, also for 'Front Door' to safeguarding), which then limit abilities to plan resources and conduct quality assurance (QA) processes.

    - All those that engaged with the study were asked for referral numbers to give estimation of size of demand across each service. However, some were able to give all parts of the system, for example, 'Front Door' through to safeguarding including adults and children, whereas others were only able to provide their service and could not access further data. This once again highlights issues with being able to see the whole system.
- There were different viewpoints and implementation of multi-agency arrangements between those using more virtual multi-agency arrangements compared to physical MASHs, particularly when these are in rural and urban areas.
    - Covid-19 restrictions have further emphasised variances within rural and urban safeguarding provisions. Rural areas seemed more prepared and functional with remote working, compared to urban areas stating concern about eroding relationships between organisations if remote working continued.
- There was evidence of effective engagement from key agencies in information sharing and decision making processes, with high levels of engagement with police, but issues with other organisations engaging as necessary. Education and CAMHS were often mentioned.
- Although not mentioned frequently, some safeguarding leads discussed issues regarding resourcing and turnover of staff. In addition, a couple mentioned their concerns in being able to adequately support their team dealing with vulnerable families, when they have lost their physical support (peer) network (due to covid-19 restrictions and remote working).
- Regarding the impact of Covid-19, there were concerns, around the pausing or reduction of early intervention and community level responses and support, with additional concerns around children that are not flagged as At Risk, or on child protection plans, with many vulnerable children not being seen by anyone outside their homes for months.
- Overall nominated safeguarding leads talked confidently about their safeguarding aims and how they were achieving these, with most acknowledging that there is still much work to be done.

Key recommendations: Phase 2

Key recommendations for future work to help continue to inform and improve effective multi-agency safeguarding have been extracted from the current study. These core questions should be asked for any follow-up study:

1. What are the views, perspectives and experiences of other safeguarding staff in regards to current safeguarding processes and asking them 'what does good looks like?' Further questions should probe further into exploring the added value in working together within safeguarding.
    a. Given the findings of the current study this should include those working within 'Front Door' Services, safeguarding teams, children and adult teams, and wider services such as early help and other agencies that are part of these processes, and also cover those across rural and urban areas.
2. Who is contributing to information sharing, decision making and risk assessments? How are they contributing? Exploration of this question would help inform resourcing and functioning (co-located/remote) of arrangements going forward.
3. Can effective safeguarding processes and practice be identified in safeguarding data?
    a. Exploration of data sets through the safeguarding system. Again, choosing a selection of different arrangements identified in the current study (e.g., children/adult/joined up, urban/rural, remote/co-located) a deeper analysis of the data in exploring decision making, agency/interventions involvement, repeats, vulnerable characteristics, etc. This will enable understanding of crossover from initial contact to longer term support and what works well.
    b. Key questions would include: What factors are present in cases that do not come back into the system? And conversely, what factors are present in those repeat cases?
4. What has been the impact of covid-19 on practitioners and collaborative working? Exploring their experiences and perspectives in trying to extract good practice to be continued post covid-19, as well as where changes need to be made and additional support needed going forward.
5. What has been the impact of covid-19 on safeguarding practice to individuals and families (users)?
    a. Consideration in terms of the impact of covid-19 on those vulnerable families. Exploring what, if any, support they have had in lockdown and impact of experiences. Therefore, engagement with children, families and adults involved with safeguarding services regarding their view on what works well and what does not.
    b. The varying impact of lockdown, and possible continuous 'mini' lockdowns on children need to be understood. Consideration of how safeguarding professionals and schools can prepare for school returns and any further disruptions due to Covid-19, but also how best to support vulnerable children

who may have experienced a range of adverse experiences over this time and may continue during self-isolation periods.

6. If/How is active live learning and feedback to practitioners being implemented and shared? Links to training, development, reflection and transparency – which were featured within the findings of this report. Is this linked to leadership and culture, and if so, how?

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Appendices

To be provided upon request:

- Interview schedule
- Consent form
- Information sheet