SAFEGUARDING LEADERSHIP ACROSS WALES

A BRIEFING PAPER

APRIL 2017

This briefing arises from a Safeguarding Leadership Summit hosted by the National Independent Safeguarding Board on 21 March 2017, which was designed and facilitated by Simon Burch. It is based on notes prepared by Lisa Griffiths, Keith Towler, Jan Pickles and Margaret Flynn. The impetus for the Summit was the question: How effective is safeguarding leadership across Wales?

The National Board accepts that safeguarding leadership is distributed across individuals, which includes people with experience of safeguarding services and their relatives. It is also distributed politically, and corporately, within and across a diverse range of sectors. The process of identifying common safeguarding ground across the Welsh Government and an array of organisations with different obligations, powers and duties highlights the importance of asserting a shared direction of travel and accountability for all of us.

The Key Issues and Questions in Safeguarding

The event began with the identification of the "key issues" facing safeguarding leaders across Wales. The following clusters of issues complement and extend the consultation with Chairs of Safeguarding Boards and the Care and Social Services Inspectorate Wales (CSSIW) and the Health Inspectorate Wales (HIW) leadership during August 2016.[1]

Shared values, vision and common purpose - is this evidenced across the Regional Safeguarding Boards, the Regional Partnership Boards, Public Services Boards and Health Boards?

The design of **an effective practice culture to safeguard children, young people and adults** is compromised by increasing demand and diminishing resources. For example, the police are struggling to meet timescales; organisational structures and "silo" thinking, plus the absence of a common language, impact on practice. The challenges of working across sectors include the conflicts between individual organisational goals and Regional Board goals and inequity, or the unequal strengths of Board participants. The jargon and terms associated with "safeguarding" such as "POVAs" and "thresholds" (which do not feature in the Social Services and Well-being (Wales) Act 2014), "closed cases" and "advocacy" are not readily understood by people known to services and their families.

Safeguarding Boards have vulnerabilities and these include the openness and adaptiveness of Boards to the experience and "voices" of people who become known to safeguarding services; the

[1] See Appendix 1 of the NISB's first Annual Report, 2016-17

prevalence of risk and risk management at all levels (we are all undertaking but not sharing risk assessments); the remoteness of procurement from safeguarding concerns; the absence of guarantees of safety; the assumption that all relevant sectors are adequately represented (the third sector involvement at Board level is not consistent across Wales); the turnover of meeting attendees; senior managers delegating attendance to less senior, operational managers; the difference between the triggers for safeguarding adult referrals for health and social care practitioners (mental health services in particular); the remoteness of Board membership from safeguarding practice; willingness to share information at an operational level – including "soft intelligence;" the administrative discretion of leaders across sectors in translating and promoting safeguarding practice; unchecked assertions and assumptions concerning adults' "unwise decisions;" the roles of agencies which are not represented on Regional Boards e.g. the Health and Safety Executive (HSE), the CSSIW and HIW; the acknowledgement that sometimes we get it wrong and we fear being honest about our mistakes in addressing the complexities of working with children, young people and adults at risk of being harmed or neglected;[2] the questions: Where are the prevention activities? What does an effective safeguarding response look like? How closely connected is our safeguarding practice to harm prevention or reduction?

The **unchecked expansion of safeguarding** means that safeguarding has its fingerprints on online safety, Child Sexual Exploitation, trafficking, "missing" children, self-neglect, self-harm, domestic violence and mental health crises. Also safeguarding concerns embrace those who are" off the radar" because they are home educated, educated in alternative settings or those who are not in education, employment or training and/ or living in group settings in Wales and beyond its borders. The roles of practitioners reviewing people's care plans, corporate parents and families, with their intergenerational caregiving, their longitudinal perspective and interactions with services are all implied rather than explicit; and although there are lots of strategies flying around, plus lots of expectations, spotting the priorities is fraught!

Shared outcomes and performance measures have yet to be identified so that we may determine the effectiveness, efficiency and timeliness of our safeguarding interventions. The "good practice" and emerging practice is barely visible – restorative justice models, for example, are emerging and require serious consideration. However, it takes **time and reflection** to collectively examine decisions and their context, to try out ideas, to get beyond our service structures and identify shared performance measures.

The Opportunities

Thinking about the opportunities in safeguarding practice identified the following:

The **favourable legislative backdrop** to creating a practice culture of collaboration – the SSWB Act, the Well-being of Future Generations Act 2015 and the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 are intended to enhance the well-being of all citizens by focusing on prevention and early intervention; reporting children and adults at risk of being harmed;

[2] See http://www.bbc.co.uk/news/uk-wales-39354451 (accessed 31 March 2017)

thinking about the long term needs of communities; and improving the Public Sector response to gender based violence.

Being a **small nation** means that it is possible to shape the discretion, responsibility and accountability of those in public office across sectors, including education. Public Health Wales' Adverse Childhood Events work is critical to understanding the significance of **prevention and resilience**; we have an interest in mutual learning in mental health; and the refresh of the policy and procedures, "In Safe Hands" and the drafting of the statutory guidance "Handling Individual Cases" are means of fostering mutual intelligibility and trust across sectors.

Regional Boards bring diverse talents, authority and resources to the table. However, the uncertainty concerning each agency's **contribution to safeguarding** requires attention, for example, "there is uncertainty where safeguarding rests in health boards…they do their own thing and don't get that the SSWB Act applies to them!"

There is scope for **sharing data and intelligence** and seeking to understand this on a Region by Region basis. For example, arguably more can be learned from (i) Housing Officers (who know the circumstances of tenants with support needs) than from considering the numbers of referrals to safeguarding by locality (ii) negotiations at service interfaces, and (iii) questioning the case for parallel, and occasionally multiple, reviews.

To function well, safeguarding leaders and practitioners should demonstrate **creativity and opportunism** to allow people time to develop ideas, reflect on them and try out or revise approaches – for example, Swansea City and County Council is implementing the Signs of Safety approach;[3] "Reflect" is a Gwent-wide and Barnardo's approach to providing one to one support to young mothers who have had children removed;[4] Wales is pioneering an Additional Learning Needs Transformation Programme;[5] a new curriculum is being developed in Wales;[6] the Future Generations Commissioner has identified the Adverse Childhood Events work as a challenge shaping her work programme; some Regional Boards are promoting practitioner forums; and the Vale of Glamorgan has created an award-winning Leadership Café.[7]

Since **the best ideas come from involved people**, the experience of those known to safeguarding practice and practitioners has to have greater prominence in our work. Self advocacy is not within everyone's gift but foster carers and teachers, those involved in the "team around the family" and careers services, for example, should be contributing to efforts to glean the experience of children

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[3] www.signsofsafety.net/wp-content/uploads/2013/11/Review-of-Signs-of-Safety-February-2014.pdf (accessed 2 April 2017)

[4] http://sites.cardiff.ac.uk/cascade/2017/03/23/launch-of-the-gwent-reflect-project/ (accessed 2 April 2017)

[5] http://gov.wales/topics/educationandskills/schoolshome/additional-learning-special-educational-needs/transformation-programme/?lang=en (accessed 2 April 2017)

[6] http://gov.wales/topics/educationandskills/schoolshome/curriculuminwales/curriculum-for-wales-curriculum-for-life/?lang=en (accessed 3 April 2017)

[7] www.valeofglamorgan.gov.uk/en/our_council/press_and_communications/latest_news/2016/November-2016/Leadership-Cafe-leads-the-way-for-the-Vale-of-Glamorgan-Council.aspx (accessed 3 April 2017)

and young people. The common ground between advocacy and safeguarding practice remains to be illustrated, most particularly in adult safeguarding.

Can we ensure that our **practice reviews** are concerned with the adequacy of safeguarding practice? Stating the prevention actions which would have helped is essential to developing better practice. The reviews are making a reality of family involvement in ways that Serious Case Reviews did not. Also, they buttress the case for shifting commissioning and management towards the promotion and advancement of **reflective practice**. We are keen to create a line between re-writing policies and strategies and the design of templates when things go wrong and being honest about errors and near misses in order to learn from these.[8] We can do better than creating, and then going on, fruitless bureaucratic excursions!

More Themes and Questions

The sifting of issues and opportunities confirmed the importance of deploying our collective resources to best effect. It also identified the following themes:

1) Voice

In 2014, the Children's Commissioner for Wales called on the Welsh Government to develop a national model of commissioning independent, professional advocacy services.[9] "Missing Voices: A Right to be Heard" hinges on Article 12 of the United Nations Convention on the Rights of the Child, that is, respect for the views of the child. The Convention encourages adults to listen to children and involve them in decision-making. It acknowledges that the level of children's participation should reflect their age and maturity and that greater weight should be given to the views of teenagers over nursery children for example. The offer of advocacy is embedded in S. 181-183 of the SSWB Act for children and adults. The backdrop is different for adults. Although the right to be heard features in Article 6 of the Human Rights Act 1998, it has not been seized upon by health and social care practitioners. People's mental health, mental capacity, autism and/ or limited articulacy, for example, may be cited as the reason for downplaying the task of gathering their views.

As starting points, consultation events, complaints and actions resulting from complaints capture something of people's experience of receiving services. Similarly, deliberate attention focused on staffs' experience of providing services via surveys and feedback events engages them in identifying improvement priorities. What are services doing to enable employees to "do the right thing?" Without a continuing willingness to become familiar with the lives and circumstances of people receiving services, and the circumstances of employees, the status quo will remain.

Although the living testimony of people with sensory losses, autism, learning disabilities, mental health problems and dementia, for example, are lacking, the part played by their families, advocates and services in supporting them is considerable. Technology is enabling digital story-telling. There is considerable scope for learning and adapting the creative approaches currently in use. Story-telling about our lives is liberating and gives us hope for the future.

The growth of advocacy demonstrates a steady move towards people's voices being heard. Since there are not enough professionals to invest time in actively listening to people, professional

[8] See, for example, Marsh, H. (2014) *Do no harm: Stories of Life, Death and Brain Surgery* London: Phoenix
[9] www.childcomwales.org.uk/wp-content/uploads/2016/04/MV_FINAL_E.pdf (accessed 5 April 2017)

advocacy is a complementary resource. The hopeful and emerging examples do not downplay the advocating role of health and social care professionals.

Safeguarding Boards can provide purposeful leadership in ensuring that people's voices and experience identify opportunities for progress. A narrow version of this may be discussions about practice reviews. More generous versions may involve inclusive learning events, the promotion of practitioner learning forums and junior safeguarding boards, judging when to ask people about their experience of particular interventions and reporting these to the Board for example. Questions which confirm the openness of Board to experience and knowledge might include: Were the interventions helpful? Did they enable people to survive crises? Did they experience decent and thoughtful care?

Too many adults are reporting that they had sought to tell people that they were being harmed as children. How are we ensuring, that collectively, we are listening? If the disclosures had come from a different source, would we have taken action?

2) Cultural Shift

The safeguarding past in Wales is untidy and the SSWB Act and statutory regulations, nested within the WBFG Act and the VAWDASV Act, are enabling us to make our way as best we can. We have been bequeathed reliance on child and adult protection policies and procedures; serious case reviews; practice reviews; reviews commissioned by Ministers; and successful prosecutions. These are all compelling teachers!

Additional springboards to "Culture shift" in Wales begin with learning from consultations such as "Our health, our health service;"[10] others include the work of the National Board, the Regional Boards, the Commissioners for children, older people, future generations and the Welsh language. In addition, there are safeguarding champions in local authorities and inspiring leadership in education, the National Society for the Prevention of Cruelty to Children and BAWSO[11] for example. The Donaldson review[12] of the schools' curriculum is an important contribution to young people aspiring to have healthy relationships, satisfying work and involvement in their communities. These are the roots of resilience.

Disclosure and Barring Service (DBS) checks are necessary for certain jobs: working with children, adopting and fostering and working in healthcare. However, there is concern that such checks are limiting opportunities for children and adults with support needs. Closer to home, taxi drivers in North Wales and in Swansea are being trained in basic safeguarding awareness. The incentive is a reduced licencing fee and the benefits include a workforce which is adding to police intelligence concerning trafficking and missing children. Such excellent practice is of fundamental importance to the day to day undertakings of practitioners across sectors. Other workforces may similarly impact on the protection of children and adults.

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[10] https://consultations.gov.wales/consultations/green-paper-our-health-our-health-service (accessed on 31 March 2017)

[11] An all Wales voluntary organisation providing specialist services to the victims of all forms of violence

[12] *Successful Futures – Report on the Curriculum and Assessment arrangements in Wales* http://www.uwtsd.ac.uk/media/uwtsd-website/content-assets/documents/wcee/successful-futures.pdf (accessed on 6 April 2017)

What are we doing to make it easy for practitioners to do the right thing? Whistleblowing has negative connotations. Arguably, *the mandatory reporting of questionable behaviour*[13] is an understandable example of the duty to report.

Social workers and their managers are too readily exposed to public outrage in the media when children and adults are harmed – even when the individuals concerned are known to other professionals. This asymmetry of blame impacts on the willingness of all professionals to acknowledge flaws in their decision-making - which is typically complex and troubling. Although the Regional Boards are in their infancy, alongside local authority members, health boards and the police, they have an important role in overseeing and ensuring accountable action. It requires high levels of honesty and accuracy, shared values and language.

3) Practice and Strategy

Unless we have a rounded appreciation of the challenges we encounter, our problem solving will be compromised. History matters and we must understand the origins of what is in place because established practice may no longer have any rationale and may even be unlawful. Mantras about partnership and everyone's responsibility are not enough. Different organisations have different goals and these have to be brought together. Finally, a challenge identified at the summit concerned information: "Surely sharing data and intelligence – even between children's and adults' services should support rather than subvert professionals' judgements."

People in positions of leadership are making a difference. They are bringing about changes in behaviour that would not occur without their actions. In Wales there are many leadership opportunities in safeguarding across the lifespan. The CSSIW brought together all agencies which were associated with Gwent Police's Operation Jasmine – inviting each to set out their duties and their powers. Such understanding is invaluable to safeguarding practice.

National Independent Safeguarding Board

6 April 2017

[13] See Davies, H (2014) Final report: Southbank International School *Independent review arising from the conduct of William Vahey* http://mandatenow.org.uk/wp-content/uploads/2016/08/27_11_14_vahey.pdf (accessed on 6 April 2017)