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National Independent Safeguarding Board Wales

Wales Safeguarding Literature Review:

Shaping the future of multi-agency safeguarding arrangements in Wales: What does 'good' look like?

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Shaping the future of multi-agency safeguarding arrangements in Wales: What does 'good' look like?

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1. Introduction

Richardson (2014, p.118) defined safeguarding as the "protection of vulnerable groups from abuse and or neglect," with this being the responsibility of all individuals who work with vulnerable groups. Yet, despite the hard work of many safeguarding professionals in attempting to protect the young and most vulnerable in society, the task can rarely be done by one specific safeguarding agency or team. A popular formalised framework that is used in England is a Multi-Agency Safeguarding Hub [MASH] with 26 out of 37 local authorities identifying they use a MASH model (Home Office, 2014, p.6). The aim of a formalised framework such as a MASH is to "identify and manage risk at the earliest opportunity by promoting a collaborative approach to safeguarding" (Shorrock et al., 2019b, p.9).

Despite much agreement on the benefits of multi-agency collaborative approaches in safeguarding, it is widely acknowledged that implementation of multi-agency safeguarding models in practice are problematic, with the implementation of these models varying across key organisations and local authorities in the United Kingdom (McManus & Boulton, 2020; Shorrock et al., 2019b). McManus and Boulton (2020) identified overlapping policies and guidance thereby making internal navigation problematic. It has also been questioned as to which agencies should be involved, how they should be involved, and resulting challenges surrounding governance, formalised structures, information sharing, funding and resources (Shorrock et al., 2019b).

The challenges of transferring the theoretical requirements of an effective multi-agency safeguarding partnership into practice are often overlooked, and there has been a lack of national reviews on the implementation of various formalised models and features of multi-agency safeguarding partnerships (Shorrock et al., 2019b). Therefore, local authorities and agencies have been free to decide on a model that suits their own needs, which may not be supported by evidence, with decisions based on resources, local opportunities and interests. Therefore, evidence is needed on how best to set up, implement and sustain multi-agency safeguarding arrangements that also consider the local context (e.g. population, service and crime data) to ensure effective safeguarding.

The current evaluation has brought together safeguarding partners across the multi-agency operational safeguarding arrangements in Wales including both frontline, operational and strategic roles. A number of different agencies have been included in the evaluation to

give a holistic overview of how each service plays a part in the whole safeguarding system. The evaluation incorporates multi-agency partners working in both adult and children services to reflect the Social Services and Well-Being (Wales) Act 2014, which states that adults have statutory safeguarding equivalence to children.

This evaluation adds to the sparse evidence base available on the implementation of formalised frameworks and features of multi-agency safeguarding arrangements. Moreover, the evaluation seeks to provide evidence on the features of an effective collaborative multi-agency safeguarding arrangement. The learning and recommendations provided in this evaluation will be suitable for all safeguarding partners.

2. Aims of the literature review

The literature review aims to present the reader with a broad overview of the existing literature exploring multi-agency safeguarding arrangements and highlighting relevant legislative developments in safeguarding in which the evaluation is situated. This section begins with a description of the relevant legislative developments. Following this, a general introduction to the theoretical benefits of formalised safeguarding frameworks is discussed focusing on features of good practice, and gaps in understanding. The report highlights the impact of the Covid-19 pandemic on safeguarding practice with a particular focus on safeguarding partners and systems. Additionally, further implications of the Covid-19 pandemic are discussed concentrating on the lack of visibility of children and adults.

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Section 1. Safeguarding in Wales and multi-agency safeguarding arrangements

1.1 The context of safeguarding legislation in Wales

Several key reports, legislation and guidance have been critical in the development of multi-agency working within safeguarding. The Children Act 1989 established one of the first statutory requirements for inter-agency collaboration and joint working, concerning children and young people. The Children Act 2004, as amended by the Children and Social Work Act 2017, which sought to strengthen this relationship by placing new duties on key agencies in English local authorities. Within Wales, the protective provisions of the Children Act 1989 co-exist with the Social Services and Well-being Act 2014 (National Independent Safeguarding Board Wales [NISB], 2021a).

Since then, other acts, policies and guidelines have been introduced to promote a multi-agency approach to safeguarding. This has included recommendations emerging from serious case reviews for example Lord Laming's (2003) report on the death of Victoria Climbie. The recommendations included developing national agency for children and families which would focus on monitoring the performance of agencies. The formation of a children and families committee in each local authority was also recommended whereby committee members should include the police, council and health service trust. A further recommendation included developing 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 that cover both (McManus & Boulton, 2020).

The Welsh Assembly Government's One Wales Strategy (Health in Wales, 2021) 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 six Health Boards and three NHS Trusts in Wales (see Figure 1). These six Local Health Boards (LHBs) have responsibility for the planning and delivering of healthcare services in their local area.

Figure 1. The six Local Health Boards in Wales[1]

The Social Services and Well-Being (Wales) Act 2014 came into force on the 6th of April 2016. The Act allows service users to have 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 emphasises the creation of good effective partnership and collaboration. The Act was distinctive in its approach requiring the safeguarding of adults to have statutory equivalence to children. For example, local authorities can 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 (NISB, 2021a). The focus of the Act is on the 'people approach', promoting people's independence to give them a stronger 'voice and control' (NISB, 2021a). The purpose of the Act is to integrate and simplify the law to allow for greater consistency and clarity to those working with individuals who require all forms of care and support. Moreover, early intervention and prevention are part of the core principles of the Act:

> *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 access to the service (Welsh Government, 2019a, p.7)*

In addition, the Social Services and Well-being (Wales) Act 2014 set up by the National Independent Safeguarding Board [NISB]. The NISB (2021a) core primary duties are:

1. *To provide support and advice to Safeguarding Boards to ensure they are effective.*
2. *To report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales.*

[1] Source for figure NISB (2021b).

3. *To make recommendations to the Welsh Ministers as to how those arrangements could be improved. (Section 132 (2))*

Furthering this, the Well-Being of Future Generations Act 2015 focuses on adopting a joined-up approach in working with people and communities, ensuring that the well-being of those living in Wales is at the forefront of decision making. When focussing on improving public sector responses to abuse and violence victimisation, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 was developed. This Act incorporated a needs-based approach (not altering the criminal law) to promote awareness, prevention and protection of those victims experiencing gender-based violence, domestic abuse and sexual violence (NISB, 2021a).

1.2 Understanding risk within vulnerable children and adults

Multi-agency operational safeguarding arrangements protect a variety of vulnerable individuals, and referrals tend to fall into one of three groups: (1) vulnerable children, (2) vulnerable adults, and (3) domestic abuse (Shorrock et al. 2019a). This report is interested in the 'Front Door' safeguarding arrangements, therefore vulnerable children and adults will be discussed.

1.2.1 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 et al., 2019b). Historically, separate policies and procedures were developed for vulnerable children[2] and adults. However, Wales is leading the way in their approach to ensure equal statutory footing for Children and Adults as part of the Social Services and Well-Being (Wales) Act 2014, and within the national Wales safeguarding procedures (Wales Safeguarding Procedures, 2021).

[2] 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 et al. 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 report, the term child abuse will be used.

Regarding children[3], the last four decades have seen substantial progress in the understanding of child abuse. 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 on the influence of a child's family, community and culture in which they grow up to aid the understanding of child abuse.

Ansley-Green and Hall (2009) note that in terms of preventative approaches to child abuse[4], safeguarding practices can be divided into three levels, the individual or family, the local area or school, and the community. This 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 taken on by social services with regular alterations to policy which has added to the confusion around the roles and responsibilities of partner agencies (Horwath & Morrison, 2007; Munro, 2011; Shorrock, 2017). This has resulted in practitioners losing focus from their 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 safeguarding being neglected, since the demands placed upon safeguarding professionals are increased.

The Office for National Statistics (2020) estimated that one in five adults aged 18-74 years have experienced at least one form of child abuse or witnessing domestic abuse and violence before the age of 16 years (8.5 million). Furthermore, 481,000 adults reported experiencing physical neglect with 3.1 million disclosing that they were victims of sexual

[3] In England a child is defined as anyone who has not yet reached their 18th birthday (National Society for the Prevention of Cruelty to Children [NSPCC], 2021). The English government uses the definition set out in the United Nations Convention of the Rights of the Child, "Every human being below the age of eighteen years" (United Nations International Children's Emergency Fund [UNICEF], 1989, p.4). In Wales, Section 3 of the Social Services and Well-being (Wales) Act 2014 states that a child is aged under 18 (NSPCC, 2021). The UK Parliament (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".

[4] Despite the broad range of programmes existing within these three levels MacMillan et al. (2008) have noted that the effectiveness of such interventions remains unknown. However, two home-visiting programmes, the Nurse-Family Partnership and Early Start are noted as being effective interventions for preventing child maltreatment and associated outcomes such as injuries (MacMillan et al., 2008).

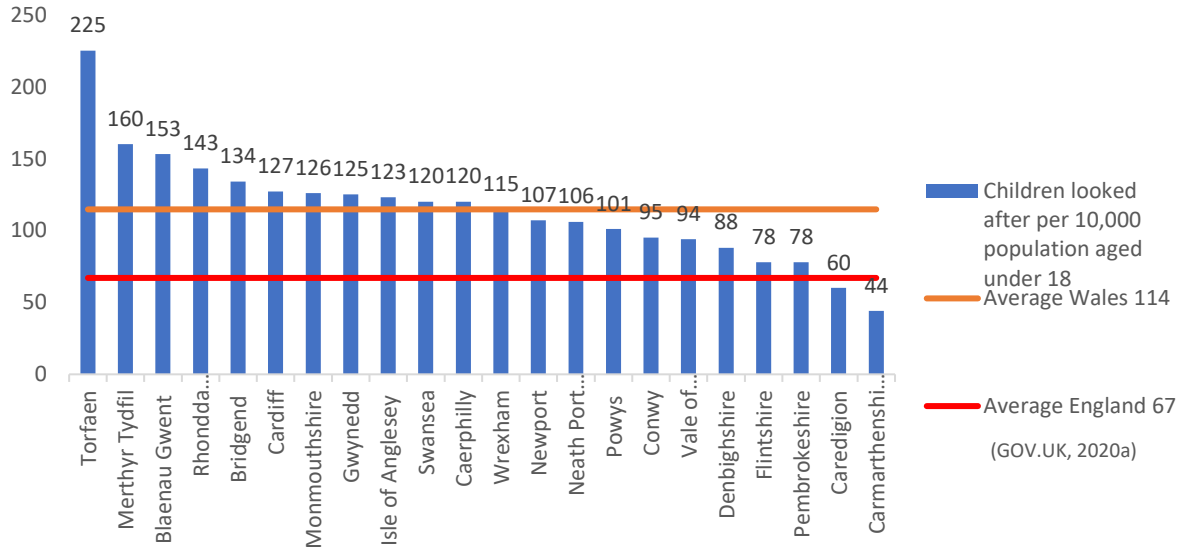
abuse before the age of 16 years. However, the data is not broken down to indicate numbers across Wales and England separately.

The latest information from across Wales indicates that the number of looked after children (aged under 18 years) on 31st March 2020 was 7,172, with this being an increase of 5% from the previous year (Welsh Government, 2021b). Data also indicated that there were slightly more males (3,865, 54%) than females (3,300, 46%), with the proportion being stable over recent years (StatsWales, 2021a). Data shows that children aged 10 – 15 years old are the most common age range of children who are looked after (2,650, 37%) (StatsWales, 2021a):

- *Under 1: 340 (5%)*
- *1-4 years: 1,330 (18%)*
- *5-9 years: 1,715 (24%)*
- *10 – 15 years: 2,650 (37%)*
- *16 and over: 1,130 (16%)*

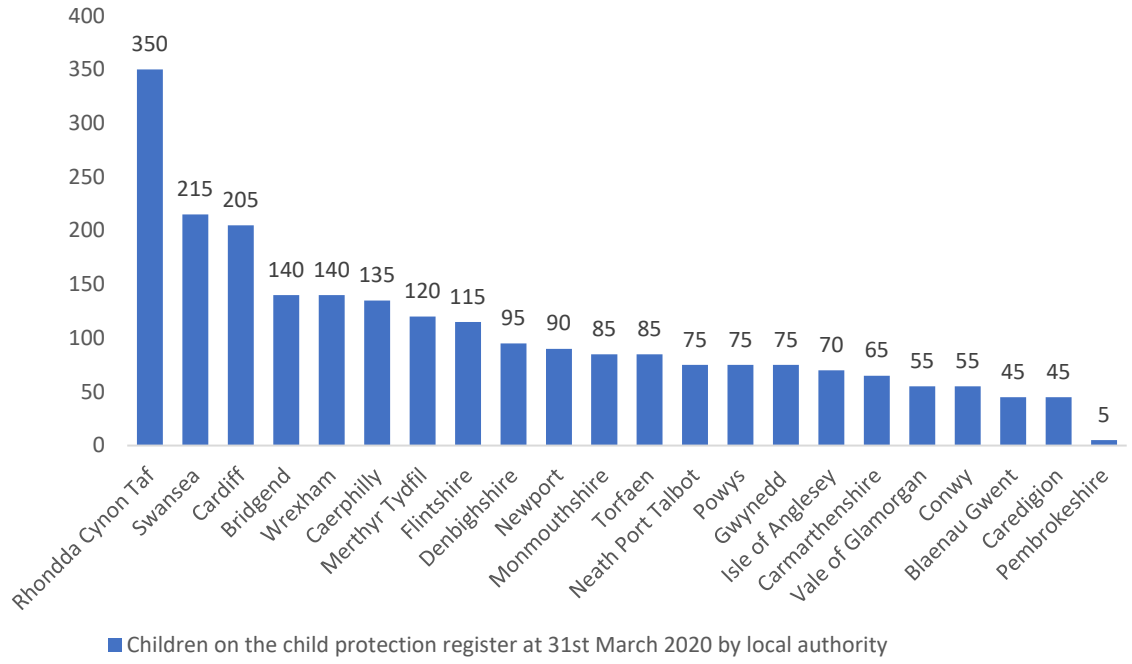
However, there were significant variations in the number of children aged under 18 that are looked after when comparing figures per 10,000 population across each local authority (see Figure 2).

Figure 2. Children looked after (31 March 2020) per 10,000 by local authority[5]



[5] Source of data StatsWales (2021b).

Figure 3. Children on the child protection register (31 March 2020) by local authority[6]



These numbers differed when taking the number of children across Wales on the child protection register into account (see figure 3). Please note that data for children on the child protection register per 10,000 population by local authority was not provided for 2020. Figure 3 shows the local authorities Rhondda Cynon Taf and Swansea having the highest number of children on a child protection register. It must be noted that there has been a significant effort across Wales to better understand and respond to looked after children, and those on a child protection register through the mandated Information, Advice and Assistance (IAA) service which aims to prevent escalation through early intervention and prevention.

1.2.2 Vulnerable adults

Safeguarding is not just about the welfare of children and young people, but also those deemed of being of adult age. An adult at risk is defined as:

> *Anyone over 18 years of age who is experiencing or is at risk of abuse, 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 (The National Archives, 2014, section 126)*

[6] Source of data StatsWales (2021c).

The Protection of Vulnerable Adults (POVA) policies and procedures in Wales are now replaced within the Wales Safeguarding Procedures, which was launched in November 2019 (Wales Safeguarding Procedures, 2021). Within these procedures safeguarding practice and guidance are outlined that underpin legislation. Specifically, a person-centred approach is emphasised which ensures the rights and dignity of an individual is at the heart of practice. The safeguarding procedures also outline the needs of the individual with a focus on personal outcomes and communication with the 'effective safeguarding system' guidance (Wales Safeguarding Procedures, 2021). It should be noted that the Wales Safeguarding Procedures (2021) do not replace any of the statutory guidance previously highlighted, but seeks to strengthen and clarify the responsibilities of professionals.

The number of reports indicating an adult was suspected of being at risk across Wales during 2018-2019 was 20,472, and 10,789 reports proceeded to an enquiry (StatsWales, 2020d). From the 10,789 reports across Wales that proceeded to an enquiry, 59% (6,388) were determined as requiring action by the local authority (StatsWales, 2020e). Rhondda Cynon Taf received the highest number of reports of adults suspected of being at risk (4,699), but only 419 of those reports proceeded to an enquiry showing the biggest difference across the local authorities (see table 1). Please note that data for the year 2019-2020 and 2020-2021 has not been published for vulnerable adults.

Table 1. *Number of Reports of an Adult Suspected of Being at Risk Reported by Local Authority and Measure (March 2018-2019)*[7]

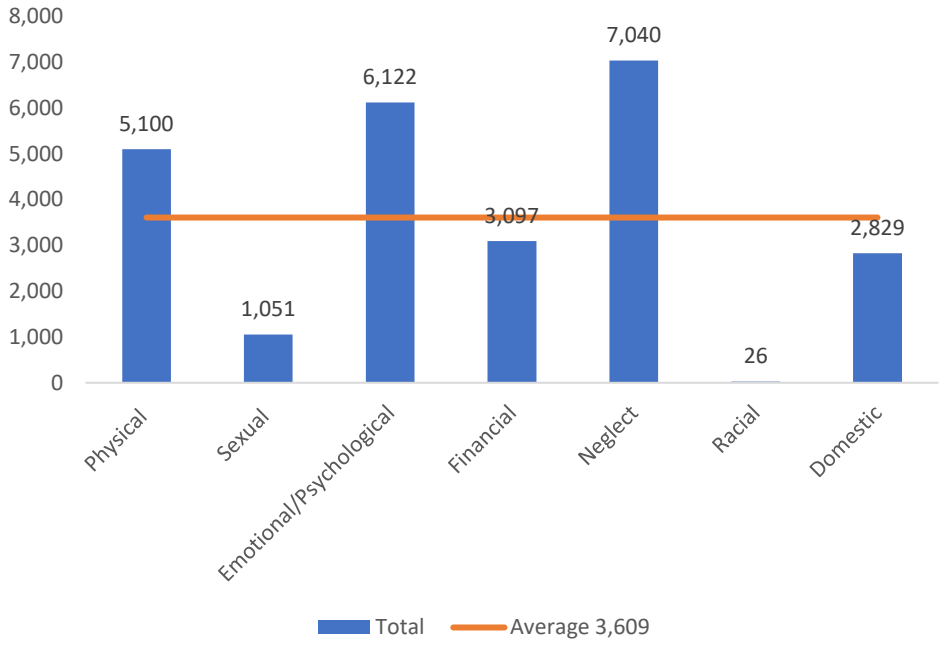
Area	Number of reports of an adult suspected of being at risk received during the year	Number of reports received during the year that proceeded to an enquiry
Total	**20,472**	**10,789**
Rhondda Cynon Taf	4,699	419
Cardiff	1,235	452
Carmarthenshire	1,198	1,198
Swansea	1,185	372
Caerphilly	996	378
Newport	929	929
Pembrokeshire	906	332
Merthyr Tydfil	866	184
Neath Port Talbot	828	702
Wrexham	827	616
Ceredigion	812	544
Powys	789	448
Monmouthshire	714	629
Conwy	686	113
Flintshire	642	567
Torfaen	637	573
Denbighshire	595	582
Blaenau Gwent	491	448
Gwynedd	468	452
Vale of Glamorgan	425	425
Bridgend	275	261
Isle of Anglesey	269	165

In addition, the source of first contact for an adult at risk was most likely to come from a provider agency (5,224), Police (4,200), or the local authority (3,397) (StatsWales, 2020f). Moreover, the place of alleged abuse was highest for an adult's private home (2,699), followed closely by care home settings (2,228), with community and health settings both recording figures below 1,000 (StatsWales, 2020g).

[7] Source of data StatsWales (2020d).

Neglect was the highest recorded type of abuse in Wales during the year 2018-2019 followed by emotional and psychological abuse (see figure 4) (StatsWales, 2019). Please note that data for the year 2019-2020 and 2020-2021 has not been published for vulnerable adults.

Figure 4. Type of abuse and neglect recorded in the year March 2018-2019[8]

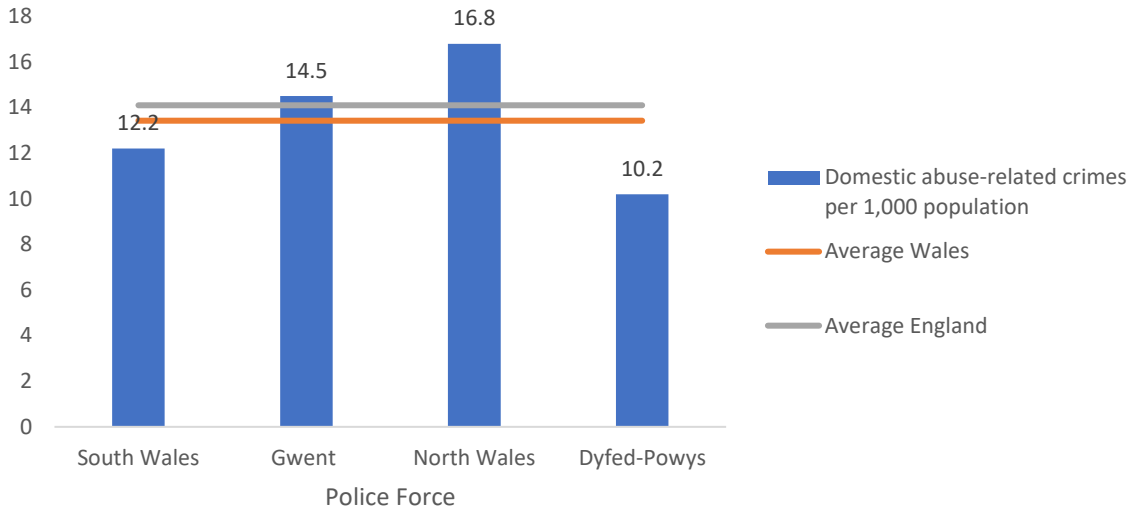


1.2.3 Domestic Abuse

Recent data shows insight into domestic abuse-related crimes recorded by Police Forces. The North Wales Police Force recorded the highest number of domestic abuse related crimes per 1,000 population in the year 2020 – 2021, and Dyfed-Powys Police Force recorded the lowest (see figure 5) (Office for National Statistics, 2021).

[8] Source of data StatsWales (2019).

Figure 5. Rate of domestic abuse related crimes recorded by Police Force area in the year March 2020-2021[9]



1.3 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 rather than working in the absence of partnership. From this perspective, Fox and Butler (2004, p.38) note the advantages of a multi-agency partnership which can be applied to any collaborative working framework, but especially within the safeguarding sector:

- **holistic approaches** to tackling social and economic issues across several organisations;
- **improving service delivery** which ensures the service is seamless;
- **devolving solution development** often through the promotion of local problem solving, based on some form of local needs analysis; and
- **increasing involvement** of service users and wider communities.

Partnerships can remove conflicting tensions between policies, programmes or interventions, something that is particularly pertinent in safeguarding. This can result in improved deployment of resources (for example, better value for money, or overhead

[9] Source of data Office for National Statistics (2021).

sharing). Thus, safeguarding partnerships delivery of services are more efficient through improved integration, the involvement of the community and service-users this latter aspect, is reflected in the Social Services and Well-being (Wales) Act, 2014. Partnership working can also build capability to resolve outstanding questions surrounding policy through stakeholder cooperation. 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 service delivery, and (2) joint problem-solving.

1.4 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. Services and agencies

Atkinson et al. (2007) noted that the impact on professionals was summarised into four different areas. The first area of impact was on a professional's personal wellbeing; literature has reported that professionals found multi-agency working rewarding and stimulating, thus increasing job satisfaction. The second area of impact on professionals was on their personal development; studies reported that as a result of multi-agency working professionals had a greater understanding of their partner agencies roles and cross-disciplinary issues. Multi-agency working also allowed professionals job roles to expand by taking on new responsibilities, therefore increasing professional development. Professional identity was identified as the third area of impact on professionals; it has been reported that multi-agency working increased accountability. The fourth area of impact on professionals was working practices; it has been reported that multi-agency working improved communication with other agencies in the partnership, accessibility of information from other agencies, and problem-solving within the partnership.

Atkinson et al. (2007) identified two levels of impact on service users. The first area of impact was that services were more efficient and accessible due to service users having a wider choice of services which were not previously available. Moreover, service users have access to early intervention and prevention services such as early help, and consequently the threshold of need can be reduced. The second level of impact is improved support and guidance for service users which is achieved through the multi-agency arrangements having services and agencies working in partnership.

Finally, the impact on agencies and services are increased positive relationships between the different agencies and services which leads to improved communication. Therefore, data sharing is enhanced and resources are shared more efficiently (Atkinson et al., 2007).

1.5 Identifying effective practices for multi-agency operational safeguarding arrangements: What does good look like?

Recently multi-agency safeguarding hubs have been introduced as a formal arrangement for operational safeguarding, which is accredited to Nigel Boulton (Golden et al., 2011). A multi-agency safeguarding hub is an example of multi-agency professionals taking a shared responsibility to identify and manage vulnerability at the earliest opportunity (Golden et al., 2011). A multi-agency safeguarding hub aims to be collaborative in its approach by co-locating safeguarding agencies, therefore leading to decisions being made about service users which incorporate a comprehensive understanding from all relevant safeguarding partners (Golden et al., 2011).

A legal definition does not exist however, the Home Office (2014) states that most multi-agency safeguarding hub frameworks are based upon three core elements; (1) information sharing, (2) joint decision making, and (3) coordinated interventions. Local authorities across the United Kingdom have varied approaches to their formal operating safeguarding arrangements due to the lack of a legal definition and resulting guidance on the set up and processes of such frameworks (Shorrock et al., 2019a; 2019b). Transferring recommendations of acts, policies and guidelines into practice is challenging due to multi-agency operational safeguarding arrangements [MAOSA] being complex forms of social interaction. Therefore, requiring the “re-negotiation of power, control and authority which

can cross different professional boundaries" (Harris & 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 a MAOSA 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 cooperation. The first was multidisciplinary working, which was defined as a single agency rarely co-coordinating with other agencies, choosing to instead 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 (2009) argued that partnerships could range from just clarifying the role and responsibilities of an agency (co-existence), 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 the 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 of Participation acknowledged the various levels of participation. Stage one the 'information stage', was deemed to be the lowest level, whereas stage five the 'supporting stage' had the highest level of participation and control (Wilcox, 1994).

Consequently, there is a lack of agreement on a single multi-agency model or framework due to the range of multi-agency models being used. However, all the models mentioned in this report, and those that were overlooked (Cameron & Lart, 2003; Atkinson et al., 2002), recognise that partnerships can vary from a simple association to a complex relationship. Therefore, for a multi-agency partnership to be established successfully certain features need to be present. 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

The Department of Health (2000) noted that 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 regularly (Salmon & 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 et al. (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 et al. (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. Agency workers are more likely to be perceived as less collaborative and prefer to work in their professional silo, and consequently effective interagency collaborative working is compromised (Lalani & Marshall, 2020).

Ehrle et al. (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, although this creates major challenges. Principally, professional approaches to safeguarding vary, with agencies using different terminology and acronyms to describe similar problems and processes (Rees et al., 2021).

A key factor of influence is common governance. Shorrock et al. (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. Atkinson et al. (2002) noted that the development of shared goals and objectives reduced the likelihood of agency agendas. Incidentally, Scott

and Bruce (1994) concluded that staff who believed in their agencies drive for innovation are 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., 2017; Salmon & Rapport, 2005). Research by Miller and Ahmad (2000), coupled with Laming (2003) recommendations, and 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 IT systems, which allow agencies to access all relevant information quickly. As Lewis (2006) argued, electronic methods of storing and exchanging information can improve communication, whilst ensuring information remains confidential. Thus, integrated information systems have the potential to help to bridge and aid the flow of communication, providing agencies with the opportunity to move away from lone working, and 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. Jones and Gallop (2003) argue that time constraints impede the initiation and continuation of multi-agency partnerships, due to the number of tasks and the lack of time to complete them.

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. The most recent responses to vulnerability have been based upon the creation and implementation of multi-agency safeguarding hubs. This implies that although partnership working can be complex and demanding, professionals are willing to collaborate to ensure the best possible outcomes for vulnerable individuals.

1.6 Multi-Agency Safeguarding Arrangements: Other factors for consideration

Over the last decade, formalised frameworks such as Multi-Agency Safeguarding Hubs [MASHs] have gained increased attention, with local authorities either setting up, or considering these formalised models as part of their safeguarding practice. However, research examining how formalised models such as MASH have improved the identification and management of risk is lacking. This has made it difficult to observe whether the benefits of the framework have been successfully transferred into safeguarding practice (Shorrock, McManus & Kirby, 2019a; 2019b). Therefore, this section of the review will consider what does 'good' look like within multi-agency safeguarding arrangements. The review will consider what makes an effective 'Front Door' arrangement, together with recent developments such as the General Data Protection Regulation (GDPR).

1.7 The making of a good 'Front Door' approach?

In discussing what makes an effective 'Front Door'[10] the Office for Standards in Education Children's Services and Skills [OfSTED] 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 (2017) acknowledges that different models in different locations can have various names such as multi-agency safeguarding hub, or 'contact referral service'. Moreover, what is seen to work in one location may not necessarily work in another. Therefore, there is a need to examine locations in terms of local history, especially group and community biographies (Fraser, 2017). This further highlighted by the following quote:

> *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 (Schooling, 2017, paragraph 4)*

[10] 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)

Despite the diversity in 'Front Door' methods, developing a multi-agency approach to safeguarding is critical to ensure effective practice. An absence of information sharing between safeguarding agencies has been highlighted through serious case reviews as a reason why individuals have unnecessarily been subjected to abusive situations (Preston-Shoot, 2017). Therefore, to ensure vulnerability is identified and managed promptly policies and guidelines enforce safeguarding agencies and services to work collaboratively (Care Quality Commission, 2015).

To ensure vulnerability is identified and managed promptly 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 or 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 professionals. Ideally, this should be formalised through the production of a handbook or clear guidelines (Walter et al., 2015).
- Easier access for members of the public, this can be highlighted by the Croydon multi-agency safeguarding hub where members of the public can access a duty social worker through a reception at the local council offices. Schooling (2017) has observed that the service is particularly well used by young people with accommodation issues. Croydon multi-agency safeguarding hub has developed a Single Point of Contact [SPOC], which consists of multi-agency safeguarding hub staff and Easy Help staff 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. For this to be achieved a culture of continued professional development should be nurtured. Schooling (2017) observes that social workers operating at the 'Front Door' can become desensitised to the serious risk due to the volume of caseloads combined with the rapid decision-making processes 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 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*" (Paragraph 32).

The publication of 'No Wrong Door' (Children's Commissioner, 2020c) detailed the need for services to 'wrap around families', particularly those families who may have complex needs such as learning disabilities and those experiencing emotional and mental health difficulties. The findings were revisited after the onset of Covid-19, whereby increases in demand for services and the need for services to work holistically required a coordinated multi-agency response. Recommendations from Regional Partnership Boards are considered a fundamental part to ensure that an integrated approach is adopted by creating teams, hubs and panels, allowing for a joined-up approach that is embedded into service delivery. This approach should ensure that the third sector are included, and that funding is regionally owned across an array of services. Regional Partnership Boards are expected to publish multi-agency pathways for support and transitional protocols for the transition from children to adult services which are accessible to members of the public. Moreover, it was recommended that Regional Partnership Boards must ensure children and young people are involved in co-production and are active participants in the Boards work.

The progress of the above recommendations and requirements have been noted by The Children's Commissioner (2022). The report identified several improvements such as the Regional Partnership Boards having an implementation plan for a 'No Wrong Door' approach, and sub-groups for issues specifically related to children. However, it was identified that there is currently no clear link between the voice of children and young people within operational

activity. Whilst some progress has been made, extreme pressure on services is affecting implementation of delivery and vulnerable children and adults accessing support.

1.8 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] on the 18th of May 2018 has meant that data storage has changed. The new regulations ensure increased checks are maintained on the protection of data, and that an individual can either withdraw their 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.

A non-statutory guide produced by the Welsh Government (2019d) 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:

> *Sharing of information between practitioners and organisations is 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, 2019d, p.11)*

The guidance document emphasises the use of professional judgement when making decisions about information sharing and following organisational procedures. Also considering several key principles such as whether sharing information is necessary and proportionate, relevant, adequate, accurate, timely, secure and recorded (Welsh Government, 2019d).

A recent analysis of adult Domestic Homicide Reviews (DHRs) conducted in England along with findings from Adult Practice Reviews, and Child Practice Reviews conducted in Wales report that information sharing needs to be improved (GOV.UK, 2022; Rees et al., 2021a; Rees et al., 2021b). The findings highlight professionals lack the understanding and confidence in the duty to share information (Rees et al., 2021a). The implementation of GDPR

and the associated Data Protection Act 2018, has increased confusion and anxiety among safeguarding practitioners. Consequently, practitioners have felt anxious to share information due to the fear of inappropriate information sharing (Rees et al., 2021b). It is vital that training is provided with all services involved in safeguarding in a multi-agency setting to reduce the barriers and improve confidence around information sharing (Rees et al., 2021b).

Section 2. The impact of Covid-19 on systems, safeguarding partners, and communication with service users

2.1 Impact of Covid-19 on multi-agency operational safeguarding arrangements

During the Covid-19 lockdown innovative ways of working had to be established while non-essential face-to-face contact was stopped, and consequently remote working and virtual meetings became the norm. Multi-agency safeguarding professionals have described this move as bringing communication into the modern-day (McManus & Boulton, 2020). It has been reported that safeguarding partnership agencies have been more involved in online meetings, and as a result productivity has increased (Walklate et al., 2021). For example, information could be looked up quickly and shared back to the group due to having easier access to files during an online meeting, or being able to action a point such as sending an email with no delay (Walklate et al., 2021).

Information sharing through online meetings has allowed safeguarding agencies to share issues and adapt the content of their meetings to focus on weekly concerns. Consequently, this has allowed multi-agency safeguarding professionals to develop solutions quickly, and support has been put in place swiftly for vulnerable adults and children (Pearce & Miller, 2020).

Significantly more agencies have been able to attend safeguarding partnership virtual meetings, for example the attendance of GPs has risen and communication with schools to gain insight and input has improved due to the use of online communication platforms (Baginsky & Manthorpe, 2020). Engagement with agencies has improved due to more agencies being able to attend meetings as this new way of working has allowed agencies to have the flexibility, and time to attend (Walklate et al., 2021).

However, a barrier that agencies experienced while working remotely is the disappearance of office conversations that allow for softer intelligence to be shared, which

has hampered the partnership approach. Other barriers include difficulty communicating with other agencies such as care home and hospital staff, and consequently the time taken to gather crucial information has increased (Local Government Association, 2021).

Virtual meetings have been described positively in the literature and have been welcomed to keep as a permanent change. The burden of travel is non-existent when attending an online meeting which is a key benefit to safeguarding partnerships that are situated in large local authorities, or remote rural locations (Walklate et al., 2021; McManus & Boulton, 2020). Additionally, McManus and Boulton (2020) reported that barriers to information sharing have somewhat diminished due to the use of virtual working.

2.2 Impact of Covid-19 on safeguarding partners

It has been reported that a high level of health and social care staff are on sick leave or leaving the profession altogether due to feeling overwhelmed with stress due to the demands of the job and working environment (Campbell, 2021). Consequently, the NHS and care systems are under pressure due to a high level of vacancies in both sectors (Campbell, 2021). Figures have shown a 25% increase in NHS members of staff experiencing poor mental health from February to May 2021 (Good Shape, 2021). This has resulted in 2.5 million working days being lost due to mental health absences, which has cost an estimated £371.2 million from lost productivity during June 2020 – 2021 (Good Shape, 2021).

Policing research has revealed that 28% of home working staff, 59% of staff who partially worked from home, and 71% of staff who could not work from home reported higher levels of stress. These figures were recorded from a sample of 2,365 participants from Police forces in England and Wales during September 2020 (Fleming & Brown, 2021). Moreover, 23% reported that their workloads had increased, and this pressure was most pronounced with police staff who remained working on-site (Fleming & Brown, 2021).

Findings also revealed that 55% of participants reported that they felt more tired during the lockdown period (Fleming & Brown, 2021). These findings were also echoed in the 2020 National Policing Wellbeing Survey, which showed 29% of Police officers and 24% of Police staff indicated that they experienced extremely high levels of fatigue (Graham et al., 2021).

Moreover, Police staff and officers reported that their supervisor or line manager was highly supportive before and during the COVID-19 lockdown (Fleming & Brown, 2021). During lockdown staff who worked from home reported that their manager was more supportive compared to staff who partially worked from home or on-site. Furthermore, 73% of staff who worked from home, 55% who partially worked from home, and 29% who worked on site were contacted by their force to ask about their wellbeing (Fleming & Brown, 2021).

The impact of working during COVID-19 on staff has been further reported by BASW (2021). A survey conducted with 1,119 Social Workers from across the United Kingdom (precise sample location not reported) between November – December 2020; revealed that 59% of participants agreed or strongly agreed that their mental health had been negatively affected by working during the COVID-19 pandemic (BASW, 2021). Furthermore, 69% of participants who worked remotely found it harder to switch off from work, and 72% felt that COVID-19 had impacted morale in their workplace (BASW, 2021).

However, McFadden et al. (2021) reported mental wellbeing and quality of working life had improved from 2018, (N=1,195) to May-June 2020 (N=1,024) for Social Workers across the United Kingdom (sample included 6% from Wales). It is important to note that the data was collected after many practitioners were settled into working from home at the start of the Covid-19 pandemic.

The positive impacts of working from home have been reported in Cook et al. (2020), which gathered the perspectives of 31 child and family Social Workers experiences of working during March – June 2020 in England. Several measures were put into place to help their team feel connected, for example managers set up virtual spaces to allow their team to collaborate and connect virtually. Managers also allowed staff to see when they were available online which helped the practitioners feel supported. Furthermore, colleagues also created their own informal spaces to communicate through WhatsApp which allowed the practitioners to share worries, frustrations, and seek reassurance which was perceived as an important factor for improving their wellbeing. As a result of the above methods, the practitioners reported feeling more supported and connected to their team. Furthermore, due to an increase in check-ins with managers and a no travel time some practitioners reported having more energy and overall increased wellbeing.

However, a barrier noted by practitioners was the lack of boundary between work and home life due to working from home. This had a negative impact on the wellbeing of some

practitioners, and this was more apparent in the practitioners who had a family. Moreover, in teams that had a high number of temporary staff and newly qualified Social Workers the impact of working from home was more prominent. The lack of face-to-face contact made it hard for newly qualified members of staff to seek support and develop supportive relationships with colleagues.

It has been reported in the literature that support structures at home and work are an important buffer from the impact of the Covid-19 pandemic. Social support was frequently reported as a key mechanism for improved mental health during this period, which included having supportive partners, friends, family and colleagues. Thus, these findings highlight that social support structures in the workplace should be encouraged, for example, peer support interventions (Aughterson et al., 2021).

2.3 Workforce resilience and retention of social care partners

The social care workforce has reported a lack of recognition and progression in their role. This has resulted in partners leaving the sector to work in a different industry offering a better working environment, higher pay, and clear routes for career progression (James, 2022). This is further supported by the adult social care sector turnover rate which is estimated at 29%, which equates to 410,000 professionals leaving their role in England in 2020/21 (Skills for Care, 2021). The shortage of social care workers has been exacerbated by the Covid-19 pandemic. Moreover, a 3% (45,000) increase in the number of adult social care jobs were available in England between 2019/20 and 2020/21 (Skills for Care, 2021). It was estimated that 1.67 million jobs were available in the sector in 2020/21 emphasising the difficulty of recruiting into the sector (Skills for Care, 2021). Child and family social workers reported high levels of stress and anxiety due to the Covid-19 pandemic, and as a result workloads and the complexity of cases have significantly increased. These factors are severely impacting the mental well-being of staff and are common reasons for staff leaving their role (Johnson et al., 2021).

Improving the retention of social care staff will require a strategic response consequently, the Social Care Fair Work Forum has been set up in Wales to tackle this (James, 2022). Manageable caseloads, reducing overwork and a better working culture (feeling supported, valued by line managers and the local authority, feeling trusted to make

professional judgements, career progression and reflective practice) have been reported as key factors for retaining staff and should be considered (Johnson et al., 2021).

Newly qualified staff working in the sector are the biggest cohort of staff leaving with an estimated turnover rate of 37% for Care Workers with less than one year of experience, compared to a 12% turnover rate for staff with 10 years or more experience (Skills for Care, 2021). The impact of the Covid-19 pandemic on social workers reported above has also been reflected in Newly Qualified Social Workers' (NQSW) experiences. Johnson et al. (2021) reported that NQSW in England experienced an 82% increase in workload stress, 77% reported feeling anxious, 77% reported increased complexity in their cases, and 67% reporting increased workloads. This has been further supported by the Social Care Institute for Excellence (2022) report on NQSW in Wales experiences of completing their degree during the Covid-19 pandemic. The NQSW reported feeling concerned about their ability to perform their role due to a lack of confidence and not feeling part of a team (Social Care Institute for Excellence, 2022). Due to the Covid-19 restrictions placements were suspended and working in an office environment was limited. Therefore, accessing informal support from colleagues and opportunities to learn through observing their team were severely impacted. Some NQSW felt unable to disconnect from work due to the blurred lines of working in their own home. Additionally, protected caseloads, opportunities for shadowing and co-working, and mentoring have all been impacted due to the lack of capacity in social work teams to support NQSWs (Social Care Institute for Excellence, 2022). All these factors have impacted emotional well-being and consequently have left NQSWs questioning whether to stay in the sector.

The report also highlighted some elements of good practice which increased NQSW's well-being and confidence in their role. This included involving NQSWs to work in multi-agency teams which increased their knowledge and confidence due to learning from other practitioners, and the ability to have a wider network of professionals to seek advice from (Social Care Institute for Excellence, 2022). This also increased the NQSWs feelings of belonging and impacted positively on their emotional well-being (Social Care Institute for Excellence, 2022). Therefore, it is crucial to provide accessible support and opportunities to build strong relationships with other multi-agency professionals alongside protected learning opportunities to improve the well-being, and retention of NQSWs (Social Care Institute for Excellence, 2022).

2.4 Impact of communicating with service users during Covid-19

The inability of practitioners to communicate online with service users in digital poverty was a concern during the Covid-19 lockdown. In April 2019 – March 2020, the Welsh Government (2021e) reported that 90% of the population used the internet in Wales, and 71% were less likely to visit a website who were economically inactive compared to those in employment (82%). Digital exclusion due to either a lack of internet connection, poor internet connection, or a lack of equipment and IT skills was a significant barrier for practitioners to work with both adults and children (Driscoll et al., 2021).

If a child or adult service user was categorised as high-risk safeguarding professionals continued to work with them face-to-face where possible during the Covid-19 lockdown. Online and telephone communication was used to keep in contact if this was not possible, and for children or adults who were deemed medium-low risk (Cook & Zschomler, 2020). As a result, users who were excluded digitally were less able to contact and receive support from a safeguarding professional due to not being able to communicate online (Cook & Zschomler, 2020). This was highlighted in the BASW (2021) survey which reported that 51% of Social Workers either agreed, or strongly agreed that they encountered more difficulties communicating with service users because of digital exclusion. The Department for Education and Welsh Government set up schemes to supply school children with internet connection and devices, however the key aim of this scheme was to support young people access their education, and it is unknown how this scheme impacted children's access to support services (Welsh Government, 2021f; Department for Education, 2020h). Some local authorities further supplemented government laptop schemes and handed out spare devices to children and families to allow them to access children services, but there is a lack of acknowledgement in the literature of what support was put into place for digitally excluded adults (Driscoll et al., 2021).

Communicating online was perceived to be beneficial for looked after young people and adolescents who reported feeling more comfortable talking to safeguarding professionals on applications such as WhatsApp and Facetime, compared to having a face-to-face conversation (Baginsky & Manthorpe, 2020; Cook & Zschomler, 2020). Virtual communication platforms allowed the young people to have a greater sense of control by professionals not "intruding" into their physical space and allowing the young people to feel more comfortable

to talk (Racher & Brodie, 2020). The use of online meetings changed the power dynamics allowing the young person to be more involved through helping with any technical issues which gave them a greater sense of confidence in meetings with safeguarding professionals (Cook & Zschomler, 2020).

However, it was also reported that relationships were much harder to build if the practitioner did not have a prior relationship with the child before the Covid-19 lockdown, and relationships were difficult to establish with children who have communication or learning difficulties (Cook & Zschomler, 2020; Aughterson et al., 2021). Moreover, practitioners reported engaging with younger children over virtual forms of communication was challenging. The practitioners had to adapt their communication to ensure the child was engaged with the call, for example finding backdrops that were tailored to the child's interests (Cook & Zschomler, 2020).

Moreover, some young people were reluctant to talk over the phone or through a video call and preferred having a face-to-face conversation. Young people reported feeling scared to communicate with safeguarding professionals through a phone or video call in their home due to the lack of privacy and confidentiality (McManus et al., 2021). This barrier was also experienced by adults who felt unable to disclose abuse or issues due to being in the same room as the perpetrator whilst speaking virtually with practitioners (Local Government Association, 2021).

Safeguarding professionals reported that it is key that assessments of young people and adults are conducted face-to-face due to the need to observe body language and identify risks that would not be accessible through virtual communication (McManus et al., 2021; Pearce & Miller, 2020). Furthermore, a barrier of virtual communication is the lack of visibility which means that an individual's emotional state is hard to assess, and harm can be more easily hidden (McManus et al., 2021). As a result, Social Workers felt concerned that their safeguarding assessments were less robust (Cook & Zschomler, 2020). 52% of Social Workers agreed or strongly agreed they had trouble in monitoring safeguarding and carrying out adult and children's assessments because of limited face-to-face access (BASW, 2021).

A key benefit of face-to-face communication is it allows the safeguarding professional to establish and build a trusting relationship with the service user, and be in tune with their situation and emotional state which is lost when using online communication. Going forward

the findings reported in McManus et al. (2021) suggest that a combination of communication methods both virtual, and face-to-face could be used to communicate with young people.

Section 3. Visibility of children, young people, and adults: the after-effects of Covid-19

3.1 Statistics and cost of child abuse and maltreatment

In England and Wales, it is estimated that one in five adults aged 18-74 years have experienced at least one form of child abuse (emotional, physical, sexual abuse, or witnessing domestic violence or abuse) before they have reached the age of 16 (Office for National Statistics, 2020). It is expected that 978 visits to A&E and 556 hospital admissions are related to child physical abuse each year in Wales (Jones et al., 2020). Abuse and maltreatment impact children's health and wellbeing and consequently, there are substantial economic impacts as a result of this. The estimated cost of child maltreatment in the United Kingdom is £89,390 per child with the largest costs from social care, short-term health and the costs resulting from a lower probability of employment (Conti et al., 2021).

Moreover, financial pressures on local authorities have increased due to increased demand and a resulting shortage of children's residential and foster care places. Councils have had to seek places from private firms which has resulted in councils such as North-East Lincolnshire, overspending by £11.8 million in the 2020/21 financial year (Pidd & Quach, 2021). Currently, only 20% of children's residential homes are owned by local authorities with private companies dominating the provision available and charging weekly fees of £150,000 (Commission Young Lives, 2021). The current demand for places outweighs the local authority owned provision available. The number of children living in unregulated accommodation in March 2020 was 6,480 which had risen from 3,430 in March 2010 (Commission Young Lives, 2021). Moreover, 64% of all children living in residential homes are placed out of their local county (Commission Young Lives, 2021). Recent news headlines have highlighted the need for regulated children's residential homes due to shocking reports that children and young people were being exploited by a private firm that runs children's residential homes in England (Titheradge, 2022). Moreover, local criminals target young people in private accommodation meaning that children are at a heightened risk of being targeted for criminal

and sexual exploitation (Commission Young Lives, 2021). Therefore, a major reform of children's residential care is desperately needed to ensure that children are safeguarded.

In September 2021, the use of unregulated children's homes for children under 16 years was banned, and Ofsted will be overseeing unregulated accommodation for 16-17 years olds under a new mandatory standard from 2023 (Commission Young Lives, 2021). A recent review of the children's social care system in England has provided recommendations. This includes creating new care standards and setting up Regional Care Cooperatives to run and commission care providers that are owned and accountable to their respective local authority (NSPCC, 2022). In response to the review the Association of Directors of Children's Services [ADCS] President Steve Crocker, emphasised the need for commitment and resources to ensure the recommendations will be implemented to achieve the best possible provision, and outcomes for children and young people (Crocker, 2022).

3.2 Lack of face-to-face contact with children and young people across all sectors

During the Covid-19 lockdown only children who had a 'Children in Need' status or had a Education, Health and Care plan (EHCP), or children of critical workers were allowed to physically attend an education setting (GOV.UK, 2021b). During the first national lockdown around 58,000 pupils attended an education setting on 30th April 2020, this represents 12% of all children who were classed as either 'Children in Need', or who had an EHCP (Department for Education, 2020a). During the second national lockdown (13th January 2021) attendance reached around 34% of all pupils with an EHCP, and 40% of all pupils classed as 'Children in Need' (Department for Education, 2021c).

When schools were open to all pupils attendance figures fluctuated, for example during the 2020/21 academic year attendance was at 87% during early September which decreased to 86% on 12th November 2020 (Department for Education, 2020b). Later in the school year attendance reached 90% on 25th March and 92% on 12th May 2021 (Department for Education, 2021d & 2021e).

Under normal circumstances, professionals such as teachers who have regular face to face contact with their pupils can detect safeguarding concerns, but with many children not physically attending school, these crucial encounters were not happening. Moreover, young people were not visible in other settings; 177 youth organisations revealed that 68% of their

services had stopped or were restricted between April – June 2020. This meant that 300,000 young people were not accessing any form of youth service provision (National Youth Agency, 2020).

Support services such as GPs, children's centres, health visitors, and community services such as libraries, religious centres, and activity and sports clubs either paused or had limited face-to-face access during the national lockdown (Romanou & Belton, 2020). In some cases, support was accessed digitally or via telephone, for example, local authorities in Wales put in place monitoring and support mechanisms for children who normally receive support from a nursery, school, college or community groups who were not under the care of social services (Children's Commissioner for Wales, 2020a). However, there has been a significant reduction in support for young people and with many children not physically being seen in education, or in other support settings the window of visibility for children was extremely limited.

3.3 Consequences of the lack of visibility of children and young people

The lack of visibility of children and young people resulted in a 50% reduction of referrals to children's social services the weeks following the national lockdown (Calkin, 2020). There have been 61,000 fewer referrals to children's social care services in England since May 2020 compared to 2017-20 (Department for Education, 2021f). A total of 243,610 referrals were made to children's social care services from May 2020 – 2021, which is 10% lower than average (Department for Education, 2021f). Furthermore, a reduction in safeguarding referrals have been reported in several local authorities. In particular, Gwynedd reported a 50% drop in all referrals compared to the same period in 2019 (Children's Commissioner for Wales, 2020b).

Throughout the vulnerability sectors, there has been a huge demand for helpline services during the Covid-19 pandemic. The National Society for the Prevention of Cruelty to Children (NSPCC) helpline reported a 43% increase in calls from adults concerned about a child from April - November 2020 (National Society for the Prevention of Cruelty to Children [NSPCC], 2020). Overall, 31,359 calls were received from adults during this period, 8,582 related to neglect, 8,302 related to physical abuse, 8,251 related to emotional abuse, and 4,796 were related to sexual abuse (NSPCC, 2020). The remaining 1,428 calls were related to

online sexual abuse, and as a result, 50% of the concerns reported were referred to external agencies (NSPCC, 2020). This shows that harm was happening to children and young people but was not being picked up by traditional services due to the lack of visibility.

3.4 Adapting to ensure children and young people are supported

During the Coronavirus national lockdown to ensure children and young people were safeguarded partnerships reported having weekly or fortnightly meetings with school staff, police, and the local authority to ensure information was being shared promptly across the partnership. This included risk assessing all children known to the local authority to ensure children who were deemed as high risk had increased multi-agency oversight (Pearce & Miller, 2020). Additionally, data from schools was shared with the local authority on the number of children who were classed as 'in need' that were not attending school. Schools shared regular updates with children's services about their contact with children from vulnerable families or children they had known to be experiencing problems at home (Pearce & Miller, 2020). However, it is unknown how schools ensured contact was maintained and how their vulnerable pupils were being supported.

Research conducted by Khan and Mikuska (2021) gathered data from early years practitioners and primary school teachers to understand their experiences of the partial school closures during the first national lockdown. Educational professionals felt concerned that they would have not had oversight of the pupils who were unknown to be vulnerable before lockdown, or those who would become vulnerable. Educational professionals felt that it was near impossible to detect safeguarding issues with pupils learning from home. This was made harder by the fact the pupils who were more likely to be at harm were the least likely to engage with online learning, either due to a lack of access or not being able to engage due to their home environment. To help schools maintain contact with known 'in need' pupils and their parents/carers contact sheets were made or well-being teams were set up to help monitor safeguarding concerns, however very few responded. Schools utilised other communication methods such as Tapestry which is an online learning journal used to communicate and share confidential information with parents/carers, although not all families would engage. Worryingly, this research highlights the difficulties educational professionals faced in detecting children who were unknown to be at risk, and without visible

interaction with their pupils they had become invisible. Moreover, even with families who were known to be 'in need' educational professionals found contact with parents/carers difficult to maintain due to the lack of engagement.

3.5 Engagement from families with services

The lack of engagement with services was legitimised by needing to stay safe under the national lockdown which gave some families the ability to 'opt out' due to the lack of face-to-face contact (Driscoll et al., 2020). In social and health care contact was made virtually, however this meant that for some families this would be impossible due to a lack of an electronic device. To overcome this some local authorities gave families laptops to enable communication (Pearce & Miller, 2020). Nevertheless, professionals felt concerned over the lack of visibility of children as a result of not having any face-to-face meetings. This heightened the risk that families might disguise compliance or hide their circumstances through their virtual meetings (Pearce & Miller, 2020). Professionals also reported fears that a child's contribution in a virtual meeting could be manipulated by their parents/carers, or a child felt unable to talk freely due to their family being able to hear their conversation (Pearce & Miller, 2020).

Universal services that support and protect children have been paused or have been severely restricted by the national Covid-19 lockdown. The lack of visibility of children has been seen across all key services, for example, schools and early years, youth, health, and children's services, and this lack of visibility has been reflected in the reduction of children protection referrals across the United Kingdom.

3.6 The lack of visibility on children who are home educated

The visibility of children and young people who are home educated is also a concern. There is currently no legal responsibilities that parents/carers need to inform the local authority that their child is being home educated (Department for Education, 2019g). On school census day in 2020, it was estimated that 75,668 children and young people were being home educated across England (Association of Directors of Children's Services [ADCS], 2020). There was an increase of 38% of children and young people being home educated from census day in 2019 (ADCS, 2020). A total of 1,025 children under the age of 15 were not registered at a

maintained school in Wales for the 2020-21 academic year (StatsWales, 2021). The figures above are questionable as they rely on the local authority records being up to date. Moreover, the absence of a mandatory register for parents/carers to register their child as being home educated affects the accuracy of the figures above (House of Commons Education Committee, 2021).

The lack of a register consequently means local authorities have no way of identifying children who are not in mainstream schools. It has been reported that 93% of English local authorities are not aware of the home educated children in their area (Children's Commissioner, 2019). Children who have a child protection plan can be withdrawn from mainstream school to be home educated; however local authorities do prioritise maintaining contact with these children (ADCS, 2020). Nevertheless, children who are not known to social care that may be at risk are invisible due to the lack of an accurate database, and this means that local authorities have no way of reaching these children (House of Commons Education Committee, 2021). Worryingly, some parents/carers use the lack of regulation to their advantage, for example, to keep out of sight of social services (Children's Commissioner, 2019).

In 2020, the Child Commissioner for Wales conducted a review of the work the Welsh Government has taken to develop better protection and support for home educated children (Children's Commissioner for Wales, 2021c). As a result, the Welsh Government developed draft regulations to establish local authority databases that would ensure each child's education could be accounted for (Welsh Government, 2021c). Implementation of the new statutory guidance and the regulations were expected in 2020. However, in the summer of 2020, the Welsh Government announced that the new guidance and regulations would not be taken forward due to the Covid-19 pandemic (Children's Commissioner for Wales, 2021d). This means that the Welsh Government has not implemented any changes, and without local authority databases it is impossible to safeguard and support the well-being of children who are invisible.

3.7 Identification of vulnerability and providing support in education settings

Currently, the issue of identifying and supporting vulnerability of children and young people in education settings is a concerning issue. The Teaching Well-being Index Survey concluded with a sample of 123 education staff from Wales that 75% felt stressed, and 30% had experienced a mental health issue in the 2020/21 academic year (Scanlan & Savill-Smith, 2021). Moreover, 61% felt they did not receive sufficient guidance on mental health and well-being at work. Overall, the National Teacher Well-being Index Score was calculated to be 44.30 for Wales, with the national adult population score for Wales being 51.40 (Scanlan & Savill-Smith, 2021). Consequently, 50% of education staff in Wales have considered leaving the sector due to extensive workloads being the biggest factor affecting their mental health and well-being (Scanlan & Savill-Smith, 2021). Additionally, schools are struggling to fill vacancies which is further highlighting the issue of increased workloads with education staff taking on extra responsibilities (PA Media, 2022).

It is widely reported child and adolescent mental health has declined and there is a severe lack of provision available to provide support. Only one in four of the 500,000 children and young people referred to Child Adolescent Mental Health Services [CAMHS] each year will receive support (Lowry et al., 2022; Campbell, 2022). Children and young people are being refused support from CAMHS due to not reaching the threshold for intervention due to the lack of provision available. Therefore, education staff are the first and potentially only point of contact for children needing support adding to their already extensive workloads (Lowry et al., 2022). Despite, education staff providing this vital role in supporting young people only 40% of teachers felt confident to support children with mental health needs, and 65% of teachers who have completed Initial Teacher Training courses do not feel able to provide this support (Campbell, 2022; Scanlan & Savill-Smith, 2021). The well-being of education staff must be maintained to allow them to be able to support children and young people achieve their best potential. Research has shown that poor teacher well-being negatively impacts their ability to improve their class mental well-being and academic results (Lowry et al., 2022). Therefore, teacher well-being is a key aspect in maintaining a supportive and positive classroom environment for children and young people (Scanlan & Savill-Smith, 2021).

The Welsh Government has recognised that it is fundamental that the well-being of education staff is improved to enable them to achieve the best in their role. In response, the

Welsh Government is providing £1.25 million in funding and increasing it to over £3 million by 2024/25 to support teachers' well-being, and mental health (Welsh Government, 2022a). The funding is part of the Whole School approach announced by the Welsh Government which aims to improve the wellbeing of pupils and education staff (Welsh Government, 2022a). Notably, the whole school approach recognises that schools need to be supported by multi-agency organisations. This ensures accessible links are formed with services that can provide their expertise to children and education staff and help to tackle the mental health crisis of children and young people (ADDYSG Cymru Education Wales, 2021). As highlighted in the survey conducted by Scanlan and Savill-Smith (2021) 42% of staff reported the culture of the education setting they worked in had a negative effect on their well-being, and 43% of education staff felt that their organisation does not support employee's mental health. Therefore, the whole-school approach needs to incorporate a framework for ensuring the mental well-being of education staff is supported by creating an environment that encourages positive mental well-being, and accessible support.

3.8 Statistics and public perception of adult abuse and neglect

According to the World Health Organisation, 1 in 6 adults over the age of 60 will be victims of abuse (World Health Organisation, 2017). Furthermore, a recent poll conducted by Hourglass (2021a) revealed that there are an estimated 143,000 older victims of abuse and neglect in Wales. The Social Services and Well-being (Wales) Act 2014, states that local authorities must submit safeguarding reports of adults at risk of abuse or neglect. In 2018/19, a total of 13,089 reports of alleged abuse or neglect were reported to local authorities for people over the age of 65, representing 52% of the overall total reports during 2018/19 (StatsWales, 2019). Additionally, a public survey conducted by Hourglass (2021b) indicated a lack of recognition of abuse towards older adults with only 6% of the public in Wales indicating a victim of abuse could be an adult 65 years and above. This is further reflected in Parliament debates. The abuse of older adults was only mentioned nine times either in the House of Lords or the Scottish Parliament with no mention in the House of Commons by Ministers or MPs (Hourglass, 2021b).

3.9 Adult vulnerability not being picked up by services due to Covid-19 restrictions

In March 2020, during the Covid-19 nationwide lockdown people classed as 'clinically vulnerable' were advised to shield. A survey conducted in August 2020 revealed that 31% of adults over the age of 70 felt unsafe leaving their home (Age UK, 2020). The British Association of Social Workers [BASW] (2020) highlighted that adult abuse and neglect were not being picked up by community services due to the lack of oversight and home visits during the Covid-19 restrictions. Moreover, with older adults being deemed as clinically vulnerable and having to shield the visibility of this group was extremely limited or non-existent.

Social Workers faced increased professional dilemmas in their role which included weighing up whether the risks of safeguarding outweighed the risk of transmission to service users (Manthorpe et al., 2021; Banks & Rutter, 2021). Visiting a service user's home increased the risk of transmission whilst not visiting could have resulted in missing information. Therefore, Social Workers had to use their expertise to make a professional judgement. For example, if an adult could not speak freely on the phone during an initial assessment, a home visit would be arranged with staff wearing the relevant protective equipment (Manthorpe et al., 2021). Other agencies stopped making home visits which further highlighted the invisibility of adults and consequently placed further pressure on social services to ensure that some form of visibility and oversight was maintained (Manthorpe et al., 2021). Due to community services stopping or reducing their home visits it was reported that there was an increase in the ambulance service submitting safeguarding referrals (Manthorpe et al., 2022). This is due to the ambulance service potentially being the first to see vulnerable adults face-to-face and their living conditions during the Covid-19 restrictions (Manthorpe et al., 2022).

Secondly, a consequence of Covid-19 is the complexity and number of adult safeguarding referrals and requests for help increasing. A study conducted by the Association of Directors of Adult Social Services [ADASS] (2021) in England, revealed that the closure and unavailability of some community and preventative services have led to a 56% increase in the number of adults seeking support from social care services since November 2020. Consequently, it is estimated that more than 200,000 adults are waiting for adult social care assessments in April 2022 (ADASS, 2022). However, it is unknown whether this figure is a consequence of new referrals or difficulties clearing a backlog of referrals, or both. The extent of the emergency is highlighted by the Director of Age UK Caroline Abrahams, "*hundreds of*

thousands of older and disabled people are having to put up with a ramshackle service, with more than half a million unable to get even to first base by having an initial assessment" (Abrahams, 2022).

3.10 Hidden victimisation of older adults experiencing domestic abuse

The hidden victimisation of domestic abuse in older adults is a concern. Domestic abuse can be defined if both people are aged 16 or over and are connected either through being in a relationship, or are relatives according to the Domestic Abuse Act 2021 (Legislation.gov.uk, 2021). The statutory definition now does not contain an upper age limit which shows awareness that domestic abuse can affect all age groups. Recently this has been highlighted in the Police recorded domestic violence and abuse incidents in England and Wales. The highest age group for all male victims of domestic abuse and violence was shown to be the 75 years and over group with 34% of male victims experiencing domestic abuse and violence (Office for National Statistics [ONS], 2021b). Additionally, the 75 years and over female group represented 45%, with the highest age range for female victimisation being the 30–34-year-old category which represented 57% (ONS, 2021b). The data highlights that domestic abuse and violence affects all age groups and increased recognition of this is starting to show. For example, the first data set for older adults 75 years and above will be published as part of the Crime Survey for England and Wales in 2023 (Herklots, 2021). The data will be crucial for understanding the scale, nature, and impact of domestic abuse and violence to determine where resources and services should be targeted (Herklots, 2021).

During the Covid-19 lockdown older adults experienced increased challenges in accessing essential goods, healthcare, and other key services. Coupled with the increased strain on health and social care services due to heightened demand left older adults vulnerable and invisible (Shepperd, 2021). It was reported that 1 in 5 of the general public in the United Kingdom knew an older person aged 65 years and above who had been abused (Hourglass, 2021c). Additionally, it was estimated that 2.7 million older adults may have been affected by domestic abuse in the United Kingdom in 2020, and 53% believed that abuse and neglect of older adults had increased due to the Covid-19 lockdown (Hourglass, 2021c). It was widely reported in the media during the Covid-19 lockdown regarding the rise in domestic abuse cases and as a result, the Home Office launched the campaign 'You are not alone'

(Hourglass, 2020). The campaign aimed to widely publicise that those who were experiencing domestic abuse could leave their house during the Covid-19 lockdown restrictions to seek support. However, the campaign was criticised as not being reflective of older adults' experiences. Older adults are more likely to suffer from health problems, reduced mobility or other disabilities and coupled with the public health guidance for those adults over the age of 70 to shield would have made leaving an abusive situation challenging (Hourglass, 2020). This further highlights the lack of recognition of older adults' experiences of domestic abuse and violence.

3.11 Actions to increase visibility of older adults in Wales

Services designed to support older adult victims of abuse are lacking. Several barriers further amplify the accessibility for older adults to seek support which include a lack of awareness of the services available, and services not seen as appropriate for older adults (Older People's Commissioner for Wales, 2021a). It is important that the signs of older adult abuse are recognised by professionals to enable support to be implemented as early as possible. Older adults are more likely to disclose to a healthcare provider with who they have an existing relationship with, therefore health services need to be able to respond and provide access to specialist services and safeguarding support. One programme which has been implemented across Wales is IRIS. The programme is supported by specialist domestic abuse organisations in primary health care settings. A specialist domestic abuse worker is situated within a primary health care settings to provide domestic abuse and violence training for staff. IRIS also allows primary health care settings to access a specialist referral pathway for domestic abuse services (Older People's Commissioner for Wales, 2021a).

A further example of good practice is the Dewis Choice Project, which provides support to older adults through building a strong and supportive relationship with a support worker (Older People's Commissioner for Wales, 2021a). Creating a strong relationship was found to be a key mechanism for older adults to get the best outcomes when accessing support for domestic abuse. Moreover, the project has developed a training programme for Independent Domestic Violence Advocates (IDVAs) to attend to ensure they understand the needs and presentation of domestic abuse in older adults (Older People's Commissioner for Wales, 2021a).

Recently, the Welsh Government has published a Strategy for an Ageing Society which shows commitment to preventing and providing suitable support to older adults who experience domestic abuse and violence (Welsh Government, 2021g; Older People's Commissioner for Wales, 2021c). This will be further supported by the development of a new violence against women, domestic abuse and sexual violence national strategy and supporting action plan to provide further guidance on responding to older adult victims (Welsh Government, 2021g; Welsh Government, 2022b). To support older male victims of domestic abuse the Older Adults Commissioner is developing a response to the ONS (2021b) figures, which show the overall highest proportion of males affected by domestic abuse are in the 75 years and over category. By gaining the perspectives of older male victims of domestic abuse views on barriers to accessing support consequently suitable support services can be developed (Older People's Commissioner for Wales, 2021b).

Section 4. Summary

This section of the report has sought to provide a review of the most relevant literature relating to safeguarding with a particular emphasis on the operationalisation of Multi-Agency Safeguarding Arrangements. In doing so, the review has highlighted 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. The report highlights key research and statistics across Wales on vulnerable children and adults, extracting data from the Welsh Local Authorities. Further sections explore the realities of implementing multi-agency operational safeguarding arrangements in practice, with a focus on the multi-agency safeguarding hub model with a focus on answering, 'what does good look like?'. Finally, the impact of GDPR and information sharing within safeguarding is explored.

Following on from this the impact of Covid-19 on systems, safeguarding partners, and service users are discussed which can be summarised into three areas. First, developments in multi-agency operational safeguarding arrangements in response to Covid-19 restrictions are outlined, considering barriers and enablers to safeguarding practice. The report highlights the impact of the pandemic on safeguarding partners' mental health and well-being with a specific focus on the impact this has on the retention. Additionally, the impact of connecting

with service users during the Covid-19 pandemic is discussed with a focus on the difficulties partners faced building a holistic picture of safeguarding virtually.

The last section of the report examines the impact of the Covid-19 pandemic is discussed in relation to the visibility of children, young people, and adults. This section outlines the increase in demand for adult and children services is outweighing the provision currently available which has significantly deteriorated since the start of the pandemic. Further sections explore the implications of the Covid-19 lockdowns resulting in a lack of face-to-face contact with children and adults across all sectors and increased escalation of risk. The report outlines the systems which were put into place to ensure vulnerable children were supported and the issues detecting children who were unknown to be at risk at the start of the pandemic. Additionally, concerns are discussed in relation to the identification of vulnerability and providing support to children and young people in education settings. Finally, the hidden victimisation of domestic abuse in older adults is considered along with promising actions to increase the visibility of older adults in Wales.

4.1 Recap of the key findings from the phase one evaluation of MAOSA in Wales

It is important to provide background information on the previous phase one evaluation conducted by McManus and Boulton (2020). The evaluation conducted interviews with safeguarding leads across the different local authorities in Wales. The evaluation aimed to ascertain the range of the current MAOSA operating in Wales and their effective features. Presented below are the evaluation findings which highlight good practice and potential directions for future improvements:

- There was evidence of successful adoption of the language and vision from the Social Services and Wellbeing Act (2014), and the new All Wales Safeguarding Policy. The practitioners highlighted the need to be ‘person centred’, emphasising that the individual and family are at the heart of every decision.
- There was evidence of an effective ‘Front Door’ service which was open and accessible for the general public and services to submit referrals to.
- Adult and children services were often seen as separate. Discussions with safeguarding leads revealed mixed feelings about whether these should be more joined up, or specialised and purposely separated.

- Some adult safeguarding nominated leads spoke passionately about recent policy and legislative amendments with a focus on adults having 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 work to do to achieve a similar level of response that is seen when safeguarding children.
- There was evidence of effective engagement from key agencies in information sharing and the decision-making processes. High levels of engagement from the Police were mentioned, but there were issues with other organisations engaging. Education and CAMHS were often mentioned.
- Although the 'Front Door' arrangements were well established, these were not always co-located within 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.
- There were different viewpoints and implementation of multi-agency arrangements between those using more virtual arrangements compared to physical MASHs. This was related to whether the local authority was a particularly rural or urban area. Covid-19 restrictions further emphasised variances within rural and urban safeguarding provisions. Rural areas seemed to be more prepared for remote working, compared to urban areas who were concerned about relationships eroding if remote working continued.
- Improvements suggested by safeguarding leads were mainly focused on the need for improved joint working, better information sharing systems and quality and volumes of referrals. Improved understanding across all professionals in terms of each agency's role, increased training to assist with this and ownership of risk were highlighted as suggestions for improvement.
- Information sharing platforms were linked to issues around data, performance reviews and quality assurance. Safeguarding leads could only give comments on their remit with anything outside their local authority being problematic. Therefore, limiting the capacity to plan resources and conduct quality assurance processes.

- Regarding the impact of Covid-19, concerns were reported on the 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. Consequently, many vulnerable children were not being seen by services.
- In addition, there were concerns from safeguarding leads regarding their ability to adequately support their team dealing with vulnerable families, when they have lost their physical (peer) network due to Covid-19 restrictions and remote working.
- Overall, safeguarding leads talked confidently about their safeguarding aims and how they were achieving these, with most acknowledging there is still much work to be done.

4.2 Aims of the current evaluation: Phase two

This evaluation aimed to identify good practice and learning of the multi-agency operational safeguarding arrangements (MAOSA[11]) in Wales. The output from this evaluation will include recommendations based on the insights of the multi-agency safeguarding partners across seven different local authorities in Wales.

The research questions to be examined in this evaluation are as follows:

1. What elements of governance and policy are effective for multi-agency working?
2. What are the structures and systems which enable and facilitate information sharing and collaborative working?
3. Which factors are involved in the effective functioning of cross-working partnership relationships? Including geographical location, co-location, and workforce stability.
4. Which elements of data collection, audits and performance management are effective for multi-agency safeguarding?
5. What has been the impact of Covid-19 upon service users, service delivery and safeguarding partners' well-being? How have services adapted and supported service users and safeguarding partners?
6. How is participation facilitated and the voices of those with lived experience of safeguarding interventions, integrated into operational activity? How do agencies

[11] MAOSA is a term used throughout this report to collectively reference any form of multi-agency operational safeguarding arrangements, which include, but not limited to, MASHs and Safeguarding Hubs.

work in partnership with service users and families? How accessible and embedded into practice is this process and what is the impact of service user participation?

4.3 Evaluation approach

In seeking to answer the above questions, the LJMU evaluation team worked with the National Independent Safeguarding Board (NISB) in identifying 7 Local Authorities across Wales as the study sites, considering the findings from the Phase 1 evaluation (McManus & Boulton, 2020). Areas selected ensured a representation of LAs across the 6 Regional Safeguarding board areas, those that used different IT systems, and collectively included those LA areas in rural and urban locations. Three separate work-streams form part of the evaluation process:

1. Practitioner semi-structured interviews exploring perspectives and experiences of multi-agency safeguarding arrangements within their LA area;
2. User voice perspective, which engaged with parents and young people regarding their direct experience of any safeguarding processes;
3. Deep dive review of local authority safeguarding performance frameworks, data, quality assurance and audits.
    a. This included semi-structured interviews and focus groups with those responsible for safeguarding performance frameworks, data, quality assurance and audits.
    b. LAs also provided their performance framework data capture tools and reports to explore key commonalities and differences in what was being collected at local level.

These can be found as separate data reports that detail the process and outcomes for each of these individual studies, with an additional Executive Summary that summarises the overarching evaluation findings regarding ‘Shaping the future of multi-agency safeguarding arrangements in Wales: What does ‘good’ look like?’. Please see these reports for further information.

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