Shaping the future of multi-agency safeguarding arrangements in Wales:

What does 'good' look like?

"A lot of the questions I face from service users is what must happen for me to get that help? I know the support is there and I know that I'm in need of it, but when does crisis point become too far gone"

Data Work-Stream 1: Practitioner experiences of multi-agency safeguarding arrangements across Wales.

November 2022

This is report 2 of 5. There are a series of reports in relation to the evaluation of 'Shaping the future of multi-agency safeguarding arrangements in Wales'.

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Data Work-Stream 1: Practitioner experiences of multi-agency safeguarding arrangements across Wales.

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Abbreviations

CAMHS	Child and Adolescent Mental Health Service
CCE	Child Criminal Exploitation
CMET	Contextual, Missing, Exploited and Trafficked
CP	Child Protection
CSE	Child Sexual Exploitation
CRU	Central Referral Unit
DA	Domestic Abuse
DHR	Domestic Homicide Review
FF	Families First
IAA	Information Advice and Assistance
IDVA	Independent Domestic Violence Advisors
LA	Local Authority
LOG	Local Operational Group
MARAC	Multi-Agency Risk Assessment Conferences
MASH	Multi-Agency Safeguarding Hub
NISB	National Independent Safeguarding Board
SCR	Serious Case Review
SH	Safeguarding Hub
SPOC	Single Point of Contact
RAG	Red, Amber and Green
PPN	Police Protection Notice
VCS	Voluntary and Charity Sector
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence

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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 such 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., 2019, 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 is problematic, with the implementation of these models varying across key organisations and local authorities across the United Kingdom (McManus & Boulton, 2020; Shorrock et al., 2019). McManus and Boulton (2020) identified overlapping policies, guidance and practice making internal navigation problematic. It has also been questioned as to which agencies should be involved, how they should be involved, and with challenges surrounding governance, formalised structures, information sharing, funding and resources (Shorrock et al., 2019).

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., 2019). 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. Thus, 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 evaluation has brought together safeguarding partners across the multi-agency operational safeguarding arrangements in Wales including both frontline, operational and strategic roles. Several 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.

Overarching Aim: To identify key features of effective collaborative multi-agency safeguarding arrangements in relation to reports of safeguarding concerns and determine '*What good looks like?*' This included six key objectives:

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 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 staff wellbeing? How have services adapted and supported service users and staff? What is impact of remote and hybrid working?
6. How is participation facilitated and the voices of those with lived experience of safeguarding interventions, integrated into operational activity and how do agencies work in partnership with service users and families? How is their voice incorporated strategically to feedback and shape future service delivery? How accessible and embedded into practice is this process and what is the impact of this participation?

2. Methodology

Study sites and recruitment

Local Authority (LA) areas included in the study were selected jointly by NISB and LJMU, considering findings from the Phase 1 evaluation report (see 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 areas and those in urban locations.

Recruitment

A list of nominated points of contact for each of the 7 LA areas was provided by the National Independent Safeguarding Board (NISB), which was agreed by each LA area. After initial agreement from the LA had been confirmed, the lead researcher provided a Microsoft Teams briefing to the nominated person within the LA along with a briefing sheet to circulate to the Safeguarding Board.

From this, the safeguarding manager for the local area then provided the research lead for their area an initial set of names and contact email addresses to contact for an interview. These were deemed to be the key people within each of the LA safeguarding arrangements. These individuals were contacted via email separately with a Participant Information Sheet (PIS) and a Consent Form, along with the project briefing sheet (all in Welsh and English). This began a snowball process whereby from each interview more names were gathered that were mentioned as part of process who were subsequently contacted via email. An individual time slot for the interview was arranged, with all occurring via Microsoft Teams.

Data collection and triangulation

There was a requirement for each LA to include a minimum of 10 interviews across their safeguarding arrangements. These included those within strategic roles, managerial and operational frontline roles. See Table 1 for the breakdown of sectors included across the 7 LAs. In total, the research project **completed 138 professional interviews** across Wales.

A team of four researchers conducted all interviews on Microsoft Teams, between March 2022 and July 2022. The interviews ranged from 25 minutes to 1 hour and 29 minutes. All interviews were conducted by the lead researcher for the LA area (an evaluation report for each LA area was also produced). Each participant was assigned a participant number within the individual reports to ensure anonymisation. Interview responses were transcribed by external transcription service and transcripts returned to LJMU, or were transcribed using Microsoft Teams. The interview data was analysed using a Template Analysis Framework, which considered the data inductively (being led by patterns in the dataset) and deductively (looking for specific concepts previously identified in the relevant literature). The research team met regularly to discuss the overarching themes from the practitioner interviews which then was used to build a template to analyse the interview data. On completion of the 7 individual reports, the findings were merged to provide a National overview of multi-agency safeguarding arrangements in Wales.

Table 1 Local Authority Participant Breakdown Summary

LA (anonymised	Total within SPs
LA 1	26
LA 2	11
LA 3	15
LA 4	18
LA 5	25
LA 6	23
LA 7	20
Total	138

Ethical Considerations

LJMU ethical processes assessed the study as no/low risk. However, usual ethical processes were implemented within the evaluation including Participant Information Sheet (PIS), Consent Forms and a Project Briefing Sheet that were provided to each participant. Each participant was offered to engage in the study via Microsoft Teams video that would be recorded on a separate digital device. The interview recording was transferred to a personal secure file on the LJMU system, and the interview recording was then sent to an external transcription service and deleted from the digital recording device. Data Protection Impact Assessment (DPIA) agreements were also required to be submitted and followed to ensure the study was GDPR compliant and Data Protection guidelines followed.

3. Main Analysis

The main analysis thematically explores the views of 138 practitioners involved in multi-agency safeguarding responses across 7 Local Authority (LA) areas in Wales. The analyses of interviews identified 7 key themes, presented over the following pages. Each theme can be accessed directly through clicking on the hyperlink below.

1. Governance and Guidance

Stakeholders were asked questions around their own role, responsibilities and organisation in which they worked for, and who they worked in partnership regarding safeguarding. An understanding of the *governance and guidance* which underpinned safeguarding practice was ascertained, and this included relevant *policy* and *procedures* which related to their roles in addition to the *legislation* which guided safeguarding practice. Stakeholders discussed *structures* and *systems* that are in place which both enabled and inhibited multi-agency working. *Leadership* was highlighted as a key factor in influencing frontline activity, and played a key role in determining *Strategy and Operation Cohesion* and implementing decisions at the top into practice.

1.1. Structures and systems

1.1.1 Front Door Services

Expertise and processes integrated at the front door increases the efficiency and accuracy of actions to enquiries and referrals. Embedding services such as mental health and wellbeing support for young people within these early processes was seen as an effective addition, particularly based on the volume of queries that have continued to increase since Covid-19. Moreover, the front door arrangements increase communication with wider agencies which allows roles to be discussed on ensuring the family needs are referred are supported.

One consideration when exploring the structure of the front door arrangements across the 7 LAs was that the ability to signpost people to neighbouring LA front doors, or even identify at regional

and national level what exists across Wales as a front door service. There is a lack of a consistent approach in the labels used for the front door arrangements, for example, IAA, SPOC, and (LA name) front door. Additionally, some front door arrangements are split into Children, Children and Family, and Adults in some areas, with areas also having to consider Police front doors such as the Central Referral Unit (CRU). Findings further highlighted that challenges can be worsened when extra layers and processes relating to different remits of safeguarding are added into the safeguarding systems, creating additional volume and complexity.

A possible solution is for an integrated front door that is consistently referred to as (LA name) IAA (to align with guidance), that is multi-agency, includes all referrals (Adults, Children, and Families) to help streamline the systems from the start of the safeguarding process. Given the level of accountability and responsibility within these initial assessments, those front doors that included multi-agency teams and shared decision making (discussed in more detail under Theme 2), should include a Principal Social Worker who can deal with adult and children queries as part of this front door team (with a Principal Social Worker within each team if Adults and Children services are separated). Acknowledging the differing geographical and demand profiles across the LAs, this would also require appropriate levels of resources to ensure management of demand for each LA area. This would, however, need careful monitoring to ensure the clear accountability and resources, with clear alignment to Directors of Social Services and statutory processes.

1.1.2 Families First (FF) and Early Interventions Services

The early intervention initiative Families First (FF) is present in all local authorities across Wales which provides support to the whole family. There was a lack of a consistent approach in the labels used to name such early intervention initiatives with some being named as Early Help Hubs. These provide, *"support for children and families regardless of their age or presenting issue as long as it is preventative in dealing with wellbeing issues"*. These services work under the premise of partnership working with families to provide multi-disciplinary support which is consent led. Early intervention programmes that were designed for younger children were highly praised. Specifically, a Flying Start programme (based in some areas) aimed for children under 4 years of age which provides multi-disciplinary support from designated health visitors, speech and language specialists, parenting support as well as childcare, all under one service.

Those services under the FF initiatives were all seen to be a crucial part of the safeguarding arrangements within each LA. Each LA had positive engagement and relationships with their FF teams, with a FF practitioner or manager taking part in the evaluation for their area. The key aspect of this support was to prevent families reaching statutory services by engaging them within the community. All LAs had clear structures and processes with their FF teams (Team Around the Family) to work below

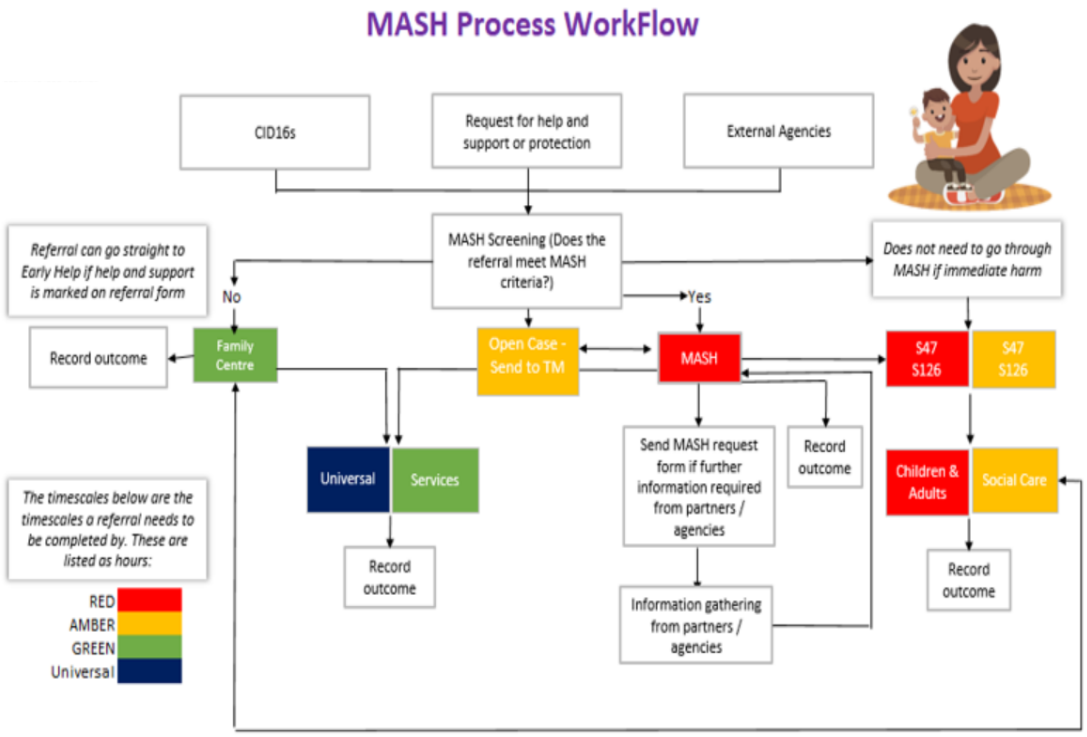
thresholds, or manage cases that have been de-escalated. FF teams that were multi-agency and co-located were seen to be *"the best example of co-location provision",* and noted to be working effectively by all those spoken to (explored further in Theme 2 Joined-up Safeguarding Process).

A key part of the FF initiatives was to also escalate cases back into the Safeguarding Hub or Children's Services should any concerns about risk and needs arise. This would usually go back to the Safeguarding Hub or MASH for further review and assessment. The FF centres could also signpost and refer individuals and families to local, community level services, if required. The support they provide aims to, *"take a therapeutic approach to working with families to reduce escalation and prevent going over to our statutory teams".* Please note that Report 4 that explores Service User Experiences provides some context on the effectiveness of these FF initiatives in safeguarding individuals and families from further harm.

1.1.3 Safeguarding Hubs and Multi-agency Safeguarding Hubs (MASHs)

Process workflows for each LA area showed how a referral would be initially screened and assessed to inform an appropriate outcome and resulting steps through the system. The importance of this workflow process is to ensure that a referral could be escalated or stepped down at any stage should it be deemed as appropriate. Please refer to Figure 1 for an example of a MASH process workflow.

Figure 1. Example MASH process workflow[1]



[1] LA MASH is anonymised as per the agreement to engage with the study.

When exploring the Safeguarding Hub (SH) or MASH within each LA there were clear differences in the terms used, whether they dealt with a combination or separate Adult and Children Services, co-location working and multi-agency involvement. Some practitioners specifically mentioned attempting, but not able to function as a MASH due to issues with combining Children and Adult Services. They felt that this was *'totally unnecessary'* more so for Adult Service practitioners that did not need to be part of Children Services conversations. However, other areas were seemingly functioning well in the structures and processes (as seen above in Figure 1) in combining Adults and Children Services together. This may, in part, due to a reluctance from some Social Workers who acknowledged the difficulty in making decisions on cases not related to their expertise. Moreover, some practitioners may not be familiar with specific legislation relating to adults and children, as there are multiple teams within both Adult and Children Services. In addition, there may be different partnership agencies for both Children and Adult Services who practitioners have built established relationships with, thus making it difficult to navigate expert advice/support and to collectively make decisions. This was acknowledged in the LA area that had combined their Adult and Children Social Workers within their SH/MASH. Practitioners stated benefits such as the resilience of the team increasing to be able to cover a child or adult referral. It was also beneficial to be able to determine support for the whole family, yet it was acknowledged that this generic working still needs some improvement. Issues such as exploitation and DA were described as examples whereby a safeguarding response was required for both adults, children and the whole family. All of which requires input from both Adult and Children Social Workers, *"We have a lot of cases where there's more than one person at risk within that family, and it makes absolute sense for us to work in that way".*

However, it was rare that Children and Adult SHs/MASHs were working together as one team. Most teams were hybrid working resulting in reduced opportunities for informal in-person discussions. One LA was seeking to integrate their safeguarding team of Children and Adult Services into one. This would take into consideration the crossover of supporting parents in safeguarding referrals thereby moving away from silo working to create, *"a shared understanding of what vulnerability is, the categories of abuse, and what they mean".* Regardless of the set-up of the SH/MASH, it was clear that resourcing these ensured good multi-agency representation, with the main partners being Police and Social Services. All SHs/MASHs did include involvement of agencies such as Health, Education, IDVAs, Housing, and Youth Justice. However, the set-up was more likely to be remote working outside the two core organisations the Police and LA, with this being more 'separate' in terms of teams, as well as policy and procedures being followed.

Even though some LAs did have separate teams for Adults and Children services, they were co-located in the same building. For the majority of SHs/MASHs, additional agencies were co-located

within the same building, which encouraged and enabled discussions when required outside their specific team (discussed further in Theme 2 Joined-up Safeguarding Processes). For screening, processing and consequently determining the outcome of referrals, many LAs had one main person within the SH/MASH who was responsible for this. Practitioners reported the benefits of this approach was that a consistent threshold was applied to each case reviewed, however, there were concerns about resilience, alongside how to ensure 'shared responsibility' in decisions. A good example was highlighted in one LA whereby a system was in place that ensured a (role) manager within the team initially reviewed the MASH referral, and then this would be reviewed again by another (role) within the team before reaching, the Principal Social Worker. This was seen as giving reassurance within the process around accountability and shared responsibility in safeguarding decision making.

An inconsistency across LAs was the location of where Domestic Abuse (DA) referrals were dealt within their safeguarding structures and systems. One LA had created a specific DA hub that sat outside Children's and Adult's pathways. This worked particularly well due to the safeguarding structure within the LA. Here, the DA Hub and the Integrated Safeguarding Hub were based within the Single Point of Contact. The DA Hub had three different pods: any adult, any Police Protection Notification (PPN) where there is a child associated, and a behaviour change programme. This preventative structure was seen to provide intervention and support for referrals to reduce the safeguarding risk. In response to a recognised national issue whereby DA cases are not reaching the necessary threshold for intervention a specific post was created to screen PPNs and track the safeguarding response to those families.

> *"There was so much demand and a lot of families kept coming in with no real intervention. So, they identified that when it wasn't quite over the threshold for Social Services that the Social Worker or lead worker could do an intervention, channel them into the right kind of avenues, and prevent it going over to SIN or CP"*

Other LAs included DA referrals within Adult Services but relied on close relationships with the Community Support/Voluntary and Charity Sector (VCS), or IDVAs to be able to support those experiencing DA. In contrast, other LAs stated that unless there was any adult care and support needs identified, DA referrals would not go to Adults Services, but would be referred to the Police or would involve Children Services if there were children present. Other structures included IDVAs being part of a LA team which involved touching base with the Safeguarding Hub. Whereas, other LAs worked in partnership with the VCS and third sector DA organisations with a seconded Social Worker as a link.

Only one LA area mentioned a Local Operational Group (LOG) as an important oversight group in their set up. The LOG acts as a multi-agency forum helping to decide what will happen with serious end cases where an issue had occurred. Moreover, the LOG is responsible for reviewing any new legislation to ensure processes and responses are aligned. The aim of the LOG is to act as a buffer to

the executive board, therefore acting as a review process to capture learning and respond to issues. Importantly the LOG can make recommendations to sub-groups such as the Child Practice Review group.

> *"We have a regular LOG meeting which all the senior staff from each agency comes to. We look at things that have gone wrong. We look a Child Practice Reviews or an Adult Practice Review, and we look at new legislation"*

However, given most LAs did not discuss LOG as part of their oversight group, this may suggest the executive function mainly sits with the Regional Safeguarding Board (RSB), but requires further exploration to understand this.

1.2. Policy, Procedures and Legislation

The implementation of the Social Services and Wellbeing (Wales) Act 2014 has resulted in a change of focus for working with adults, children and families which is underpinned by five principles:

- Promoting wellbeing
- Voice and control
- Prevention and Early Intervention
- Co-production
- Collaboration

In addition, in 2019, an app detailing the Safeguarding Procedures which support delivery of the Act was introduced. The app builds on the statutory guidance and encompasses a single set of safeguarding guidelines for children and adults at risk. This app aims to standardise practice between sectors and agencies when working with a child or adult who may be at risk of abuse, neglect or harm. Regarding the Act and Procedures, practitioners had a mixed response as to how useful they were. Some practitioners referred to the Act and Procedures as a 'Bible' with regards to holding strategy meetings and valued the practical guidance which the app offered for various situations, and applauded the user-friendly language. Some stakeholders noted that the Act has clarified guidance around responsibility and has resulted in *"partners are more engaged",* and that these responsibilities are shared more widely.

The Procedures and the Act were particularly well received amongst those working within safeguarding adults and it was noted that they have *'given adult safeguarding a legal footing'* with the duty to report adults requiring support. In addition, the focus on wellbeing allows for greater collaboration between agencies, both statutory and VCS. An additional benefit is the Act gives adults and children the same priority which reduces challenges during the transition from Children to Adult Services.

> *"We've set up the Exploitation Vulnerability Board, so things are really developing, because adults have got that legal footing and it gives them as much strength as children. That's the nature and the purpose of the Social Services Wellbeing Act was recognising that there has been a gap in the past"*

However, there were also cases for concern around the underlying premise of working in partnership with children, which is detailed within the Act and Procedures. Practitioners felt that the Social Services and Wellbeing Act has *"been written for Adult Services and then modified".* Therefore, leading to practitioners questioning whether this is compatible with practice and the level of autonomy and control children have within the Safeguarding Procedures.

Additionally, within Adult safeguarding Section 5 of the Safeguarding Procedures: Safeguarding Allegations/ Concerns about Practitioners and Those in Positions of Trust, has led to Adult Social Services now chairing Professional Strategy Discussions to address safeguarding allegations. The implementation of Professional Strategy Discussions has increased accountability, yet it was unclear if training allowed for this process to be easily implemented. This could be challenging when it involved health professionals which require specialist knowledge that they are not necessarily 'clinically trained to do'. More generally, stakeholders who worked within Children's Services noted that for some of them, there was not a great deal of change which has come about through the new Procedures, but possibly different terminology used. Whilst some stakeholders stated that the Procedures clarified certain aspects of safeguarding, others felt that it needed to be clearer on issues such as consent and capacity. Moreover, some stakeholders felt that whilst there was a renewed focus on safeguarding due to the Procedures, it has, for some *"created vagueness around things that needed to be clear"*. There were also concerns regarding the implementation of the Act and embedding it into practice as, *"it can be quite difficult because the resource for training isn't always available".* It was also highlighted for multi-agency working *"the law and guidance can be interpreted differently for different people and different practitioners".* As 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). This change was implemented to reducing silo responses to adults, with of a focus on wellbeing and improving people's quality of life, regardless of different types of vulnerability across different ages.

The Social Services and Well-being Act (Wales) 2014[2] now require practitioners to work in equal partnership with service users. A key component of this relationship between the practitioner and service user is to ensure that a 'what matters' conversation take place. This ensures that the service user's voice is reflected in the assessment process. The Act also requires consent to work with

[2] https://socialcare.wales/service-improvement/what-matters-conversations-and-assessment#section-30988-anchor

families to assess their Care and Support needs as part of a safeguarding assessment and providing support. Whilst this was deemed positive, it also raised tensions around how to work with families and individuals who do not want to engage with support. This raised further uncertainties around where safeguarding responsibilities lie.

Whilst having Procedures electronically available through the app allowed for everyone to have access to the most up to date versions, stakeholders felt that finding information was challenging due to the electronic format. A paper version was preferred as it allowed for ease of communication between practitioners for example, *"can you look on page 231, that third paragraph down".* Generally, the introduction of the Act and Procedures was beneficial as they allowed for practical support and prioritised safeguarding for both children and adults, although this was experienced differently depending on the area of safeguarding practitioners worked in. Some LAs had taken this further at a regional level, developing a regional threshold document that contained rules and processes regarding what constitutes a referral and more detailed guidance on screening cases. This was seen as a positive enabler in implementing the Wales Safeguarding Procedures, in that it acts as practical guide for professionals, ensuring that everyone within the multi-agency arrangements can adopt the guidance, being clear in its message of safeguarding being everyone's responsibility.

Additionally, LAs were seen to actively create their own policies in response to high risk, complex and increasing demand areas such as a Hoarding Policy. The policy outlines clear processes for staff, including the need to have a multi-agency panel following identification. Most LA areas regarding new policy mentioned Hoarding as a key concern within Adults Services, with an increased recognition of a multi-agency approach required to respond to this concern, particularly including Fire Service and Housing. This was seen as welcomed addition in terms of policy and guidance being implemented at local, regional and national level and provides clarity around whether service users are deemed to have capacity.

Furthermore, following a national strategy from Welsh Government in response to VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence), each region was asked to work together to create a regional strategy in response to VAWDASV. This requires production of an annual delivery plan and specific actions in response to the strategy, and how they are engaging with specific DA services within their area. However, there should be more statutory guidance and information regarding DA to support this. In addition, it was noted that when MARACS and IDVAS were first set up by the Home Office, there has been no updates since and clarity would be welcomed to build on. As time has moved on, practice has also evolved and it was felt that this evolution could be updated in legislation, to enable more clarification on multi-agency safeguarding in this area. A review and potential update in existing guidance regarding MARACS and IDVAS in relation to any new guidance

concerning VAWDASV. This would help to clarify related processes, as well as agency expectations and responsibilities.

> *"I think there were some real misses with the legislation that's come out recently. The UK DA bill, there's loads of bits in there that don't go far enough with being explicit. I know they are talking about making IDVAs statutory, but that's since the conversations we've had around Hidden Harm. You've got time lag with the legislations"*

More generally in regards to multi-agency operating, Terms of Reference were mentioned across the LAs as important feature in allowing for greater transparency within strategy and steering groups across the multi-agency safeguarding arrangements. These allowed practitioners to be "*singing off the same hymn sheet, and a clear, shared understanding of each other's roles and the information that's held on people's systems"*. However, practitioners across some agencies that did state there were issues within policy and procedures when trying to implement in practice, when additional requirements are added to roles and responsibilities without clearly defined protocols. This can result in more pressure and responsibility being given to the LA as other agencies may feel that it is their duty complete but, "*it doesn't mean that your job is done as long as you've told somebody else about it, it's not a hot potato, you still have to hold on to your responsibility."*

1.3. Leadership: Strategy and Operation cohesion

Across Wales, it was felt that the leadership and strategical influence had a direct impact upon how multi-agency working functioned operationally. A key aspect in effective leadership, therefore, effective multi-agency working, was the stability and continuity of the leadership team. This was seen as more likely to be present in smaller LA areas, where movement was less likely to occur, where this stability of the leadership also descended into the teams, providing a unit of support for the multi-agency teams. With a key aspect that comes with continuity being *'a sense of trust'.* This continuity also served to allow practitioners to feel as though senior leaders understood the demand, roles and responsibilities placed on its services and staff, "*if our leaders don't understand why we do what we do, we're on a bit of a bit of a sticky wicket."*

Previous experience and expertise were seen as important in the leadership structure. One such example included a manager within adult safeguarding having Occupational Therapy (OT) experience, and the OT team was co-located within Adults Social Services. Occupational Therapists felt integrated within the team and reported having a strong relationship with Social Services, which was described as *'refreshing'.* Practitioners suggested that this improved information sharing and created a seamless transitionary service in care between agencies. Similarly, when a manager with experience of working in a Safeguarding Hub moved to another LA team, there was a renewed commitment to investment into safeguarding responsibilities. This involved harnessing the valuable skills of practitioners in the team who manage risk as part of their daily duties, to be reframed in the

context of safeguarding and align to objectives with other safeguarding agencies to develop the services that are offered. Consequently, this expertise has, *"grown their service to accommodate more referrals so that they can work with more people".*

This was a model that was reflective across many teams, with a senior manager within a Learning and Innovation Team (with much responsibility for performance, quality, data, audits and training) having a background as a Social Worker. This ensured that what was being asked from staff was required and operationally useful, which strengthened the strategic to operational congruence. Practitioners could therefore understand the reasons for some of the more frustrating aspects of their role, such as data recording and collection, by feeding back regularly to these teams to improve the safeguarding response.

Further good practice highlighted a LA where senior staff within the MASH team screened and reviewed referrals coming in before going to Principal Social Workers (PSWs). Consequently, staff reported that accountability in any decision making was shared within the team.

> *"(Previously) There was no protection for the Social Workers. There was no management oversight. They go into a central box that we call the contact box and the PSW's will go into those. They'll put key directions and RAG ratings on and then allocate them out to Social Workers. By the time the Social Workers have got them, they've been seen by managers twice"*

An important part of effective leadership was seen as those individuals who were able to *'roll their sleeves up'* and get involved in supporting the team. It was also noted that resources and capacity is an issue for all agencies, all services and all teams and that previously, service managers have been described as 'service focussed'. There needs to be consideration as to how agencies can collaborate and manage a seamless transition of service delivery, and ensure that service users receive a joined-up response. It was acknowledged that despite a critical lack of resources across the board, more must be done to create new ways of working and adopt, *"a management ethos that needs to be thought outside of the box".*

2. Joined-up Safeguarding Processes

The safeguarding process for both Children's and Adult's Services have many elements which aim to ensure a joined-up process, although for Children's Services and Adults these often tend to be separated. Several key features which illustrate how the process is joined up include *sharing information,* the establishment of *multi-disciplinary teams and co-location* of agencies. Enabling collaboration required understanding *agencies thresholds* and pathways to support, the role of *consent* to work with adults and children and the *responsibility* of all agencies regarding safeguarding. To support understanding and join up the safeguarding process ongoing *consultation* between agencies and multi-agency *training* was beneficial to clarify responsibilities, and partnership working

arrangements. Additionally, the delivery of services was discussed and their *accessibility* to young people, families and adults as well as the *consistency of these services* in different areas, and the *resources* available to provide and maintain a service. This all links to the investment being made in staff in terms of recruitment and retention, which has been highlighted as a national issue. All these features impact the ability for agencies to maximise a joined-up safeguarding process for service users.

2.1. Sharing Information

Recommendations within most national SCRs (Serious Case Reviews) and DHRs (Domestic Homicide Reviews) centre on the need for better information sharing. These highlight the need for efficient and transparent sharing of information across agencies that have sight and access to the individual and their circumstances. Across most LA areas, information sharing is considered to work well, and established relationships facilitate this process. It was felt that because professionals *"know each other a lot"* information, when relevant is shared freely. Relationships were seen as the main feature of effective and efficient information sharing, regardless of the system being used, co-location/hybrid working, or agencies involved in their arrangements. Positive information sharing narratives tended to involve those individuals that had been in place within their geographic area and agency for several years. Consequently, these professionals had developed relationships with people across their LA (discussed more in Theme 3.3).

The new Safeguarding Procedures clarified agencies responsibility in needing to share information. It was clear that for the safeguarding leads both adult and children, they felt that sharing concerns even if they are not sure of the level of serious harm, is better than not sharing. Ensuring there was clear procedures and protocols in place to aided effective information sharing across agencies. Some practitioners had encountered problems in sharing information with some agencies or individuals. Moreover, a lack of knowledge regarding sharing information, impacted on whether appropriate referrals were being received. It was highlighted that there is flexibility for receiving information from certain services as they would rather have the information than not have it and some stakeholders stated that, *"we don't refuse anything*". Thus, highlighting the importance to ensure a front door service which is open to receiving information from all services and the public.

For some agencies, there were concerns around the continuation of sharing information once a referral has been placed to safeguarding teams, and when safeguarding teams require follow-up information. Consequently, resulting in delays in responding, for example if waiting for Probation to answer further questions around scales of risk and who risk concerns. Follow up information after referral submission was also noted to be an issue for referring agencies. The VCS agencies play a key role in safeguarding as they are often working closely with individuals and families when risks escalate to safeguarding concerns. Some VCS agencies struggled to receive information back from the LA on

referrals despite being the agency who were working face to face with the individual or family. An emergency service worker discussed not being able to access information due to not seeing them as *"having a role to play in safeguarding".* It was suggested that improvements should be made to referral pathways. Moreover, given safeguarding is rarely a linear process and that some individuals require ongoing support, it was felt that feedback of information beyond the point of referral was useful to continue to manage risk and need.

Amongst different agencies there were said to be challenges in the cycle of information. For example, updates and progress on whether a Social Worker has been allocated, which may have been made regarding a safeguarding referral does not always happen. For example, if an agency has been deemed as not being required at a certain point, there is no way of standardly obtaining information to ascertain if that situation has changed. Moreover, knowing whether a case had been taken forward or not, with no feedback or access to information meant that actions or outcomes were invisible. Agencies noted that they, *"assume that if you don't hear from them, that there isn't a role for the [agency]".* This is helpful given that safeguarding is not always a one-off crisis but sometimes requires other agencies to continue working with referred individuals, regardless of the outcome of the referral, therefore oversight of information is helpful for the referring agency.

In contrast within one LA, the sharing of information between frontline practitioners to the SH/MASH was seen to be working well due to the placement of a Police Detective Sergeant in the SH/MASH team. That individual was providing feedback to those frontline officers that were putting inappropriate referrals into the SH/MASH, whether this was a quality issue, or threshold issue. This was seen to be increasing the proportion of appropriate referrals being receive. The process allows feedback to be provided to referrer to advise where the referral may be better placed for support and why. By providing this feedback, it was felt that this helped direct future referrals and ensuring that they were sent to the most appropriate agency.

In some instances, obtaining further information was noted to be challenging at times, particularly after Covid-19 as this has put a strain on services such as Health, and *"the follow-up hasn't been as timely as what we want it to be".* However, Health is a broad area and Health Visitors were often praised for being *"prepared to pass everything over"*, and continued post referral information sharing. However, for Mental Health, it was challenging to share information with CAMHS.

> *"They don't often share much information, they just do that verbally and I'm sure that they have lots of stuff that they could share, which they don't. We very rarely see much from CAMHS come through, except for referrals, no assessments, nothing really from them. I do have to chase them, it's quite difficult"*

The lack of accessibility for children's mental health support was prominent within interview discussions, *'You're bashing your head against a wall all the time because CAMHS are not available because they don't have enough workers to be able to see our children'.* CAMHS also were noted as not always in attendance at multi-agency meetings, alongside Probation Workers and representatives from Adult's Services, within some LAs. Receiving reports was also mentioned to be challenging. It was acknowledged that mental health referrals are sharply rising and that CAMHS are under resourced as a service.

> *"There are very little children that are assessed and have support, we often feel that we are banging a door that just doesn't open. I don't think I've ever in my whole career ever had a Mental Health Worker come to any multi-agency meetings for the children that they are working with, and I think it is the lack of staff that they've got, it's a real issue for children"*

When working with Education there was a huge variety in how schools operated with some being very good at sharing information, and others less forthcoming. It was noted that information was shared last minute which makes it challenging to respond, *"Education can be slow. I think they tend to keep things, they're like, oh why didn't you ring, they're just slow to react and leave things to the last minute".* A way to combat this was discussed by two LA areas, one that had employed an 'Educational Link Worker' within the Safeguarding Hub who were responsible for sharing information between the schools and the Safeguarding Hub. The other LA area employed an Educational Safeguarding Officers within their Children's Services team to advice, support and assist all schools in the area. This service was provided to schools within the LA but also was available for private schools and independent schools.

Multi-agency meetings such as strategy discussions were a valuable forum for sharing information. The meetings operated on a formal strategic level and at the operation level. The meetings had a core individuals attend, although specialist agencies would attend where relevant. Within these specific forums, sub-groups between a smaller number of agencies softer intelligence and contextual information would be shared, depending upon the purpose of the meeting. For example, one LA area discussed their Contextual Missing Exploited and Trafficked [CMET] multi-agency panel. The CMET panel was split into two groups strategic and operational. The multi-agency CMET operational panel is focused on frontline safeguarding concerns.

In addition to multi-agency meetings, the use of a duty inbox was considered an effective way of sharing information between other agencies and having a single point of contact for each agency. This method for sharing information appeared to be mainly via email with designated mailboxes in use for sharing concerns and obtaining information quickly. This was especially helpful for District Nurses, to ascertain information quickly, such as if an individual is known to their service. Email trails were also used to keep track and evidence the information that has been shared. This approach to

sharing information was particularly beneficial for conducting information lateral checks when receiving referrals, for ongoing cases and sharing information about how agencies were working with service users. Moreover, there were examples where outside agencies were given access to in-house databases, for example in Education, which was beneficial to practitioners to ensure they were kept up to date and inform the delivery of their support.

> *"The Headteacher added me onto the MyConcern system, which worked so much better because I was getting the information that I needed instead of emails going back and forth"*

A shared database was something which was discussed frequently, and stakeholders agreed it was the way forward for multi-agency working without it *"duplicating the paperwork".* It was felt by some stakeholders that a shared database was in part, already operational, with 5 out of the 7 LAs using WICCIS as their main information recording system. Some agencies noted that they can access a 'read only' version of the databases on WCCIS, and therefore can update themselves regarding what support or progress has been made by other agencies working with families. This allowed for continuity and a coherent service delivery whereas previously, "it *could sometimes take us weeks to find out if there was a Social Worker involved".*

However, despite having training, other agencies are not at the level yet where this is operational. Across many LA areas many practitioners had concerns about whether the vision of the new information systems could be achieved operationally.

> *"It would be much easier if we were all on the same system and everyone was using the same recording system. You must ring and hail people for information. One system that everyone knew would be a massive improvement"*

WCCIS was the centre of much dissatisfaction amongst practitioners across all LAs that were using the system. Regarding this *'over-promise'* of its capability regarding information sharing across the key safeguarding partners, with additional concerns raised about the accuracy of data recording, and extraction from the system (discussed later in Theme 5). There seem to be the over-simplification of the capability of the WCCIS system versus the complexity it subsequently introduced within the MA safeguarding arrangements. One LA team talked about having to spend a year working on WCCIS to make it operational before being able to do anything meaningful with it.

Given Police were the key partner within all multi-agency safeguarding partnerships, the separate systems of police (e.g., MHUB), and LA systems (e.g., WCCIS), were seen to be functional within those formal arrangements such as the MASH/SH, but otherwise would cause problems for those seeking information. This would undoubtedly result in referrals going back into the central system to be assessed/reviewed, with the practitioner who is often the one working directly with the individual/family left outside of any decisions or rationale.

One LA area talked more comprehensively about the consideration of data recording and

sharing from point of initial referral form, where this information is copied to all other forms automatically that other agencies have access to. This was seen to be less traumatising for the service users and reduce the delays when agencies were trying to identify the relevant information to inform decisions on risk, and response. This was enabled by Children's Services, Adult's Services and other hubs (e.g., DA Hub) sharing and accessing the same system, and that they have, *"designed our forms so that they automatically copy from one to another. Information that comes in on our referral form, which is called the practitioner request for IAA".* However, even with this shared system in place, the system itself (WCCIS) was deemed to be *"not service user friendly",* with many practitioners citing system crashes, issues with updates and one noting *"it's not quick or easy to access things".* Resulting in practitioners having to record information manually increasing the risk of information being missed, or decisions being delayed, and subsequent performance metrics and dashboards being inaccurate. There has also been duplication whereby people are manually typing documents due to the system (WCCIS) being down.

The ask and same request was reiterated across all LAs in that the information sharing platforms are not yet fit for purpose, with WCCIS being mentioned most frequently as the main issue. The ability for safeguarding agencies to be able to access a central system across the LA area that involves key partners such as Police, Health and Education, was seen as a crucial requirement in minimising outcomes such as SCRs and DHRs.

> *"Communication amongst the multidisciplinary team needs to improve… if there was a central location where we could share information for service users, particularly over safeguarding concerns, it may improve communication"*

Furthermore, the ability to share information across other neighbouring LAs has not been delivered with their current systems. This was seen to be a further risk in ensuring information and intelligence being reviewed and assessed was accurate and up to date, due to increased risks in child criminal exploitation (CCE) and child sexual exploitation (CSE), which is acknowledged to cross LA and regional boundaries.

2.2. Multi-Agency Teams and Co-location

There is no doubt that Covid-19 has impacted on co-location of any multi-agency safeguarding arrangements. The rapid and necessary movement to online sharing of information and working has been consistently maintained as we have emerged out of lockdown restrictions. What is certainly different across the LA safeguarding arrangements is whether this has reverted to a 'business as usual' model regarding co-location of multi-agency teams, or hybrid working arrangements, with some multi-agency teams and professionals' adamant that they would prefer to continue their role working from home. This was very much debated across the LA areas with the most popular current mode of

working being that of hybrid, where teams would come into the office around two days a week. The level of hybrid working tended to depend on the type of service, with Safeguarding Hubs and MASHs more able to work flexibly within a hybrid, or remote model, compared to those that require frontline delivery, e.g., Early Help Hubs, Family Services, and those working within Adults and Children's Services. Stakeholders mentioned a better work-life balance of being in the office for duty and then working at home for other elements of the job.

The geography of the area was also an aspect of why many multi-agency teams had remained hybrid working, or mainly remote working. For example, if there is a large area to cover with different Health boards or LAs it can be complex. Hybrid working was mainly functioning through the platform Microsoft Teams, which practitioners saw as an effective way of communicating regularly through a range of functions, such as daily video conferencing, or open live video calls to allow open discussions within small teams. The use of 'Teams Channel' on Teams was also used to pull together individuals from different agencies into one group discussion, where posts, updates, documents and calls can be shared with those members.

> *"You don't need to be in the same building. My manager and I choose to communicate via Teams because it's easier to speak like this than to sit there with masks on. Teams has made a huge difference"*

However, there was much discussion around the importance of face-to-face discussions within and across the multi-agency safeguarding teams. This was centred on the ability to have more informal discussions when required, discuss in more detail aspects such as thresholds, but also in terms of difficult conversations when decisions are needed to be challenged and how *"it's a lot easier to have those face-to-face discussions about cases", as "you wouldn't have to jump through so many hoops to get information".* The benefit of being face-to-face and co-located also allowed for different agencies to learn from each other and allows for a shared understanding and clarity regarding thresholds.

> *"Having those challenging discussions with one and another and with the people we're working with, never mind our partners. So, you need to be in the room to have those discussions"*

The development of relationships which lies at the heart of multi-agency working was felt to be enhanced by co-location and was evident through many of the Police and Social Services co-located models, where relationships had been developed though organic activities such as chatting about non-work topics. Whereas before it would be, *"lots of telephone conversations and they would be a couple of minutes long, it would be a quick hello and how are you, but you aren't really building them relationships up much."*

Moreover, the ability to be able to learn from other practitioners through hearing their daily interactions and dealing with different cases was considered crucial. This was particularly important for newly qualified Social Workers. Much conversation centred on the ability for all practitioners to continuously learn, with questions raised about how this can be done when remote working. Understanding about any new policy or guidance, new services or provisions, new individuals within roles, all these factors were seen as better adapted and implemented into practice in a natural setting where you can observe these being implemented. Furthermore, this also allowed the identification of training needs, skills deficits, where individuals (particularly newly qualified) can observe and learn, and any issues can be addressed quickly.

However, many were still asking the question of whether a typical co-located MASH model was the better approach within their safeguarding arrangements, with some areas having tried this and reverted to their previous working model. This may require further unpicking regarding people's understanding of a MASH, given current operating where some MASH models are mainly remote working and therefore do not conform to pre-determined framework of a number of agencies physically co-located (more than Police and Social Services). Covid-19 has certainly changed the operational workings of a 'MASH' model, which should be considered in any labelling arrangements going forward.

> *"We tried doing the MASH, which was going to be Children combined with Adults, Police and other agencies joining us, but it didn't work. It did seem like it was very much catered for Children's Services. We were going to have Education, Families First, there was going to be a lot of people within the MASH, which I think would be fantastic for Children's Services but not so beneficial for us (Adults). Amalgamating us was good in that you got to meet others, because Children's and Adult's are very separate"*

Regardless of practitioners understanding of the requirements to label themselves as MASH, a key aspect that seemed to allow practitioners to feel confident in remaining remote working as part of their multi-agency safeguarding team was if they had been working for the LA and service for several years (this was only mentioned by LA employees). The years of experience was correlated with a belief of having well-established and maintained relationships with key agencies and individuals, therefore removing the need for a co-location working model.

Some LAs had taken the co-location multi-agency teams to another level by placing these co-located teams where critical moments for engagement and support are most likely to occur. Specifically, regarding DA, the IDVA model which involved an IDVA worker being based at a hospital within the safeguarding team, and this was felt to be hugely beneficial. This took the focus away from a DASH referral card/ form having to be completed as the IDVA was already based in the hospital, therefore reducing delays in accessing support.

"If there's any DA issues within any patients in A and E, or the psychiatric unit, then there'll be an IDVA there. That will be a huge improvement…because there's a lack of Health Workers in general who would submit the card to DASH"

Another LA had adopted a similar model of an IDVA being located within the hospital with discussions on seeking to develop a multi-agency hub within the hospital to address the needs of patients, of which the IDVA would be part of this. The team would include Mental Health professionals, Housing representatives and Drugs and Alcohol services and be available each Friday, to address any concerns.

Furthermore, one LA area recognised the importance of their Family Hub in terms of providing DA support, without bringing attention to the individual seeking this service. Therefore, as part of general activities within the Family First Centre, the IDVA would get involved in activities, subsequently allowing for more informal conversations to occur without the worry of being seen speaking to a specialist. This was seen as a fantastic trauma informed way of engaging with individuals on their terms, in a non-judgemental, open and accessible way.

2.3. Holistic Safeguarding Responsibility: Thresholds, Consent, Confidence and Competence

'Safeguarding is everyone's responsibility' was the most popular statement across all LAs in Wales. There was consensus that a multi-agency approach was the only way to address safeguarding and that all agencies had a part which required, "*everybody taking ownership of safeguarding and not just the Social Worker"*. It was noted that safeguarding should underpin all work which is done with individuals and is part of everyone's job remit with each sector, and each agency having a contribution to make.

"The idea being is that we give a loud and clear message that safeguarding is a golden thread that goes through all of us. I compare safeguarding to infection prevention, everybody is interested in using the pump dispenser before going on a ward and I just think, open your eyes and ears to safeguarding in the same way"

Responsibility of safeguarding across all agencies varied in practice. Ultimately, the responsibility of safeguarding seemed to fall to statutory Social Services for Children and Adults. However, it was clear from their perspective that issues around consent, partnership working and incorporating the 'What Matters' element into referring cases for safeguarding support varied considerably. There were frustrations from safeguarding teams that once a referral comes in that it was expected that someone else would deal with the appropriate actions.

"'I've told the Social Worker; I don't need to tell anyone else'. If someone has given you concerns, then you need to make sure that as a professional, you take that forward from your own role. We all have a say in safeguarding"

Some people's understanding of safeguarding is to simply pass on the information and that placing a referral, '*absolves them of any responsibility'* and their part of the safeguarding process is complete. One LA discussed a pilot that was being run in one of their areas due to high number of NFAs (No Further Action) falling out of their MASH that were coming from the Police. The recognition of the unnecessary demand it was creating due to Police Officers being told *'to put a PPN in and cover your backside',* required a *'cultural challenge'.* Therefore, the Early Help Family Centres worked with the Police to encourage referrals to them as opposed to a PPN's with this being targeted at the Police supervisors.

> *"Target those managers within the Police Service to make sure that they've got the same understanding and they recognise an Early Help referral is appropriate, if not more in some instances than a safeguarding PPN"*

Furthering this, many felt that safeguarding requires continuous follow up and ensuring all relevant agencies are working together to support people to live safely. In certain situations, this can involve *"helping practitioners developing that competence"* as it was noted that not all practitioners have the confidence to speak to individuals before submitting a referral. However, if this conversation takes place, it can ensure a more proportionate response from the LA and promote partnerships working. It was also mentioned that practitioners may be unnerved by the enormity of safeguarding and may feel out of their depth dealing with it but that, *"'Oh, it's safeguarding, I don't know what to do', well, yes you do, you do it every blooming day".*

Blockers and challenges in achieving a holistic safeguarding response centred on the understanding and application of thresholds, consent, which subsequently related to practitioner competence, "*We all have different thresholds and that's sometimes becomes problematic".* Understanding agency (thus individual practitioner) responsibility of safeguarding was voiced by many practitioners. This was due to a lack of understanding about whether threshold would be met within the SH/MASH for a referral, and particularly around the inclusion of any necessary and relevant information to inform subsequent actions.

> *"A safeguarding lead was saying, we need a Social Worker to come and assess the situation. We've said, we don't have the evidence to say that he is under the influence. So, we will call in loggerheads then"*

At times, agencies referring cases for safeguarding assessments may feel they lack the confidence to gain more information from the family. However, an alternative point of view was that transparency can be better for the working relationship and ensuring the family are aware, *"(LA) are keen to advocate from the Social Services Wellbeing Act, and from the Wales Safeguarding Procedures, that families are providing consent and promoting that".* The relationship the referrer often has with the person they are referring, was seen as an important feature of being able to gather as much

information as possible it was noted that, *'people think that we've (Social Service) have got a magic wand and we haven't'.* It was suggested that there may be a fear of repercussions if another agency outside of the LA has the conversation about 'What Matters' as it could damage the existing relationship. However, it was highlighted that having an honest conversation could be of benefit, *'Well it might strengthen it because you'll understand a little bit more'".*

Children's Services in one LA stated work was being undertaken to look at referrals which have been submitted from the Education sector and to examine what more could have been done, by whom at various stages, to prevent the young person being involved within the Child Protection system. This would identify and assess whether having the 'What Matters' conversation earlier, if appropriate, would have changed the outcome. Yet, there is still *'nervousness around what's Child Protection'.* This was all linked to the quality of the safeguarding referrals received, which were often seen as 'vague' and lacking information.

> *"The standards of some referrals are poor. I always refer to the one where we just had a name and the reason for referral was 'help'. We always challenge senior managers within [sector]. You'll see an improvement for a while and then it will slip back again"*

One LA area discussed their significant efforts to improve referrals coming in, particularly regarding adult concerns from the Police. This was significantly improved by having a Detective Sergeant as part of the MASH co-located (hybrid) team, where they would directly feedback to Officers if there was information missing, or if further information was required. Due to this feedback, Officers confidence and understanding of thresholds for Adult referrals improved thereby reducing the inappropriate referrals. Another way that was seen to reduce unnecessary referrals coming into the Safeguarding Hubs was to encourage conversations with a duty team or safeguarding teams. It is important to reduce inappropriate safeguarding referrals to reduce the workload that is taken up by referrals that are in the system that are deemed not appropriate.

> *"Once it's come through to us, there are certain things that we have to do with that referral. We can't just say, "No that doesn't meet thresholds." That all takes up time. If it didn't come through to us in the first place, we wouldn't need to do it, and we could focus on the things that are safeguarding"*

A complicated issue when furthering discussions on the understanding and application of thresholds is how these can vary due to socioeconomic status. Levels of poverty, aspirations of young people and communities as well as lack of opportunities ultimately change threshold levels, with demand also playing a part within this. This can change the nature of vulnerability too, which all needs to be understood by those referring into a service and those responding to any safeguarding referrals.

> *"We have a poverty and deprivation in [geographical area], but we also have affluence and entitlement. So, the conflict between recognising safeguarding throughout those is different. The thresholds are automatically different. Good can look very different in different parts of an area just to ensure that safeguarding is working"*

Furthermore, on the varying thresholds being applied, some agencies noted that even before Covid-19 the criteria for thresholds had risen and their referrals were not being accepted. The referring agencies could not understand why, *"We wouldn't do anything with that' whereas you think 'you would have before' so the criteria has been stepped up".* Whilst it was noted that Child Protection threshold remains unchanged, what has changed is the requirement to obtain consent to work with families at Care and Support level. With the change of the law and introduction of the Social Service and Wellbeing Act (2014), a requirement of consent from service users to access statutory Care and Support Needs was mandated, meaning that if any family was to access the service it must be done in partnership with the family. It was observed that this may result in more Child Protection referrals to bypass the requirement for consent. However, if the referral does not meet the threshold criteria for Child Protection then the referring agency who has the relationship with the family must gain their consent to work together.

> *"Has this been sent in under Child Protection so that they don't have to have that conversation with the family and gain their consent? Sometimes you're going to have to throw it back and say it doesn't reach the threshold, you need to go back and have that conversation with the family"*

The issue of gaining consent was a source of contention for both Adult's and Children's Services and where cases were not accepted for support as a family did not consent or engage. The VCS and other statutory agencies stated that they can feel like *'you're back on your own'* when they believe the family needs further support beyond what their agency remit can offer. However, it was evident that the requirement for consent was not just noted in law, but also valued as a way of partnership working with families due to the *'invasion of private family life'.* This can contribute to the barriers and poor reputation of engagement with Social Services.

> *"I don't think Child Protection has gone higher, I think that threshold is spot-on, the safeguarding procedures are extremely clear. The threshold for Care and Support because of the need for consent, has made it higher because sometimes we would be offering Care and Support and the families wouldn't want it"*

Similarly, regarding Adult's Services there were tensions around submitting referrals with issues relating to capacity and consent. It was evident that unless the individual was deemed as not having capacity, the referring agency should be working in partnership and gain the individual's consent for a referral. Gaining consent was acknowledged to be a difficult in practice, as professionals are limited in what they can do if an individual's actions are not harming others, or they do not want any support.

It was noted capacity and who should assess this were not always well understood amongst agencies and that this can be a 'battle' for both the referring agency, and the duty teams.

> *"They would send it back saying, 'Well, there's nothing I can do until you have consent', then I say, 'Well, I'm not sure if this person has capacity?' Then it goes into this ping pong, 'It's not up to us, it's up to the GP' Safeguarding should be a very clear process"*

Frustrations were also noted when agencies felt that an individual who was being referred to Adult's Social Services had consent. Consequently, this was not accepted as there was uncertainty regarding what further support was required and confusion as to where the safeguarding responsibility falls for adults at risk. One aspect of good practice that was discussed in a LA MASH that maximised confidence at an individual level, individual agency level, as well across the multi-agency team in achieving a holistic safeguarding response was a review process. This was conducted on a regularly (monthly) basis. As part of this review, any recent SCRs outside their area would be used to scrutinise their individual, agency and multi-agency response to understand if the same outcome would have occurred. This allowed them to discuss, challenge and review decisions and actions that would have occurred at each stage of the SCR. Furthermore, this would help to understand potential areas that need to be strengthened on the back of the SCR scrutiny process. This increased practitioner confidence in testing their systems, processes and decision making in a safe, but challenge-encouraged environment. Another LA also used this approach as part of their review processes, which enabled them to review and amend specific policy to be inclusive of other risks.

> *"We have a workshop in [LA] area and we learn from Child Practice reviews, even if they're not our own. We looked at our Hoarding Protocol and realised that there wasn't much content around children. So, we got a task group together and added a checklist of things to look for and questions in the context if there are children living in the home"*

Additional good practice identified the ability to bring a larger group together to share concerns around place and space vulnerabilities using platforms such as Microsoft Teams. This provided a holistic safeguarding response to current concerns.

> *"There was 63 people present in this virtual space where we talked about what we knew had happened. There was a sense of shared responsibility, everyone was accountable for responding. Everybody stepped up and was valued for their contribution to solve the problem"*

2.4. Consultation and Training

To ensure that referrals are appropriate for safeguarding and ultimately ensure that children, adults and families have access to support, it was suggested that good practice involves a consultation discussion at the point of referral. This would enable Social Services to communicate the type of information they require to meet the necessary thresholds and to advise on what the referring practitioner can put in place to support and manage risk with the individual or family. It also allows for the referring agency to have a 'What Matters' conversation. This process can allow for new

information to be discussed and ensure further action is coordinated and appropriate. It was also noted that these discussions often go back and forth with *'constant discussions and feedback'.* Practitioners were positive that this consultation was effective as it ensured that referrals were appropriate and other agencies had access to timely advice.

> *"We request them to ring first, to clarify and we could advise at that point, maybe you need to speak to the child again, to ask one question and then come back with a proper referral. It takes a bit of time because there is a backlog"*

Another area for developing understandings in how organisations can achieve a holistic safeguarding response is through training. It was felt that training, particularly multi-agency training, would be beneficial. Notably for mental capacity as practitioners were *'quite scared'* due to the significant implications of such a decision. The response towards multi-agency training was variable in discussing how often it happened and which agencies were invited. It was thought to be hugely beneficial to have multi-agency training as all agencies are part of the same safeguarding system, and to understand other agencies, *"roles and responsibilities".*

> *"Joint training, especially around promoting capacity and consent. Because you can have very different approaches, and it's not always from Health and Social Care. They don't consider that somebody might need to be consulted before putting that referral in"*

Joined training may be beneficial around specific processes and protocols such as Child Protection. It would be helpful to ensure all agencies are on the same page in multi-agency meetings and working towards a collective goal. It was felt that safeguarding training had been affected by Covid-19, but it had continued via online delivery throughout and while this was possible, it can help when all agencies physically are together to develop relationships.

> *"The training has gone ahead, we've done the best with the circumstances that we were given, but sometimes if you were in a big room with different agencies, it's easier rather than all of us in a virtual room"*

One LA area noted that mandatory safeguarding training with designated safeguarding leads often occurs every couple of years within schools. In addition, Education specialist from the LA as well as Children's Services staff offered termly training updates and refreshers to reflect current issues. This is a key issue as it was highlighted that training must be something which is revisited, ongoing and refreshed. The turnover of staff from all agencies means that new staff need to be kept up to date with processes, and ensuring new staff can develop wider relationships across the LA. This would link in with the Social Care Wales Social work workforce plan 2022 to 2025, with a key aim within this to 'build confidence in the workforce' and ultimately improve social care (see Social Workforce Plan, 2022).

> *"Staff changeover not only in Social Services, but also in Education, the number of staff that safeguarding needs change all the time, it's hard to constantly address it, because we still have quite basic things that are missed from safeguarding"*

Following on from this were conversations about how training was delivered, particularly due to the impact of Covid-19 meant that training was delivered online. Whilst this was seen as a necessary move for training to continue, given the importance of relationships within multi-agency safeguarding arrangements. Many were seeking for training to be in person to, *"get a chance to mingle, like networking, isn't it? That's missing at the minute".* Moreover, it was agreed that training which was delivered to a group of practitioners across a variety of agencies would be beneficial. For example, by different agencies participating in training together particularly regarding being able to understand different agency roles, responsibilities and therefore subsequent decision making.

> *"We've had Child Sexual Exploitation training and that was around joint investigations with the Police, but it would have been nice to have had partnership agencies within that training because we could have all shared what approaches we take"*

Furthermore, given that one of the main aims of multi-agency training is to "*clarify your understanding on how partnership arrangements work*". Training also allows multi-agency partners to develop strategic relationships. One LA area held workshops in their Early Help Hubs with multi-agency professionals within that locality invited, with the aim to *"launch the Continuum of Need but also to make a start on networking and developing multi-agency relationships".* However, frustrations are apparent given that some agencies take part in silo training.

> *"Most agencies do silo safeguarding training, and it's a bit of a bugbear of mine. The Police quite like to keep it with the people who do that in the Policing point, but you miss the Social Care perspective"*

Practitioners discussed ensuring they were responsive to current concerns and demands within safeguarding by delivering training on these issues and working in partnerships with relevant agencies, *"We'll develop relationships wherever we feel there is something to be developed. Trying to do some work with NSPCC now around sexualised behaviour, that's becoming an issue in schools".* Most mandatory training was delivered online within the LA teams and practitioners would get *"plenty of different circulars",* and reminders to complete training. Consequently, this has moved away from internally developed (silo) inputs and now incorporates a '*comprehensive suite of training'.*

A final issue raised was around the time needed to complete all the necessary training in keeping up to date with any new policy, guidance, or thematic specific training. In addition, the lack of tracking and monitoring of training to capture non-attendance and follow up. Furthermore, comments have been regarding certain aspects of training that are not mandatory for Social Workers in Adult's Services. Despite the argument that perhaps only doing training that is pertinent to the area

in which practitioners work, this has the potential to leave loopholes in the knowledge of practitioners. In addition, further issues were raised regarding potential implications for not enforcing Level 3 safeguarding training to be renewed. It has been noted how changes in Welsh guidance, transferring from a different authority and/or area (children to adults), and length of service, may result in practitioners running into potential issues that could have been easily avoided. Training was felt to be an important activity for all practitioners including newly qualified Social Workers and those with vast experience.

> *"The safeguarding adult training is not mandatory to renew. In health it is, but not for Social Workers. There doesn't seem to be a mandatory annual update safeguarding training for staff in the LA. That's an issue"*

2.5. Service Remit, Capacity, Consistency and Accessibility

> *"A lot of the questions I face from service users is what must happen for me to get help? I know the support is there and I know that I'm in need of it, but when does crisis point become too far gone"*

There were many examples given across Wales of effective multi-agency practice, with much of this centred at the Family First Centres, Early Help Hubs and Flying Start initiatives. The collaboration between these agencies was noted to be joined up working under one scheme, with families able to access a range of support due to Health Visitors having smaller caseloads, more group work and additional intervention such as speech support offered.

> *"The Early Help Hubs which don't hit the criteria for safeguarding concerns, but there'll be an opportunity for third sector to intervene. If it does get embedded and diverts a few of these individuals to parenting lessons, or to have help with their drug referral. Then fingers crossed it's a great thing. However, it will come to funding, demand, and ability to deal with what we're responding to"*

However, a challenge was that was noted in more rural areas is accessibility of these services due to sheer geographic size, with certain wards being able to offer this service. This essential early intervention was noted to be of real value to families but despite this, access to this service was described as a 'postcode lottery'. It was noted that some services are commissioned on the basis that they deliver a wide range of services and while this may be correct, where they deliver them is variable and it was argued that *"the truth is they might offer them, but they don't provide these services in the communities of the people who need it".* Stakeholders noted that if a service is located around 30 miles away, public transport across rural routes could potential entail a counselling appointment taking a whole day, which may not be feasible and is *'setting people up to fail'.* In addition, people may not have money to travel longer distances and that we should be realistic in our expectations of how accessible services are.

> *"Team Around the Family, it's a postcode lottery, rural Wales, in particular, that is a big challenge for different areas and different workers, depending on what their patch is, some people can get all sorts and some people try and accessing parenting and there is no worker because of where they live, it's a shame really"*

Capacity to deliver services and service remit were interlinked in discussions across Wales. It was also noted that demand for all services was seen to have increased for all LA areas. This is against limited capacity and resources to be able to meet the demand, *"Workload's gone in one direction and staff numbers have gone in the other direction".* Half of the LAs specifically mentioned that this demand most often fell with Families First. This was seen to occur for a few reasons. First that thresholds for Child Protection were increasing due to the higher demand, resulting in less reaching necessary intervention within the Children's Team. Furthermore, those practitioners working within these Families First centres were aware of this likely outcome, so were holding onto *'more complex and high-risk cases'* knowing that it would be stepped down to them anyway, and that by continuing to work with them they were *'at least getting some support'.*

> *"We've noticed particularly since the pandemic, referrals were getting more complex and we're having referrals from families with lots of historical involvement with Children Services, perhaps Child Protection"*

However, differences were observed regarding if thresholds were rising as some practitioners viewed thresholds as being static, and it was whether resources could meet demand, *"The thresholds don't change, it's the ability to cope that does, whether it meets the threshold for their services or not".* Capacity and service remit concerns were raised when discussing Health Services, such as Health Visitors and mental health support. This was seen to impact on the ability to achieve a multi-agency response as when a referral comes in for a family and the support from one agency is dependent upon another, it can limit what different agencies can do when expert input is required.

> *"We're less reliable, a few years ago we were able to ask Health Visitors to visit weekly to check families, they're not in a position where they can do that at the minute. We must accept and understand that if they haven't got anyone, they haven't got anyone"*

Demand has been noticeably increasing, even before Covid and this has impacted upon access to services.

> *"It's been a nightmare because mental health thresholds, over the last few years even before Covid, were just going up and up. It was like you've almost got to be dead, it's like you've got to have killed yourself, oh then we'll look at you"*

The sheer lack of accessibility for children's mental health support was prominent within interview discussions, "*You're bashing your head against a wall all the time because CAMHS are not available because they don't have enough workers".* The lack of partners working in children's mental health is affecting the support available to children. Moreover, this is further reflected in that partners working

in mental health are unable to attend multi-agency meetings for children they are supporting due to service demands.

> *"There are very little children that are assessed and that have support, we often feel that we are banging a door that just doesn't open. I don't think in my whole career ever had a Mental Health Worker come to any multi-agency meetings for the children that they are working with, and I think it is the lack of staff that they've got"*

The demand for mental health support for adults and children is increasing and the current service is not meeting the demand. There is a need for more partners working in mental health, *"100%, that's top of my list. We need more people to help us deal with mental health".* A good example within one LA of adapting to demand and providing support to adults is through developing a meeting arrangement to provide specialist support for attempted suicide, *"I'm working on a project now to have significant attempted suicides brought into a meeting arrangement, so that we can provide support to those who are impacted by an attempted suicide".* Additional concerns were raised about mental health support capacity regarding Adult's Services as some services go up to 25 years only.

> *"What we haven't got is community mental health for anyone over 25. I've took up to 21-25, if they've looked after children, if they've been in care, then we've got somewhere they can be referred to. But anyone over 25, "Oh, hang on now. What can we do for these people?"*

In addition, even where there is eligibility, waiting lists are long and optimal support is when it is accessible at the right time.

> *"It's all about the right support at the right time. There's that disparity between getting in there when you need to get in there, and then telling the Mum that, "Actually, you'll have to wait six months before you're going to get any therapy"*

There was also discussion around the need for hospitals when discharging patients to ensure care plans are in place. Participants linked this to issues around capacity and pressures being felt across all universal services and a, *'huge issue which is all linked to the lack of care'*. That the need to move patients on resulted in people being discharged without approved and reviewed care plans, with concerns raised about the safety of individuals. This also highlights on competing pressures between agencies of Health and Social Care.

> *"Hospitals are putting pressure on us to find care that just isn't there. And then we're coming back to hospitals, "Why have you just discharged that person when, clearly, that wasn't safe?" And they will have pressure from above because they've got to get the beds empty"*

Linked to theme 2.3 discussing thresholds, it was also noted the changes that can occur to thresholds within services due to demand and capacity to respond. A surge of referrals was seen to subsequently affect referrals that reach threshold.

> *"They need to invest in the service and then the threshold would be able to be consistent. If there's a high demand on the Social Work teams then that threshold is going to be potentially raised, so, they can manage the number of cases, because if you have 50 cases come through*

the door on a Monday morning, and you've already got Social Workers near to burn out, then they're going to raise the threshold"

Additional service capacity and service remit issues were raised regarding the lack of residential placements being available. The noted changes over the years in lists from the family placement team of foster carers available *'used to be a 2–3-page document'*, whereas now this was noted to be *'two or three names'*. Participants suggested that this may lead to a high-risk situation of young people left in Police custody due to lack of appropriate residential placements.

"They're sitting in a Police Station, and we've got nowhere to put them. They could be in a Police Station all night. Well, that's not right for a child. So, resources have an impact"

In addition to the provision of support services being available only in certain areas or limited in its remit/capacity, there was observations that funding can sometimes be last minute and available only for a limited time, such as at the end of the financial year when grant money needs to be used. This can result in the LA paying for activities such as karate or swimming lessons for children and young people, which whilst enjoyable, is not helpful or conducive for sustainable outcome. Any benefits from engaging in these positive activities is temporary adding to the inconsistency of service delivery and support.

"If you're telling a family, 'We've got this mountain of money and we've got things that we can get you, what do you want', but then maybe first week of April, you're going to be saying, 'Do you know what, we haven't got funding for that anymore'. The message is so inconsistent. Because if you want sustained change, you must put in the resources"

The short-term and postcode lottery of funding services, particularly regarding early intervention was felt to be unhelpful and a wasted opportunity. It was noted how these may get worse as practitioners noted they are *'doing more with less',* and *'there is only so much creativity'* that can be used. In addition, it was argued this could "*be avoided if proper early intervention and proper kind of support structures were put in place"* to prevent families having later involvement with Social Services and crisis teams. It was highlighted that whilst these specialist services and activities are indeed valuable and necessary, the funding is *"not new funding, they take the funding away from core services",* and so issues around accessibility and consistency need to be considered. Moreover, service providers must have realistic expectations of what is reasonable, for them to be effective. Good practice included when the practitioner based themselves in a location to eliminate travel for the service user or working within people's homes to ensure that their support service was accessible.

Other points of good practice to buffer against issues of increasing thresholds due to service remit and capacity, allowed some LAs to develop policy around repeat referrals. One LA had set in place a 'three report benchmark' within their MASH. This was seen as particularly effective in being able to review frequency of reporting against an individual, with their processes requiring an update

on the individual. This was often the result of single point of access referring the individual to the community mental health team, but nobody within the multi-agency safeguarding arrangements receiving updates as to whether *'this had been actioned or just filed away'.* All LA areas did note that within their Early Help, Families First provision, they felt able to escalate if necessary and ensure actions in supporting the individual/family were agreed, *"If there are several incidents that don't meet threshold, we would look at escalating if they've been three or more referrals that don't meet threshold".* Although previous themes have highlighted a better approach when considering submitting a safeguarding referral is to consult with the relevant MASH/SH team first, capacity issues within these teams may make the referral submission an easier process to 'double check' that they are doing the right thing.

> *"We know that it is not meeting threshold, but we go to [MASH] sometimes to double check that we are doing the right thing, and then it comes back to the Social Worker for a case management role. We would investigate what the allegation is and address it via Social Work rather than it being dealt with via safeguarding"*

3. Partnership Working and Collaboration

Partnership working and collaboration between sectors, agencies and practitioners was a fundamental underpinning factor in successful multi-agency working. In addition to *statutory services* collaborating, there is an understanding and recognition of the integral work of the *VCS* and requirement to ensure collaboration includes VCS organisations. *Established relationships* were seen to be facilitated through *workforce stability* and sustained effort within and across agencies. Finally, *professional challenge* was discussed by stakeholders as a part of successful partnership working, allowing for the best outcomes to be achieved for those accessing services.

3.1. Voluntary and Charity Sector (VCS) and Statutory Agencies

Stakeholders observed a mutually beneficial working arrangement with statutory agencies and the VCS or third sector, with positive relationships between the agencies described. In some LA areas, it was highlighted that VCS sector organisations have an important to role to play within the multi-agency safeguarding arrangements. This was clearly a commitment to ensure that VCS agencies are valued not only for the service they provide, but also providing a platform within the more formalised meetings to give them a voice. From the VCS viewpoint they feel valued for their voice and being part of the multi-agency safeguarding arrangements which has been achieved through, *'hard work'* and a *'change in our strategic direction and key priorities'.*

> *"We're a voluntary agency but we're not made to feel any less important within those systems. On the contrary I think people come to us for that specialist view. It is a partnership where we feel valued for our contribution"*

Moreover, established relationship between VCS sector agencies and strategic level partners in the multi-agency safeguarding arrangements contribute to the VCS sector partners feeling valued, *"It's established relationships we have a long-standing Head of Service, and Lead for Exploitation. Our relationship makes that an easy process".* Where DA services were contracted to the VCS, it was noted that IDVAs were viewed with the same professional status as Social Workers.

> *"The professional status of the IDVA gives them confidence, they see themselves on an even keel with the Social Workers. I think that's taken a while to be honest but because we've been so invested in, we've been lucky. It's created a culture where the IDVA's voice is as important as the Social Worker's"*

The role of VCS as part of formal meetings and within the structures of their safeguarding arrangements was seen to be essential, given they were often the agency with the established relationship with the family/individual. Bringing those practitioners into these meetings to be part of any joint decision making was seen as providing plans and actions that were achievable and realistic for those that were being supported. The representation of the VCS within these meetings tended to be based on the service and practitioner that was supporting the case being discussed, rather than VCS being a permanent feature of the arrangements.

> *"Depends on what that person needs and who's identified with that person. There isn't always a set attendance, people are invited, who are specific to that case, and voluntary sectors are invited, if they are working with that person"*

In some instances, VCS were more involved as a permanent feature of key meetings and groups, rather than brought in for individual cases, given their expertise is not just on an individual level. They also have greater awareness of community vulnerabilities and effective ways to engage with individuals and communities. This is beneficial at a strategic level, although this was not standard practice everywhere.

> *"I am third sector and I do represent a sector rather than an organisation. But they do invite, and they don't always come, the co-ordinators of the VCS in the three different regions, but there's nobody else like me that goes. You wouldn't have VCS, perhaps mental health being on the board groups"*

VCS agencies were also seen as essential partners to statutory agencies. Linking with the specialist skills and working arrangements provided by VCS, specifically on an operational level, there are specialist areas within the community whereby the VCS can offer knowledge and skills which enhance a range of support offered. By addressing gaps within services that are often not *'burdened by the same level of procedures and protocols'* as statutory services can allow for more flexibility.

> *"We've got Community Connectors within those teams, which are employed by the third sector. Their role would be to try and look at what's available within communities, what's not available, where are the gaps? So, we try to develop services within the area"*

Furthermore, it was identified that VCS organisations may be more effective in working with statutory services in supporting certain types of vulnerabilities and exploitation. For example, one LA area highlighted difficulties when responding to harm outside the family home, which may not be as well supported by the traditional Child Protection system and it is, therefore, difficult to provide support. In achieving this, a range of services and professionals worked together to provide their professional insights and respond.

Much of the VCS involvement in LA safeguarding arrangements was seen at early intervention level, through the Early Help Hubs, Families First Centres, and other initiatives such as Flying Start. Here the engagement and involvement of VCS practitioners was seen as essential in providing support within the community to "*reduce the number of children and families requiring statutory services".* However, it was also noted that often these early intervention services were left in precarious positions when trying to support families and young people with additional needs. It was noted particularly that due to demand and resource issues within Health Services, children and families with disabilities and additional needs were falling through the gaps. Early intervention services often work on a time limited basis and were recognising that the thresholds for specialised long-term support were too high. This then left families and young people with no support after engagement with their 12-week programme. This was seen as the biggest issue in being able to work in partnership with those key safeguarding agencies.

> *"When it's at a point where, we've done as much as we can do, but the needs exceed. We have children who were kind of left without services that can support them and that's not always around safeguarding issues. That's around the support that they need in order to be as independent as they can be according to their disability. That's the biggest gap"*

In addition to any early intervention services there were specific thematic areas where VCS involvement was seen to be more prominent as part of the wider multi-agency response, with this mainly centred on DA services. All LAs described key relationships with DA VCS who were part of their safeguarding arrangements, with some more formally part of Safeguarding Hubs (e.g., the DA Hub), and others part of services within the Families First team and within the community. Here the DA VCS discussed being a rarity in terms of VCS representation as part of the LA safeguarding meetings. An IDVA interviewed in one LA area reported that there were strong relationships, and this was attributed to an inclusive management style whereby DA is recognised as a key area in safeguarding, and having the same management structures meant they felt *"very much immersed into the Children Services".*

Some LA areas were also recognising below threshold vulnerabilities and working with VCS in providing services such as substance misuse for under 18s in trying to reduce later more critical issues. Moreover, through use of Community Connector roles where the LA work with the support service, whose role is to identify VCS organisations that can support the various needs within the community.

> *"Their role is to look at what the third sector can provide to support families, children, and adults, but one of the things that we would do is we'd work closely with (Name) to ensure if there are third-sector organisations offering provision, they develop some form of provider list, who have gone through proper safeguarding checks and regulation"*

Most LA areas still described a limited presence of VCSs, with this linked to those LA in rural and large geographical areas of Wales, but also, most importantly, the demand on these services within local communities The rural nature of some remote areas resulted in a lack of presence of large national charities, which were found in bigger cities, so this support is lacking. Due to the nature of demand and variable thresholds due to this demand (see 2.5), this was putting more pressure on VCS and community services and their response times to those in need. Obtaining advocates and accessing peer support services was also noted as problematic due to waiting lists. It was highlighted that these waiting lists were not helpful when operating an early help service and that services were already *'over our limit with referrals'.*

> *"We don't have as many different national agencies within our location. So, the likes of Barnardo's, NSPCC, etc., because of our rural location it's not particularly economic for them, given our size, to co-locate or locate in our area"*

The inability to respond at an early intervention point with those VCS and community services was seen to then have a knock-on effect with these vulnerabilities likely to escalate, and therefore end up in safeguarding.

> *"DA providers within [LA] don't really exist, and when you look at the size of contracts that we've got, the amount of money that's available, it's difficult to get new people on board, and so, the LA either have to provide those services ourselves or there's limited provision, and I think there's limited provision, and that's a risk in itself, you haven't got the expertise, you haven't got the wraparound support that some of these families will need at that preventative level, so things escalate and then you're having to deal with them within statutory services"*

Clearly further investment to meet the demand of early intervention services was a clear request from those interviewed across Wales to respond to the significant increase in referrals that has arisen since Covid. Furthermore, even when there was additional funding available to LA areas, it was the inability to plan the use of this in collaboration with VCS to respond to vulnerabilities within communities, in a more sustained and evidence base way, as funding was not sustainable.

> *"In March you see loads of traffic works going on. Because all the councils are trying to spend their money before the end of the budget year. Well, it's the same with Welsh Government funding. I had to go out and find the agency and say, "Can I pay you all upfront, please, and can you give us a service for two years?""*

3.2. Established Relationships and Workforce Stability

Multi-agency working was noted to be dependent on the relationships between practitioners. These relationships were said to be effective due to being *"very mature and respectful"* which in turn fostered the development of new relationships. As mentioned under Leadership within Theme 1.3,

the stability across the whole service including the leadership team was seen to enable effective partnership working whereby practitioners are familiar with structures across areas. Some even took this further by stating the stability, and therefore established relationships, were seen across their region.

> *"We've got a relatively stable population, in terms of Senior Leaders. So, we're able to spend time building and maintaining those relationships, we know one another very well. We know what the structures are across the region, and so communication is good"*

The established relationships also allow for an opportunity to build trust and respect, offer advice and work collaboratively across a range of tasks, *"We will give each other advice. We can phone up and say, "Look, I'm a bit unsure about this", and trust each other in that sense".* This allowed for practitioners to reach out for advice when unsure about thresholds, or concerns. This subsequently ensured those referrals being received are more likely to be appropriate referrals that require review and action. Therefore, allowing the prioritisation of those cases that require immediate support.

Some practitioners stated making the effort to have informal conversations allowed for the development of relationships between practitioners. Thus, enabling better access to information and greater partnership working, particularly in the absence to co-location.

> *"It does pay off being a pain, saying to someone, oh, could I use your bathroom? Oh, could I use your cup? Even though you possibly don't need to, but it gets your foot in the door, it gets you seen. That's the same with GPs, I have very good working relationships with most of the GP practices in our area. I have spent time talking to reception staff, the practice manager, finding out a little bit about them, who they are, where they live, do they have children? All this communication opens a few doors"*

Furthering the importance of face-to-face interactions, practitioners were positive regarding the benefits of being co-located at the Single Point of Contact, which includes the Integrated Safeguarding Hub (see Theme 2.2 for further information). This has been a successful mechanism in which multi-agency partners have been able to communicate with ease and have a better understanding of other partner's roles. When co-location was not in place, or a hybrid model of working, ensuring the structures in terms of oversight of key agencies allowed relationships to develop.

> *"We commission services to work alongside Early Help, so although they're not co-located, we do have really good relationships with them, and it helps that the services all sit under the one Principal Officer"*

Rural LA areas seemed to report higher stability within their multi-agency teams, particularly within their Social Work teams, which was seen as a significant factor in developing relationships across sectors and increasing cooperation. Moreover, rural locations may be a contributory factor to workforce stability in that there were less options for people to move around and having little resources, therefore having to *"work creatively together".* In contrast, in some LA areas there was a high turnover of staff within Social Services (also discussed in Report 1 – Literature Review). This was

felt to be disruptive for the families they were working with and more challenging for receiving updates for information and having that 'go to' person when working in a multi-agency capacity. It was also felt that agencies were also not always informed when a Social Worker had left and who was taking over their duties. This could cause delays when trying to ascertain information updates, required by other agencies.

> *"They may only be there for a month and then they're gone again. For maintaining that effective communication and ensuring that everything's done, it doesn't necessarily take place, but I think that's due to the pandemic. It's due to the environment, stress, and being ill"*

This was also mentioned as an issue in Police representatives, as due to promotion processes, often a key member of the Police will be established within the Safeguarding Hub/MASH or be the point of contact for additional queries, but would regularly move on.

> *"You'll get a Chief Inspector, or an Inspector in post, and you'll do an excellent piece of work with them, it's all rocking and rolling and they move somewhere else and bring someone brand new in. Whilst the new person doesn't come and change anything, it's like you've got to start from scratch again"*

As mentioned within Theme 3.1 regarding involvement of VCS, the issue of funding for some key partners and initiatives also causes issues in establishing relationships across key safeguarding partners. The high levels of changeover of staff, or sometimes complete removal of services, can lead to gaps in service delivery whilst other pathways and connections are made, *"the annual recurring kind of funding, it doesn't lead to stability. They come, they go, it leaves gaps".*

3.3. Professional Challenge and Reflection

> *"Mutual respect for each other's professionalism and responsibilities. We all recognise we have a job to do and we're all here to serve the public and the people that we we're obliged to... We don't come into the job to do harm to people, we want to do the best we can for everyone. But we're all coming at that from a slightly different perspective, and I think it's just learning to walk in each other's shoes can take some time"*

Although many practitioners reported relationships are established and that practitioners and agencies work well together it was noted that this does not make the various stakeholders *"yes people"*. It was felt that in order to best support service users and families, different agencies had to advocate for what they felt was the best course of action for their service users in accordance with policy.

> *"Ethically, we're working together to develop an understanding of the principles of the safeguarding features under the Social Services Wellbeing Act. I think it's a healthy debate for challenge"*

The Safeguarding Procedures were a helpful tool in promoting challenge and placed the emphasis away from individuals and more about collaboratively following the procedures independently and assessing all stakeholder's contributions.

> *"It's about being able to challenge that in a professional and respectful way and having the tool to allow us to do it. So, it's not making people feel, oh you're being difficult for the sake of being difficult. It allows us that independence and give the pros and cons of everybody's decisions and then try and come to a solution"*

It was stated that ultimately, challenge within safeguarding was a necessary part of the job. Many practitioners clearly articulated that they were comfortable in their ability to challenge decisions when necessary *'to hold those discussions and this is really important that they take place'.* It was noted that there is often a degree of confidence required amongst agencies which allows individuals to express their opinions and concerns in a safe environment. Challenge was noted as being a two-way process: *"I've challenged people I get on with very well and they equally challenge me as well".* Ensuring there are clear processes and protocols to employ should professional disagreements require additional support for resolution, was key, particularly during outside informal conversations. Having robust protocols in place allowed for a basis to initiate more informal conversations and enabled practitioners to feel comfortable to escalate any concerns. Other areas had specific protocols for resolving professional disagreements and disputes which can be utilised should debates not be resolved during a meeting.

> *"You have to challenge because the job is about safeguarding, we don't always see eye-to-eye, thresholds can be different but it's about how you manage those professionally, isn't it, through professional difference, the protocol which we've got"*

Importantly professional challenge was seen by some LA as a positive part of their multi-agency safeguarding arrangements. That professional challenge is a necessary learning requirement to ensure continued effective, holistic safeguarding responses. By expanding and encouraging professional challenge to not only statutory but also to those key VCS agencies around the table, this is seen to have a huge impact on practitioners feeling valued.

> *"It's a good learning environment by encouraging us to have what could have been difficult conversations like talking about a case saying, "Actually I wouldn't have done that", but in a way that it doesn't impact our relationship. We're very much trying to push it's all about learning as well as developing"*

4. Staff Investment, Recruitment and Retention

> "*When you've got staff that have been repurposed, and you're still running a service, that's difficult, isn't it? It's like the swan effect, above the water everybody is looking fine but underneath, they are peddling like nothing on earth"*

There was a recognition that working within multi-agency safeguarding can be an incredibly stressful job. Investment into staff support and ensuring their wellbeing is nurtured, is vital. In addition to a rise in demand for services it was also highlighted that there was a shortage in staff and issues around recruitment of new workers as well as retention of existing staff.

4.1. Recruitment and Retention

> *"There must be a drive to have a national pay scale for Social Workers because we're competing against each other. It's not doing anyone any good. There should be something done about Social Work agencies and the way that they rip us off"*

The recruitment of new practitioners was felt to be hugely challenging and that this was an issue even before Covid-19 with university courses reporting lower take up of places. It was felt that since Covid 19, people are revaluating what they would like from a career and contemplating a job in Social Services for example, when arguably *"we are expecting them to give 110% every single day".* This was seen to be further worsened by the fact that the recruitment of Social Workers is a national issue, which is resulting in LA competing against each other in recruitment.

> *"I think now people are making more choices about working in other sectors or doing something different because it's tough. It really is tough"*

Some LA areas seem to have higher rates of staff vacancies for Social Worker roles than others, with this seen to be linked to the geographical location of the LA area and cost of living in some areas. Despite recruitment campaigns, recruitment remains an issue with one area noting they only had 1 new applicant in 4-5 months despite having adverts out *'constantly'*.

> *"When you're at the western extremities or northern extremities of any country you're at the end of any line around recruitment. We haven't got those large cities where you get the next students or trainees who come through and fill those vacancies. Also, what you have is an area which is particularly costly to move into. So, it's another barrier for newly qualified staff"*

The reliance on agency staff was also felt to be negative as not only did it cost huge counts of money for the LA, but it also meant that any work was temporary and within Social Work and multi-agency working. Stability and consistency in relationship building is paramount (as discussed within Theme 3).

> *"When agency staff were moving around, jobs were not done, tasks are not completed. The aftermath is there still a recruitment issue. People are not willing to work for minimum wage when conditions are so poor. The job is so hard"*

In order to encourage recruitment and facilitate practitioners becoming qualified an increase in bursaries from the Welsh Government is needed. On a local level the authority is sponsoring individuals to become qualified and gain the necessary experience, however, this was recognised as a long-term solution and does not address the current shortage and investment that is needed now,

"We know that's not a quick fix, but it's about trying to establish a workforce".

It was noted that common themes in serious case reviews included a lack of communication and often lack of staff, *"The same old things come out of those reviews all the time, no one ever does anything".* There must be an equal focus on retention as well as recruitment. Whilst many teams felt stable and that they mainly lost people to promotion, or to other LA areas that were offering a better package. It was also stated that in some LA teams where there was a high turnover of staff and issues such as pay freezes for example, are not an incentive for a *"very stressful job".*

Additional challenges were identified when the incentives to recruit provided better packages to the new staff rather than the current work force, thus making current staff feel undervalued for their continued commitment (discussed more in Theme 4.3 below). This not only caused problems across LA teams, but also with neighbouring LA areas.

> *"Our LA has decided to make enhanced payments for Social Work frontline staff where there's difficulties in recruiting. Some of my team struggle with that because they feel that they work just as hard, and why should one get something, and the other ones don't"*

Given the importance raised around Families First and Early Help Hubs in responding to the huge volumes of demand just below thresholds, it was also noted by practitioners within them that often staff within these roles are employed on a fixed term basis due to funding grants. This can cause significant issues in the recruitment and retention of staff, particularly when there is investment in each practitioner that joins the team due to training requirements. Although, it was also noted that this team had received notification of funding for 3 years very recently. This was seen as a significant positive movement in maintaining their service to their community.

> *"People want certainty whether they can pay their mortgage next month, and I don't blame them for moving on if they can find something permanent. But it does mean we're stuck in this constant cycle of recruitment and training"*

4.2. Practitioner Wellbeing and Support

Staff wellbeing was felt to be a poignant issue, particularly after the Covid-19 pandemic where much discussion centred on staff feeling that they were reaching levels of burn out. This was the result of working through Covid-19 over the last 2 years, trying to support those communities and individuals with reduced visibility, whilst also trying to manage their own families, health and wellbeing, *"people worked and worked and worked and people's emotional health has been suffering".*

There were many examples of flexibility and support from leadership and management which ensured staff wellbeing was responded to. Examples included flexible working, regular checking in and providing opportunities for practitioners to debrief. There were also examples of informal meet ups online whereby work was not an agenda item and gave staff space to simply catch up and try and inject humour into the situation to *'lighten the load'.* There was also a recognition that performance

indicators would not be prioritised and that the support was to simply help practitioners to keep going, letting people offload their worries and supporting them.

> *"My focus totally changed from doing the normal work to just keeping them going. We had a coffee catch up every couple of weeks and they could come in and scream"*

There were many elements of good practice for supporting practitioner wellbeing. These ranged from formal wellbeing strategies to informal weekly Team meeting drop-ins with practitioners. Many stakeholders reported finding the meetings useful and found it was worth persevering with. It was noted however, that face-to-face support is preferred, *"There's no substitute for that kind of moral support, putting an arm around someone or making a cup of tea".*

Other supportive interventions included regular clinical mandatory supervisions, some with qualified counsellors and psychotherapists and this was within statutory and VCS organisations. Other formal interventions included Trauma, Risk, Intervention Management (TRIM) which involves a briefing after a traumatic incident, a one-to-one supervision session and a follow-up. This was stated to be different from counselling whereby the focus is, *"allowing people to say what they're thinking at the time and how things affected them and normalising reactions and responses"*. In some agencies there was a designated wellbeing room for staff to use and one stakeholder noted that they had a masseur perform massages for staff, as employers recognise the stressful impact which safeguarding work can entail. TRIM was adopted by different statutory agencies in different areas.

Other agencies provided Resilience Training which was a spoken highlight and related to managing situations outside of work as well as in work, and it was felt this should be rolled out further than managers. Other packages of support included Care First, for practitioners to be able to speak to someone independent about their wellbeing. Whilst most stakeholders felt their employers were supportive of their wellbeing and that managers were approachable and receptive to supporting practitioners, especially for providing formal support such as Occupation Health access to counselling. It was suggested that more could be done before staff reach a crisis point, mandatory support to check-in on people which could be signposted from HR. For some LA areas this was felt to be done effectively by line manage, "*I push my keyboard aside and say, "Right, just tell me how you're doing." And I make sure it's not a token gesture".*

Within the Police it was noted that there was a mandated yearly wellbeing assessment with a counsellor, which was noted to be helpful and well received. It was noted, however, the support provided in some LA areas via Occupational Health were very poor, with huge delays to have an assessment.

4.3. Recognition and Feeling Valued

In pulling together the issues of recruitment, retention and practitioner wellbeing, was the importance of staff recognition and feeling valued within their role and team. This often centred on simple, but important ways in recognising an individual's contribution and taking the time to show interest in them as a person.

> *"I feel valued with my team and the people that I work with, and I hope that they feel valued with me because I'm a very strong believer that I will always ask them about their family, and how things are at home before we talk about their cases"*

Partners also spoke about ensuring their team had the opportunity to input into key decisions. This was reflected in allowing partners to feel their voice is equal to other partners within the multi-agency safeguarding arrangements. This was evidenced in everyday work by ensuring inclusion in decision making, and in more formalised events, where individuals are celebrated for their commitment and achievements.

> *"The event we had celebrating the success of individuals and teams in relation of their impact, particularly during Covid. It had a huge impact. It made people feel valued and recognised when otherwise they may have been lost"*

This was further reflected in the following quote whereby a partner appreciated having a celebration day to take as leave, which made them feel valued for their work, *"It's those little things that help us to feel appreciated".* Although there was lots of talk where staff felt valued within their working teams there are areas in which staff felt their role and continued contribution was not valued, with this centred on those individuals that had provided a long service to their organisation.

> *"You don't even get a chocolate watch, after 20 odd years, you don't get any recognition for not taking any sick or coming into work when you're bad"*

Furthermore, partners felt there are inequalities between different roles which had a knock-on effect with partners not feeling valued for their role and contribution. This was reflected in the following quote which shows there are inequalities between Adult and Children's Services. Partners within Adult Services do not feel valued due to the lack of understanding of the pressures they face within their role.

> *"Children's Services, for example, there's talk about the golden hello when they join the service and a bonus when you stay, that's not been offered to Adult Services, and we've got the same pressures in terms of staffing that they have. So, I know people are feeling a bit deflated"*

Moreover, partners felt there are inequalities in the terms and conditions of partners from different services who are co-located and completing similar work. This led to some further discussions about a lack of understanding and value of some of the multi-agency safeguarding partners' roles. Partners spoke positively about the importance their role plays in ensuring effective safeguarding and there is sometimes disparity in this recognition and pay scale, despite all being key safeguarding partners.

> *"It's the difference between our terms and conditions for employees, we've got Support Workers working alongside LA Support Workers, and there's about a 5-to-6000-pound difference in their salaries. The terms and conditions need to be equitable, when we are co-locating and doing like for like work"*

> *"If you miss that Youth Worker out, you're missing a trick, because they know what's happening in that area. I don't think we give a Youth Worker qualification as much justice as it deserves"*

A disconnect from senior managers and those more operational staff was noted in one LA area. They noted that they were fighting against a staffing crisis of Social Workers and staff in frontline and operational roles, yet significant investments were being made to senior management roles. This was worsened when these roles were not seen to be advertised or offered to current team members, and when senior managers were further promoted, they were replaced by outside staff. This led to the staff member and their team feeling devalued.

> *"How they can justify spending all that money on another layer of senior management. People on the ground are looking for scraps to try and survive and they're paying an outside agency"*

Finally, practitioners felt that the Social Work profession was *"very undervalued, both by ourselves, and by the public, for lots and lots of different reasons".* This was further reflected in the following quote which shows how partners felt that there is a lack of understanding and negative stigma attached to the role of a Social Worker. This stigma and lack of value severely affects their working relationship with service users and can over time impact on practitioner wellbeing.

> *"You'll only ever see a bad paper on Social Work and nothing about the good and it doesn't help in terms of the way in which we support and work with families"*

5. Impact of Covid-19 Pandemic

The impact of the Covid-19 pandemic has shifted the landscape in service delivery for multi-agency working. The restrictive measures such as social distancing and lockdowns have resulted in an *escalation of risk and increased need* for individuals requiring support. Alongside this there is post-crisis exhaustion, which has left families and individuals with reduced levels of support and isolation when service support was reduced, as well as professionals and practitioners fatigued and at risk of burn out. *Service adaption* was an inevitable consequence of continuing to meet these needs and address risk, whilst remaining in keeping with the legal restrictions. *Remote working* has been a valuable contingency plan for continuation of service but has also posed as a huge *challenge* with respect to delivering services, and for those accessing support. Yet, innovative practices have been developed and adopted as a result of having to work remotely and *benefits* to this model of work have been reported.

5.1. Escalation of Risk, Increased Need and Service Adaption

There was a notable lack of visibility of individuals and families who may have needed support during the lockdowns of Covid-19. Services were reduced and public buildings such as schools were closed to mitigate the risk of the virus, with people told to stay at home. This resulted in a significant lack of support at a time when the pressures of being asked to remain at home were increased for individuals and families. Whilst steps were taken to ensure multi-agency safeguarding responses were still active in dealing with concerns, these obviously prioritised *"those most high-risk cases, leaving much of our emerging risk invisible".* It was highlighted that making these decisions was stressful and added a lot of pressure *"because you're doing it all blind".* It was noted that safeguarding risk increased significantly, whilst visibility decreased.

> *"We removed our preventative flags in that suddenly things that helped us prevent a situation escalating for families were gone"*

Due to universal services such as Health Visitor checks being scaled back and routine procedures such as injections postponed or delayed this resulted in *'an awful lot of eyes in the community'* being lost. It was felt that alongside the lack of visibility, cases involving neglect across children, but also self-neglect within adults increased, and even now services feel they have not got the full picture of the scale of harm that has occurred. This may suggest a need to build in more systems-based work in monitoring the risk profile in communities to understand any key changes that occur (to help understand those that might be more hidden/missing). But also recognising the potential accumulated unmet need and risk that has likely escalated in this period, resulting in increased complexity due to lack of visibility and support.

> *"We were picking up across the across the region, severe neglect and serious issues of children that we probably would have picked up on if the Nurses had been open. I don't think we've got the full picture of that yet. There's probably more out there"*

The result of the lockdowns was felt to be that consequently there is an increase in need which has developed due to the escalation of risk. In addition, cases are felt to be now more complex, *"there is a massive increase in issues with young people and workloads. Care and support are much more ingrained and complex".* Whilst initially referrals decreased during Covid-19, most likely due to the lack of visibility of those who may have required support, this was then followed by a significant increase in referrals. Most LA areas have stated this has not returned and stabilised to pre-Covid-19 levels and that the *'floodgates have opened',* with *'no signs of let up'.*

Concerns were furthered in that the reliance on universal services such as education to be *the 'line of sight to receive disclosures',* but many children have not re-engaged with school since the

Covid-19 restrictions have ended and are felt to be a *"lost generation".* Within Adult's Social Services, the impact of the Covid-19 lockdowns was described as *'terrible'.* Older people living in residential homes had not been seen by professionals and families for a substantial amount of time. This lack of contact resulted in a lack of visibility of service users as families often are the people who report safeguarding concerns. This was also true for service users who lived independently, but who are reliant upon community services for care and support.

Whilst statutory services maintained that some face-to-face working was still operating during lockdown, other VCS organisations felt that they had more responsibility as visits were reduced by statutory services. They did acknowledge that the statutory services were also *"inundated with referrals".* It was, however, noted that in some instances there were a reduction in referrals such as those for DA and referrals for refuges. However, it was not felt that this was due to lack of risk but more that there was less opportunity to seek support, *"the message is to stay home, it's an ideal situation for a perpetrator, isn't it? It's total control".*

With regards to adapting to restrictions, it was noted that multi-agency working was imperative, and it was vital that agencies who were still seeing service users to be able to share information regularly. Health agencies were particularly valuable during this time and practitioners being *"mindful of every visit"*. There were also examples of good practice such as daily meetings to share information and WhatsApp groups were also set up to share information between practitioners. In instances whereby meetings had to be cancelled due to other priorities, such as within Health, there were mitigations put in place such as, *"producing reports with key information, key actions and RAG rating them so that there was no drift, we were maintaining momentum with our work".* RAG rating systems were commonly used across LA areas to help determine levels of support and oversight required from agencies, with the frequency of multi-agency meeting increased to ensure effective information sharing. However, there were instances whereby delays in sharing information have impacted upon other practitioners meeting deadlines for assessments, in particular Health services.

> *"We have a duty within seven days of the report, and that has slipped over the last two years because we struggle to get information from the hospitals"*

A particular concern post Covid-19 was the effect it has had on carers. Many discussed that more carers are reaching breaking point, after the last 2 years of caring with reduced support. This has resulted in the care that was being managed within the community prior to Covid-19 now being brought to the attention of statutory services. It was felt that need intensification had accumulated and the requirement for support was now urgent, but services are reported at *"breaking point from the number of referrals".* Moreover, work needs to be caught up on from when only priority needs were able to be responded to, including paperwork which needs *"considerable work"*.

Good practice was noted by one LA who changed their essential visit criteria to enable them to work with a child or young person to prevent the escalation of need whilst adhering to the Covid-19 restrictions. Moreover, one LA area discussed their service adaptation at early intervention level recognising their limitations in their use of indoor space during the restrictions. They contacted local schools and arranged to book out their playground spaces. The huge benefits this likely had on the families at the time and as we emerged from Covid-19 is difficult to capture, but recognising the increased stresses being experienced behind closed doors and still seeking to find ways to support this 'below safeguarding threshold' concern was vital. Providing support to families and young people through new methods during Covid-19 restrictions was imperative. For example, agencies used social media accounts such as Instagram to communicate with young people, with also increased engagement with young people within their spaces. An example of a service adaption was given where the practitioner moved their visits with a young person to a skate park, which subsequently increased the level of engagement, *"He's talking his head off telling this Social Worker everything because there was no eye contact".*

5.2. Remote Working: Challenges, Benefits and the Future

Services have adapted to Covid-19 by offering support and working collaboratively online where possible and there have been many advantages to this adjustment. The main advantage highlighted was that practitioners were able to deliver services or remain in some form of contact with service users remotely. Practitioners could continue multi-agency working in a virtual capacity and therefore meetings to sharing information was possible. Also, the lack of travel was stated to be very convenient for practitioners as they could use their time more effectively and not lose *"half an hour each way"* commuting.

Stakeholders noted certain agencies such as the Police, previously have struggled to attend multi-agency meetings due to the nature of their work, yet there is *'no issue now really'* and attendance has increased. This is also true for the health sector with consultants from hospitals attending meetings, which was not always possible when this required face-to-face meetings. The move to virtual meetings on Microsoft Teams was observed to be *'here forever with us now'* as it is an efficient way of working. In addition, the frequency of meetings has also been increased therefore support can be put in place quicker.

For some LA safeguarding teams, working from home was available prior to the pandemic and therefore they felt well equipped to make the transition from face to face in the office to online. However, it was highlighted that it could be intimidating chairing large meetings on Teams, especially when people have their cameras off and it was stated that *"you don't get a lot from facial expressions, from nodding of the head".* The informal conversations and debriefs which practitioners often had

experienced before and after meetings rather than the more formal information exchange during a meeting, were also noted to be missing and harder to facilitate over Teams. Other areas of challenge around working at home was when practitioners were also caring for young children or had other people in the house which could compromise confidentiality.

Some practitioners felt moving online had negatives as some service users did not have technology and there was a missing element of rapport building when speaking online rather than face-to-face. However, stakeholders mentioned that some families preferred the online meetings as they felt less intimidated, and service users felt more empowered, *"they don't feel they're in front of everybody being criticised".* A compromise in approach was seen to provide some opportunity for discussion with the individual/family in how they would prefer to engage going forward.

> *"Our team now will go out on the first visit, second visit, see how the dynamic is between the family and if things are okay, then do the sessions online to save them time"*

However, whilst the move online has been highlighted as being more productive, it was reported to have disadvantages as well, with the driving round being described as a *'nice part of the job'.* Stakeholders discussed missing the support they received previously from colleagues, particularly when working with challenging cases. The ability to a physical separation from the workspace and home space was key, wanting to switch off and put the day *'behind you'.*

> *"When you chair a very difficult meeting, and then you leave I'm in my attic on my own. It's a very nice room, but you want to have that debrief and talk about it and have a cup of tea and have a joke as well"*

With regards to working in partnership with colleagues from different organisations it was noted to be more challenging as practitioners do not get many opportunities to meet and therefore, '*don't really know what's going on'.* Moreover, the informal conversations with colleagues and *'soft intelligence' which* was noted to be missed when working virtually. Casual catch-up conversations whereby relationships are built, and information is organically shared, which may have happened before a formal meeting are not possible over Teams. Within organisations practitioners questioned their levels of productivity of attending many meetings in a short period of time as it may not allow time to think and reflect.

> *"Previously I might have had two, maybe three meetings in a day with travel time in between, you can have anything up to seven meetings a day squeezed into your calendar and it's about trying to manage that. Then you start asking yourself well, how effective am I because I've had so many hats on today, I need to focus on one thing and get that work done"*

There was a hope for stakeholders to be able to return to in person working and adopt a hybrid model. Thereby, allowing for the flexibility that remote working affords, to be combined with the face-to-face benefits of working such as informal opportunities to consult and support colleagues.

"We're used to seeing him in the kitchen making tea, or if you've got a question, oh hang on, [senior manager] is there, you could just pop in, not as often now, but it does make a difference"

It was also noted that having a hybrid model which allows families more flexibility and choice would be a welcome move for some stakeholders. Whilst some families would want face-to-face meetings, for others the opportunity to participate remotely was helpful, particularly when they lived in rural areas whereby public transport was challenging. Again, the Service User Experiences report (Report 4) echoes some of the flexibility needed in approach to families.

Although as a service they are trying to encourage individuals and families back into their communities and re-engage with activities, this is against a backdrop of staff that are also stuck in their new routine and want to continue to remote work. In addition to this another LA area surveyed their staff to try and determine their thoughts on working arrangements, with responses stating they want to return to the office, yet this was not happening in practice. Wellbeing surveys were used by several LA areas regularly to monitor changes in how staff wanted to work to ensure they were aware and could adapt policies and requirements to provide flexibility. This was seen to be a positive engagement activity within the LA area and showed care for their staff's wellbeing and willing to adapt working arrangements to help maintain effective working.

6. Data, Audits and Performance Management

All practitioners regardless of their agency and role were asked about their use of safeguarding data. This captured what is important within data capture for safeguarding, particularly to those working on the frontline and how this might identify any disconnect from formalised recording, and measures to those metrics deemed operationally critical. However, please note that Report 3: Safeguarding Performance Framework, also explores performance metrics, data and audits in more detail.

The way in which data is utilised varied depending not only across LA area, but also by safeguarding agency. However, there were clear methods for documenting and using safeguarding data to identify *trends, demands and potential gaps to inform practice,* which illustrates *performance indicators* and the *impac*t of services. Furthermore, there was further identification of how this *informed organisational learning and accountability* across the multi-agency safeguarding arrangements.

6.1. Informing Practice: Trends, Demand and Gaps

All agencies stated that they collect data regarding the service users whom they work with, and their interventions. Data can include information on referrals to services therefore various needs can be identified and actions which follow can be monitored. This can include number of statutory visits

completed, and strategy meetings held. These factors help to understand the need and demand for services. In addition, information such as number of assessments which have been completed, and whether they were completed within expected timeframes. This information is recorded by practitioners and collated by analysts and then reviewed and usually disseminated by managers. Data is collected for monthly and quarterly reports to identify patterns of referrals and trends which help to understand what service delivery should look like and design appropriate interventions to, *"inform local authorities about services and support".*

> *"We look at the reasons, are there trends? Have we seen an increase in referrals? A decrease? What the reasons are, are there age bands? Or are they service bands? Or what are the common themes and threads that we can look at to improve services?"*

Data regarding young people's behaviour in schools and attendance levels can be monitored to ensure that support is provided. In addition, specific data was also collected and fed back to a multi-agency panel groups that deal with issues such as Missing Children to allow for a timely and targeted effective multi-agency response. This included contextual information such as particular locations and spaces. Some areas discussed how the recording of vulnerability in places was difficult within their systems and required them to assign the concern to an individual person, not a place. This may result in missed opportunities in being able to share intelligence and information in identifying risks. This was evident for residential homes in that data and information had to be recorded when linked to an individual, which did not allow for a contextual picture to be gathered for a particular place, which was felt to be helpful.

> *"We get referrals where there's, no identified alleged person to be responsible for the abuse and it could be multiple residents. We can't record them on those databases because it's not under one person"*

Furthermore, to ensure safeguarding practice on the frontline is as effective data provides evidence on where increased strategic support is required. Therefore, data allows the transparency in the pressure being felt within the safeguarding system, *"That's what we pass to that strategic board, "We're seeing these trends, how can you support us in responding to them?".* An interesting point that was discussed by some practitioners was ensuring that when exploring data for key trends it also examines where there are gaps or reductions. That the absence of demand may also provide information about practice, *"we might have regular referrals from one area but none from another. That tells us we need to do more work in the other areas".*

Examples of using data to inform initiatives were also given, with plenty of examples of how this was particularly helpful regarding Early Intervention services, where demand was particularly high. The benefits of looking at the data and understanding not just the quantitative demand, but also the context and nature of the demand enables services to be developed in response to community

needs. Within one LA area, early intervention projects were founded upon the basis of analysing data. For example, an Early Assessment Project was established to triage families referred who needed contact urgently, thereby a worker would be appointed quicker compared to generic support.

> *"As a result of that the engagement rates are increasing, because we're not a crisis team, we are voluntary. Even though that's our stance, well actually if it's crisis it sits in CP, but if you as a Mum, as a parent, it's a crisis for you at the time"*

The identification of key trends and service gaps was also reportedly used to provide support and highlight where funding should be targeted, ensuring an evidenced based approach in decisions around commissioning. In addition to data and reports being collated within individual organisations, data and certain metrics are reported back to Welsh Government. A clear message across LA areas was that there was very little, or no feedback from Welsh Government on how the data is being used to inform any policy or guidance nationally, but that the requirement to continue to record and analyse locally was valuable.

> *"I'm not sure whether we've seen anything come back from it to influence policy or practice going forward"*

6.2. Performance Indicators, Quality Standards, Audits and Impact

When considering data in terms of performance indicators, alongside quality standards and audits, these all feed into open forums such as annual LA reports, with much of the Welsh Government required measures at LA level published on websites such as StatsWales. Therefore, there is pressure to accurately record and respond to these indicator requests, but with key questions as to whether the data being shared across Wales is consistent. What does the overall picture on these measures tell us about the demand and profile of safeguarding across our Children, Adults and Communities? And how does this help inform the effectiveness of safeguarding responses across Wales? In doing this, practitioners discussed the data collected at local level, their thoughts on national measures and how these impacts on their service at local, regional and national level.

Most statutory safeguarding organisations noted a detailed structure in place which provided the LA area with a comprehensive reporting system and framework. This detailed how delivery groups, operating alongside safeguarding forums, report information up to a safeguarding and governance performance group at Director Level. This information is subsequently formatted into a report and then disseminated; therefore, data is cascaded to those that are part of the safeguarding response. A good example of bringing different aspects of data together was seen in a reporting format called AAA: Alerts, Assurance and Achievements. The report covers areas of concern and escalation, but also good elements and the impact of their work.

> *"It goes out to the whole organisation what the data looks like, but more importantly, the narrative around that, what does that mean and what do we need to do next, and how that informs our practice"*

There needs to be an understanding of the pressures on practitioners and the significant time needed to fill in relevant forms to the required detail. However, without accurate and timely input of data by professionals, the data becomes meaningless, or worse, inaccurate. Most LA areas talked about having to spend significant amount of time in their performance teams, chasing gaps, or querying data and rectifying gaps or inconsistencies.

> *"They're not filled in at all, so the data, when it comes to the end of year it's always skewed. There's always somebody having to go through all of those that haven't been inputted correctly to see what's happened with the case"*

Moreover, there were issues around the accessibility of data whereby the format of some forms meant that information is difficult to extract. Many LA areas had either spent significant resources in trying to find solutions to this issue or were still developing ways to make this more streamlined. For example, creating a case chronology which allows for easier access to information regarding an investigation.

> *"There would be one document which will show the case chronology of what happened from the beginning to the end. It makes it much easier to collect the data, for it to be more easily scrutinised for the quality, and for it to be correct"*

Another consideration, which was being innovatively addressed within one LA area, was how to capture the journey in safeguarding. It was discussed that the metrics are very static and final, whereas the journey is much more incremental, with those smaller steps not recognised in the achievements of the practitioner or the individual they are working with. One such example was given regarding the measure how many children have been discharged from being looked after by the LA. The development of the Risk Model in Children's Social Services which documents risks around significant harm and aims to ensure that decision making is underpinned by a framework which is more consistent. Effective Child Protection and Steps to Change include guidelines and further areas where progress made by families can be discussed and scored to understand what incremental progress has been made, rather than the data surrounding whether a child has been returned home.

> *"We should be clear about what needs to change so that those changes are owned and understood by the families and that they don't feel that we keep changing the goal posts. So as soon as they think they've achieved what we were after, we change the agenda, and we say that we're now concerned about something different. Then we have this measurement metric which allows them to try and map how they're going to make progress. It allows them to celebrate success and build on the strengths or the achievements that they're making"*

However, it must be noted that most practitioners across the LA struggled with this, admitting that capturing smaller progress was not part of their recording or service, but recognised its importance.

It was also noted that the VCS are good at collecting specific data regarding the impact of their service delivery as evidence of their impact which is required for the renewal of their contracts. It is, therefore, an imperative part of their work and firmly integrated into their way of working.

> *"We're possibly not as good, because our heart's not in it, because we just want to get on with doing the job, because the data we're collecting is fairly meaningless (referring to statutory service), but I think for third sector, voluntary services, they're very good with that"*

Basic blockers were noted by practitioners when discussing the responsibility of recording and extracting data, with the forms used to collect data not always having the appropriate spaces for noting contextual or crucial information. This resulted in practitioners advocating for more investment in collecting qualitative data via independent researchers to capture the voice of those they work with and to, *"find out what the outcomes from their behalf are, how they perceive it and their treatment".* Most LA areas discussed striving to ensure that service delivery is as effective as possible, and posing questions to themselves about *"What could we change to make this better? What could we pilot in the team? What could we change on the system? What do we need to do to help staff know about this information, so it changes their practice?".* This was further highlighted through a piece of work undertaken by a LA area called *What Matters*, which had a key aim of understanding what effective safeguarding looks like from the from service user perspective. These findings were then developed into *value steps* which are used as a checklist to ensure that the service workflows are focused on ensuring effective safeguarding is being delivered for all service users.

Finally, whilst data was mainly spoken of positively, it was highlighted that there are quite a large amount of data performance indicators and the purpose of collecting these was not always clear. There was a lack of understanding on the published data from the Welsh Government, it was noted that the data looks very different across Wales, *"we need to have an understanding between the counties of why that is different and try and bring it more in line with what we should be doing".* Having joined up conversations about the measures collected at national level may allow for increased consistency in issues such as thresholds for statutory intervention.

> *"The Welsh Government collect far too many key performance indicators and I think they collect ones that are unnecessary. Well, why do you need to do all that information? Welsh Government is a bit far removed from reality"*

6.3. Organisational Learning and Accountability

The above sub-themes highlight the importance of identifying safeguarding demand, trends and gaps in data, as well as how these are used as part of national, published performance indicators. This subtheme identified how these informed LA organisational learning and accountability. A key aspect of this was centred on collecting data to inform decision making, and actions to respond to safeguarding concerns, *"What's the data telling us, how do we translate that into identified learning*

and lessons".

Examples were given across the LA areas showing how data was being used to inform changes in policy and practice, this included reviewing the processes in relation to a Section 47 (cases involving significant harm) when an increase within a certain cohort was identified. By exploring the context of the surge in data it allowed the LA to emphasise the need for information queries to occur first before escalating to Children's Services. Other examples allowed for more specific and tailored responses to a type of vulnerability such as child criminal exploitation and county lines. By identifying increases in specific types of referrals there is opportunity to initiative a proactive multi-agency response to address and respond to a trend.

Audits were regularly used as a mechanism to effectively review current practice and identify learning to improve service delivery across LA areas. The frequency of these meetings varied, with effective practice identified in a LA area that completed this as part of the weekly referral meeting. Partners clearly stated that the use of multi-agency audits were a fantastic way that helps practitioners to develop, with this including their written, assessment and risk assessment skills.

> "*The EWOs (Education Welfare Officers) will attend and Social Workers and area teams that want to learn how to develop their written skills, assessment, risk assessment, so not to be so risk adverse which is something important for newly qualified and new staff"*

The rich conversations that take part during the audit meetings allow partners to learn from other multi-agency partners and develop their skills. Moreover, partners were able to use this meeting to seek advice on cases which enabled all partners' expertise to be is utilised to ensure the right response is taken. Furthermore, to ensure there is accountability of any recommendations and actions from these audit meetings, a report is produced every six months on what learning has taken place and what learning is desired for the next 6 months. The report highlights upcoming targets and practice improvements from the previous report. The recommendations are a mechanism which highlight accountability and allow an intervention to be applied to improve practice in the areas which need further development.

Another LA area as part of their regular audit process, would review any recent SCRs outside their area, which would be used to scrutinise their individual, agency and multi-agency response to understand if the same outcome would have occurred. This allowed them to discuss, challenge and review decisions and actions that would have occurred at each stage of the SCR. Furthermore, this would help understand potential areas that need to be strengthened on the back of the SCR scrutiny process. Doing this seem to bring a collective accountability to their safeguarding processes. This may result in changes to policy, the strengthening or adapting of teams, but also inform where further training is required.

"Looking at key themes that are coming across within safeguarding and what referrals that we're seeing, and then we target training"

7. Lived Experience Voice and Participation

Capturing the voices of those service users with lived experience of working with services around safeguarding is a key aspect to service user participation. *Partnership working with service users and families* was discussed in relation to the active role that they played during their time working with safeguarding organisations, and how much input this process allowed for them to participate. It also explored how *consultation and participation* was facilitated after any support or intervention and how this *feedback* was sourced, collated and acted upon to *shape future service delivery.* It should be noted that a separate report explored service user voice in their experiences of the safeguarding process. Please see Report 4 for more detail (Service User Experiences).

7.1. Partnership Working with Service Users and Families

"We don't talk to children enough, do we? We always talk about the voice of the child, and some of the major safeguarding pitfalls and failures, have been where we have focused more on the adults in children's lives, and not them"

Partnership working with families is something which is aspired to within Children's and Adult's services across most LAs, with many talking about this being a 'priority' now that restrictions had been lifted since Covid-19. However, the level at which this was being delivered varied greatly across LA areas, with some making much more progress than others.

The introduction of the 'what matters' agenda has provided a vehicle for formalising the collaborative working with service users and families and ascertaining what matters to them. This is very much a part of the aim in working with people within safeguarding.

"We've got a bit of an approach across the service called 'What matters', or 'What's important'. The first point of contact we have with children and families, the first conversation we have is understanding what matters to them. So that's from the front door, and then that carries on through into completing an assessment and developing a plan"

Some LA areas emphasised the need for engagement with individuals and families right at the start of the process to ensure they can be honest and clear about the safeguarding process and what is trying to be achieved within it.

"Before any conference goes ahead, [my team] meet the families, they tell them about what the process looks like, what they can do if they're unhappy with anything, what the complaints look like and if the children are placed on the register what it means for them, and for the children"

Given the difficulties of some safeguarding processes being undertaken, honesty was seen as key factor in this engagement as well as using the expertise of those 'seniors' in social work to try and make some of these challenging processes more supportive. It was felt that building trust to be open and honest was vital when developing relationship and supporting families.

> *"They need someone to be honest with them and I talk to them about everything that's going to happen. If there is no relationship, no trust, how are they going to trust what you're saying"*

Utilising the skills of partners ensures that service users feel comfortable to engage recognising the needs of the individual, alongside which agency has the closest relationship and if any additional expertise and insight is required. For example, if carrying out a Section 47 enquiry to ensure the best information is gathered a practitioner with an existing relationship with the family could be used such as youth worker, or qualified family support worker. Upskilling partners was also highlighted to ensure that the partner with an existing relationship could continue working with a family whilst also utilising their existing relationship as a key mechanism of support.

> *"If we've got a Social Worker who's got an amazing relationship with a family, we don't want to be referring onto somebody else, we want to upskill them"*

Furthermore, partners in youth work were often utilised to work in partnership with young people to ensure their voice is heard and supported*, "We've got our Youth Workers on the ground, and one of their purposes is to ensure they advocate for the young person's needs".* Independent advocacy was something which many stakeholders mentioned for both Children and for Adult's Services and this was promoted and referred to by LAs and was facilitated by outside organisations, *"their voice is heard, and they have good representation"*. The use of an advocate provides an important mechanism in which services can work in partnership to support the service user. It was also mentioned that in instances where an individual is deemed not to have capacity there are different communication aids and close working with the family and friends, yet it was acknowledged that independent named advocates can be helpful as well to represent a service user's views. This can work for all sides, for example, regarding DA, an IDVA, *"can advocate on behalf of the victim against Social Workers or vice versa, they can be that bridge between the victim and the Social Worker"*. It was also highlighted that ascertaining the view of individuals is something which should be ongoing and threaded through multi-agency discussions.

Within the Prevention Teams at Families First there were mentions of a tool by one LA area, the 'Distanced Travelled' tool whereby families are asked to score how far they felt they had progressed and where they needed more support when working with the agency. This allowed the family to determine their own areas of support and engage in a discussion together to explore action going forward.

"They'll give a score at the start of our intervention and that will feed into our assessment and shape the work"

In addition to the Distance Travelled tool, Families First offer questionnaires at the end of service to understand what could have been improved and how they have felt during the intervention. This form goes out to parents and there is a separate form for young people to ascertain their views. Other statutory services had protocols in place for service users including young people to have their opinion heard during the process of an intervention. Advocates were offered to ensure the wishes and feeling of individuals were understood and heard.

"People with long term managed care or with managed care should be captured at all those reviews in terms of what's gone well or not gone well, or if it's something that they're asking for and we cannot deliver that"

However, the take up of advocates was not always high and sometimes there were tensions around balancing what the family wants verses what the service users wants and if there is capacity to respond to their requests.

"Often that isn't taken up because people say they can speak for themselves, or they have got family members. I think with family members sometimes a bit of a dichotomy cause the family may have one issue that they want resolve. That's not what the cared for person wants at all"

Another area which was being developed and addressed as a priority was ensuring that victims who report crimes to the police, particularly those who are victims of DA, are kept in contact with and updated on the process and continue to be involved, *"we've been banging that drum for a long, long time but it still happens".* It is seen as an important part of developing trust between professionals and victims and service users, but it was admitted that logistics of staffing rotas can contribute to delays.

Whilst working in partnership with service users during assessments and interventions was part of routine working, it was acknowledged that audits should have more inclusion if service users' voices when they have gone through the process. This includes using workbooks designed for children to explore their wishes, feelings and desired outcomes and the utilisation of independent reviewing officers. Progress has been made across LA areas, with some further in achieving this than others, but priorities were around the uptake of these provisions and that, *"we've got those mechanisms there; it's just how well used they are".*

7.2. Consultation, Participation and Feedback to Shape Future Service Delivery

Feedback from children, young people, adults and families once an assessment or intervention had been complete was noted to not always be common practice within statutory organisations. In some areas of Adult Services there were examples of questionnaires being sent out to families to understand what they felt worked well and for residential homes. There were service user forums for service users and families to ensure that their voice was heard.

Within some areas such as child protection, there were complaints forms which were standardly handed out, but these do not always capture elements of good practice. Moreover, the return of these forms was seen as low with one stakeholder noting that, *"I don't think I've had one back since we've been doing it".* It was, however, felt to be an area which was being built on and trying to understand what works for young people and discussions around a child participation conference. There was an acknowledgement that what needs to be fed back also needs to be actioned and this could be a challenge, for example one area noted it could be that service users and families could be of the view that, *"they don't want to go back to a face to face"* and if this is the case, how will the LA respond and act on this if it is felt that moving back to face to face meetings or direct work is the way forward.

There were examples whereby service users were offered opportunities to be included in shaping service provision and to learn what was working and what was not working through groups and forums, such as wellbeing services and transformation forums whereby parents and carer representatives are on boards. There were also residential meetings for service users, families and friends, and suggestion boxes, all for their voices to be captured. Again, this was felt to be something which could be developed further.

> *"We can always do more in terms of participation and co–production...We need to find out what's working for people and what people need"*

One LA area within their Children's Services discussed how, *"young people are invited to feedback in their experiences give us good feedback in relation to how we should be designing things"*. Following on from this there have been creative ways in which young people have fed back including poems, rapping and traditional power-points. The feedback was also considered meaningful and valuable and that if services ask and seek feedback, they will receive it.

> *"When we were changing the name of the team, for example, that went out to all the families that we worked with for them give suggestions. I think generally if you ask, you will get it"*

Collecting and collating service user feedback is occurring in some areas of multi-agency working and it highlighted that ascertaining feedback and participation from service users is part of the process. That *'one of our performance indicators is about the person's participation',* but that it was not perfect, and it was acknowledged that practitioners do feel *'there is more they could be doing'.* More

specifically this was discussed as, *"something that we need to strengthen in terms of getting them to participate in strategy meetings"* thereby encouraging decision making to be made with service users and not for them.

> *"How we bring a young person into those meetings, how we're directly involving them in all of those. The less decisions you can make for them, and the more decisions you need to make with them"*

Capturing service user and family feedback in one LA area was the responsibility within their *'Learning Improvement Team where we use an appreciative enquiry. To get feedback, that's powerful'.* The team also worked with young people in developing service feedback capture tools, therefore, resulting in more appropriate and engaging tools for their age group. This also includes using service user panels which allow the service users to voice their opinions on improving the service, and a Participation Officer whose key role is to capture the voice of service users.

Within Youth Justice young people's voices were captured using service delivery feedback at various points during their intervention which ensured feedback was actioned while working with the service user. Areas within Youth Justice also initiated survey monkeys for specific areas of their services to ascertain how helpful young people found them, or what they could do to improve their support. The main mechanism that the Youth Justice team adopt for both their preventative services and those children who are working with court orders is through an app. This app is child-friendly and entails questions such as how listened to did you feel, were your views respected, were you told what was going to happen.

> *"It's interactive, child centred and the younger child would have less questions and for older children, the words would be more relevant"*

There was a consensus that working in partnership with service users and families was positive and valued but there are uncertainties and variances across agencies around how this should be approached, facilitated and responded to.

> *"All services should have, or there should be some sort of representation from service users for all services, but I wonder how it should be managed"*

The impact of Covid-19 was given as the main reason for delayed plans to consult with service users. There were discussions about services being resumed such as working with family's post- intervention to explore their experiences of service delivery. Certainly, the appetite of including service user voice within multi-agency safeguarding arrangements was a priority for all LAs, and the value when this was captured was articulated to have much wider benefits across the service. The process of ascertaining what the experience of service intervention had on the family, from their perspective was felt to be hugely insightful.

> *"When you listen to people and their experiences, you think, "Why would we have done that? Why did we do that?" or, "How did that make you feel?" It is quite grounding and makes you*

think, "God, what have we done to people really?" It's not because anyone is out to do any harm at all, it's the system"

However, this was seen as a piece of the system in motion whilst trying to manage to the demand, scale and complexity of safeguarding referrals since Covid-19. With this alongside a reduced and exhausted workforce.

"When you've got staff that have been repurposed, and you're still running a service, that's difficult, isn't it? It's like the swan effect, above the water everybody is looking fine but underneath, they are peddling like nothing on earth"

In other statutory departments there was feedback collected, but not collated as such. The take back in one agency said they receive about 10% of questionnaires back and they include stamped addressed envelopes for convenience. In others, there is the option to complain, or give complements after an intervention, but not necessarily a set feedback questionnaire or form. Some practitioners felt that this would be helpful and to have a mixture of open and closed questions as *'the narrative of someone's evaluation is so important'.* It was also noted that there is a very active carer's network in some LA areas. Consultations to families about what they feel is important and what they need are also undertaken which resulted in 200 washing machines being distributed and installed to service users in one LA area. As a result of *'listening and we're trying to be reactive with the resources that we've got'* based on what responses they had received. Other engagement activities included conducting a *'loneliness and Covid'* survey, but it was felt that there was a poor response and that they are considering future surveys are outsourced to specialist agencies given the resources needed to facilitate them.

4. Key findings and recommendations

The following section pulls together the qualitative findings identified as key features of effective multi-agency safeguarding practice. The review findings are based on the multi-agency safeguarding arrangements in 7 LA areas. The review includes the voice of agencies across adults to children and families, as well as from the front door (IAA) services through to statutory interventions, with all agencies who were seen as part of that system included. Practitioners from Social Services, Police, Health, Education, Youth Services, Youth Justice, Fire Service, Voluntary and Charity Sector and Third Sector agencies provided their voice. The findings aim to answer the following; how are the safeguarding arrangements currently working, what was working well and how things could be improved.

Subsequently, in attempting to achieve the key aim of the project 'What does good look like in multi-agency safeguarding arrangements?' the Themes and Subthemes were reviewed. This identified a model of essential features for achieving 'Collective Safeguarding Responsibility' within the multi-agency arrangements. The model and its elements are detailed below, with consideration of evidence for its inclusion, example quotes and best practice example(s).

4.1. Collective Safeguarding Responsibility Model

The key message from this (and many previous) reports is *"safeguarding is everyone's business".* However, implementation of that sentiment relies upon effective multi-agency working and achieving Collective Safeguarding Responsibility, within and between organisations and across sectors. The Collective Safeguarding Responsibility is dependent upon certain criteria being fulfilled through practitioners within each agency that are part of the safeguarding process and facilitated through structures and processes, as outlined in Figure 1.

Figure 2. Overarching Model of Collective Safeguarding Responsibility

Figure 1 outlines the two core elements of achieving Collective Safeguarding Responsibility, detailing 'Practitioners and Agencies' and within the multi-agency 'Structures and Processes'.

Figure 3. Key Elements within Collective Safeguarding Responsibility

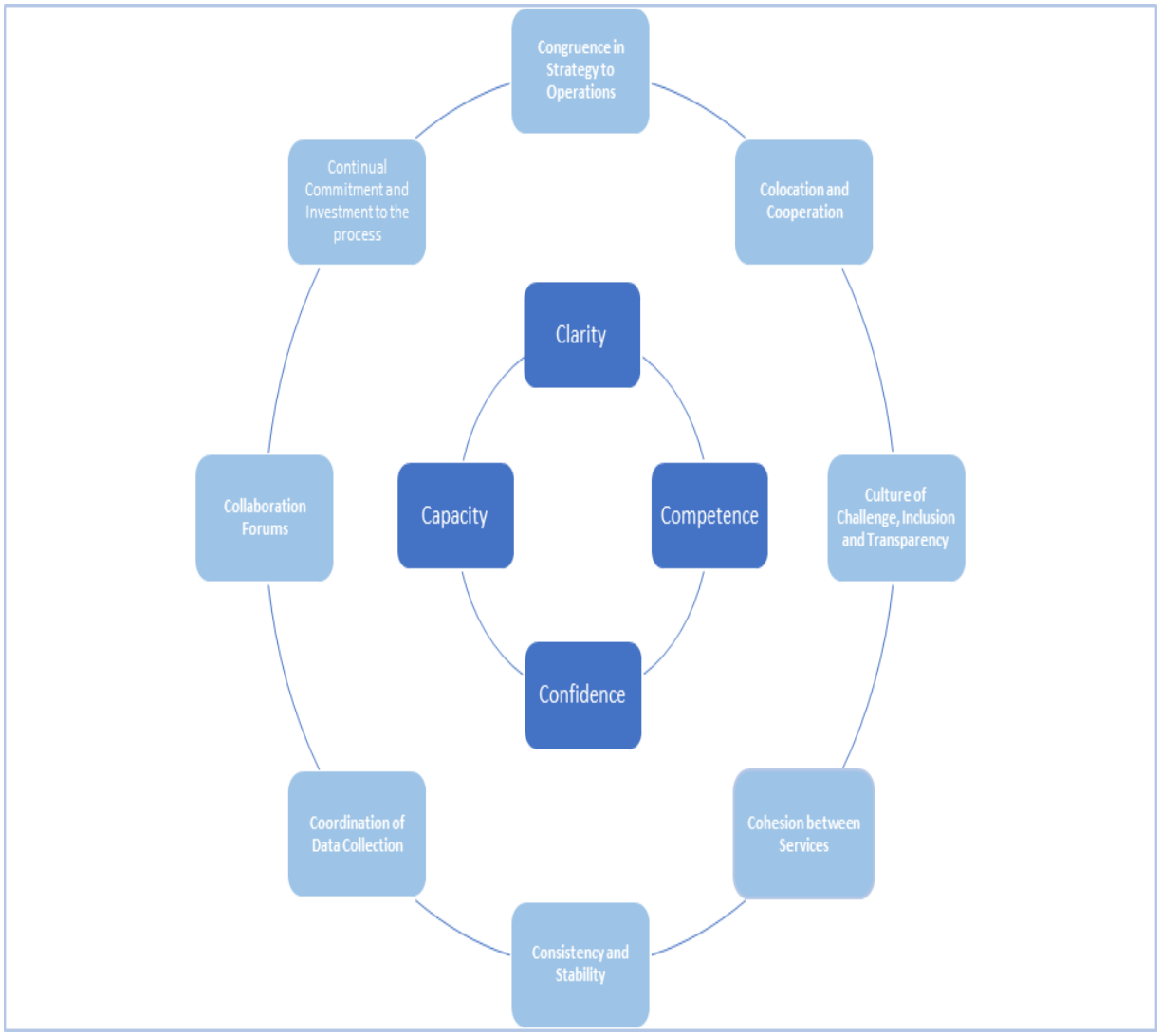


Figure 2, above, provides the details of what is required within the two core elements (Practitioners and agencies (dark blue) and Structures and Processes (light blue). The model also highlights that the practitioners and agencies at the centre of this, demonstrating the necessary individual and agency competencies needed to be able to achieve each of the Structures and Processes. One cannot be achieved without the other, requiring the Practitioner, Agency and Structures and Processes to be working together in achieving Collective Safeguarding Responsibility.

Achieving Collective Safeguarding Responsibility: The 12 C's:

This section will examine each element of Figure 2 in terms of evidence of its inclusion, with practitioner quotes, as well as evidence of good practice for each.

Practitioners and Agencies

First, taking the centre of the Key Elements of Collective Safeguarding Responsibility (Figure 2), this highlights 4 key features for Practitioners and Agencies that was identified within the current evaluation report. These included: Clarity, Confidence, Competence and Capacity.

1. Clarity

Explanation: Practitioners must have a comprehensive understanding of what the needs of a service user are, what outcomes are desired in order to safeguard and clarity over the expected remit of the agency for which they are referring to.

Evidence: Within the practitioner interviews, examples were given of individual roles and agency remits being understood through having a shared Threshold document which clarified safeguarding expectations. Alongside this was the consistent review and sharing of safeguarding demand and user expectations within panels/meetings. This enabled practitioners to have continued clarity on the changing nature of the vulnerability demand, whilst cognisant to their agency thresholds and processes to be able to respond effectively. However, in contrast some practitioners stated that due to lack of feedback on referrals (with many stating they do not know what happens next), and changing thresholds due to increased demand, clarity regarding their role and service remit was not clear. Lack of clarity at individual and agency level was seen to then impact on the Confidence and Competence of practitioners.

> *"As multi-agency leads and as a requirement from the Regional Safeguarding Board, we created a regional threshold document to outline how our processes would run and what would constitute a referral. It involves guidance on screening cases etc. So, the processes are mapped out"*

Good Practice Examples:

- ✓ The development of a Threshold document at Regional level agreed across the agencies to facilitate multi-agency decision making about what is within that agencies remit, and therefore practitioner responsibility. Regional level documents also allowed further consistency and clarity across LAs, rather than these being created at LA level. Allowed clearer understanding for those organisations working across LAs such as Police and Health

- ✓ Joint-agency scrutiny of cases, such as (Serious Case Reviews) SCRs were completed as part of regular multi-agency forums. This provided a platform to scrutinise decisions across the agencies and identify ownership of roles and thresholds to ratify the current arrangements. Asking the question within this process, would the same outcome have occurred? By understanding each agency and practitioner's role within this process was seen to further strengthen the expectations in terms of service remit.
- ✓ Practitioners across some multi-agency forums also spoke of Terms of Reference. This allowed them to be clear on what groups sit within the meeting and assign clear responsibilities across the group.
- ✓ Within Safeguarding Hubs, having Educational Link Workers was felt to be useful for clarifying thresholds and advising on appropriate action which must be taken by each agency. It also facilitated the exchange of information at different stages of the safeguarding process. This was particularly helpful as schools and education provision are viewed as a key partner within the safeguarding process yet there can be different approached amongst different institutions.

Recommendations:

- ➢ Development and agreement of a multi-agency Threshold Document at Regional level.
- ➢ Agreed Terms of Reference across key multi-agency forums/groups.
- ➢ Regular multi-agency review of SCRs/DHRs to scrutinise roles and remits in decision making across agencies (helps review the changing nature of threshold and ratify service remits and capabilities).
- ➢ Ensuring there is resource to facilitate building relationships and allow for dialogue and consultation between the Safeguarding Hub and referring agencies to clarify processes and expectations, for example, Education Link Workers.

2. Confidence

Explanation: Practitioners must have the confidence within their own ability and support from their organisation to be able to carry out the appropriate safeguarding responsibility within their own role. These safeguarding responsibilities must be clarified through their own organisation and alongside partner safeguarding agencies, to ensure collective safeguarding responsibility is understood.

Evidence: Confidence was a key factor from an individual practitioner and agency perspective. This was also linked to Clarity and Competence. Examples were given whereby agencies did not have the confidence to gain necessary information from families, or individuals, that would provide the required (minimum) information needed for threshold assessment. Confidence was linked to fear of impacting on relationship with families, particularly when dealing with education and those agencies

working at universal services level. The other key issue regarding the Confidence of practitioners was the fall-back position of putting referrals in to 'cover your backside'. A lack of confidence in practitioners and more generally from agencies/organisations led to issues around information sharing and inappropriate safeguarding referrals being received that should be signposted to early intervention services.

"It's got to be the integrated Safeguarding Hub and the wider integrated Single Point of Contact, the relationships within there and the trust across agencies works well. The confidence with each other really, to be able to know that I can pick up the phone or make a Teams call to somebody and know that it will be answered, and they respond"

Good Practice Examples:

- ✓ One LA area Children's Services stated there is work being undertaken to look at specific referrals which have been submitted from the Education sector and to examine what more could have been done, by whom at various stages, to prevent the young person being involved within the child protection system. This would identify and assess whether having the 'what matters' conversation earlier, if appropriate, would have changed the outcome. Identifying the points within the safeguarding process where there are issues and providing feedback and additional training if need be, was seen to increase the confidence of practitioners in gathering the information from the person of concern. Therefore, this would result in higher quality and appropriate referrals.
- ✓ One LA area discussed their significant efforts to increase the confidence (and competence) of those referring in, particularly regarding adult concerns from the Police. This was significantly improved by having a Detective Sergeant as part of the MASH co-located (hybrid) team, where they would directly feedback to officers if there was information missing, or if further information was required. Due to this feedback, this has gradually increased the confidence, competence and most importantly the officers understanding of thresholds for Adults, with a high proportion of referrals received requiring action.
- ✓ Early Help Family Centres worked with the Police to encourage referrals to them as opposed to a Police Protection Notification (PPN) with this being targeted at the supervisors, who were seen as the one encouraging their officers to submit a PPN.
- ✓ Most LAs talked about the importance of 'consultations' with the safeguarding team before submission of referrals. Regardless of the demand and business of the team, being able to have conversations about concerns before referrals went in, provided learning opportunities and increased confidence in the decisions and actions taken.

- ✓ LAs spoke about carrying out training to referring services such as within Education. This training included multi-agency practitioners such as those working within Social Services and prevention teams so that a range of cases could be discussed with an opportunity for questions.

Recommendations:

- ➢ Provide a clear pathway/platform for conversations/consultations with a duty team or safeguarding teams to help understand what is required and what likely decision would be taken on the information at that time. This also requires a proactive culture change to facilitate an inclusive and approachable environment which allows for ongoing dialogue and discussion. This is to allow increased understanding and confidence in levels of thresholds and quality of information subsequently received.
- ➢ Regular review and identification of the safeguarding process to understand where there are potential issues in information sharing (blockers), or where referrals received lack information. This should inform the targeting of training/workshops to those agencies and individuals within a multi-agency forum to help boost the confidence and understanding of a collective safeguarding responsibility.
- ➢ Providing feedback on referrals to frontline staff. This was seen as a key factor that increased the proportion of PPN referrals that were subsequently actioned, rather than being 'NFA'd' (No further action). Lack of confidence was most often linked to not knowing what happens to a referral or information when submitted.
- ➢ Targeting of training regarding consent and transparency for Education regarding concerns with families. Many practitioners reported lack of awareness from families when referrals were received, which often explained a lack of information within the referrals as conversations had not occurred. Unless it is significant harm, families should be made aware of the referral.

3. Competence

Explanation: Practitioners must have the competence and relevant skills, knowledge and experience to be able to carry out the appropriate multi-agency safeguarding responsibility within their own role.

Evidence: Competence was seen as a key feature in achieving Collective Safeguarding Responsibility. As highlighted in the above points, Competence can be achieved by providing Clarity and Confidence to the workforce. Being seen as Competent within the multi-agency safeguarding arrangements relied on factors such as experience, knowledge and skills, which all required continuous and sustained effort. This became more problematic within a multi-agency setting when these key factors worked in silo, with training, skills development and feedback were either absent or agency focussed. Even

within the role of Social Services this was seen as problematic, due to the creation of specific specialisms of Children and Adults. Whilst two LAs had clearly moved their approach to combine their safeguarding responses in allowing a more omnicompetent Social Worker, and as such, a multi-agency response, this approach was seen as controversial by many.

"I've always been very conscious of, training and safeguarding training. In a lot of local authorities training is specifically for Adult Workers and you're thinking, DA effects everybody, you know, exploitation. There's all these themes and you're like thinking why is that just for Children's Social Workers? Shouldn't Adult Social Worker's be aware of it?"

Good Practice Examples:

- ✓ Two LA areas had merged their Safeguarding Hub/MASH to include Children's and Adults. This was done as a stepwise process with one service first established, then the movement of the other occurred. Given the issues regarding resources of Social Workers, this was seen to be working effectively by all practitioners. Initial reluctance to move outside specialisms was met with increased competences from the work force, with increased resilience and increased communication within the team. Those LA areas that were seen to have larger demand tended to work more effectively when there was co-location (same building) of Adults and Children which improved the sharing of knowledge, and skills across the teams.
- ✓ As mentioned in 'Confidence', feedback to those frontline workers enabled practitioners to understand the expectations of thresholds and information quality, with this evidenced as occurring at Early Help points as well as within the Safeguarding Hubs/MASHs.
- ✓ Training and particularly multi-agency training whereby agencies could share perspectives and knowledge alongside each other, was deemed as helpful.
- ✓ One LA area had integrated their Safeguarding Hub with their front door service as well as having a DA Hub as part of this. By providing an integrated and coordinated multi-agency hub it thereby encouraged daily conversations and increased the general knowledge and skills of practitioners as well as the efficiency and effectiveness of decision making on information sharing and thresholds.

Recommendations:

- ➢ Improved coordination between Adults and Children Services in developing omnicompetent workers. Whilst the issue of 'specialisms' within Social Care is a controversial topic, there was evidence of clear benefits when staff were able to understand the vulnerability across the lifespan. As indicated within the quote above, having competences to be able to understand and identify risks across adults and children is an important skill, particularly within Social Care

due to the nature of vulnerability often linked by families, or communities. This can be achieved by:

- Integrating Adults and Children at the Front door, and subsequent Safeguarding Hub/MASH;
- Providing opportunities for increased joined up working across Adults and Children by co-locating teams in the same building;
- Training that focusses on both Adults and Children practitioners, removing silo, specialism training.

- Similarly, the competence (and collective safeguarding responsibility) was seen to improve when co-locating integrated teams such as Early Help, Safeguarding Hubs and DA services.
- As per the previous recommendations under 'Confidence' ensuring regular feedback to those completing safeguarding referrals to improve their understanding of what information can be shared, what makes a quality referral and improved understanding regarding thresholds.

4. Capacity

Explanation: There must be adequate staffing levels and resources to be able to respond to and fulfil their safeguarding responsibilities, in a meaningful, timely and collaborative manner. Funding must be sustainable and not short-term. Funding that must be spent within certain timeframes can hinder long-term support and development.

Evidence: The evidence from the review found that Capacity to deliver services and service remit were interlinked in discussions across Wales. It was also noted that demand for all services was seen to have increased for all LA areas. This is against limited capacity and resource to be able to efficiently and effectively meet the demand. The majority of the LAs specifically mentioned that this demand most often fell with Families First. This was seen to occur for a few reasons. First, that thresholds for Child Protection were increasing due to the higher demand, resulting in less reaching necessary intervention within the Children's Team. Furthermore, those practitioners working within these Families First centres were aware of this likely outcome, so were holding onto *"more complex and high-risk cases"* knowing that it would be stepped down to them anyway, and that by continuing to work with them they were, "at *least getting some support".*

Capacity and service remit concerns were raised when discussing Health services, such as Health Visitors and mental health support. This was seen to impact on the ability to achieve a multi-agency response as when a referral comes in for a family and the support from one agency is dependent upon another, it can limit what different agencies can do when expert input is required.

"Workload's gone in one direction and staff numbers have gone in the other direction. It's a double whammy, really, and that's through Police, Health Board, Social Care, and everybody's in the same position"

Good Practice Examples:

- ✓ Areas of good practice included when the practitioner based themselves in places to eliminate travel for the service user or working in people's homes to ensure support service was accessible.
- ✓ Other points of good practice to buffer against issues of increasing thresholds due to service remit and capacity, allowed some LAs to develop policy around repeat referrals. One LA had set in place a 'three report benchmark' within their MASH. This was seen as particularly effective in being able to review frequency of reporting against an individual, with their processes requiring an update as to what was happening with the individual. This was often the result of single point of access referring the individual to the Community Mental Health Team, but nobody within the multi-agency safeguarding arrangements receiving updates as to whether *'this had been actioned or just filed away',* which they were then able to follow-up.
- ✓ All LA areas did note that within their Early Help, Families First provision, they felt able to escalate if necessary and ensure actions in supporting the individual/family were agreed.
- ✓ Multi-agency co-located teams allowed for agencies such as housing to be based within a prevention team. This was at no extra cost allowing for streamlined referrals and better collaboration and joint working.
- ✓ A good example within one LA of adapting to demand and providing support to adults at point of crisis has been through developing a meeting arrangement to provide specialist support for attempted suicide.

Recommendations:

- ➢ The demand for mental health support for adults and children is increasing and the current service is not meeting the demand. There is a need for more partners working in mental health, *"100%, that's top of my list. We need more people in the Health sector to help us deal with mental health".*
- ➢ The short-term and postcode lottery of funding services, particularly regarding early intervention was felt to be unhelpful and a wasted opportunity as the benefits of investing resources into early intervention can be very beneficial to families. It was noted how these may get worse as practitioners noted they are *'doing more with less',* and *'there is only so*

much creativity' that can be done.

- A need for more consistent investment into early intervention, this could prevent families having later involvement with Social Services and crisis teams.
- Service capacity and service remit issues were raised regarding the lack of residential placements being available. The noted changes over the years in lists from the family placement team of foster carers available 'used to be a 2–3-page document', whereas now this was noted to be 'two or three names' (PEMB). This leaves a high-risk situation of young people often left in Police custody due to lack of appropriate residential placements. Therefore, increasing the promotion and incentives around residential placements are an urgent need.

Structures and Processes:

The outer elements of Collective Safeguarding Responsibility (Figure 2) require the inclusion and implementation of the 8-point criteria within the multi-agency safeguarding arrangements. These are outlined in detail below.

5. *Congruence in Strategy to Operations*

Explanation: There must be a commitment to ensuring that priorities at strategy level cascade down to operational level effectively. Understanding of policy and implementation of shared guidance can unite agencies in aligning their responsibilities, but the structures and processes which underpin this must be workable, relevant and inclusive to all agencies. Having strong relationships at a leadership level was felt to be valuable as these influenced frontline practice.

Evidence: Stakeholders were asked questions around their own role, responsibilities and organisation in which they worked for, and who they worked in partnership with. An understanding of the *governance and guidance* which underpinned safeguarding practice was ascertained and this included relevant *policy* and *procedures* which related to their roles in addition to the *legislation* which guided safeguarding practice. Stakeholders discussed *structures* and *systems* that are in place which both enabled and inhibited multi-agency working. *Leadership* was highlighted as a key factor in influencing frontline activity and played a key role in determining *Strategy and Operation Cohesion,* and implementing decisions at the top into practice.

"To move from POVA which is very, very siloed. Now, the Police have taken on much broader, the number of referrals, and the differences of referrals, it can be an 18-year-old on drugs being sexually exploited by older groups, and it could be someone with a learning difficulty being exploited by the old drunk to get them money. So much vulnerability is out there, and it's when you can get people seeing and identifying those risks. It is going to be a safer place, and it was a good to use the word wellbeing because that's what it's about, isn't it? It's about making life better for people."

Good Practice Example:

- ✓ Good practice identified from interviews highlighted a LA area where senior staff within the MASH team screened and reviewed referrals coming in before going to Principal Social Worker (PSW). The process within the LA had referrals screened by 2 senior staff members, which staff then reported feeling that the accountability in any decision making was truly shared and understand within the team, allowing for less pressure and anxiety in making these decisions in silo.
- ✓ Congruence in Strategy to Operations was also seen to be working well when those that were in Strategic roles had progressed from the professional role (e.g., Social Worker, Probation Officer). These leaders tended to be seen as able to *"roll their sleeves up"* and get involved in supporting the team. This subsequently allowed open and accessible to conversations when issues arise.
- ✓ Similarly, managers who had worked within different departments and agencies and, therefore, had a good understanding of different service remits was felt to be effective to the functioning of the arrangements. Examples included those working within a Safeguarding Hub before managing a Youth Justice team or having an occupational background. Experience provided from these roles enhanced the understanding of different areas of support which allowed an alignment of service delivery.

Recommendations:

- ➢ Leadership was seen as a key factor in congruence in Strategy to Operations with the LA required to ensure their management approach seeks to:
    - Represent varied agency practitioner experience as part of their leadership team to represent the multi-agency arrangements delivered operationally. The experience of practitioners across the agencies aided implementation and cohesive working across the arrangements
    - 'Roll their sleeves up'. It was less often that practitioners felt their leaders were able to truly understand the demand and nature of their role. Those that talked about their managers taking time out to do a day in their role resulted in increased trust and collaboration across the safeguarding structures.
    - Linked to a later key finding (point 9), the commitment to staff within the workforce to invest in upskilling and developing through promotion, allowing the continuation of relationships and understanding of structures and processes was seen to be an important factor.

6. *Co-location and Cooperation*

Explanation: Establishing, developing and sustaining multi-agency relationships for many of LA areas required some form of co-location to enable effective cooperation.

Evidence: The evidence from the review found that many practitioners were in favour of a hybrid working model within their safeguarding arrangements to maximise cooperation between agencies. Whilst there was not complete agreement on the need for co-location across all agencies and practitioners, the review did find where this did exist there was positive conversations about information sharing, staff retention, staff wellbeing, which facilitated Collective Safeguarding Responsibility.

> *"The disadvantage of not being collocated is that shared understanding, the best way to determine and understand what people's thresholds are is when you work in the same locality and buildings because you learn from each other"*

Good Practice Example:

- ✓ One LA area recognised the importance of their Family Hub in terms of providing domestic abuse support, without bringing attention to the individual that they were seeking this service. Therefore, as part of general activities within the Family First Centre, the IDVA would get involved in activities, subsequently allowing for informal conversations to occur without the worry of being seen speaking to a specialist. This was seen as a fantastic trauma informed way of engaging with individuals on their terms, in a non-judgemental, open and accessible way.

  "The Team Around the Family in Flying Start, is probably the best example of co-location provision where we've got Health Visitors, Midwifery services, and our Team Around the Family, and Social Workers co-located within the one building".

- ✓ Some LAs had taken the co-location multi-agency teams to another level by placing these co-located teams where critical moments for engagement and support occur. Specifically, regarding domestic abuse, the IDVA model which involved an IDVA worker being based at the hospital within the safeguarding team, and this was felt to be hugely beneficial. It took the focus away from a DASH referral card/ form having to be completed as the IDVA was already based in the hospital, therefore reducing delays in accessing support.
- ✓ Having a multi-agency front door system to respond to initial safeguarding concerns, even if it was just Police and Social Services, was felt to be advantageous in that conversations could take place quickly which made for faster decisions to be made and prompt, appropriate action to be taken. It also allowed for a greater understanding of different agencies responsibilities, systems and remit.
- ✓ Co-location of Adults and Children's Services who were co-located with other agencies within their Safeguarding Hubs, such as the Police, was helpful as there could be interaction between

the different teams. Having integrated duty desks for different Social Services teams was felt to enhance joint safeguarding responsibility. Having a Safeguarding Hub both in Adult's Services and Children's which different agencies and practitioners could work flexibly from was felt to be hugely beneficial for sharing information and building relationships.

- ✓ In the absence of formal co-location arrangements, some LA's noted that they would make use of partnering agencies premises to base themselves. This strengthened the relationships between practitioners and enhanced cooperation in joint working and understanding different remits, but also allowed for those working in more rural locations to have a base to work from in different areas when required.

Recommendations:

- Hybrid working was seen as the most effective way for multi-agency safeguarding arrangements to operate. Theme 2 (specifically 2.2.) details the benefits reported by current staff, new staff and practitioners across agencies when provided with face-to-face opportunities on a regular basis.
    - This was mainly centred on the ability he ability to be able to learn from other practitioners through hearing their daily interactions and dealing with different cases was considered crucial.
    - This was particularly important for newly qualified social workers. Much conversation centred on the ability for all practitioners to continuously learn, with questions raised about how this can be done when remote working.
    - Understanding about any new policy or guidance, new services or provisions, new individuals within roles, all these factors were seen as better adapted and implemented into practice in a more natural setting where you are hearing and seeing this being implemented around you.
    - Furthermore, this also allowed the identification of training needs, skills development opportunities, where individuals (particularly newly qualified) are able to observe and learn and any issues addressed quickly.
    - Additional benefits were seen regarding the ability to separate practitioner's home environment to work and provide an escape from the constant Teams calls.
- When co-location was not in place, ensuring the structures in terms of oversight of key agencies under one principal officer allowed these relationships to develop and function effectively.

- Establishing effective relationships was also created through specific working groups, where practitioners were brought together in the creation of an initiative and then working together operationally within it.

7. *Culture of Challenge, Inclusion and Transparency*

Explanation: There must be ongoing, open dialogue between all relevant safeguarding partners to pursue appropriate agency support and make effective safeguarding decisions. This requires a culture of (positive) challenge, inclusion and transparency in safeguarding decision-making and action.

Evidence: The evidence from the review found that although relationships within multi-agency arrangements were well established and practitioners and agencies work well together it was noted that this does not make the various stakeholders *"yes people"*. It was felt that in order to best support service users and families, different agencies had to advocate for what they felt was the best course of action for their service users in accordance with policy. The Safeguarding Procedures were mentioned as a helpful tool in promoting challenge. It placed the emphasis on collaboratively following the procedures independently and assessing all stakeholders' contributions. Therefore, in order to adopt a multi-agency approach, inclusion and respect of statutory and VCS agencies is required. This ensures a variety of agencies are included within strategy as well as operational meetings and that their unique contribution is acknowledged and utilised.

"It's a mutual respect for each other's professionalism and statutory responsibilities. We all recognise we have a job to do and we're all here to serve the public and the people that we we're obliged to... We don't come into the job to do harm to people, we want to do the best we can for everyone. We're all coming at that from a slightly different perspective, and it's learning to walk in each other's shoes can take some time"

Good Practice Example:

- Examples were given regarding clear processes and protocols that were employed should professional disagreements require additional support for resolution, outside informal conversations. Having these in place enabled practitioners to feel comfortable to escalate any concerns.
- One LA area clearly had invested in a culture of professional challenge within their multi-agency safeguarding arrangements. This was communicated to all agencies and staff as a necessary learning requirement to ensure continued effective, holistic safeguarding responses. By expanding and encouraging professional challenge to those key VCS agencies, this is also seen to have a huge impact on practitioners feeling valued and part of the partnership response.

Recommendations:

- Develop, implement and share clear Policy around Professional Challenge, with details of processes to follow should more formal procedure be required. This should be clearly encouraged and communicated as a part of continued learning and scrutiny processes.
- Make professional challenge a part of weekly business. Some LA areas used their scrutiny panels to review decision-making across professionals and agencies. Taking partners through SCR from other areas, for example, allows scrutiny of processes without feeling the accountability of any particular outcome. This allows professional challenge to be encouraged through the whole safeguarding system from the front door to the final outcome/decision.
- One LA talked about sharing decision-making as part of the review processes with other LA areas within their region. This allowed a further professional challenge and the ability to consider any consistency issues in decision making, and action to provide a Collective Safeguarding Responsibility across the region.
- Involving VCS and other key agencies as part of any strategic review and scrutiny processes as well as localised operational meetings ensures holistic multi-agency practice.

8. Cohesion between Services

Explanation: For there to be joint ownership, it requires processes to be aligned, with seamless transitions across teams and agencies.

Evidence: The evidence from the review found varied approaches to joint working across services, with some areas having agencies more formally integrated as part of their safeguarding arrangements with these co-located to help facilitate information sharing and joint ownership. These variations were identified across Adults and Children Services

"Integrate the safeguarding team, Children and Adults, we're going to be one team. So, you've got a shared understanding of what vulnerability is, the categories of abuse, and what do they mean. I think eventually, we'll knit it in, and we'll get rid of the silos"

Significant issues were raised with all LAs around a lack of cohesive working with Health partners, particularly Mental Health support. The varied engagement with VCS agencies also impacted on LAs achieving Collective Safeguarding Responsibility.

"The current sort of safeguarding issues coming out around young people and mental health. It is massive.. I've just read one this morning, a 10 year old, saying that they feeling really low, want to kill themselves, you know, ten I wouldn't have even known what that was when I was ten, you know, and it is massive and there's a huge gap In services for young people's mental health cause cams is not enough. And but I also feel by them not attending these strats. And I know we have a health representative, but they're not. They haven't got any power. And any sort of young people's mental health type strats that CAMHS need to be there because I don't think they take enough responsibility"

Good Practice Examples:

- One LA area was seen to have integrated their Adults and Children together within their MASH/Safeguarding Hub. Although initially met with resistance, practitioners reported increased cohesion between Adults and Children's, increased resilience within their workforce and increased competence and confidence as an individual practitioner.
- An IDVA interviewed in one LA area reported that there was strong relationship with the LA Safeguarding Hub. This was attributed to an inclusive management style whereby domestic abuse is recognised as a key area in safeguarding. Moreover, being employed by the local authority and having the same management structures enabled them to feel, *"very much immersed into Children Services".*
- Some LA areas were also recognising below threshold vulnerabilities and working with VCS in providing services, such as substance misuse for under 18s in trying to reduce later critical issues.
- One LA area also gave an example of using Microsoft Teams to bring together larger groups of professionals to share concerns quickly around place and space vulnerabilities.
- One LA area employed 'Educational Link Workers' within the Safeguarding Hub who were responsible for sharing information between the schools and the Safeguarding Hub. Another LA area employed Educational Safeguarding Officers within their Children's Services team to advice, support and assist all schools in the area.
- One LA area highlighted difficulties when responding to harm outside the family home, which may not be as well supported by the traditional child protection system. In achieving this, a range of services and professionals worked together to provide their professional insights to ensure the safeguarding response was effective.
- There were also examples whereby agencies working alongside each other in the Safeguarding Hubs were combining forms to save on duplication. In addition, one area aligned referral processes within the hub to ensure that any referrals requiring Youth Justice support were taken off the system and transferred to Youth Justice system. This ensured that they were actioned efficiently regardless of point of entry.
- Other examples included developing joint case management systems to align joint working and share safeguarding responsibility whilst having a lead professional, which could be changed depending on any developing safeguarding risks.
- Transitional working was present within Prevention Teams and statutory teams such as when stepping down cases so that before an agency stopped working with a family, there was an introduction to the voluntary support agency to identify areas where support could be put in

place with consent. Without this introduction, voluntary take up of prevention services could be lower.

Recommendations:

- Review operational processes between Adults and Children's Services, with a minimum requirement of ensuring there is co-location within the same building (not necessarily sat together), or as a hybrid team. This should also seek to better align training requirements, meetings and forums to be opened across Adult and Children practitioners, as well as other agency staff.
- The role of specialist domestic abuse (DA) workers as part of integrated Safeguarding Hubs/MASHs were seen as an effective addition to multi-agency teams. This provides the specialist support for this high demand vulnerability, which often does not meet necessary threshold support for intervention. One LA had their DA Hub within their Integrated Safeguarding Hub, ensuring a streamlined process and understanding across practitioners working across the team.
- Being responsive to the changing nature of vulnerabilities within the local community and having established relationships with the VCS to develop and implement services in response to this was seen as effective.
- Linking to this is a need for a LA and National commitment to ensure that VCS agencies are valued not only for the service they provide, but also providing a platform within the more formalised meetings to give them a voice and learn from the expertise.
- Use of specific forums, sub-groups between a smaller number of agencies softer intelligence and contextual information would be shared in the appropriate environment, depending upon what the purpose of the meeting was. For example, one LA area discussed their Contextual Missing Exploited and Trafficked [CMET] multi-agency panel. The CMET panel was split into two groups strategic and operational. The multi-agency CMET operational panel is focused on looking at how to deal with safeguarding concerns on the frontline.
- Use of Community Connectors to provide information regarding support and services within the community. This can help to build resilience and cohesion for Early Intervention responses.
- Adopting joint forms and developing aligned protocols between agencies to avoid duplication, where possible and ensure that referrals are managed seamlessly between agencies.
- Transitional meetings whereby if any agency feels a case could be stepped up or stepped down, there are joint meetings with families and both agencies to prevent escalation of risk or continue support when risk reduces and manage transitions.

9. *Consistency and Stability*

Explanation: For Collective Safeguarding Responsibility to be achieved there must be Consistency and Stability within and across LA areas, and across those key safeguarding agencies. Practitioners noted that this was contingent on recruitment, retention and staff wellbeing being effectively prioritised within safeguarding arrangements.

Evidence: Multi-agency working was noted to be dependent on the relationships between practitioners across these various agencies, with these being developed over time. Consequently, for these relationships to develop, it requires a consistent and stable workforce, with staff recruitment, retention and wellbeing to be considered.

There was a recognition that working within multi-agency safeguarding can be an incredibly stressful job. The recruitment of new practitioners was felt to be hugely challenging. This was seen to be further worsened by the fact that the recruitment of Social Workers is a national issue, which is resulting in LA's competing against each other in recruitment, causing pay differences across LA areas. The reliance on agency staff was also felt to be negative as not only did it cost huge counts of money for the LA, but it also meant that any work was temporary and within Social Work. Multi-agency working, stability and consistency in relationship building is paramount. This was all against a backdrop of increasing demand being felt since Covid-19 (see Theme 5.1 for more detail).

"I think the one thing in Wales, particularly in Wales is that there has to be a drive to have a national pay scale for social workers because we're competing against each other. It's not doing anyone any good really. There should be something done about agencies, social work agencies and the way that they rip us off to be honest with you"

Furthermore, stability across the whole service including the leadership team was seen to enable effective partnership working whereby practitioners are familiar with structures across areas. Some took this further by stating the stability was evident across their region. These established relationships increased opportunities to build trust and respect, offer advice and work collaboratively across a range of tasks. Moreover, it encouraged a greater knowledge base to be built alongside more open information sharing, resulting in a more confident workforce.

In contrast, it was highlighted that in some LA areas there was a high turnover of staff within Social Services. This was felt to be disruptive for the families and more challenging for receiving updates for information and having that 'go to' person when working in a multi-agency capacity.

"The annual recurring kind of funding, it doesn't lead to stability, it doesn't lead to practitioners knowing what their families can access. They come, they go, it leaves gaps, and then you are causing a change in the workforce"

Good Practice Examples:

- ✓ One LA area talked positively about the Consistency and Stability not only across their own agency, but also across their multi-agency arrangements from Strategic to Frontline. There was clear transparency in role opportunities with the focus on investing in current staff and maximising their experience, skills and relationships gained. This was also linked with how staff were rewarded within the LA, with practitioners stating they were given a day's leave to say thank you.
- ✓ A couple of LA areas showed huge commitments to the engagement and involvement to key VCS organisations as part of their safeguarding arrangements. This was seen as most effective when they formed part of formal groups and forums, rather than individual practitioner brought in on a case-by-case basis. Providing a consistent place for key VCS led to them feeling more valued and part of the Collective Safeguarding Responsibility.
- ✓ In some LA's there was an investment in staff wellbeing and ensuring support and value for practitioners was in place. Moreover, managers had a good understanding of operational issues and had a culture of an approachable management style so practitioners could access support when needed.
- ✓ One LA had invested in sponsoring several practitioners in order to allow them to experience a variety of placements and a sponsored qualification.

Recommendations:

- ➢ Nationally, increased bursaries from Welsh Government to encourage recruitment and to facilitate people to become qualified. Regionally, LA's can consider sponsoring individuals to become qualified and gain the necessary experience. However, both options are recognised as a long-term solution and does not address the current shortage and investment that is needed to recruit.
- ➢ There must be an equal focus on retention as well as recruitment. Whilst many teams felt stable and that they mainly lost people to promotion, the issue of losing them to neighbouring LA areas that were offering a better package was problematic. It was also stated that in some LA teams where there was a high turnover of staff and issues such as pay freezes.
- ➢ Providing consistency in incentives across Wales for the recruitment of staff. Issues were raised around better packages to new recruits than the current work force, thus making current staff feel undervalued for their continued commitment (discussed more in Theme 4.3). This not only caused problems within LA teams, but also with neighbouring LA areas.
- ➢ Ensuring as part of retention plans, staff feel valued. Lots of innovative ways that wellbeing checks were being implemented (see 4.3) and recognising the effort of staff. For example, a

partner appreciated having a celebration day to take as leave, which made them feel valued for their work.

- Recognising where the demand issues are and targeting resources accordingly. Early Interventions Services, such as Families First and Early Help Hubs were under significant pressure responding to the huge volumes of demand just below threshold.
- Linking to the above point, it was also noted by practitioners within Early Intervention Services that staff within these roles are often employed on a fixed term basis due to being linked to specific funding grants. This can cause significant issues in the recruitment and retention of staff, particularly when there is investment in each practitioner that joins the team due to training requirements. This also impacts on the continuity of services delivered within the local area.
- The negative press and stigma attached to the role of Social Work requires a National Campaign to change the societal view and culture of the role, with staff noting feeling *"very undervalued, both by ourselves, and by the public, for lots of different reasons"*. This was seen as an essential requirement to help improve the Consistency and Stability of Social Work currently.
- Linked to the high turnover of staff reported across key safeguarding agencies was the need for better communication across the partnership to ensure continuity of information sharing and support.
- Furthermore, Consistency and Stability was also discussed regarding short-term funding of staff and initiatives, with this seemingly improving with some services stating that they are receiving 3 years funding for the first time since starting their service. This needs to a priority particularly within Early Intervention services.
- Due to safeguarding often being reported as a stressful job, there must be an investment in staff support and recognition of the importance of wellbeing. There must be adequate levels of support in place for both practitioners and managers with a clear understanding of the frontline challenges acknowledged at strategic level to ensure staff are given access to the appropriate support. There should be recognition and value of staff and commitment to their individual training and development needs as well as working through flexibility options to ensure that staff have a good work life balance.

10. Coordination of Data Collection

Explanation: There must be a commitment to enabling effective coordination of safeguarding data collection. This requires a clear understanding at LA level, and nationally, how multi-agency safeguarding data is recorded, analysed, used and shared to inform safeguarding practice.

Evidence: The way in which data is utilised varied depending not only across LA area, but also by safeguarding agency. However, there were clear methods for documenting and using safeguarding data such as to identify trends, demands and potential gaps to inform practice and allowed for an illustration of performance indicators and details around the impact of their service. Furthermore, there was further identification of how this informed organisational learning and accountability across the multi-agency safeguarding arrangements.

All agencies stated that they collect data regarding the service users whom they work with and interventions that may be put in place. Data can include information on referrals to services and their sources so that various needs can be identified and the monitoring of specific actions which follow. This can include the number of statutory visits complete, strategy meetings held and so on. These factors help to understand the need and demand for services and what the reasons are. In addition, information such as number of assessments which have been complete, whether they were completed within expected timeframes. This information is recorded by practitioners and collated by analysts and then reviewed and usually disseminated by managers. There is data which is collected monthly and quarterly reports to ascertain a clear picture. The aim is to identify patterns of referrals and trends which helps to understand what their service delivery should look like and design appropriate interventions to *"inform local authorities about services and support".*

A shared database was something which was discussed frequently with stakeholders agreeing it was the necessary way forward for multi-agency working. It was felt by some stakeholders that a shared database was in part, already operational, with 5 out of the 7 LAs using WCCIS as their main information recording and information system. Much frustration was voiced by LA areas regarding their current system, particularly those using WCCIS, with many stating that the system was 'overpromised' in terms of what it would deliver.

"At one point I said it's preventing us from delivering a safe and effective service because the system was down for 9 days when they did a national upgrade. We were recording information manually, but when you can't even go in and look, how do you make safe decisions if you can't see what's current information"

Good Practice Examples:

- ✓ Most statutory safeguarding organisations noted a detailed structure in place which provided the LA area with a comprehensive reporting system and framework. This detailed how delivery groups, operating alongside safeguarding forums, report information up to a safeguarding and governance performance group at Director Level. This information is subsequently formatted into a report and then disseminated; thereby, the data is used to

inform to those that are part of the safeguarding response, *"that way, you know that it's going to all those bases".*

- A good example of bringing different aspects of data together was seen in a reporting format called AAA: Alerts, Assurance and Achievements. This ensured that within the report was the inclusion of areas of concern and escalation, but also understanding what has gone well and the impact of their work.

"It goes out to the whole organisation what the data looks like, but more importantly, the narrative around that, what does that mean and what do we need to do next, and how that informs our practice"

- ✓ One LA area discussed the static and fixed nature of safeguarding metrics, whereas the journey is much more incremental, with those smaller steps not recognised in the achievements of the practitioner or the individual they are working with. They had developed and implemented a document where progress made by families can be discussed and scored to understand what incremental progress has been made, rather than only having data on whether a child has been returned home.
- ✓ Most LA areas discussed striving to ensure that service delivery is as effective as possible, and posing questions to themselves about, *"What could we change to make this better? What could we pilot in the team? What could we change on the system? What do we need to do to help staff know about this information, so it changes their practice?".* This was further highlighted through a piece of work undertaken by a LA area called *What Matters*, which had a key aim of understanding what effective safeguarding looks like from the from service user perspective. These findings were then developed into *value steps* which are used as a checklist to ensure that the service workflows are focused on ensuring effective safeguarding is being delivered for all service users.
- ✓ Examples given across LA areas regarding how data was being used to inform changes in policy and practice. Examples were given such as the review of processes in relation to Section 47 when an increase within a certain cohort was identified. By exploring the context of the surge in data it allowed them to emphasise the need for information queries to occur first before escalating to Children's Services. Other examples allowed for more specific and tailored responses to a type of vulnerability such as child criminal exploitation and county lines.

Recommendations:

- ➢ LA areas discussed using data collection in several ways to help improve their Collective Safeguarding Response, which should be considered as part of each LA safeguarding response:

- Clear mechanisms of data reporting regularly to frontline practitioners and safeguarding teams to help understand why data collection is important and how it can help direct safeguarding support.
- Data was seen to be able to identify key trends and service gaps, which subsequently were used within funding support applications, providing a clear evidence base of need.
- In ensuring safeguarding practice on the frontline is as effective as possible data provides evidence on where increased strategic support is required. By providing the data evidence to strategic boards and regional groups, questions were raised about this evidencing the increased demand and the need for further support in responding to it. Therefore, data allows the transparency in the pressure being felt within the safeguarding system.
- The exploration of data for trends and demand also examined gaps and reductions. The data highlights an absence of demand may also provide information about practice, whether that is due to some areas requiring more community awareness raising about what to do if they need support or have concerns. It is not always about trying to respond to the top levels of demand but recognising the absence of it too.
- The benefits of looking at the data and understanding not just the quantitative demand, but also the context and nature of the demand enables services to be developed in response to community needs and increase the reach of the safeguarding response.

- A national review is required of WCCIS, alongside a review of other systems being used across LA areas to compare functionality. Most of LA's using WCCIS reported that they were forced into spending a significant time in making the system work for them. Yet there were still issues in the accuracy of data extracted, and functioning issues, such as when upgrades or changes were required. Further issues identified by partners include:
  - The system not being used by partners that were said to be implementing it, mainly Health.
  - The lack of access to neighbouring LA areas that were also using WCCIS, therefore, potentially missing information when dealing with exploitation that is known to cross LA boundaries.
  - The metrics and measures required by Welsh Government were not seen to be present within the system, or easily recorded and extractable. Hence, significant work was required to be able to make the systems work to extract the reportable data.

- When the system was down, which was reported to happen frequently, the risks raised due to this were very concerning, with information not being available. This subsequently put additional pressure on professionals to keep paper records and spend more time updating systems, or risk being seen as breaching policy and guidance.
- The importance of being able to have a safeguarding data system that allows practitioners to easily see the chronology of their service user/referral.

- Basic blockers were noted by practitioners when discussing the responsibility of recording and extracting data, with the forms used to collect data not always having the appropriate spaces for noting contextual or crucial information. The requirement for open, qualitative responses was seen to be an essential aspect of data collection to help provide the context of the information being inputted.
- Practitioners advocated for more investment in the collation of qualitative data via independent researchers to capture the voice of service users to feedback into the safeguarding arrangements, and response.
- Regular audits were seen as an effective mechanism to review current practice and identify learning to improve service delivery across LA areas. The frequency of these meetings varied, with effective practice identified in a LA area that completed this as part of the weekly referral meeting. Partners clearly stated that the use of multi-agency audits were a fantastic way that helps practitioners to develop, with this including their written, assessment and risk assessment skills.
    - To ensure there is accountability of any recommendations and actions from these audit meetings, accountability through reporting is required. These reports should highlight upcoming targets and practice improvements from previous reports. The report recommendations should be seen as a mechanism in providing clear accountability to improve practice in the areas identified as requiring further development.
- There were concerns from practitioners regarding the minimal, or complete absence of feedback from Welsh Government on how the data is being used to inform any policy or guidance nationally. Suggestions wanted to see a more collective responsibility and transparency from Welsh Government down to Regional and Local level in sharing how the data is being used. Being able to more directly feed into this agenda was seen as a crucial part of their safeguarding response in being able to contribute to the discussions, understand any changes in requirements concerning data collection and reporting. Having joined up

conversations about the measures collected at national level may allow for increased consistency in issues such as thresholds for statutory intervention.

- Many practitioners had concerns on the stark differences in the data across LA areas which is published nationally. Practitioners acknowledged that they were aware that some indicators were being interpreted and therefore reportedly differently. There were concerns that there had been no efforts from the Welsh Government to try and encourage more consistency in the regular reporting, which requires urgent attention.
- Given the huge demand and public nature of safeguarding data recording and reporting, there needs to be sufficient investment within each LA area and at regional level to be able to manage this demand. There were variations in the staffing support regarding data management and performance, which requires further exploration to reiterate the importance of these roles as part of the multi-agency safeguarding arrangements. Most LA areas talked about having to spend significant amount of time in their performance teams, chasing gaps, or querying data and rectifying gaps or inconsistencies. This, however, often came down to the data recording system itself not being fit for purpose.

  "They're [forms] not filled in at all, so the data, when it comes to the end of year it's always skewed. So, there's always somebody having to go through all of those that haven't been inputted correctly to see what's happened with the case"

11. Collaboration Forums

Explanation: There must be Collaboration Forums with service users, families and carers to feedback on their experiences to ensure services are effective in achieving their aims.

Evidence: Capturing the voices of those service users with lived experience of working with safeguarding services is a key aspect to service user participation. Partnership working with service users and families was discussed in relation to the active role that they played during their time working with safeguarding organisations, and how much input this process allowed for them to participate. It also explored how much consultation and participation was facilitated after any support or intervention and how this feedback was sourced, collated and acted upon to shape future service delivery. Collaborative working with families was aspired to within Children's and Adult's Services across most LAs, with many talking about this being a 'priority' now that restrictions had been lifted since Covid-19. However, the level at which this was being delivered varied greatly across LA areas, with some making much more progress than others.

"A lot of the questions I face from service users is what must happen for me to get that help? I know the support is there and I know that I'm in need of it, but when does crisis point become too far gone"

Good Practice Examples:

- ✓ The introduction of the 'what matters' agenda has provided a vehicle for formalising the collaborative working with service users and families and ascertaining what matters to them. This is very much a part of the aim in working with people within safeguarding and was mentioned across most LA areas.

  "The first point of contact we have with children and families is understanding what matters to them. That carries on through into then completing an assessment and developing a plan"

- ✓ Within the Prevention Teams at Families First there were mentions of a tool by one LA area, the 'Distanced Travelled' tool whereby families are asked to score how far they felt they had progressed and where they felt they needed more support. This allowed the family to determine the areas they felt they need support and facilitates a discussion with the practitioner to explore actions going forward.
- ✓ In one LA, service users were offered opportunities to be included in shaping service provision and to learn what was working and what was not working through groups and forums. For example, wellbeing services and transformation forums whereby parents and carer representatives are on board. There were also residential meetings for service users, families and friends, and suggestion boxes, all for their voices to be captured.
- ✓ A Families First team offered questionnaires at the end of service to understand what could have been improved and how they have felt during the intervention. This form goes out to parents and there is a separate form for young people to ascertain their views.
- ✓ One LA area within their Children's Services discussed how *"young people are invited to feedback their experiences in relation to how we should be designing things".* Following on from this there have been creative ways in which young people have fed back including poems, rapping and traditional power-points.
- ✓ Independent advocacy was something which many stakeholders mentioned for both children and for adults and this was promoted and referred to by LAs which was facilitated by outside organisations. The use of an Advocate provides an important mechanism in which services can work in partnership to support the service user. It was also mentioned that in instances where an individual is deemed not to have capacity there are different communication aids and close working with the family and friends, yet it was acknowledged that independent named Advocates can be helpful as well to represent a service user's views.
- ✓ Active carers groups were discussed as being helpful for views to be heard and consultations with service users and families which had actionable outcomes. For example, service users

and families were asked about practical aids of support which resulted in 200 washing machines being distributed and fitted.

- ✓ Peer-led service user groups were identified in one LA whereby a service user group initiated between practitioners and service users could be consulted on their views, and experiences to feedback into future service delivery. It also provided an opportunity for peer-led support and for service users to form connections and friendships.

Recommendations:

- Emphasis on the importance of the first 'What matters and what is important?' conversation with the service user. This needs to be specifically addressed at local level operationally to ensure this is done meaningfully and captured as part of the core agreed aim of the safeguarding response all practitioners should have sight of.
- The above point links to discussions within some LA areas that emphasised the need for engagement with individuals and families right at the start of the process. Being honest and clear about the safeguarding process and what is trying to be achieved within it, and how they prefer to engage going forward within the process.
- Reviewing current recording of service user involvement in multi-agency forums, and where/how feedback is being collated to inform the requirement of this as a performance measure. Whilst most felt they were capturing their service user voice in some capacity, all agreed *"there is more they could be doing"*. More specifically this was discussed as *"it's something that we need to strengthen in terms of getting them to participate in strategy meetings".* The presence of service users in strategy meetings would encourage decision making to be made with them and not for them.
- Increased engagement and collaboration to utilise the skills of partners to ensure that service users feel comfortable to engage and the needs of the individual are recognised. This often links to the agency that has the closest relationship with the individual and if any additional expertise and insight is required.
    - For example, partners in Youth Work were often utilised to work in partnership with young people to ensure their voice is heard and supported, *"We've got our Youth Workers on the ground, and one of their purposes is to ensure young persons' voices, they advocate for the young persons' needs".*
- Independent advocacy was something which many stakeholders mentioned for both children and for adults. This was promoted and referred to by LAs and was facilitated by outside organisations. The use of an Advocate provides an important mechanism in which services can work in partnership to support the service user. In instances where an individual is deemed to

not have capacity there are different communication aids and close working with the family and friends, yet it was acknowledged that independent named Advocates can be helpful as well to represent a service user's views.

- There must be consideration of the design and implementation of tools that can capture the journey of the service user, rather than focus on more static, fixed measures of achievements and outcomes. For example, the 'Steps to Change' and 'Distanced Travelled' tool mentioned within good practice (above).
- Innovative ways need to be designed to offer service users a way to engage in feedback and service provision, rather than just providing questionnaires on completion of an intervention. As identified in good practice, one LA area was providing platforms to encourage feedback in the form of rapping and poems, as well as more traditional ways to allow them to be represented on the Boards.
- Creation, facilitation and the promotion of service-user and carer forums, panels, groups whereby service users are given the opportunity to discuss their experiences with their peers, and feedback to practitioners to influence future service delivery. Consultation must be meaningful and transparent. Consideration must also be given to how these forums are resourced, sustained and embedded into multi-agency culture and practice. This must be addressed strategically and operationally.

12. Continual Commitment and Ongoing Investment

Explanation: There must be Continual Commitment and Ongoing Investment into multi-agency working as a process of continual reflection, evolution and progress which is underpinned by sustaining relationships.

Evidence: Given the nature of changes and updates within safeguarding, multi-agency working must be recognised as something that requires continual coordination and investment from strategic level to facilitate operational level frontline practice. Opportunities for practitioners to come together to share good practice or carry out training in a multi-agency forum should be facilitated. This should not be viewed as a one-off annual arrangement, but an ongoing regular event for the exchange of perspectives and to deal with emerging issues as they arise. This is particularly crucial after the Covid-19 pandemic whereby many agencies' referrals may have increased in complexity with limited agencies resources available. In addition to any new policy or practice changes that practitioners need to be updated on, there were also issues of staff turnover, which was seen as affecting partnerships and relationships that underpin successful multi-agency working. Opportunities to learn from different agencies should be present at strategic and operational level with these as a regular feature of multi-agency practice.

"To have agencies sat around the table, to have training around, say thresholds or interpretation of the procedures and the law. To have everyone sat around the table to go, this is what this means to me, in this situation I would do that. If you have that understanding and you can build relationships and share information"

Good Practice Example:

- ✓ Partners spoke about ensuring their team had the opportunity to input into key decisions. This inclusive practice was reflected in allowing partners to feel their voice is equal to other partners within the multi-agency safeguarding arrangements. This was evidenced in interviews in everyday work by ensuring inclusion in decision making and that all views are listened to. Also, in terms formalised events, where individuals are celebrated for their commitment and achievements.

Recommendations:

- ➢ For multi-agency working to be successful, it requires investment of time and resources in being able to build those relationships, having congruence in strategy and operational working, devising aligned protocols to encourage and facilitate practice. Consequently, this requires the multi-agency safeguarding arrangements to embed the time for this into the Corporate Safeguarding Policy. This should clearly identify the mechanisms in providing the necessary space and time for multi-agency debriefs/reviews, to 'take a breath'.

  "We meet with them on a monthly basis, and we could do it [share ideas and practice between agencies] in that, but the problem I see is them having the time to follow it up because when they're getting a ridiculous amount of DTRs coming through daily, how are they supposed take time and stop and take a breath? They can't"

- ➢ Investment into multi-agency training and events to share good practice, to discuss common challenges and issues and to ascertain collective solutions and ways of working strategically and operationally.
- ➢ A continual commitment was also mentioned in terms of the leadership culture within safeguarding. That the nature of high-risk decision making and consequences of 'bad decisions' naturally resulted in a high blame and accountability culture. In challenging this, it requires a constant and sustained effort in ensuring systems, processes and therefore individual workers and agencies are not left holding all responsibility. Some great examples were given within individual teams (such as MASH) where managers were 'unpicking this' and re-orientating staff to their specific part in the safeguarding response. Therefore, no decision should ever be made in silo.

"I established a no blame culture right from the beginning because I was unpicking a lot of that practice but not with a view of going forward, not with the view for performance management… what they do is they risk assess and look at safety and wellbeing and they don't realise that's all safeguarding"

- Half of the LAs specifically mentioned that safeguarding demand most often is managed within their early intervention services, with a finite level of support that can be provided. This was seen to occur for a few reasons. First that thresholds for Child Protection were increasing due to the higher demand, resulting in less reaching necessary intervention within the Children's Team. Furthermore, those practitioners working within these Families First centres were aware of this likely outcome, so were holding onto *"more complex and high-risk cases".* Knowing that the cases would be stepped down to them anyway, and by continuing to work with the service user they were *"at least getting some support".* Alongside this is the national recognition required that *"early intervention universal service is not an unskilled service"*. There must be a recognition that joint working on complex cases must be an ongoing process between early intervention teams and statutory services, which must be joined worked and reviewed to ensure that relevant support can be provided before a situation reaches crisis point.
- Funding must be long-term, and agencies given notice of when funding will be released. When there was additional funding available to LA areas, this was usually required to be spent quickly and within a certain (short-term) time frame. Therefore, the inability to plan the use of this in collaboration with VCS to truly respond to vulnerabilities within communities was seen as problematic. Greater warning of fund availability to allow for evidence to be gathered at local level to ensure funds are being targeted where needed, and subsequently becomes more sustainable and embedded within a holistic safeguarding response.
- Given the identification of level of demand at early intervention level through Families First centres, Early Help Hubs, Flying Start, there requires a commitment of investment to these services over a longer period (seen as 3 years minimum). As mentioned within point 9, stability within the workforce enables consistency in service provision and an improved Collective Safeguarding response.
- There needs to be a national recognition that a lack of resources in each agency creates a barrier to collaborative working. At national level a review of staffing shortages across all safeguarding agencies in providing a joined-up approach is required. This needs to avoid creating competition across LA areas and agencies due to differences in incentives and packages for study, recruitment and retention of staff.

- Services need to ensure their support is accessible and sustainable. Stakeholders also noted that if a service is located around 30 miles away, but a service user does not have a car, public transport across rural routes that could potential entail a one-hour counselling appointment taking a whole day, which may not be feasible and is *"setting people up to fail"*. In addition, people may not have money to travel longer distances and that we should be realistic in our expectations of how accessible services are. Ensuring the review of demand and where services are placed is required to be continually reviewed to ensure a continued commitment to effective safeguarding.
- Most importantly, all the recommendations evidenced above (point 1-11) in terms of the Practitioners, Agencies, Structures and Process are all factors that require a continual commitment. Continued investment is needed to maximise achieving a Collective Safeguarding Responsibility at Local, Regional and National level.

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