Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales:

What does good look like?

National Executive Summary Report

November 2022

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Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

National Executive Summary Report

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1. Introduction

Richardson (2014, p.118) defined safeguarding as the "protection of vulnerable groups from abuse and or neglect," with this being the responsibility of all individuals who work with vulnerable groups. Yet, despite the hard work of many safeguarding professionals in attempting to protect the young and most vulnerable in society, the task can rarely be accomplished by one specific safeguarding agency or team. A popular formalised framework, used in Wales, is a Multi-Agency Safeguarding Hub [MASH] (Home Office, 2014). The aim of a formalised framework such as this is to "identify and manage risk at the earliest opportunity by promoting a collaborative approach to safeguarding" (Shorrock et al., 2019, p.9). This model was originally developed in England, and adopted widely across England and Wales. An early 2014 Home Office review concluded that whilst two-thirds evidenced a multi-agency model in place, only half used the term 'MASH'. Other terms such as Safeguarding Hubs have been adopted in Wales to represent their multi-agency safeguarding model.

Despite much agreement on the benefits of multi-agency collaborative approaches in safeguarding, it is widely acknowledged that implementation of multi-agency safeguarding models is problematic, this varies across key UK organisations and local authorities (McManus & Boulton, 2020; Shorrock et al., 2019). McManus and Boulton (2020) identified overlapping policies and guidance, thereby making internal navigation problematic. There have also been questions over which agencies should be involved, how they should be involved, and the resulting 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 models that suit their own needs. These may not be supported by evidence, with decisions based on resources, local opportunities and interests. Therefore, evidence is needed on how best to set up, implement and sustain effective multi-agency safeguarding arrangements that also consider the local context (e.g. population, service and crime data).

The current evaluation has brought together safeguarding partners across the multi-agency operational safeguarding arrangements in Wales, including frontline, operational and strategic roles. A number of different agencies have been included in the evaluation, to give a holistic overview of how each service plays a part in the whole safeguarding system. The evaluation incorporates multi-

agency partners working in both adult and children's 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 the features of multi-agency safeguarding arrangements. Moreover, it seeks to provide evidence on the features of an effective collaborative multi-agency safeguarding arrangement. The learning and recommendations provided in this evaluation are suitable for all safeguarding partners.

Aims of the Evaluation

This evaluation aimed to identify key features of effective collaborative multi-agency operational safeguarding arrangements (MAOSA[1]) in Wales, to determine 'What does good look like?' The output from this evaluation includes recommendations based on evidence obtained from seven Local Authority (LA) multi-agency safeguarding partners in Wales. The specific research questions addressed within the evaluation were:

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

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

Evaluation Approach

In seeking to answer the above questions, the LJMU evaluation team worked with the National Independent Safeguarding Board (NISB) to identify seven Local Authorities (LAs) across Wales as the study sites, considering the findings from the Phase 1 evaluation (McManus & Boulton, 2020). The areas selected ensured a representation of LAs across the six Regional Safeguarding board areas. They used different IT systems, and included both rural and urban locations.

Three separate data work-streams were completed as part of the evaluation to ensure a mixed-methods and multi-level approach, allowing for the fullest picture of safeguarding in Wales to be captured and examined. These were:

1. Exploration of ***safeguarding practitioners' perspectives*** through semi-structured interviews which engaged practitioners and their experiences of multi-agency operational safeguarding arrangements (MAOSA) within their LA area.
2. Exploration of ***service users' experiences of safeguarding***, through semi-structured interviews which engaged with parents and young people regarding their direct experience of any safeguarding processes.
3. Deep dive review of LA ***safeguarding performance frameworks***, data, quality assurance and audits. This included:
    a. Semi-structured interviews and focus groups with those responsible for safeguarding performance frameworks, data, quality assurance and audits.
    b. LAs also provided their performance framework data capture tools and reports to explore key commonalities and differences in what was being collected at local level compared to national safeguarding metrics.

In addition, a comprehensive Literature Review was completed as an introduction to the evaluation (**Literature Review**). Each of the data work-stream reports is available as an individual evaluation report, with this **Executive Summary Report** bringing the findings together.

2. Key Phases of the Evaluation

The LA areas included in the study were selected jointly by NISB and LJMU, considering findings from the Phase 1 Wales safeguarding report (McManus & Boulton, 2020). The areas selected ensured a representation of LAs across the six Regional Safeguarding board areas. They used different IT systems, and included LAs in rural and urban locations.

This section will detail the approach for each of the data work-streams. All three began with the recruitment phase, which resulted in seven LA areas consenting to be part of the full evaluation. A list of nominated points of contact for each area was provided by NISB and agreed by the LAs. After initial agreement from the LA lead had been confirmed, the lead researcher provided a Microsoft Teams briefing to the nominated person within the LA, as well as a briefing sheet to circulate to the Safeguarding Board, to ensure wider approval of the evaluation.

Methods

Data Work-Stream 1 – Practitioner Experiences of MAOSA

Each LA was required to include a minimum of ten interviews across their safeguarding arrangements. These included practitioners within strategic, managerial and operational frontline roles. See Table 1 for the breakdown of the sectors included across the seven LAs. In total, the research project completed **138 professional interviews** across Wales.

A team of four researchers conducted all interviews on MS Teams, between March and July 2022. The interviews ranged from 25 minutes to 1 hour 29 minutes. All interviews were conducted by the lead researcher for the LA area; an evaluation report for each LA area was also produced. To ensure anonymisation, each participant was assigned a participant number within the individual reports. Interview responses were transcribed either by an external transcription service (and the transcripts returned to LJMU), or 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).

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

The research team met regularly to discuss the overarching themes from the practitioner interviews; these were then used to build a template to analyse the interview data. On completion of the seven individual reports, the findings were merged to provide a national overview of MAOSA in Wales. The main analysis thematically explored the views of 138 practitioners. It identified seven key themes, with key findings and recommendations detailed in section 3:

Theme 1: Governance and Guidance

Theme 2: Joined-up Safeguarding Processes

Theme 3: Partnership Working and Collaboration

Theme 4: Staff Investment, Recruitment and Retention

Theme 5: Impact of the Covid-19 Pandemic

Theme 6: Data, Audit and Performance Management

Theme 7: Lived Experience Voice and Participation

Data Work-Stream 2 – Service User Experiences of MAOSA

Interviews and focus groups were carried out with a number of individuals across Wales who had accessed support which formed part of the wider safeguarding response. Adults, young people and children may come into contact with safeguarding support in various different ways and may be accessing support across all parts of the safeguarding system. This includes Adults' and Children's Social Services and Early Help support, as well as several organisations (statutory and non-statutory) across Wales that deliver services, programmes, projects and interventions to safeguard adults and children and provide wellbeing support.

Individuals receiving safeguarding support may not know they are part of the wider safeguarding system and may not refer to the support as safeguarding. They may be engaged with a specific type of support – for example, working with a Social Worker, Key Worker or Mentor – and in a programme of activity that supports their safeguarding needs. Therefore, interview questions focused on specific support, rather than referring to safeguarding procedures.

The research team liaised with seven areas in Wales. These contacts were derived from work-streams one and two of this research and through established contacts in Wales. A number of contacts could not support the project at the current time; however, seven services invited users to participate in the research. **Ten service users** from three areas in Wales participated in the research. There were four one-to-one interviews and one focus group (n = 4) with adults, one interview with a young person, and feedback provided via a youth worker for another young person. The adult participants were either involved in Adult Social Services or parents engaged with Children's Services; seven were in service user voice groups and the eighth continued to access a family support project. The young people were engaged in children's services and a community project.

Two researchers from the team led all interviews and focus groups on Microsoft Teams, between July and September 2022. The interviews/focus groups ranged from 20 to 60 minutes. Interview responses were transcribed either by an external transcription service (and the transcripts returned to LJMU), or using Microsoft Teams. The interview data was subjected to thematic analysis.

Discussions with key stakeholders when scoping out the feasibility of this research are also utilised and presented here. We also discuss relevant information, documents and case studies from three areas across Wales (see appendices in Service User Experience Report) provided by organisations to showcase examples of capturing service user voice.

Data Work-Stream 3 – Safeguarding Performance Framework

This data work-stream required two stages to the evaluation to provide a deep dive review of LA safeguarding performance frameworks and management:

- Stage 1: Review and Development of Safeguarding Performance Indicators. This sought to gather data capture tools that provided details of any Performance Indicators (PIs) collected by each LA area to help them collect, understand and share their safeguarding arrangement processes and outcomes.
- Stage 2: Semi-structured interviews and focus groups with those responsible for safeguarding performance frameworks, data, quality assurance and audits. This sought to provide some further understanding regarding the metrics collected (as provided in stage 1), but also to explore the strategic and operational aspects of data within the safeguarding arrangements.

Method Stage 1: Review and Development of Safeguarding Performance Indicators

This phase sought to identify any PIs that were recorded and collected across six LA areas in Wales (one LA was unable to provide any information in time for the study). This was achieved by a nominated individual, usually within the LA performance team, sharing blank data capture tools (e.g. Excel) with the listed variables (headers) included. No actual data was shared as part of this process.

The purpose of this review was to identify and potentially improve the existing list of PIs currently requested by the Welsh Government to monitor and evaluate performance as regards safeguarding of adults, children and carers. The existing PIs reviewed were considered in terms of:

- Depth, breadth and representativeness of current national reporting.
- Fitness for purpose.
- How the PIs potentially aligned with the themes and concepts of Report 2 (Practitioner Report).

A review of all the LA indicators yielded a list of more than 600 individual performance and information measures. Many of these duplicated Welsh Government PIs; however, we also identified locally devised measures that supported or expanded on the standard PIs. A thorough review of these measures was undertaken as follows:

- All versions of the national PIs were removed.
- The remaining measures were examined for duplication, paying close attention to the terminology and specification of the measure.
- After removal of duplicates, the remaining measures were reviewed for:
    - Relevance at national level.
    - Added value to existing PIs.
    - Relevance to emerging themes and ideas from qualitative research.

Overall, ***68 new PIs were reviewed as fulfilling the above criteria***. These are presented within the Analysis section as suggested considerations to review alongside the existing suite of National Measures. These measures were split into overall categories of Adults', Children's, and a new category of Staff/Safe Workplace.

Method Stage 2: Semi-Structured Interviews and Focus Groups with Data and Performance Management Teams

The business manager for the LA gave the research lead for their area a list of names of people with responsibility for data and performance management within their LA safeguarding arrangements. These individuals were contacted via a group email with a Participant Information Sheet (PIS) and a Consent Form, along with the project briefing sheet (in both Welsh and English). From this, arrangements were made, subject to availability of staff. This led to individual interviews taking place in some LA areas; in others, focus groups were held involving two or more staff members. All but one LA engaged in this phase of the evaluation. This resulted in the following final data set:

- LA area 1: 3 focus groups; total of 7 staff
- LA area 2: 1 individual interview
- LA area 3: 4 individual interviews
- LA area 4: 2 focus groups; total of 5 staff
- LA area 5: 2 individual interviews
- LA area 6: 1 individual interview

This resulted in ***20 staff members*** providing their experiences about data collection, performance frameworks, indicators and quality assurance frameworks within their LA area.

One researcher in the team led all interviews and focus groups on MS Teams, during June and July 2022. The interviews/focus groups ranged from 48 minutes to 1 hour 16 minutes. Interview

responses were transcribed either by an external transcription service (and transcripts returned to LJMU), or using Microsoft Teams. The interview data was analysed using a Template Analysis Framework, which considered the data inductively (led by patterns in the dataset) and deductively (looking for specific concepts previously identified in the relevant literature).

Ethical Considerations

LJMU ethical processes assessed the study as no/low risk for data work-streams 1 and 2. However, the usual ethical processes were implemented within the evaluation, including a Participant Information Sheet (PIS), Consent Forms and a Project Briefing Sheet; these were provided to each participant. Each participant was invited to engage in the study via a Microsoft Teams video call that would be recorded on a separate digital device. The interview recording was transferred to a personal secure file on the LJMU system; it 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 were followed. As the data capture tools requested and provided by each LA did not contain any data, there was deemed to be no/low risk in the use of these.

Higher-level ethical approval was obtained for data work-stream 3 as this part of the evaluation required speaking to individuals about their personal experiences of safeguarding processes within Wales. The research team worked closely alongside key organisations in Wales to identify types of support, specific programmes and support pathways. Earlier stages of the wider research project were essential in linking in with the appropriate organisations and stakeholders. The research team utilised gatekeepers from key organisations to support recruitment. Ethical approval was sought and granted from the LJMU Research Ethics Committee and age-appropriate information sheets were developed, alongside rigorous consent procedures for gatekeepers, adults, and children and young people.

3. Key Findings

3.1. Practitioner Experiences of MAOSA

The following section pulls together the extensive qualitative thematic findings identified as key features of effective multi-agency safeguarding practice. The review findings are based on the multi-agency safeguarding arrangements in seven LA areas. This review includes the voices of agencies across adults to children and families, as well as the Front Door, Information Advice and Guidance (IAA) services, through to statutory interventions – all the agencies who were seen as part of that system. Practitioners from Social Services, Police, Health, Youth Justice, Youth Service, Fire Service, Voluntary and Charity Sector (VCS) and Third Sector agencies provided their voices. The findings were developed into a model of essential features for achieving 'Collective Safeguarding Responsibility' within multi-agency arrangements. The model and its elements are detailed below, with consideration of evidence for inclusion; example quotes and best practice example(s) are provided in the main report.

Achieving Collective Safeguarding Responsibility

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

Figure 1. Overarching Model of Collective Safeguarding Responsibility

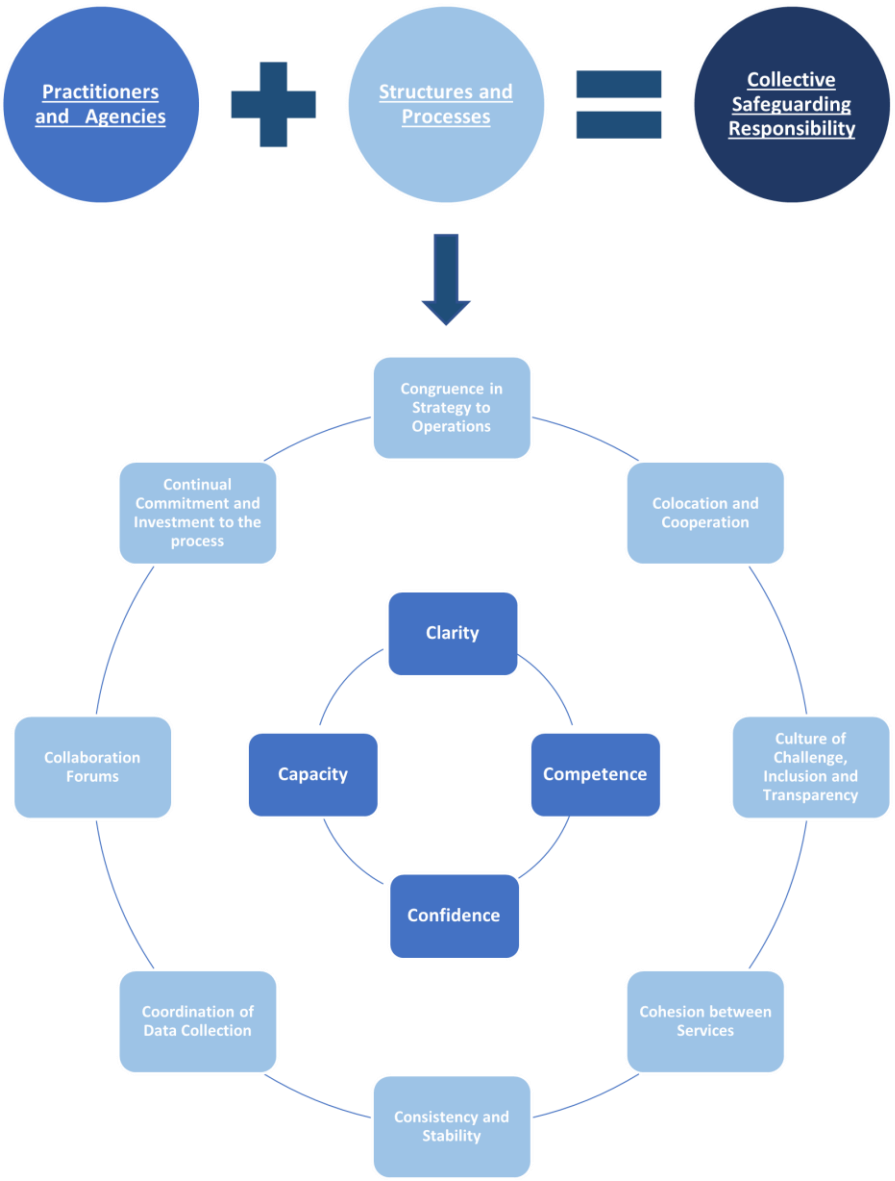


Figure 1 outlines the two core elements of achieving Collective Safeguarding Responsibility: Practitioners and Agencies (dark blue) and Structures and Processes (light blue). It provides the details of what is required within these two elements. The model also shows how practitioners and agencies are at the centre of this, highlighting the necessary individual and agency competencies needed to be able to achieve each of the structures and processes. One cannot succeed without the other: to achieve collective safeguarding responsibility, practitioners, agencies, structures and processes must all work together.

Achieving Collective Safeguarding Responsibility: The 12 C's

This section will examine each element of Figure 1 in terms of evidence for its inclusion.

1. Practitioners and Agencies

First, taking the centre of the Key Elements of Collective Safeguarding Responsibility (Figure 1), four key features for Practitioners and Agencies were identified within the current evaluation report: Clarity, Confidence, Competence and Capacity.

Clarity

Explanation: Practitioners must have a comprehensive understanding of the needs of a service user and the desired outcomes. There must also be clarity over the expected remit of any agency with which they may be working in partnership, and the thresholds and responsibilities of agencies to which they may refer service users for safeguarding interventions. This allows for a holistic understanding of safeguarding responsibility.

Recommendations

- Development and agreement of a multi-agency safeguarding referral Threshold Document at the regional level. This document should also detail the feedback referring agencies can expect when submitting safeguarding referrals.
- Agreed Terms of Reference across key multi-agency forums/groups.
- Regular multi-agency review of Serious Case Reviews (SCRs), Adults' Practice Reviews (APRs) and Children's Practice Reviews (CPRs) to scrutinise roles and remits in decision-making across agencies (helps review the changing nature of threshold and ratify service remits and capabilities).

Confidence

Explanation: Practitioners must have adequate training and support from their organisation to ensure that they have confidence in their own ability to carry out safeguarding responsibilities within their role. These safeguarding responsibilities must be clarified through their own organisation and alongside partner safeguarding agencies, enabling a collective safeguarding responsibility to be understood.

Recommendations

- Provide a clear pathway/platform for conversations/consultations with LA safeguarding duty teams, other safeguarding teams or MASHs to help understand what is required and what decision can likely be taken on currently available information. Additionally, provide feedback to referring agencies on decisions ensuring that they are up to date with any safeguarding processes, as they may still be working with the family. This also requires a proactive culture

change to facilitate an inclusive and approachable environment that allows for ongoing dialogue and discussion.

- Regular review and identification of the safeguarding process to understand where there are potential issues in information sharing (blockers), or where referrals have received a lack of 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, including the need for transparency and consent when making referrals.

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. Reviewing competence is key to accommodating progress and changes within the multi-agency safeguarding environment. This requires clarity on agency safeguarding responsibilities, in addition to the confidence to competently deliver appropriate safeguarding.

Recommendations

- Improved coordination between Adults' and Children's Services. This could be achieved through developing omnicompetent workers who have knowledge in both areas, or having representation of both services at the front door. Whilst the issue of 'specialisms' within Social Services is a controversial topic, there is evidence of clear benefits when staff are able to understand vulnerability across the lifespan. Having competence in understanding and identifying risks across adults and children is an important key skill, particularly within Social Services. This is due to the nature of vulnerability, which is often linked by families or communities. This can be achieved by:
    - Integrating Adults' and Children's Services at the front door, and the subsequent Safeguarding Hub/MASH. Co-location is seen to be a successful application to bring together these services.
    - Providing opportunities for increased joined-up working across Adults' and Children's Services by co-locating teams in the same building.
    - Further discussion in how training can be provided to both Adults' and Children's practitioners to increase collaborative working and the understanding of roles, risks and decision making. Also to agree and identify where specialism training is required.

Capacity

Explanation: There must be adequate staffing levels and resources to be able to respond to and fulfil safeguarding responsibilities in a meaningful, timely and collaborative manner. Funding must also be sustainable; short-term pockets that have to be spent within certain timeframes can hinder long-term support and development. Data highlighting where demands for services are highest can assist in allocating resources. Equally, the fact that successes of Prevention Services are not easy to measure should not act as a barrier to funding these services, given that Early Help, and their support to meet previously unmet needs, was felt to be beneficial by many. If practitioners have clarity on what their safeguarding responsibilities are, and the confidence and competence to deliver these safeguarding interventions, there must be adequate resources and capacity for these interventions to be feasibly delivered.

Recommendations:

- There is a need for more partners working in mental health as services are not meeting demand.
- Stable and consistent funding of services is needed across areas to prevent a 'postcode lottery' of service provision, particularly early intervention.

2. Structures and Processes

The outer key elements of Collective Safeguarding Responsibility (Figure 1) require the inclusion and implementation of an eight-point process regarding structures and processes, within multi-agency safeguarding arrangements. These are outlined in detail below.

Congruence in Strategy to Operations

Explanation: There must be a commitment to ensuring that priorities at strategy level filter down effectively to operational level. 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 this influenced frontline practice.

Recommendations

- Leadership was seen as a key factor in this area. LA management approaches should be required to seek 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.

- Investment in creating opportunities and mechanisms to ensure that various operational demands and frontline challenges are communicated to senior leadership.
- Commit to staff within the workforce, investing in upskilling and developing through promotion. Allowing the continuation of relationships and understanding of structures and processes was seen to be an important factor.

Co-location and Cooperation

Explanation: For the majority of LA areas, establishing, developing and sustaining multi-agency relationships required some form of co-location to enable effective cooperation. Rather than full-time co-location, a hybrid working model within safeguarding arrangements was often preferable 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 that where this did exist, there were more positive conversations about information sharing, staff retention and staff wellbeing. This ultimately facilitated collective safeguarding responsibility. It must be noted that co-location in itself cannot facilitate collaborative working and there must be investment into building relationships between agencies and professionals. This should also include developing shared protocols and ways of practice to underpin the move towards physical co-location of services.

Recommendations

- The opportunity to work via a hybrid model was seen as the most effective way for multi-agency safeguarding arrangements to enable learning from each other, particularly for new staff.
- Being able to work, where possible, in the same office as other team members was seen to be beneficial for sharing information, both relating to immediate cases and updates in legislation, opportunities for training and the like. It also helps with understanding different agency remits, managing expectations across agencies and building meaningful partnership relationships.
    - Additional benefits were seen regarding the ability to separate practitioners' home environment from work and provide an escape from constant online video calls.
- Where co-location was not in place, placing the structures in terms of oversight of key agencies under one principal officer allowed these relationships to develop and function effectively.
- Specific working groups should be set up where necessary to enable effective relationships to be established and form opportunities whereby practitioners are brought together in the creation of an initiative and then work together operationally within it.

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. This is easier when partnering agencies have established and stable relationships. Whilst statutory agencies are fundamental in safeguarding, other agencies also have roles to play; for example, those in the third sector who may support with domestic abuse, exploitation and housing support.

Recommendations

- Develop, implement and share clear policy around professional challenge, with details of processes to follow should more formal procedures be required. This should be encouraged and clearly communicated as a part of continued learning and scrutiny processes, to make professional challenge part of weekly business.
- Share good practice and review processes across different LA areas to address consistency and encourage scrutiny.
- Involve third sector organisations and other key voluntary and charity agencies, where appropriate, as part of strategic review and scrutiny processes, and in localised operational meetings to ensure a holistic multi-agency practice.

Cohesion between Services

Explanation: For there to be joint ownership of safeguarding responsibility between agencies, processes must be aligned, with seamless transitions across teams and agencies. This can be achieved through formally integrating agencies as part of their safeguarding arrangements through governance, and by co-locating agencies to help facilitate information sharing and joint ownership, both across Adults' and Children's Services.

Recommendations

- Review operational processes between Adults' and Children's Services, with consideration of co-location within the same building (not necessarily sat together), as a hybrid team. Training requirements should also be better aligned, and meetings and forums opened up to both Adults' and Children's practitioners, as well as other agency staff.
- The role of specialist Domestic Abuse (DA) workers as part of integrated Safeguarding Hubs/MASHs was seen as an effective addition to multi-agency teams. They provide the specialist support for this high-demand vulnerability, which often does not meet the threshold support for intervention. This enabled the timely and fluid sharing of information, which often involved working with the same families, as well as DA being a high demand vulnerability. One

LA had their Domestic Abuse Hub within their Integrated Safeguarding Hub, ensuring a streamlined process and understanding across practitioners working across the team.

- Understand and involve local third sector and voluntary and charity organisations to understand what services are available locally, but also to provide a platform within the more formalised meetings to give them a voice and learn from their expertise.
- Implement localised specific forums or subgroups across a small number of agencies to enable the sharing of relevant and 'softer' intelligence and contextual information, ensuring information sharing is appropriate and proportionate depending upon the purpose of the meeting. For example, one LA area discussed their Contextual Missing Exploited and Trafficked [CMET] multi-agency panel. This panel was split into two groups: strategic and operational. The multi-agency CMET operational panel was focused on 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 build resilience and cohesion for Early Intervention responses.
- Adopting joint forms and developing aligned protocols between agencies where possible, to avoid duplication and ensure that referrals are managed seamlessly between agencies.
- Transitional meetings, so that if any agency feels a case could be stepped up or down, there are joint meetings with families and both agencies to prevent escalation of risk or continue support and manage transitions when risk reduces.

Consistency and Stability

Explanation: For collective safeguarding responsibility to be achieved, there must be consistency and stability within and across LA areas, and across the key safeguarding agencies. Practitioners noted that this was contingent on recruitment, retention and staff wellbeing being effectively prioritised within safeguarding arrangements. Multi-agency working depends on relationships, and this is more challenging when there are instabilities in staffing levels.

Recommendations

- Nationally, increased Welsh Government investment into bursaries would be beneficial, to allow for training and qualifications to be gained, encouraging recruitment and helping individuals to become qualified.
- Regionally, LAs may consider sponsoring individuals to become qualified and gain the necessary experience. However, both options are recognised as long-term solutions which do not address the current shortage; investment is needed now to recruit.

- Provide consistency in incentives across Wales for the recruitment of staff. Issues were raised around better packages for new recruits than the current workforce, thus making current staff feel undervalued for their continued commitment.
- Ensure that as part of retention plans, staff feel valued. The review identified many innovative ways of implementing wellbeing checks and recognising the commitment and determination of staff efforts to ensure that adults and children are safe.
- Recognise and understand where the demand issues are and target resources accordingly. Early Interventions Services, such as Families First and Early Help Hubs, were under significant pressure to respond to the huge volumes of demand just below thresholds.
- The negative press and stigma attached to the role of social work require a national campaign to change the societal view and culture of the role. Staff noted feeling *"very undervalued, both by ourselves and by the public, for lots and lots of different reasons"*. This was seen as an essential requirement to help improve the consistency and stability of social work.
- Long-term and stable funding is paramount. This needs to be a priority, particularly within Early Intervention services. Consistency and stability were discussed in regard to short-term funding of staff and initiatives; this was seemingly improving, with some services stating that they were receiving three years' funding for the first time since starting their service.
- Agencies to given advanced 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 effective use of this in collaboration with VCS to respond to vulnerabilities within communities was seen as problematic. Greater warning of fund availability will allow for evidence to be gathered at local level to ensure funds are being targeted where needed. This will subsequently become more sustainable and embedded within the holistic safeguarding response.
- A national conversation is needed to identify and agree approaches to caseloads and opportunities for further support, which should link in with an earlier recommendation on a national 'positive' recruitment campaign. There needs to be greater transparency in the reporting of staffing levels at local, regional and national level including access and uptake of support and training, within national metrics to force this conversation into action.

Coordination of Data Collection

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

Recommendations

- Review of local and regional qualitative metrics to understand context and provide richer narrative around complexities and impact.
- LA areas discussed using data collection in a number of ways to help improve their collective safeguarding response. This should be considered as part of each LA's response:
    - Clear mechanisms of regular data reporting to frontline practitioners and safeguarding teams. This is to help them understand why data collection is important and how it can help direct safeguarding support within their role, emphasising the point that data is imperative for strategic and operational issues.
    - Ensure that appropriate data analysis platforms are used to analyse trends, demands and gaps in services; for example, Power BI.
- Review qualitative metrics to understand context. A national review of the Welsh Community Care Information System (WCCIS) is required, alongside a review of other systems being used across LA areas, to compare functionality. The majority of LAs using WCCIS reported that they were forced to spend significant time 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. Other issues were also raised:
    - The system was not being used by partners that were said to be implementing it, mainly Health.
    - There was a lack of access to neighbouring LA areas that were also using WCCIS; and therefore, potentially, missing information when dealing with exploitation that was known to cross LA boundaries.
    - Metrics and measures required by the Welsh Government were not seen to be present within the system, or easily recorded and extractable. Hence, significant work was required to make the systems work to extract the reportable data.
    - When the system was down, which was reported to happen frequently, the risks caused by this were very concerning, with information not being available. This put additional pressure on professionals to keep paper records and spend more time updating systems, or risk being seen as breaching policy and guidance.

- It is very important to have a safeguarding data system that allows practitioners to easily see the chronology of their service user/referral. The WCCIS system is reported to be deficient in being able to provide this simple safeguarding function.

- Barriers and 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. This could also provide space for service user voice.
- Regular audits were seen as an effective mechanism to review current practice and identify learning to improve service delivery across LA areas. Multi-agency audits were seen as an effective way to help practitioners develop their writing, assessment and risk assessment skills.
    - Reporting is necessary to ensure accountability of any recommendations and actions from these audit meetings. The reports should highlight upcoming targets and practice improvements from previous reports. Report recommendations should be seen as mechanisms for providing clear accountability, to improve practice in the areas identified as requiring further development.
- Increased collective responsibility and transparency from the Welsh Government in sharing how data is being used to inform any changes in policy, guidance or legislation, e.g., through regular national safeguarding reports and meetings. Having more joined-up conversations about the measures collected at national level may allow for greater consistency over issues such as thresholds for statutory intervention.
- Many practitioners expressed concern that a release of national data would highlight stark differences between the numbers across LA areas. They acknowledged they were aware that some indicators were being interpreted – and therefore reported – differently. There were also concerns that the Welsh Government had not tried to encourage more consistency in some of the regular reporting. This requires urgent attention.
- Given the public nature of safeguarding data recording and reporting, and the huge demand for it, there needs to be sufficient investment within each LA area and at regional level. Most LA areas said that their performance teams had to spend significant amounts of time chasing gaps, or querying data and rectifying gaps or inconsistencies.

Collaboration Forums

Explanation: To ensure that services are effective, there must be Collaboration Forums with service users, families and carers to give feedback on their experiences. Capturing the voices of those with lived experience of working with safeguarding services is a key aspect of service user participation. Partnership working with service users and families was discussed in relation to the active role that users play during their time working with safeguarding organisations and how much input this process enabled them to give. Participants also discussed 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 Adults' Services across most LAs, with many talking about this being a 'priority' now that Covid-19 restrictions had been lifted. However, the level at which this was being delivered varied greatly across LA areas, with some making much more progress than others.

Recommendations

- Emphasis on the importance of that first 'What matters' and 'What is important?' conversation with the service user. This needs to be specifically addressed operationally at a local level to ensure it is done meaningfully and captured as part of the core agreed aim of the safeguarding response that all practitioners should have sight of.
- The above point links to discussions within some LA areas about the need for engagement with individuals and families at the start of the process, being honest and clear about the safeguarding process, communicating what it is intended to achieve, and ascertaining how service users and families prefer to engage within the process.
- Current recording of service user involvement in multi-agency forums should be reviewed, along with where/how feedback is being collated to inform the requirement for this as a performance measure.
- There needs to be more engagement and collaboration, utilising the skills of partners to ensure that service users feel comfortable to engage and the particular needs of the individual are recognised. This often links to the agency that has the closest relationship with the individual; additional expertise and insight may be required.
- Many stakeholders mentioned independent advocacy for both children and adults. This was promoted and referred to by LAs and facilitated by outside organisations. An advocate provides an important mechanism by which services can work in partnership to support the service user.
- There must be consideration of the design and implementation of tools to capture the journey of the service user, rather than focusing on more static, fixed measures of achievements and outcomes. Examples include the 'Steps to Change' and 'Distance Travelled' tools mentioned

within good practice.

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, underpinned by sustaining relationships. Given the nature of changes and updates within safeguarding, multi-agency working must be recognised as requiring continual coordination and investment from the strategic level to facilitate operational-level frontline practice. Opportunities should be provided for practitioners to come together to share good practice or carry out training in a multi-agency forum. This should not be viewed as a one-off annual arrangement, but an ongoing regular event for exchanging perspectives and dealing with emerging issues as they arise.

Recommendations

- For multi-agency working to be successful, time and resources must be expended on building relationships, achieving congruence in strategy and operational working, and devising aligned protocols to encourage and facilitate practice. The multi-agency safeguarding arrangements must therefore embed the time for this into the Corporate Safeguarding Policy. This could align with the development and review of staffing metrics to understand the demand and pressures of the system alongside any regular safeguarding indicators within Quality Assurance/audits and Performance Review meetings.
- Record and review access and engagement of multi-agency training and events. As per positive movements within Social Care Wales and the multi-agency safeguarding training framework[2], these events facilitate the sharing of good practice, discussion of common challenges and issues, with the aim of developing solutions and ways or working more effectively strategically and operationally.
- A continual commitment was also mentioned in terms of the leadership culture within safeguarding. The nature of high-risk decision-making and the consequences of 'bad decisions' have naturally resulted in a high blame and accountability culture. Challenging this requires a constant and sustained effort to ensure that systems, processes and therefore individual workers and agencies are not left holding all responsibility. Some great examples were given of individual teams (such as MASHs) where managers were 'unpicking this' and re-orientating staff to their specific part in the safeguarding response. No decision should ever be on one person in silo.
- Half the LAs specifically mentioned that safeguarding demand was most often managed within

[2] See: National-Safeguarding-Training-Standards-Final-Draft.docx (live.com)

their early intervention services, which can only provide a finite level of support. This was seen to occur for a few reasons. Firstly, thresholds for child protection were increasing due to higher demand, resulting in fewer cases reaching necessary intervention within the Children's Team. Secondly, practitioners working within Families First centres were aware of this likely outcome, so were holding onto *"more complex and high-risk cases"*; they knew that these would be stepped down to them anyway, and that by continuing to work with them they were *"at least getting some support"*. There needs to be national recognition that *"early intervention universal service is not an unskilled service"*. Joint working on complex cases must be an ongoing process between early intervention teams and statutory services, which must be jointly reviewed to ensure that relevant support can be provided before a situation – for example, ongoing neglect – reaches crisis point.

- Services need to ensure their support is accessible and sustainable. Stakeholders noted that if a service is located around 30 miles away and the service user does not have a car, using public transport across rural routes could potentially result in a one-hour counselling appointment taking a whole day, which may not be feasible and is *"setting people up to fail"*. The location of services should be continually reviewed to reflect demand and ensure a continued commitment to effective safeguarding.
- Most importantly, all the above recommendations, both for Practitioners and Agencies and Structures and Processes, require a continual commitment with continued investment to maximise collective safeguarding responsibility at local, regional and national levels.

3.2. Service User Experiences of MAOSA

Service User Voice: Meaningful Inclusion embedded into Multi-agency Service Delivery

Our findings showed that peer-led service user feedback forums were often regarded as useful mechanisms for service users and families to have their voices heard, listened to and acted upon. They also provide opportunities for peer-led support. Multi-agency safeguarding relies on partnership working between practitioners, agencies and service users; as such, all voices are integral to the process. Partnership working depends on understanding all perspectives; it requires honesty, transparency and inclusion within decision-making, as well as ongoing dialogue. User-friendly documentation is essential, as is communication with service users and families; service delivery must be accessible, appropriate and fit for purpose. This can be supported by meaningful input from service users, incorporated into planning of the services designed to support them. Consultation, collaboration and co-production between agencies, service users and families must be addressed and

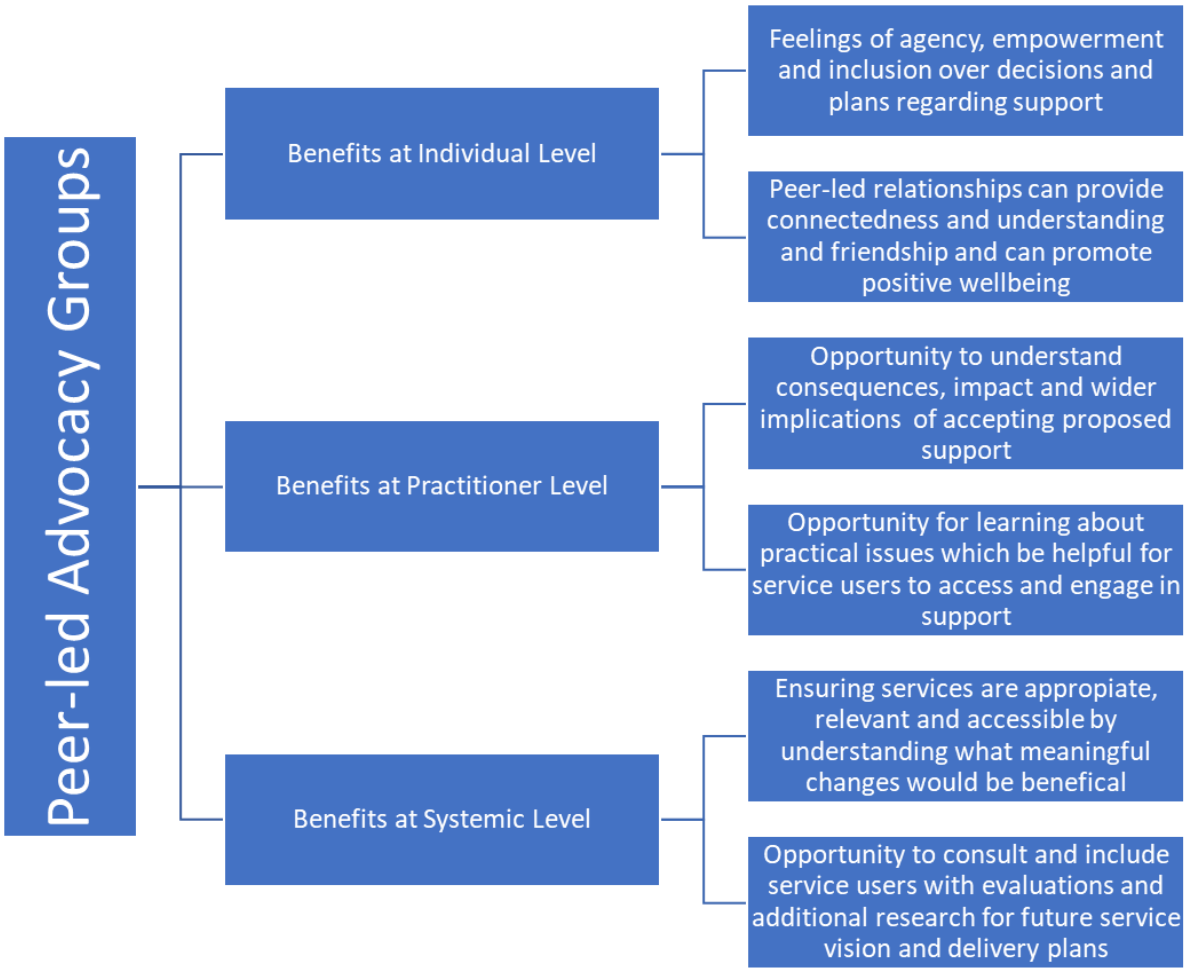
resourced at both strategic and operational levels, to ensure all are embedded sustainably within service delivery.

- **Strategically** – Service user feedback panels/groups/forums must be acknowledged as a priority for developing services. Leadership should therefore have designated accountability for the process, budgets with resources for implementation, and monitoring of feedback for integration into service delivery.
- **Operationally** – Service user feedback panels/groups/forums must be acknowledged as a mandatory way of working in partnership with service users and families. They must be coordinated by a designated person or team, with all practitioners feeding into the process. They must also be actively promoted to service users. Panels should be held regularly in a meaningful and accessible format. Service users must benefit from involvement and the results of their input should be communicated.

There must also be regular communication between strategy and operations to understand what can be learned and potentially implemented, and to authorise changes to service delivery.

Due to the nature of safeguarding, and the issues around power dynamics that can be at play between agencies, service users and families, there must be systems and processes that build on the individual relationships between practitioners and service users to facilitate partnership working. In order to align service delivery with the needs of service users, there must be a recognition of the importance of providing a mechanism which promotes, facilitates and incorporates the voices, views and perspectives of service users. This must be embedded into service delivery plans.

Figure 2. Benefits of Peer-led Advocacy in developing relationships and partnership working



3.3. Safeguarding Performance Framework

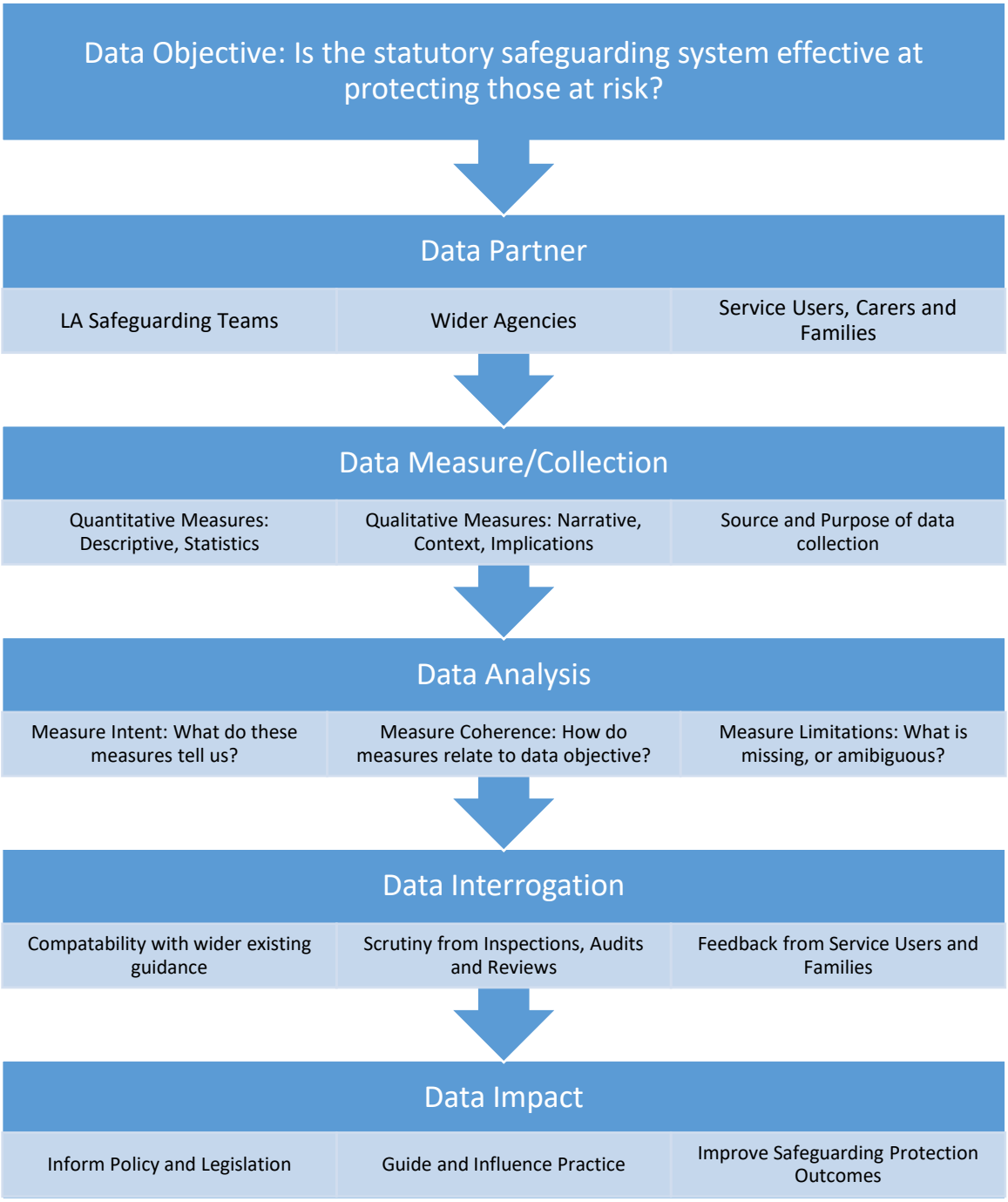
A key aspect of this part of the evaluation was the ability to see and acknowledge the operational variance in safeguarding across LA areas, and to determine effectiveness through evaluating performance in safeguarding activity. This was important to practitioners in regards to being able to prepare and seek support for the varying types of demand and the unmet needs of individuals and families, assess the risks, and enable a proportionate but effective response. It was felt that this should be facilitated and coordinated at a national level, and further developed and localised within regional safeguarding boards. Whilst the multi-agency function reportedly works operationally within the safeguarding arrangements, the safeguarding data measures being captured, reported and shared are driven by and focused on LAs. Therefore, the widening out of multi-agency (e.g. Police, Health, Education Third Sector, Probation, Voluntary and Charity Sector) data collection and collation was seen as a future aspiration for safeguarding arrangements, if we are to evidence the effectiveness of the process.

The importance of data utilisation – the nature and source of data collected, how this data is used and for what purpose – is essential in understanding performance management and ultimately assessing the effectiveness of safeguarding practice. Whilst an arguably overwhelming number of safeguarding metrics and measures are submitted to the Welsh Government and even more are collected locally, missing data metrics remain which would be helpful in determining the effectiveness of the safeguarding process. These include, firstly, incorporating user voice to understand the experiences of the individuals and families who have been through the safeguarding system. Secondly, given the importance of multi-agency working within safeguarding, it is crucial to collect data from a variety of agencies, allowing for a holistic understanding of the safeguarding process. Thirdly, it would be beneficial to have a clear collective objective to which all data metrics relate, such as whether safeguarding is effective. To further understand effectiveness, it must be acknowledged that qualitative measures are required within data collection. These would seek to build on and explain the quantitative measures detailing safeguarding activities, and to further explore their impact.

In addition to the utilisation of data within the strategic arena of performance management, data should also be integrated and embedded into operational practice. The purpose of data collection must be understood and recognised as relevant to all members of the safeguarding workforce and something which is not only everyone's responsibility, but is of value to all roles. Continually ensuring that data is accurately recorded (with time and space for practitioners to do so) and that it captures what it needs to (through both quantitative and qualitative metrics), is key to evidencing best practice. Data needs to be succinct yet purposeful. A set of quality performance indicators for national multi-agency safeguarding data would be integral in determining the effectiveness of safeguarding processes and gaining a collective understanding of what 'good' looks like. This led us to develop the

Safeguarding Data Utilisation Model (Figure 3), with five key elements to encourage safeguarding teams to agree on what is meant by 'safeguarding' and how can data help us capture this.

Figure 3. Safeguarding Data Utilisation Model



In analysing the local and national metrics currently employed to measure safeguarding activity, we undertook a refinement process to understand the combination of these data measures which demonstrated effectiveness overall relating to safeguarding. Findings across reports showed the importance of understanding and capturing data relating to the safeguarding journey which

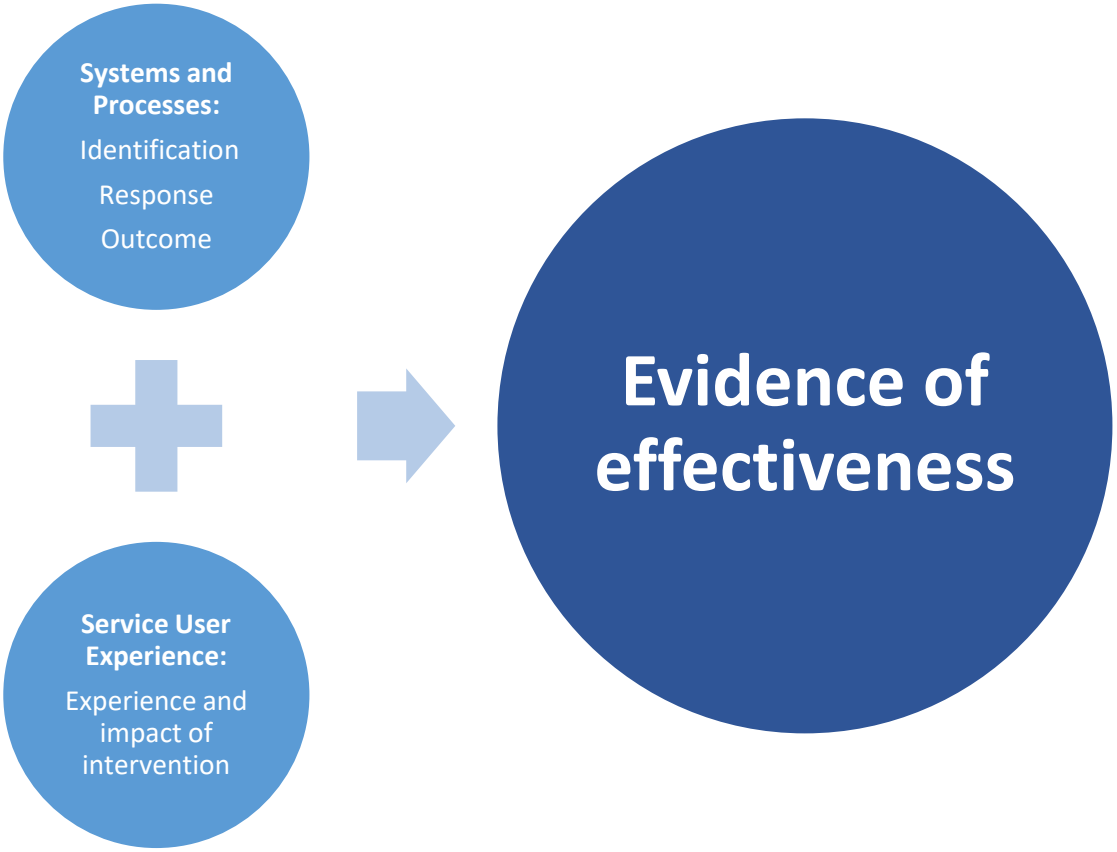
individuals and families can experience upon entering the safeguarding system. This is crucial in ascertaining if the interventions put in place are effective. The aims of the Safeguarding Adults Boards are to protect adults at risk of abuse or neglect,[3] including those who have care and support needs which mean they may not be able to protect themselves. Similarly, Safeguarding Children's Boards are intended to protect children who are experiencing or are at risk of abuse, neglect or other harm, and to keep children from becoming at risk of such harm.[4] Therefore, the beginning of the safeguarding process can be a referral to an LA Adults' Services Team, generic or specialised to explore care and support needs, or directly to an LA Adults' Safeguarding Team for potential safeguarding protection. For children, it may begin with referral to a Prevention Team who may respond to an unmet need; this could potentially prevent escalation of risk to significant harm. The process could also bypass this stage and present as a referral to Protection Teams, for example via a 'Duty to Report' form to an LA Duty Safeguarding Team, MASH or SH, or it may begin through concerns of friends, family or neighbours that a response is required to potential risk of significant harm.

To understand if safeguarding is effective, there must be an understanding of the systems and processes that are involved in identifying and responding to safeguarding concerns, and the outcomes of safeguarding interventions. However, simply understanding the processes and structures that are in place does not adequately indicate whether these are effective at safeguarding people. Therefore the experiences of service users must be sought to understand the impact of interventions.

[3] *https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/role-and-duties.asp*

[4] *https://law.gov.wales/safeguarding#:~:text=Section%20135(1)%20of%20the,abuse%2C%20neglect%20or%20other%20harm.*

Figure 4. Safeguarding Performance Framework: Evidence of Effectiveness



The process of identifying and responding to a safeguarding concern involves several stages:

- Identifying Safeguarding Concerns: Safeguarding is everyone's responsibility. The safeguarding process begins with an individual or agency being alerted to a child or adult potentially at risk of harm.
- Responding to Safeguarding Concerns: Concerns must be assessed to determine the risk of harm and the appropriate level of support from the relevant agency.
- Outcome of Safeguarding Intervention: What do the processes and structures, in addition to the experience of the service user, tell us about effectiveness? How do data metrics evidence this?

Furthermore, to understand the effectiveness of safeguarding processes, we need to understand the safeguarding journey and how people enter and exit the system. This allows us to understand which agencies are involved and when. Figure 4 provides an overarching view of the children's safeguarding system, to illustrate the various routes by which children can enter, re-enter and process through the safeguarding arrangements.

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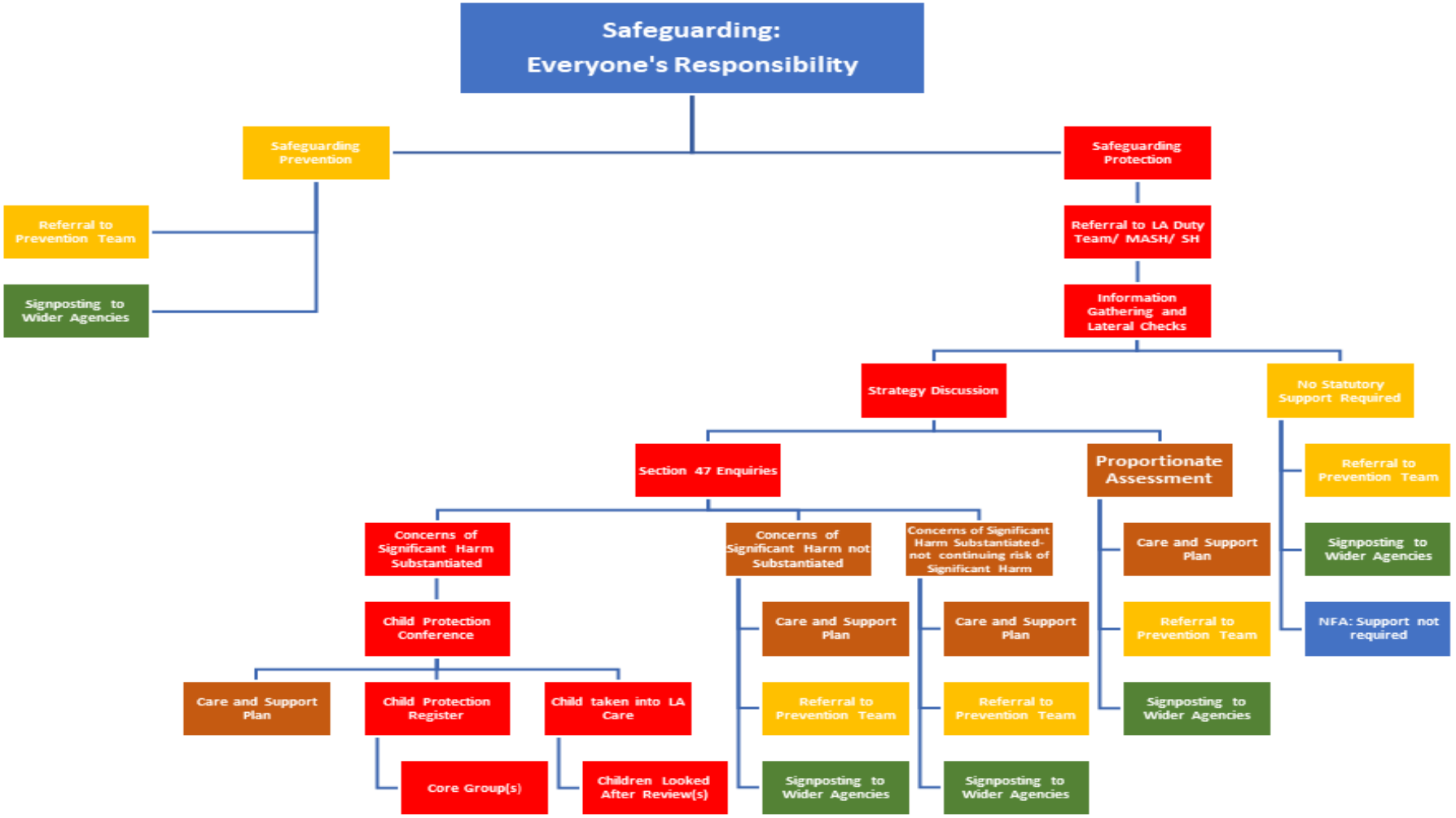
National Independent Safeguarding Board Wales

Figure 5. Example of a Multi-agency Safeguarding Process for Children[5]



*Wider agencies could be statutory (e.g. Health, Education, Youth Justice, Police but could also be Third Sector/ Voluntary and Charity Organisation

[5] NB this process map informed the initial draft of the Children's Performance Indicator Prototype. A similar process is to be developed for adults by the National Multi-Agency Safeguarding Performance Framework (NMSPF) working group.

4. Key Recommendations

The key three work-streams of the evaluation (Safeguarding Practitioner Experiences, Service User Experiences and Safeguarding Performance Framework) have identified numerous recommendations. The following section brings them together, summarised into three levels:

1. Recommendations that can be reviewed, developed and adopted at a local level; these are relatively straightforward to implement within safeguarding partnerships.
2. Recommendations that may require additional resources, research or review before implementation, and therefore additional time before adoption.
3. Recommendations that require national and/or government input and support, such as those relating to amendments in national policy, guidance or legislation.

Level 1 Recommendations: Local level actionable

- Local-level review of the Overarching Model of Collective Safeguarding Responsibility, alongside the detailed 12 C's. This will enable regional boards to understand whether the key factors at individual/agency level, as well as the structures and processes, are included within the current arrangements and are operating effectively.
- Design and implementation of tools that capture the journey of the service user, rather than focusing on more static, fixed measures of achievements and outcomes. Examples include the 'Steps to Change' and 'Distance Travelled' tools mentioned within good practice (see Safeguarding Practitioner Experiences report).
- Development and agreement of a Multi-Agency Safeguarding Referral Threshold document at regional level. This document should also detail the feedback referring agencies can expect when submitting safeguarding referrals. A key 'terms of reference' could also be developed to support this.
- Ensure clear understanding across the safeguarding response, particularly of the use of data when interpreting safeguarding 'activities'. For example, the number of individuals recorded as having engaged with an activity/intervention measure, versus interpreting this as effectiveness and impact – how do we know that engagement led to an improved outcome? This will often require additional qualitative information (context/narrative) to form part of any data performance reports.
- Prioritise the development of service user feedback panels/groups/forums, to be coordinated by a designated team/person(s), ideally strategically and operationally. All practitioners should be able to feed into the process.

  - These groups need to be actively promoted.
  - They should be held regularly, in a meaningful and accessible format.
  - The results of engagement from service users should be communicated back into the groups, community and wider safeguarding arrangements.
- Consider hybrid working, with key days each week for staff to work in the same office. This is seen as essential in the development and support of new staff, for staff being able to check in and continue to learn, and to support the workforce more generally.
- Implement co-location or 'touchdown' sharing of offices where possible, for multiple external agencies to build relationships, understand their different remits and responsibilities, and share timely information to streamline service delivery.

Level 2 Recommendations: Further understanding, research, resources required

- A working group to review the draft Performance Indicator (PI) Children's Prototype (see section 4.1 below) to be used at local, regional and national levels to help record and understand the effectiveness of safeguarding arrangements across Children's Services. The working group should seek to adapt the Children's PI Prototype to data metrics for adults and create an Adults' PI Prototype. This work should aim to co-produce a National Multi-agency Safeguarding Performance Framework across both Adults' and Children's Services.
  - The group should develop to include other agencies, to build their data into the framework.
  - The group should develop to include Adults' Services.
- Investment in dedicated Performance Management Teams, with the necessary skills, resources and data systems to be able to work alongside safeguarding teams and produce meaningful, accessible reports for wider consumption. These teams should engage with social workers on the frontline visiting individuals, recording information and making decisions, through to the various local and regional boards that require updates on quality assurance and effectiveness.
- Review of leadership structures across each LA to sit as part of Regional Safeguarding Boards (RSB), to encourage consistent and positive relationships as a key feature (for more information, see Congruence in Strategy to Operations in the Safeguarding Practitioner Experiences report).
- Development of policy regarding Professional Challenge at RSB level; this should be nationally reviewed and promoted.

Level 3 Recommendations: Require national/government input, decision-making and action

- The evaluation did not find conclusive evidence that those LA areas with a MASH were operating more effectively than those without one (or that did not use the term MASH). This was mainly due to some areas operating similar arrangements to those defined within a MASH model, but choosing to call it something different; for example, a Safeguarding Hub.[6] The evaluation did find that those areas that had co-located at least one partner agency into the same building (even if hybrid working) were able to illustrate improved multi-agency safeguarding working, both qualitatively (through a wide range of practitioner interviews) and quantitatively (within various safeguarding metrics). Therefore, a move away from the term MASH may encourage areas to develop and embed a model of multi-agency working, which at a simple level requires the presence of a key single point of physical contact from partner agencies working within the team, at least part-time during the week.
- A review of WCCIS functionality, and a wider scoping exercise to understand other systems being used both inside and outside Wales.
- Increased feedback and use of safeguarding data requested by the Welsh Government from LAs. There was a clear lack of any functional or meaningful work being done with the safeguarding data collected. The production of national annual reports, pulling the data together and providing additional context and narrative, was described as much needed. This would potentially identify and address inconsistences/anomalies in data collection.
- Increased funding for safeguarding responses that require specialist mental health services/support.
- Review and increased transparency around the crisis in LA Care provision, with increased need for promotion and incentives around residential and foster placements.
- Consideration of developing or encouraging omnicompetent workers who can work across Children's and Adults' Social Services, with representation of both services at the front door. The evaluation showed clear benefits of being able to recognise vulnerabilities across the lifespan, since concerns are often linked by families or communities.
- A need for increased bursaries from the Welsh Government to encourage recruitment and help people to become qualified. Regionally, LAs may consider sponsoring individuals to

[6] Some LAs differentiated the terms MASH and Safeguarding Hub, with a MASH involving more than one agency outside the LA (usually Police), and a Safeguarding Hub only requiring one external agency. However, the evaluation found MASHs with just police present, and Safeguarding Hubs with more than one agency. Therefore, the term 'MASH' does not seem to require a different model of multi-agency working to other models.

become qualified and gain the necessary experience. However, both options are recognised as long-term solutions that do not address the current shortage; investment in recruitment is needed now.

- Inconsistency in incentives and pay offered to social workers across Wales has caused competition and tension between neighbouring LAs; new recruits have also often received better packages than current staff. A national review and agreement are required to reduce current barriers to filling vacancies and retaining staff.
- There should be investment in understanding staff resource, demand and wellbeing. Steps should be actively taken to ensure staff are supported within their work and achieve a work-life balance.

4.1. Developing and Testing a Prototype of Safeguarding PIs (National Multi-agency Safeguarding Performance Framework (NMSPF))

From the evidence provided in the five Safeguarding Reports completed for the NISB Evaluation (Literature Review, Practitioner Perspectives, Safeguarding Performance Framework, Safeguarding Service User Experiences, and Executive Summary) we have identified a number of PI safeguarding measures. These should be seen as a starting point for consideration and discussion as part of an agreed National Multi-agency Safeguarding Performing Framework 'PI Prototype' for Children. Whilst the initial NMSPF will include safeguarding data for both Children and Adults, the first phase of the process will deal with the former group. This is by intent. This stage is focused on stimulating discussion, reflection and learning from this evaluation and process; the learning will then be taken forward to co-produce an Adults' PI Prototype. This should include the following key themes of PIs, based on our evaluation:

1) Identification: Safeguarding Referrals Prevention and Protection
2) Response: Safeguarding Protection Enquiries and Progression (Section 47 Enquiries for Children)
3) Outcome: Removal of Statutory Intervention
4) Experience: User Voice
5) Additional: Staff Workforce

A ***National Multi-agency Safeguarding Performance Framework (NMSPF) Working Group*** should be convened, with the aim of co-producing a comprehensive set of data metrics (including qualitative measures) to formulate a **Children's PI Prototype (NMSPF-C)**, in the first instance. This NMSPF-C should aim to evidence whether the safeguarding process is effective for children. There will also be

a PI Prototype that incorporates data metrics relating to safeguarding adults (NMSPF-A). Both Prototypes can then be piloted across Regional Safeguarding Boards (RSBs) and evaluated to understand the effectiveness of the whole safeguarding system at LA, RSB and national levels.

To assist the NMSPF Working Group, it is important to discuss the following questions regarding each safeguarding measure:

- Is this measure already collected? By whom? For what purpose?
- How accessible is this data to retrieve and collate?
- What information is missing or unclear from the data measure?
- Is a qualitative measure required to accompany the quantitative measure: Key Issues and Implications?
- Which additional multi-agency data measures would enhance understanding and analysis?

Performance Indicator (PI) Prototype: Children's Safeguarding Metrics for Multi-agency Safeguarding Arrangements

This final section gives a draft outline of key metrics for assessing whether multi-agency safeguarding arrangements are effective in keeping children safe. This is based on the evidence obtained throughout the all-Wales evaluation. The current metrics are to be ***shared with the NMSPF Working Group for improving the safeguarding PIs, ensuring they are accessible and meaningful in evidencing safeguarding effectiveness, with further work to develop a similar prototype for adults.***

Identification: Safeguarding Referrals – Prevention

1. How many Referrals to Prevention Teams (quarterly/annually)
    a. Number and percentage of Repeat referrals, where families have had previous referral to Prevention Teams (quarterly/annually)
        i. 'Rate' per 10k population

    b. Number and percentage of referrals which are passed on to LA Duty Teams/Safeguarding Hub/MASH (quarterly/annually)

Identification: Safeguarding Referrals – Protection

1. How many Referrals ('Duty to Report' forms and family/friend/anonymous) to LA Duty Team/Safeguarding Hub/MASH (quarterly/annually)
    a. 'Rate' per 10k population

2. Number and percentage of referrals which are repeat referrals (quarterly/annually)

    a. Number and percentage of new referrals (quarterly/annually) resulting in:
        i. No further LA action
        ii. Referral to Prevention Teams

iii. Care and Support Needs
iv. Section 47 Enquiries

b. Number and percentage of repeat referrals (quarterly/annually) resulting in:
   i. No further action (any advice/signposting provided)
   ii. Referral to Prevention Teams
   iii. Care and Support Needs
   iv. Section 47 Enquiries

3. Referral source (can be broken down in number and percentage into sector agencies like Police/Health/Education/Third sector/Youth Justice/Prevention/Friends/Family/Anonymous)

4. Category of harm **identified/described by the referrer** (Amount, percentage of cohort, rate per 10k population; can include more than one category)
   a. Neglect
   b. Physical Abuse
   c. Sexual Abuse
   d. Emotional/Psychological Abuse
   e. Financial Abuse

5. Nature of safeguarding concern **identified/described by the referrer**: (Amount, percentage of cohort, rate per 10k population; can include more than one category)
   a. Domestic Abuse
   b. Extra-Familial Harm
   c. Young Carer
   d. Health concerns – Child or Parent
      i. Mental health
      ii. Physical health
   e. Drug and Alcohol Use – Child or Parent
   f. Disabilities
   g. Bereavement
   h. Parental Imprisonment
   i. Educational welfare
   j. Homelessness
   k. FGM (Female genital mutilation)
   l. Honour-based violence
   m. Radicalisation
   n. Other?

Response: Section 47 Enquiries

1. How many Initial Strategy Meetings?
   a. Number and percentage which took place within agreed timescale
   b. Number and percentage which progressed to Section 47 enquiries
   c. Number and percentage which progressed to Care and Support Needs

2. How many Section 47 enquiries (Amount, percentage of cohort, rate per 10k population) CH/022 (Only asks how many progress to CP Conferences)
    a. Number and percentage of assessments completed within deadline
    b. Number and percentage completed in language of choice
        i. Number and percentage of Section 47 enquiries for children who have had more than one Section 47 enquiry in 1, 2, 3, 4 years.
    c. Number and percentage of Section 47 enquiries which were referred to a Child Protection Medical
        i. Regarding physical injuries
        ii. Regarding neglect

Response: Section 47 Progression

1. Number and percentage of Section 47 enquiries which progressed to Care and Support Plans CH/023J & K
    a. Total number of children on Care and Support Plans
    b. Number and percentage of children who had already been on Care and Support within 1, 2, 3 years (when, how long)

2. Number and percentage of Section 47 enquiries which progressed to CP Conference

3. How many Initial Child Protection Conferences?
    a. Number and percentage which took place within statutory timescales

4. Number and percentage of Section 47 enquiries which progressed to the Child Protection Register

5. Total number of children on the Child Protection Register (amount, percentage of cohort, rate per 10k population)
    a. Number and percentage of children who had already been on the Child Protection Register within 1, 2, 3 years (when, how long)

6. How many (Initial) Core Groups?
    a. Number and percentage which took place within statutory timescales

7. Number and percentage of Section 47 enquiries which progressed to child becoming Looked After
        i. Total number of children becoming Looked After (LAC) during year
        ii. Total number of new episodes of children becoming Looked After (LAC) during year
        iii. Children placed within LA care outside of responsible LA area
        iv. Children placed within LA care outside of Wales

8. Number and percentage of children offered independent advocacy
    a. Number and percentage who took up the offer

Outcome: Removal of Statutory Intervention

1. How many children removed (de-registered) from
    a. Care and Support Plans
    b. Child Protection Register 3, 6, 9, 12 months (quarterly)
    c. LA Care (Looked After)
2. How many children on Care and Support Plans stepped down to
    a. Prevention Teams
    b. Other agency support (who?)
    c. No follow-on support
    d. Moved out of area
3. How many children on LA Child Protection Register stepped down to
    a. LA Care and Support
    b. Prevention Teams
    c. Other agency support (who?)
    d. No follow-on support
    e. Moved out of area

Experience: Service User Voice

(Across various stages and in addition to incorporating the voices and wishes of individuals in their current assessment)

1. Are there any mechanisms in place for gathering service user, carer and family feedback, and if so, at what stage in safeguarding process (Possible tick list of various platforms, e.g., questionnaires, online forums, peer support groups)?
2. What have been the messages from User Voice feedback, for those received (Top 3 annually)?
3. What are the challenges in obtaining service users' feedback?
4. What are the priorities and expectations by year 2?
    a. What is the mechanism in place for gathering service user, carer and family feedback, and at which stages in the safeguarding process does it operate?
    b. How do we quantitatively measure the number of individuals who have provided feedback?
    c. How do we qualitatively measure the nature/themes of feedback?
    d. How can we measure any changes/actions made from feedback (demonstrate listening, responding and the impact on future services)?

Additional Considerations for Discussion/Review: Staff Workforce Implications

How do you record/document workforce staffing deficits within your safeguarding arrangements that may impact on decision-making and/or response?

Workforce competence

1. Number and percentage of practitioners who attended multi-agency training alongside practitioners from other agencies (in 12, 24 months)
2. Number and percentage of relevant staff who have completed Safeguarding Children training in the year

Vacancies/turnover

3. Vacancies

   a. Number and percentage of staff in safeguarding roles who have been in post longer than 6, 12, 24 months
   b. Number and percentage of established FTE posts in safeguarding teams that are filled by permanent staff
   c. Average level of vacancies for social worker posts in safeguarding teams
   d. Number and percentage of safeguarding teams that are fully staffed with no vacant posts for 3, 6, 12 months
   e. Number and percentage of safeguarding managers who have been in post longer than 1, 2, 3 years
   f. Number and percentage of safeguarding staff who are temporarily employed through a recruitment agency

4. Does the organisation have a formal method for collecting data on staff wellbeing?
   a. How is this data utilised?
   b. Any changes/actions resulting from feedback (list top 3)?

5. Is there opportunity to work flexibly (hybrid working)?
   a. When working with service users directly
   b. When engaging in multi-agency meetings
   c. Who makes this decision?

6. When a case is closed down, is there an opportunity to record how many core group members have been allocated to and worked with the family, and from which sectors?

5. References

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