

The Collective Safeguarding Responsibility Model: 12 C's

THE ENACTMENT OF 'SAFEGUARDING IS EVERYONE'S RESPONSIBILITY'

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Introduction to The Collective Safeguarding Responsibility Model: The 12Cs

The 12C Model is derived from a robust research evidence base and developed in partnership with key stakeholders. This research has explored multi-agency safeguarding in relation to children, adults and families, through a variety of thematic areas.

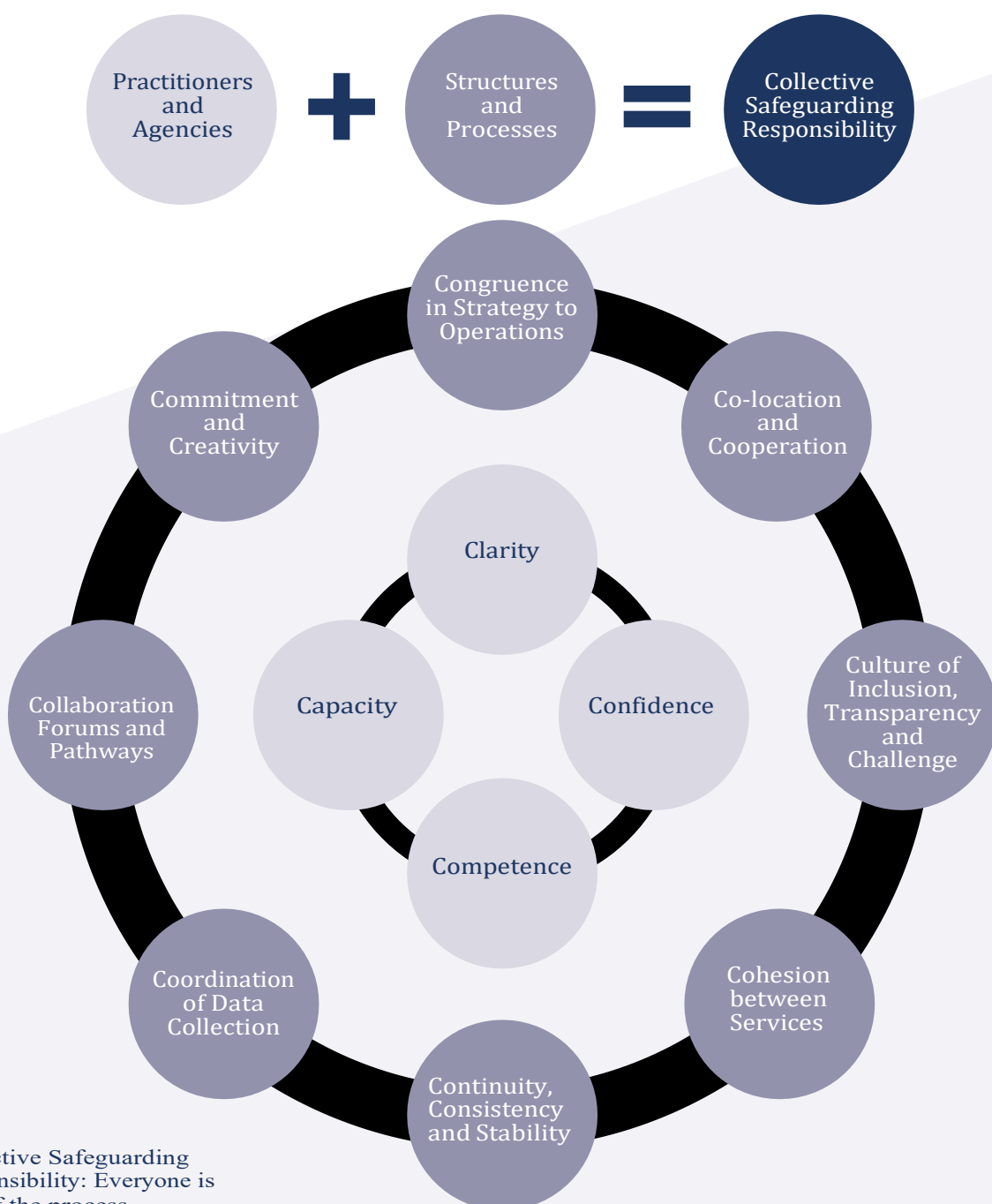
Whilst each specialist area of safeguarding has its own unique features, characteristics and challenges, there are patterns which reoccur when identifying and responding to risk. A multi-agency response to safeguarding is widely accepted as the most effective approach by policy makers, senior leadership teams and practitioners alike. Yet, despite a wealth of academic literature, several high-profile inquiries and a plethora of policy, implementation of effective multi-agency safeguarding remains a significant challenge. Challenges include a lack of clarity in relation to safeguarding roles, remits, responsibilities and expectations of partner agencies. In addition, there can be uncertainty in applying a shared understanding of thresholds and decision-making for risk, support and intervention. The sharing of relevant information in an appropriate and timely manner is frequently highlighted as an ongoing barrier to collaborative working. Underpinning this, there is often fragmentation and disconnect across agency structures, processes and procedures. Whilst alignment and joint access across sector systems would undoubtedly be beneficial, establishing and maintaining functional working relationships between key practitioners is integral to collaboration. Collaborative working arrangements must also be reviewed and evaluated to understand impact and optimise effectiveness.

Safeguarding is a community endeavour, whereby the whole is greater than the sum of its parts. No single agency can assume safeguarding responsibility for children, adults and families. Whilst safeguarding is indeed everyone's responsibility, we need to go further to ensure that this responsibility is a **collective one**.

The Collective Safeguarding Responsibility Model: 12 C's

THE ENACTMENT OF 'SAFEGUARDING IS EVERYONE'S RESPONSIBILITY'

The Collective Safeguarding Responsibility Model: 12 Cs, illustrates the enactment of '*Safeguarding is Everyone's Responsibility*'. The model offers a guidance tool for Regional Safeguarding Boards, Safeguarding Partnerships and Local Authorities to demonstrate measures which are being adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.



DEFINITIONS

PRACTITIONERS AND AGENCIES:

Clarity: Clarity must be provided to practitioners regarding the expectations of safeguarding responsibilities. This is within their own role, as well as partner agencies' roles and remits, particularly regarding anticipated outcomes and likely timelines. Seeking clarity must be an ongoing process at various stages in the safeguarding process.

Confidence: Practitioners must have belief in their ability and skill set to fulfil their safeguarding role. This occurs within their own agency and in partnership with others through collaboration. Practitioners require opportunity and space, to process and reflect on their own experiences and to learn from other agencies. Building confidence is an ongoing process that requires support from leaders and peers.

Competence: Practitioners must have investment into developing their skills, experience, and knowledge to fulfil their safeguarding role within their own agency and in partnership with others, through collaboration. Practitioners require opportunity and space to process and reflect on their own experiences and to learn from other agencies. Developing competence is an ongoing process.

Capacity: Practitioners must be provided with adequate time, space, and resource to effectively fulfil their safeguarding duties and to do so in partnership with the relevant partner agencies.

STRUCTURES AND PROCESSES:

Congruence in Strategy to Operations: Congruence between senior leadership teams, the frontline workforce, and all levels in between, is imperative. Implementation of this congruence should facilitate a 360-degree, fluid exchange of communication which promotes achievable objectives, shared understanding and provides a comprehensive overview of any safeguarding challenges, as and when they arise.

Co-location and Cooperation: To establish, develop and sustain partner relationships, there should be protocols and working arrangements which guide, facilitate, and support this process. Relationships must be continually and actively invested in, and not assumed to be an automatic by-product of safeguarding being legally mandated as 'everyone's responsibility'.

Culture of Inclusion, Transparency and Challenge:

Consideration should be given as to how all relevant agencies and practitioners can be meaningfully included in safeguarding processes. Promotion of ongoing, open dialogue between all relevant partners is required and must be maintained. Professional challenge should be enabled and encouraged, to advocate for appropriate and holistic safeguarding support. This must actively be implemented into a workplace culture, which is endorsed both strategically and operationally.

Cohesion between Services: The potential fragmented nature attached to working with multiple agencies should be recognised, acknowledged and addressed. Actions must be taken to align safeguarding processes to enable seamless transitions between services. This can include shared responsibility, joint ownership, and collaborative case management between agencies, enabling a flexible and personal safeguarding response which reflects the evolving nature of concerns.

Continuity, Consistency and Stability: Service delivery should have consistency in the support provided. There should be stability in workforces to allow for relationships to develop with families and individuals and to offer continuity with development plans. This requires ongoing strategic planning regarding both in the long-term and the short-term, to invest in current retention of staff and future recruitment. The funding of commissioned services should endeavour to be long-term wherever possible. Organisations should seek to understand and respond to staff wellbeing. Appropriate support and supervision must be provided in addition to opportunities for career development and progression.

Coordination of Data Collection: Performance management data and frontline practice are inextricably linked. Practice should be accurately reflected in data collection and data collection should meaningfully inform practice. This requires both qualitative and

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quantitative data analysis. Multi-agency data should be coordinated, collated, analysed, and disseminated to understand not only any safeguarding activity undertaken, but to determine the effectiveness and impact of any activity.

Collaboration Forums and Pathways:

Understanding the experiences of those who have accessed safeguarding services, is paramount in determining the effectiveness of any safeguarding intervention. Collaboration forums and pathways should be developed and promoted to ensure the perspectives of those individuals and families are heard, understood and acknowledged. Collaboration should be

facilitated during periods of service intervention and feedback sought retrospectively after intervention. This process must be widely accessible, with appropriate support provided. Prioritisation, management and ownership of collaboration forums and pathways should hold both strategic and operational level responsibility and be utilised to inform future service delivery.

Commitment and Creativity: Creativity, innovation and a progressive approach are integral to collective safeguarding responsibility. There must be a commitment to the sustainability and evolution of multi-agency working within safeguarding, with designated leadership and accountability across sectors.

Good Practice Examples:

PRACTITIONERS AND AGENCIES

There are examples of good practice being undertaken to develop Clarity, Confidence and Competence across regional areas. Capacity was noted to be influenced by supportive leadership and through effective processes and structures, but ultimately it is driven by adequate resource, appropriate investment and sustainable funding.

• A Regional Threshold Document

This was noted to be beneficial for agencies from different sectors to clarify safeguarding referral expectations. Alongside this document was the consistent review of safeguarding demand on services, shared within multi-agency panels and meetings. This enabled practitioners to have continued clarity on the changing nature of vulnerability, whilst being cognisant of their agency thresholds and processes, in order to respond appropriately according to their own agency remit.

• Joint-agency Scrutiny of Cases

Scrutiny of reviews such as Child and Adult Practice Reviews 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 and ratify current arrangements. This included asking questions such as how different agencies would have responded in this situation and questioning whether the same outcome have occurred. This process allowed each agency and practitioner's role to be understood, in addition to clarifying and reviewing the safeguarding processes and structures in place.

• Sector Specific Multi-Agency Representation within Safeguarding Team/ Hub or MASH

This was felt to increase clarity in sector specific processes, which in turn increased confidence and competence in referring agencies responding to safeguarding concerns. For example, having the Police based within the Safeguarding Hub alongside Social Workers, was noted to speed up decision-making, subsequent action and follow up, as there was a sector specific knowledge of agency remit. In addition to the Police, having Educational Link Workers based within the Safeguarding Team also enhanced clarity of submitting referrals, managing risk, and ascertaining the most appropriate and up to date information. This clarity allowed for a development of confidence and competence as link workers also facilitated training for practitioners.

• Referral Audits

Referral Audits were being undertaken to examine safeguarding referrals and reports which had been submitted from a specific sector such as Education. The aim was to ascertain what more could have been done, and by whom at various stages, to prevent a young person being involved within the child protection system. For instance, this could identify and assess whether having the 'what matters' conversation earlier, if appropriate, would have changed the outcome. Identifying key points within the safeguarding process where there are issues and providing feedback and additional training, when required, was seen to increase the confidence of practitioners in gathering information from the person of concern. This could result in higher quality and more appropriate referrals.

- **Informal Consultations with Multi-agency Safeguarding Hub (MASH)/Safeguarding Hub Teams**

This consultation allowed for clarification on safeguarding concerns by offering advice at the point at which it is required. It also facilitated discussions regarding which information was necessary from referring agencies to ensure that a referral had the appropriate level of detail to direct action. These conversations helped to build relationships and enabled feedback discussions to take place to understand updates and progression of referrals.

- **Multi-Agency Training**

This was noted to be key in ascertaining clarity for the multi-agency safeguarding process. Allowing practitioners from different sectors to come together to learn and discuss specific safeguarding issues in a collaborative environment allowed for shared learning, holistic understanding and a collective responsibility to be developed. This enhanced practitioner confidence and competence in responding to safeguarding concerns. This training was felt to be required regularly, to reflect current trends, challenges, and emerging practice.

STRUCTURES AND PROCESSES

CONGRUENCE IN STRATEGY TO OPERATIONS:

- **Operational Practitioner Experience**

When leaders had frontline practitioner experience, it was seen as advantageous to understanding the operational issues, challenges and pressures. This supported a broader understanding and holistic approach when resolving any potential disconnect between strategic vision and operational viability.

- **Strategic and Operational Joint Decision-Making**

Examples of having two senior practitioners screening safeguarding referrals that are submitted to a MASH, in addition to a Principal Social Worker, allowed for greater discussion, trust and accountability within a team. Moreover, it contributed to self-reported decreases in pressure and anxiety in making decisions in silo.

- **Proactive Managers and Leaders**

Having managers and leaders who were prepared to 'roll their sleeves up' and get involved with frontline activities to ensure that they had up to date knowledge in responding to current safeguarding



challenges were viewed as valuable. As was having managers present, who were visible and engaged in conversational discussions with team members, either over video calls, or face to face.

- **Multi-sector Experience**

Managers and leaders who had significant experience of safeguarding, such as within a certain profession and then moved to manage another team, were found to broaden understandings of safeguarding and influence the way that team applies safeguarding knowledge. This contributed to an aligned vision and enhanced overall collective safeguarding responsibility.

CO-LOCATION AND COOPERATION:

- **Hybrid Multi-Agency Front Door**

Having the Police co-located within the Safeguarding Hub/MASH was noted to have multiple benefits in facilitating joint work, such as initiating timely discussions and faster decision-making. It shaped future action and allowed for clarity regarding roles, sectors and remit at various stages of the safeguarding process, as opposed to a one-off interaction. Having the opportunity for other agencies such as Early Intervention and Prevention Teams, Youth Justice and Health Professionals to base themselves out of the Hub on certain days of the week, was beneficial in establishing relationships and acted as a central point in communicating updates. This enabled an organic process for practitioner relationships to develop, creating a collective safeguarding responsibility.

- **Inclusion of Domestic Abuse Practitioners within Safeguarding Hubs**

Including Domestic Abuse Practitioners within the MASH/Safeguarding Hubs was seen as advantageous in ensuring that appropriate, timely advice and expertise were utilised in decision-making. It also generated shared knowledge and understanding and facilitated relationship development for those cases requiring ongoing safeguarding support. Having IDVAs (Independent

Domestic Violence Advocates) based within hospitals was felt to be beneficial for providing a point of further support and linking agencies.

- **Early Intervention and Prevention Co-located Teams**

The co-located teams of Health and Social Care including Social Workers, Family Support Workers, Health Visitors and Midwives, all based within one building was felt to have benefits in allowing a joint approach between practitioners. This provided a more streamlined and accessible service for families in one central base. Some areas had a wider remit of agencies collaborating on a flexible basis from one base, such as Housing Advisors and Psychological Wellbeing Practitioners.

- **Inclusion of Children's and Adult's Services**

The inclusion of Children's and Adult's Services being located together within the same office or building was noted to be beneficial for developing practitioner relationships and ascertaining a crucial insight into the processes and structures of key partner organisations. This was particularly valuable when responding to whole family issues.

- **Cooperative Working Base Arrangements**

In rural locations where co-location was logistically more challenging, some areas stated that they would utilise partner agencies buildings to base themselves on certain days. This strengthened the relationships between practitioners and enhanced cooperation in joint working and understanding different remits, without the requirement of having to work from a central location. It also had the advantage of working from an area which may be local to families and individuals for home visits and direct work.

CULTURE OF INCLUSION, TRANSPARENCY AND CHALLENGE:

- **Inclusion and Representation Meetings**

Having an inclusive approach involving both Statutory and Voluntary and Charity Sector agencies, at both operational level and strategic level, was considered key. These multi-agency meetings ensured that unique perspectives and knowledge are shared, facilitating a holistic safeguarding response.

- **Clear Guidance Documents**

Clear processes, protocols and procedures that were documented, accessible and promoted to practitioners were fundamental in ensuring consistency in understanding. For example, the Protocol for the Resolution of Professional Differences, was highlighted as allowing appropriate levels of challenge and escalation to be facilitated formally, should it be required.

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- **Investment in Culture of Professional Challenge**

In addition to formal guidance and protocols, an active commitment and investment to developing a culture of professional challenge was reported by some areas, facilitated by leadership. All agencies and practitioners were recognised and valued as having key knowledge, skills and expertise and therefore were encouraged to contribute and express their opinions, experiences and perspectives.

COHESION BETWEEN SERVICES:

- **Combined Children's and Adult's Safeguarding Team**

In some areas there was restructuring to formulate one combined safeguarding team for Children's and Adult's safeguarding. This was noted to increase understanding of the whole family, create a shared understanding of vulnerability and reduce silo practice. It was also felt to increase resilience within the Social Service workforce and develop competence and confidence for individual practitioners.

- **Integrated Duty Desks**

Within Adult's Services it was highlighted that practitioners from different agencies were involved in a rota for receiving and responding to referrals which came in from the duty desk. This allowed for a shared learning and perspective to be developed as well as encouraging collective responsibility.

- **Joint Case Management**

There were examples of joint case management systems which allowed for the most appropriate service to lead but enabled ongoing reviews to facilitate a more seamless service transition. For example, Occupational Health and Adult Safeguarding were identified in one area as having a system whereby the lead professional could be flexibly changed accordingly, dependent on the circumstances. This is based on regular discussions and reviewing shared information between the two teams, to ascertain appropriate response to families and individual's needs.

- **Transitional Support**

For families who may no longer require statutory intervention, it was found that having Early Intervention/Prevention Practitioners invited to their final meeting provided a comprehensive introduction. This facilitated greater engagement between families and Early Intervention and Prevention Services, ensuring families had a continuation of support to prevent crisis, where appropriate. This joint working between Statutory and Early Intervention and Prevention was also highlighted as being beneficial when there were concerns a family required an escalation in support from Early Intervention to Statutory. In this scenario, joint meetings with the family between services were considered most effective.

- **Aligned Forms and Protocols**

On many occasions agencies working alongside each other within Safeguarding Hubs combined forms to save on duplication such as Social Services and Police. 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 the Youth Justice system within a short timeframe. This ensured that they were actioned efficiently by the appropriate agency, regardless of point of entry.

CONTINUITY, CONSISTENCY AND STABILITY:

- **Recognition, Development and Progression**

There were instances of rewarding staff and recognising their hard work, such as giving practitioners a day's leave to thank them. There were further examples of investments in current staff and working to develop skills with clear opportunities for career progression.

- **Staff Wellbeing**

Examples of investment in wellbeing included opportunities to participate in therapeutic support, offering courses and access to specialist practitioners when required, such as support for trauma.



A culture of approachability was evidenced in some areas whereby practitioners felt they could comfortably approach managers and leaders to discuss concerns or worries. There were also notable opportunities to facilitate casual, non-work-related conversations which occurred both face-to-face and online.

- **Recruitment**

Some local authorities were actively sponsoring individuals to become qualified as Social Workers and paying for qualifications and providing a variety of holistic placements to develop experience.

COORDINATION OF DATA COLLECTION:

- **Shared Database Access**

Despite many logistical challenges, there were examples where WCCIS was being utilised well across agencies, which enabled a sharing of timely information. For example, one region highlighted that Domestic Abuse Practitioners having access to the system which allowed them to understand immediately if there was Social Service involvement, which was key in multi-agency working. There were case examples where safeguarding practitioners were able to access different organisations databases, such as Police Officers who were seconded to organisations such as Youth Justice and those working closely with Education who were able to access school databases.

- **Data Reports**

A good example of bringing different aspects of data together was seen in a reporting format called AAA: Alerts, Assurance and Achievements. Within the report was the inclusion of areas of concern and escalation, but also an understanding what had gone well and the impact of their work. This was shared with the whole organisation and used to inform future service delivery.

- **Documenting Incremental Progress**

There were examples within local authorities whereby there was a focus on the safeguarding journey of families and individuals and a recording of incremental steps of progress towards goals.

- **Analysis of Data Trends and Deep Dives**

There were examples of analysis being conducted including quantitative data and audits, to explore cohorts of service users, levels of engagement and patterns and thematic trends in data. This was used to influence future decision-making, processes, and pathways. For example, a triage system to ascertain which families and individuals who had been referred needed immediate contact from an agency during a crisis and those who

could be placed on the standard waiting list, to increase engagement of support. Other examples allowed for more specific and tailored responses to safeguarding issues and designated pathways to respond to a particular type of vulnerability, such as child criminal exploitation and county lines.

COLLABORATION FORUMS AND PATHWAYS:

- **'What Matters' Agenda**

The introduction of the 'What Matters' agenda in Wales has provided a vehicle for formalising collaborative working with individuals and families and understanding what matters to them at the first point of contact and assessment, as well as collaboratively developing a plan of support.

- **Independent Advocacy**

Advocacy was something which was promoted by local authorities, but was facilitated by outside organisations. The use of an advocate provides an important mechanism in which services can work in partnership to support an individual. It was also noted that in instances where an individual is deemed not to have full capacity, there are communication aids and close working with the family and friends. However, having an independent named advocate can be additionally beneficial.

- **'Distance Travelled' Tool**

In Early Intervention and Prevention Teams, consultation was sought with families at the beginning of the partnership working to understand where they felt they needed support and what goals to work towards. A 'Distanced Travelled' Tool was completed when support and interventions were coming to an end, to understand what progress had



been made, in the form of a scoring system and accompanying narrative.

- **Satisfaction Survey**

Early Intervention and Prevention Teams offered a Satisfaction Survey to adults and children at the end of the partnership working to understand if their support had benefitted families and if so, in what way, capturing what could have been done better. It also explored further details around if they felt practitioners were clear, whether families felt respected, understood, supported and if their progress had been acknowledged.

- **Interactive Feedback Apps**

Within Youth Justice there were examples of interactive apps being utilised to understand the experiences that young people had working with Youth Justice practitioners, how they had helped, in what way and how this could be improved. Similarly, with a focus on whether they felt they were listened to, respected, understood, and supported. Encouragingly, there were plans to offer further opportunities for feedback at a review point during the middle of the partnership working, in addition to the beginning and end. This would allow any changes to be acted upon whilst working together and seek to influence this journey.

- **Consultation Projects on Service Delivery Design**

Examples were discussed whereby young people were invited to feedback on their experiences. This included groups of young people who were cared for by the local authority to have an input into future service design and delivery. This offered a creative approach, inviting young people to create poems, songs, and raps to express their opinions.

- **Conversations with Former Service Users**

Conversations with individuals and families who have previously accessed local authority support

were being conducted by one local authority, to understand their experience of receiving safeguarding interventions and to learn what could be done better to provide the most effective service possible.

- **Resident and Carer Forums**

Within Adult's care provision there were examples of residents and carers forums, whereby families and individuals had a platform to be consulted and opportunity to raise concerns and suggestions.

- **Peer-led Service User Groups**

Peer-led service user groups were identified in a local authority, whereby a service user group was initiated between practitioners and individuals and families. In this forum, individuals and families be consulted on their views and experiences to feedback into future service delivery. It also provided individuals with an opportunity for peer-led support and chance to form connections and friendships.

- **Independent Evaluation**

In some organisations, particularly the third sector, there were examples of independent evaluations being commissioned to understand effectiveness and impact of service delivery. Examples included consultations and interviews with individuals who had accessed services, to understand their perspectives and experiences. This helped to inform future practice and service delivery.

COMMITMENT AND CREATIVITY:

- **Creating Opportunities for Practitioners to Network**

It was noted that having the opportunity for practitioners across agencies to come together through training and networking was fundamental in forming relationships, creating shared understanding and stimulating rich discussions and debates. It also offers a space to reflect and discuss current safeguarding challenges across sectors. Opportunities to celebrate practitioners for their commitment and achievements was also suggested to recognise good practice.

- **Valued Contributions from Team Members**

Having the opportunities for practitioner teams to be consulted to contribute to key decision-making for services was recognised as motivating, inclusive and beneficial to stimulating creativity and sharing positive ways of working.

- **Innovative Working**

It was highlighted that some leaders and managers are proactive in encouraging, embracing and facilitating new ways of working, which require a change from the working norm. This drive to be brave and initiate change through different ways of working was noted to be helpful from top-down management, but also operationalising ideas from the ground up.





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