The National Independent Safeguarding Board Wales, in partnership with Metropolis, Manchester Met University, are pleased to announce an online conference.

National Safeguarding Week 2023
National Independent Safeguarding Board Webinar:

"Strengthening Our Collective Safeguarding Responsibility"

Wednesday 15th November 2023
9.30m – 12.00pm and 12.30pm – 3pm
via Microsoft Teams

#SafeguardingWales

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

Manchester Metropolitan University

University of Liverpool

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Gofal Cymdeithasol Cymru
Social Care Wales

Agenda

Morning Session:

- 9.30 Welcome & Housekeeping by Tony Young
- 9.40 Workforce Context by Tony Young
- 9.50 Foreword by Deputy Minster
- 10.00 Findings from Thematic Analysis of CPRs : 3RS Risk, Response, Review, Manchester Met University and University of Liverpool
- 11.00 Comfort Break
- 11.10 Rapid Review in Child Protection Decision-Making, Care Inspectorate Wales
- 12.00 Close of morning session

Afternoon Session:

- 12.30 National Safeguarding Training, Learning and Development Standards: Where are we now? Social Care Wales
- 13.20 Comfort Break
- 13.30 Activity: Taking recommendations forward in practice across sectors. Interactive discussion with Padlet with all presenters
- 14.55 Concluding Remarks
- 15.00 Close of afternoon session

Llywodraeth Cymru
Welsh Government

Julie Morgan AS/MS

Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Chair of National Independent Safeguarding Board Wales (NISB)

Tony Young

Consideration of the Workforce Context

- **Shaping the Future of Wales research 2022**:
  - Across workforces involved in safeguarding
  - Demand on data/audits/performance, lack of expertise and resource
- **BBC article Wales 2023:** Social work: Stress as demand increases in Wales - BBC News
  - Doubling of safeguarding referrals
  - Significant overspend (One Children's services had overspent by £7.5m this year)
  - Chronic recruitment and retention problems;
  - Unprecedented demand on cash strapped Social Services Directors (SSDs)
- **Social Care Workforce Survey 2023:** https://socialcare.wales/research-and-data/workforce-survey-2023
  - 26% quite or very likely to leave social sector in 12 months, 44% within 5 years
  - Reasons: pay (66 per cent), feeling overworked (54 per cent) and poor employment or working conditions (40 per cent)



Risk, Response and Review:

Thematic Analysis of 33 Child Practice Reviews (CPRs) in Wales 2023

Prof. Michelle McManus, Emma Ball and Prof. Louise Almond

15th November 2023

Commissioned by:

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

UNIVERSITY OF LIVERPOOL

MAMRA

Manchester Metropolitan University

Research Background Context

Exploration of integrated multi-agency operational arrangements (2020)

Shaping Future of Safeguarding (2022)

- The Collective Safeguarding Responsibility Model: 12Cs
- National Performance Framework (children)

Risk, Response, & Review: Child Practice Reviews (2023)

Format of CPR Analysis Report: 4Rs

Risk:

Index Child and Family Characteristics within CPRs

Response:

Organisational and Agency Involvement Prior to the Index Incident

Review:

Quality of CPRs

Recommendations

1.Practitioners and Managers

2.Boards and Authorities

3.Policy Makers

Sample

- 33 CPRs
- 11 Extended
- 21 Concise (+1 historical)
- 28/33 (85%) index incident after implementation SSWB Act (April, 2016)
- 8/33 (24%) index incident after Safeguarding Procedures (Nov, 2019)
- Covid-19 (review period/CPR process) 21/33 (64%)
- Index incidents from 2013 – 2021

Risk Findings: Descriptives

Two thirds of CPRs were **prompted by a child's death.**

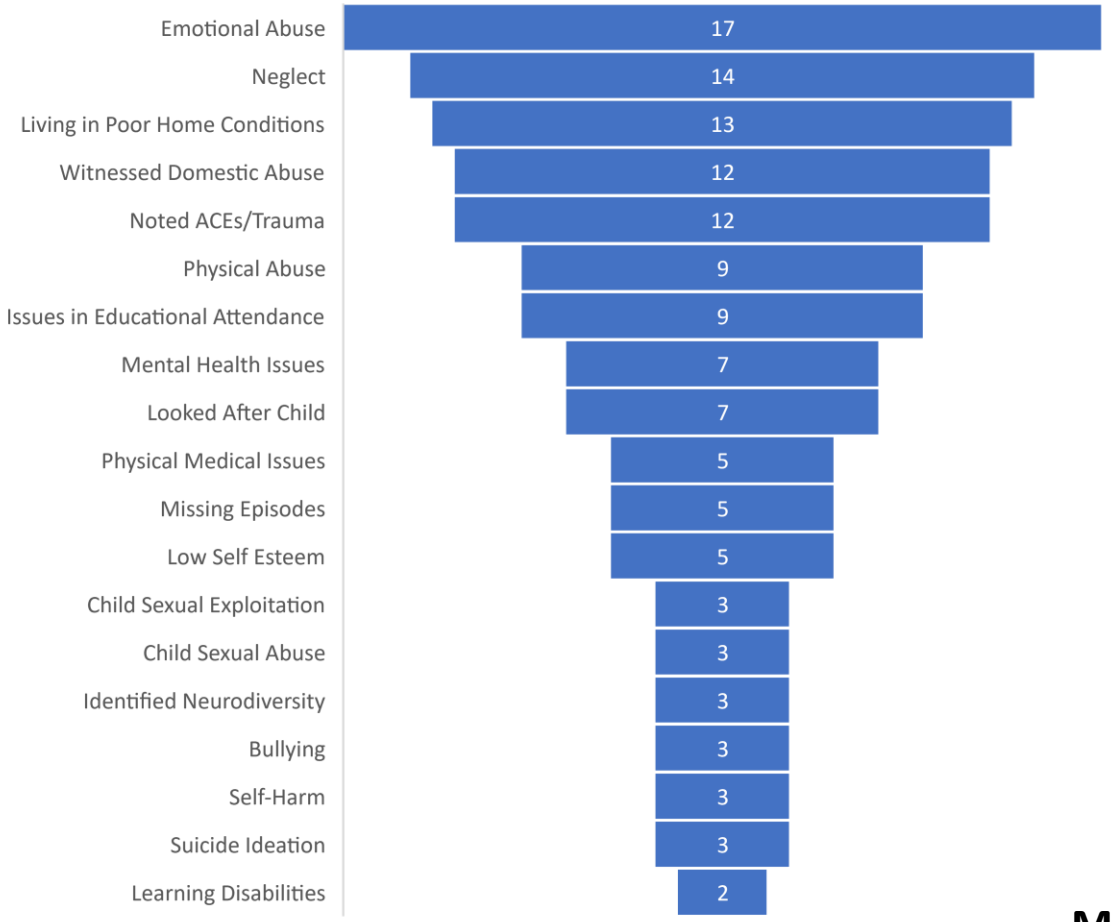
Suicide, other medical/health issues and non-fatal physical abuse were the **most common incidents.**

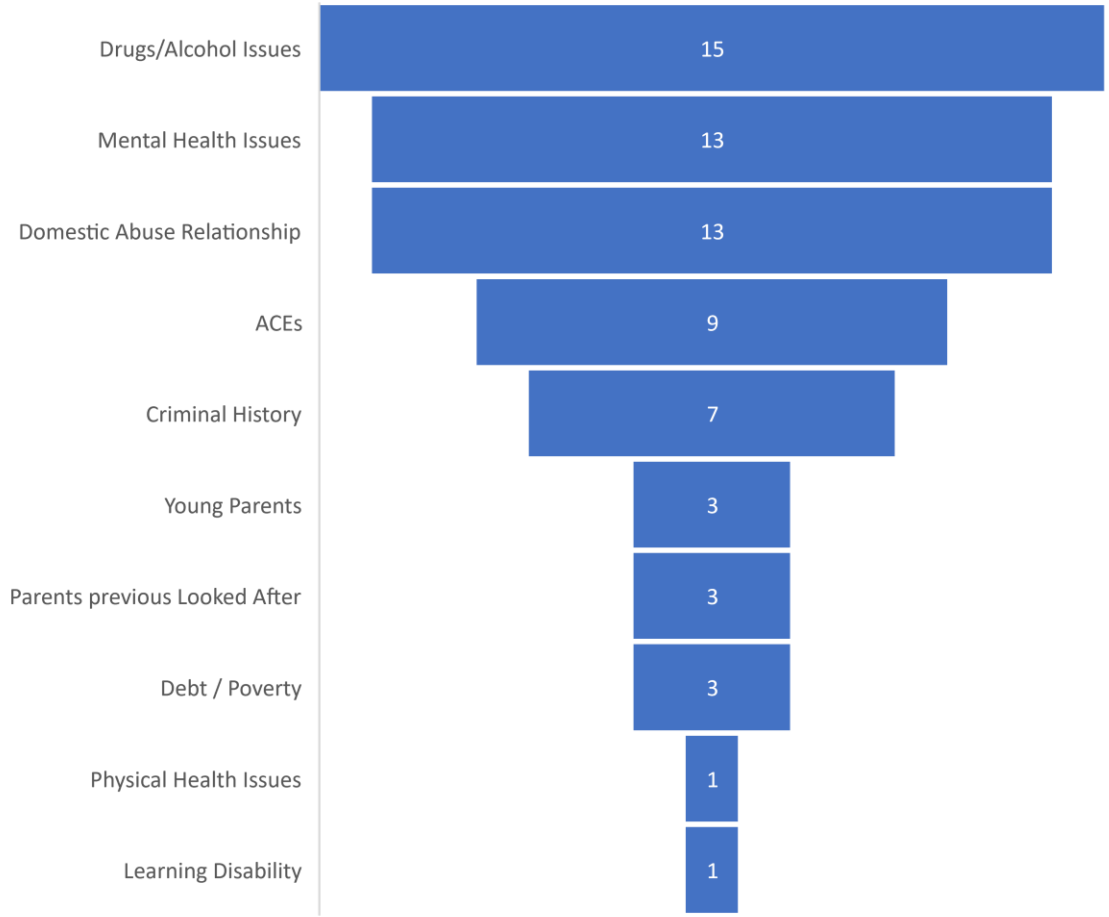
1/5 of the children were up to 3 months old when the incident occurred, while a fifth were 13 years old and over.

3/4 of the children had a **sibling**. Of these, a third had **half-siblings** and two thirds were the youngest in the family.

45% recorded a large sibling group (3 or more children). Child subject to the CPR was youngest child in 66% of 21 cases.

Children's most common vulnerabilities were emotional abuse, neglect and living in poor home conditions.



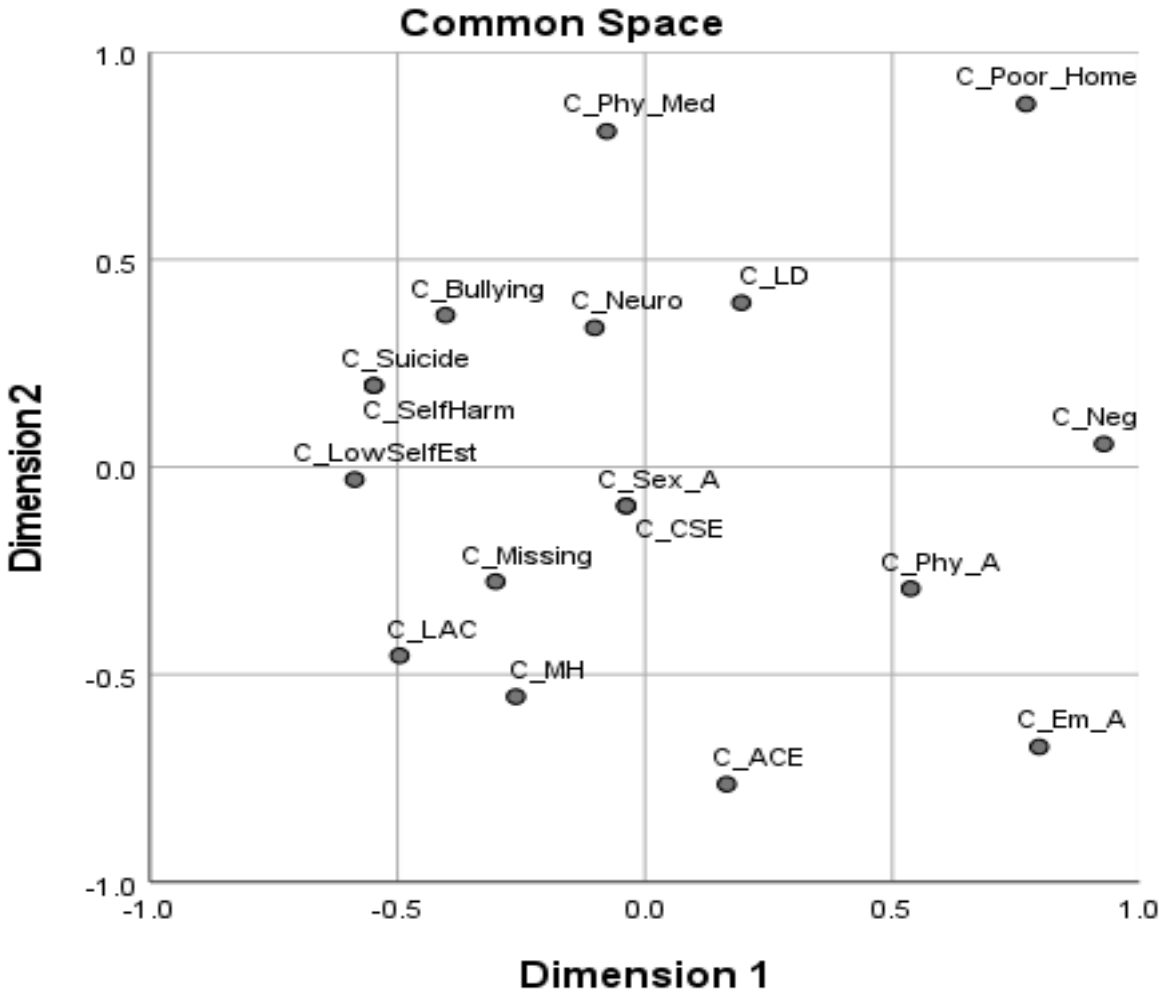


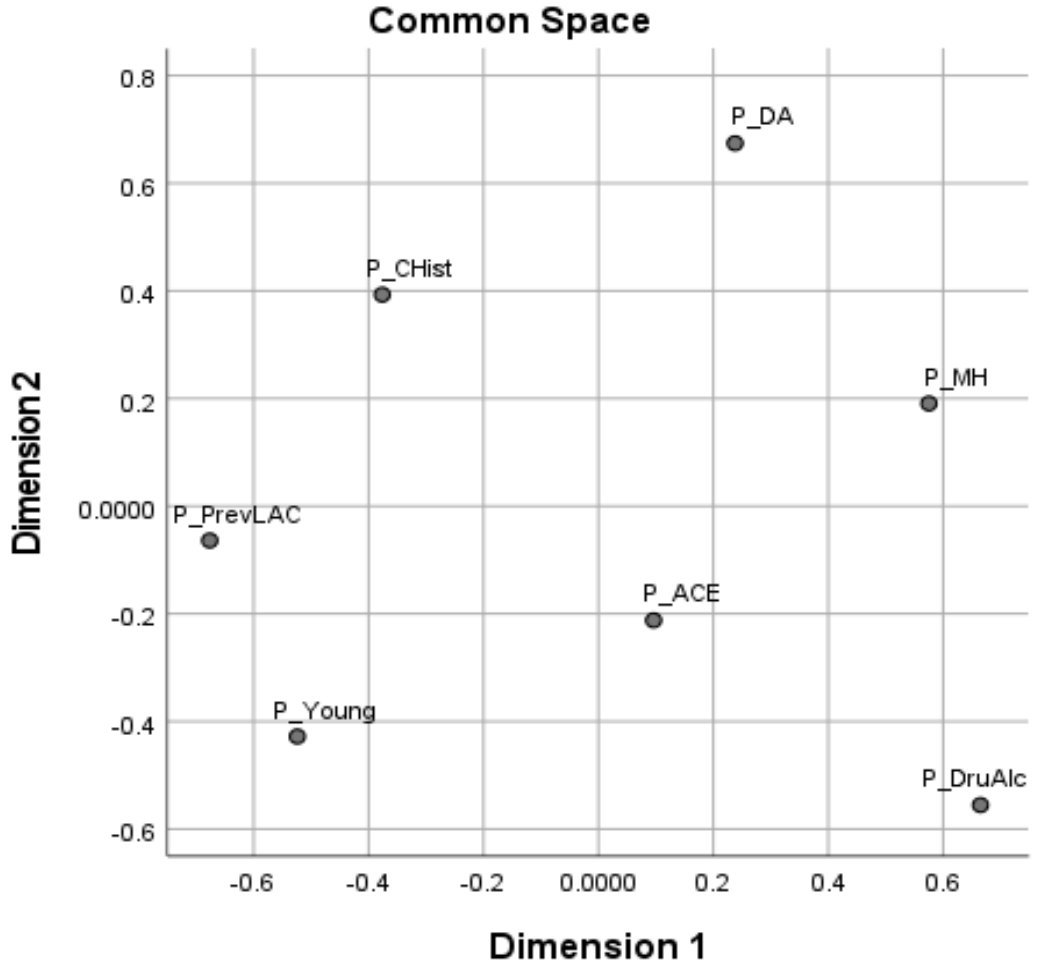
Most common parental/carer risk factors were drugs/alcohol misuse, mental health issues and domestic abuse relationship.

Correlations

Parental/Carer Indicators	**Mental Health**	**Drugs/ Alcohol Misuse**	**Criminal History**	**ACES**	**Domestic Abuse Relationship**	**Young Parents**	**Previous Looked After**
Mental Health Issues		.51***	.49***	.76***	.62***	.39*	.39*
Drugs/Alcohol Misuse	.51***		.42*	.53***	.51***	.35*	
Criminal History	.49***	.42*		.51***	.64***	.35*	.61***
ACES	.76***	.53***	.51***		.48***	.52***	.52***
Domestic Abuse Relationship	.62***	.51***	.64***	.48***		.39*	.39*
Young Parents	.39*	.35*	.35*	.52***	.39*		.63***
Previous Looked After	.39*		.61***	.52***	.39*	.63***	

Proxscal


Common Space
C_Poor_Home
C_Phy_Med
C_LD
C_Bullying
C_Neuro
C_Suicide
C_SelfHarm
C_Neg
C_LowSelfEst
C_Sex_A
C_CSE
C_Missing
C_Phy_A
C_LAC
C_MH
C_Em_A
C_ACE
Dimension 2
Dimension 1
1.0
0.5
0.0
-0.5
-1.0


Common Space
P_DA
P_CHist
P_MH
P_PrevLAC
P_ACE
P_Young
P_DruAlc
Dimension 2
Dimension 1
0.8
0.6
0.4
0.2
0.0000
-0.2
-0.4
-0.6

2.Response Findings: Descriptives

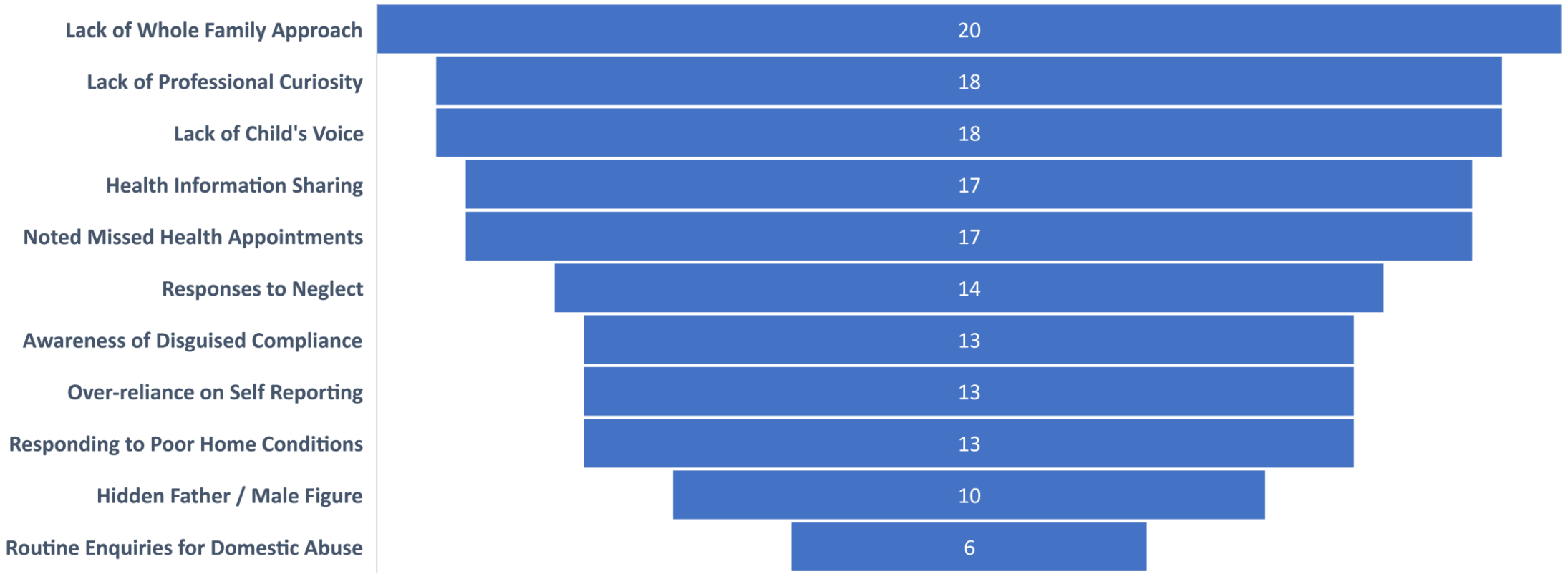
1/3 involved a child that was on the Child Protection Register and/or was a looked-after child at any point in the 6 months before the event.

94% of index children and families had been flagged or were known to Children's Services at any time*. Just **2 of the 33 were unknown to authorities** (no safeguarding concerns).

Over half of CPRs recorded a referral/report to Children's Services, which they deemed to be below the level of seriousness which requires threshold for intervention.

Other key agencies aware of the child or their family included the Police (20 cases out of 33), Midwife/Health Visitor (19) and GPs (17).

Response: Recommendations from CPRs

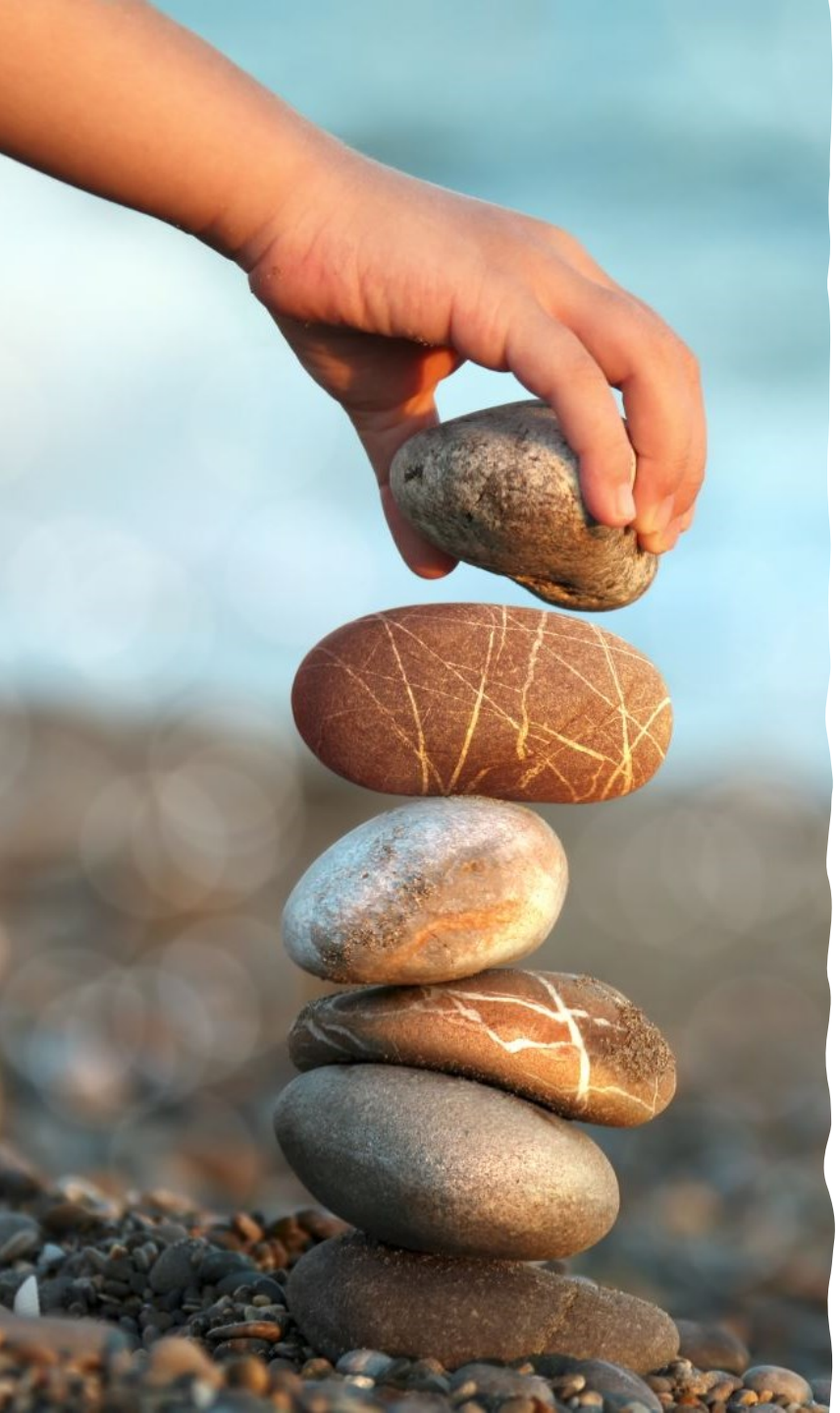


Thematic Analysis

“In adding all of the factors together, a more worrying picture emerges”.

Response Findings: Themes

Themes across Multi-Agency Involvement and Learning		
1. Practitioner and Agency Challenges	1.1 Assessing Needs and Risk: Clarity and Challenge	Transparency
		Professional Curiosity, Self-Report Reliance and Disguised Compliance
	1.2 Consideration of Co- occurring Harms and Historical Relevance	Previous Trauma and Agency Involvement
		Accumulation and Interaction of Risk factors
		Remit and Safeguarding Lens
	1.3 Whole-Family Focus	Siblings
		Parental Unmet Needs
		Limited understanding and inclusion of fathers
	1.4 Child's Voice: Capturing, Recording, Utilising	Engagement, Exploration and Re-cording
		Utilising Child's Voice to Influence Decision- making and Action
2. Structures and Process Barriers	2.1 Escalation and Referral Process Ambiguity	
	2.2 Pathway and Coordination of Safe- guarding Responsibility	
	2.3 Health Organisational Complexity	
3. Wider Influences on practice and processes	3.1 Workforce Issues	
	3.2 Covid-19 Pandemic	
4. Identified Good Practice	4.1 Social Services	
	4.2 Health	
	4.3 Education	
	4.4 Police	



Child's Voice: Capturing, Recording, Utilising

- Themes were identified around engaging and capturing the child's voice and understanding their **daily lived experience.**
- Questions around:
  - How and where are a child or young person's view **recorded**?
  - How do these views **influence future decision-making**?
  - How are the **outcomes shared** with a young person, in relation to their wishes and decisions and where is this documented?



Co-occurring Harms and Interacting Risk Factors

Accumulation of risk factors can result in a **'cumulative effect'** of risk, which is not always duly considered.

One such example was the use of cannabis. Cannabis use by parents or carers may have no/little impact upon parenting ability. However, when there are other **co-occurring concerns alongside** such as potential neglect, the impact of cannabis use could be **more significant**.

"Risk assessments in relation to referrals had been too heavily weighted on episodic events"

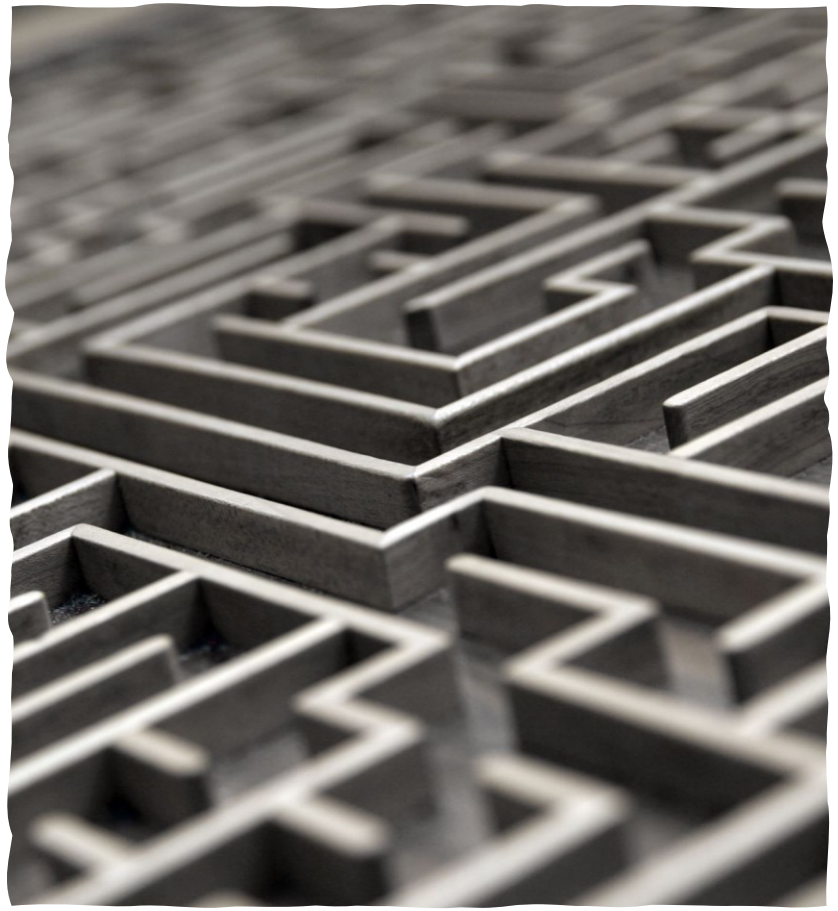
Professional Curiosity

- A ‘lack of’ or ‘increased need’ for Professional Curiosity was noted in over **60% of CPRs** (N = 18).
- This could suggest that practitioners may not have the experience, **confidence** or **competence** to consider or challenge alternative narratives to the accounts being put forward by families.
- Potential lack of **capacity** in having adequate time and resource to comprehensively respond to safeguarding referrals.
- Term ‘Professional Curiosity’ **is ambiguous** and does not fully acknowledge the potential **organisational and structural barriers** which may undermine the ability to exercise any such curiosity.
- Professional Curiosity needs further exploration: How is this curiosity **encouraged, facilitated** and **embedded** into practice?



Iceberg underwater Free Stock Photos, Images, and Pictures of Iceberg underwater (vista.com)

Pathway and Coordination of Safeguarding Responsibility



Longstanding observations that **information sharing** needs to be appropriate, more frequent and robust. However, **the structures and infrastructure** which support (or indeed, inhibit) this sharing of information, are often inadequate.

Lack of 'soft' information sharing ability.

"Agencies shared that there is often information that would assist decision making not known to Children's Services decision makers, as it is held on other agencies systems and has not met the threshold for a Child Protection referral"



Health Complexity

It must be recognised that Health as a sector **is segregated** by **diverse remits**, **complex structures** and **fragmented IT systems**.

CPRs show that information is often **known but not routinely shared.**

"Health Board does not have a single patient record"

"Health practitioners held a number of important pieces of information in respect of the family that could have assisted with decision making"



Deep Dive: Missed Health Appointments

CPR19: Child was two years old when found unresponsive at home. Had severe medical issues, but there were also a number of concerns and referrals made to Children's Services regarding the mother's associations within a **household that had substance misuse**. This was alongside health practitioners across a range of services recording **missed health appointments** by the mother for her child. The care coordinator was within **Flying Start and they were unaware** of any missed appointments.

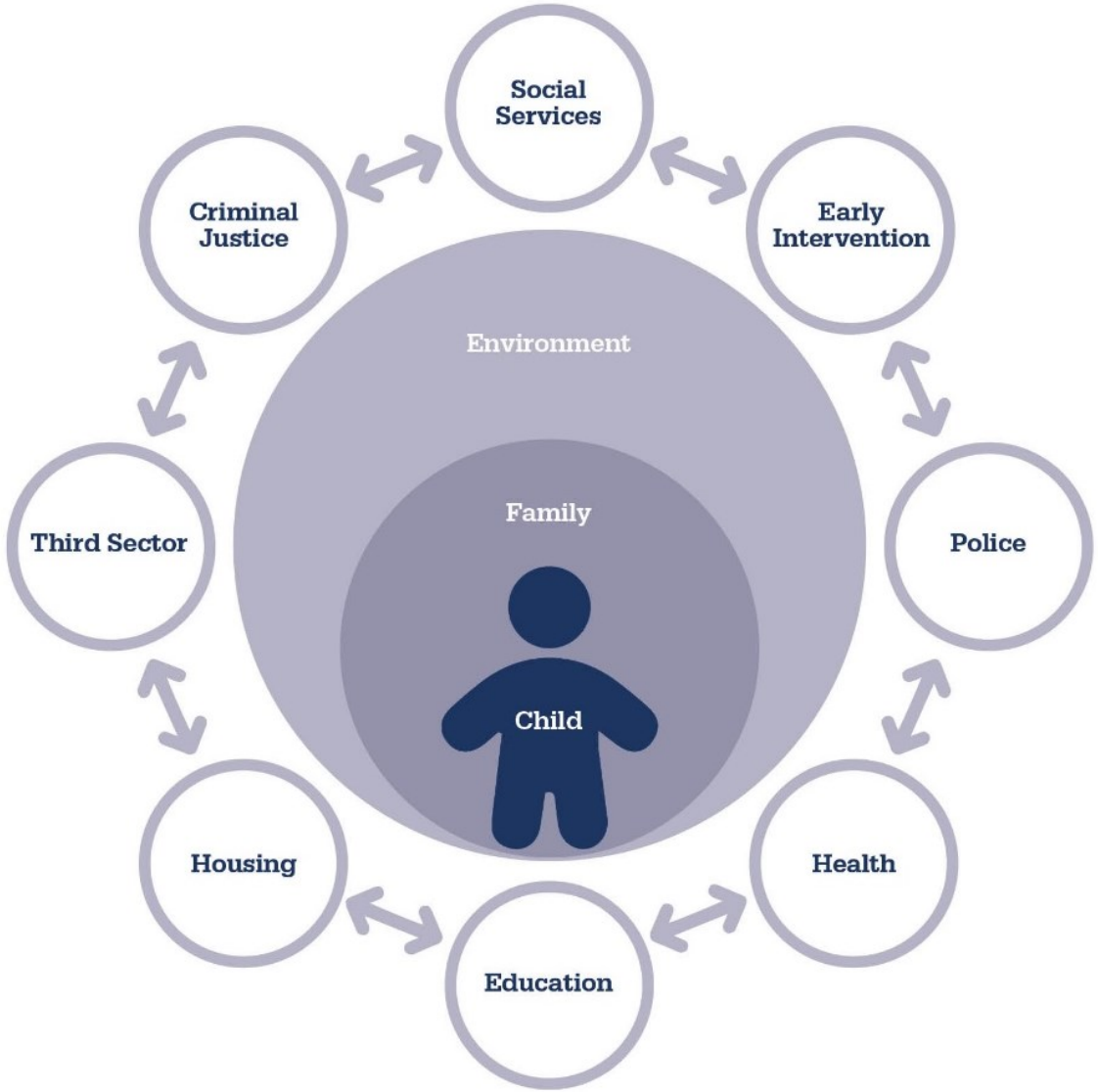
The CPR notes that **no single professional within or outside of health had any oversight to risk assess** the implications of the increasing number of missed appointments. Was noted as being **seen in isolation** by each department including the Health Visitor, hospital admissions (planned), Emergency Department, and Therapy.



Deep Dive: Missed Health Appointments

- Many CPRs raised the issue of missed health appointments, with reference to the **'Was not Brought' Protocol** needing to be followed and actioned.
- But even for this one aspect of intelligence, there is a lack of ability to **record, collate and share** this information.
- Questions remain as to **ownership, accountability and coordination** of future action required to respond to this information through a safeguarding lens.
- This is because we do not have the ability to specifically:
  - **Code** (record) this key information (e.g., missed health appointments) clearly, easily searchable and extractable
  - **Trigger Point** to recognise when this information becomes a concern
  - **Notify** other agencies of this information (share information).
  - **Collate, Overlay and Progress** this key information and with other child/family/environment information to understand the wider child/family circumstances

Model of Multi-agency Connections, Considerations and Complexities



Good Practice Examples

Social Services

Social workers creative methods to engage children, such as bringing a Rubik's cube when a child has expressed an interest in them.

"At the point where the information in the safeguarding referral became known, agencies acted effectively and promptly to safeguard the child".

Understanding families need continued support once no longer threshold for statutory support and sought transitionary service delivery

Health

Prompt alert being shared by the hospital to Health Visiting Services to make them aware of attendance.

Information sharing working well between Health Visitors and services such as School Nurses, with two professionals meeting informally discussing joint cases

Health Visitors wide delivery of support, such as providing housing support and ensuring families understood the CP process

Police

Providing an experienced officer to interview a child, to ensure their voice was heard and understood

Providing detailed historical information for Child Protection conferences, as well as being vocal in articulating where they felt a case needed to be escalated

Providing a sensitive and timely response to families.

Education

Schools being proactive in submitting referrals for support for children and for wider family support,

Education Welfare Service was also noted to have an in-depth log detailing their interactions with a family they were working with.

School database being utilised to ensure any safeguarding concerns were captured

Wider Agencies

Advocacy Services were *"extremely well positioned to intervene and enable the multi-agency group to hear and act"* on a child's view

Housing officers working with families to maximise their income and avoid rent arrears.

Pharmacist drew attention of the frequent and excessive repeat prescriptions dispensed to a mother in the months leading up to the pregnancy.

Review: Quality of CPRs



- Given the aims of a CPR, it is vital that they are **clear, consistent** and offer recommendations which can be translated into **meaningful actions.**
- The quality of CPRs, was analysed in terms of structure, content and **adherence to established processes**.
- There was **variability across CPRs** which included adherence to terms of reference and missing information regarding index child e.g., gender and age as well as key dates.

Timelines included within the CPR Review Period

Time in Months	Mean/SD	Median/Range	Frequency
From Referral to Sub-Group - Sign-Off	21.63 / 6.64	20.7 months / 22.9 months	14
From Index Incident - Sub-Group Referral	7.46 / 9.87	4 months / 37.4 months	17
From Index Incident - Learning Event	20.29 / 9.38	18.6 months / 33. 8 months	23

Recommendations



PRACTITIONERS AND MANAGERS



BOARDS AND AUTHORITIES



POLICY MAKERS

1. Recommendations for Practitioners and Managers

1.1. Multi-Agency Partnership Training

- Regular, multi-agency training ensures common understanding, facilitates regular discussions of different agency perspectives and strengthens roles and expectations in recognising and managing safeguarding concerns.
- Training should specifically address:
  - The **child's voice as the daily lived experience of** the child.
  - **'Whole Family' approach** and developing competent and confident workforce. Practitioners need to be clear on individual agency responsibilities and the processes and pathways for collating intelligence in identifying emerging risk.
- Key thematic areas: **neglect and poor home conditions,** which were identified as key interacting risk factors within the analysis, as well as within wider reports.



1.2. Professional Curiosity

- Strategic discussions to be initiated at LA and RSB level for clarification.
- Focus on how Professional Curiosity is **encouraged, facilitated and embedded into practice** within and between all relevant professional agencies.
- More clarity is required to explore how curiosity is **reviewed and monitored** for maximum and continued effectiveness.



1.3. Prioritising Support and Supervision for all practitioners



Managers:

- Clarity on expectations for formal safeguarding supervision for relevant practitioners (frequency, duration and objectives of supervision). How this will be internally reviewed and monitored.
- Provide and review informal opportunities for practitioners to access safeguarding support.



RSBs:

- Assurance (RBS level) that regular and effective supervision is taking place across sectors, which may require, for example, returned reports from relevant agencies to the RSBs.
- Monitoring provide confidence that supervision across safeguarding partners is purposeful, impactful and of sufficient quality.

2. Recommendations for Boards and Authorities



2.1. Threshold Uncertainty, improving Decision-Making, Agreement and Challenge

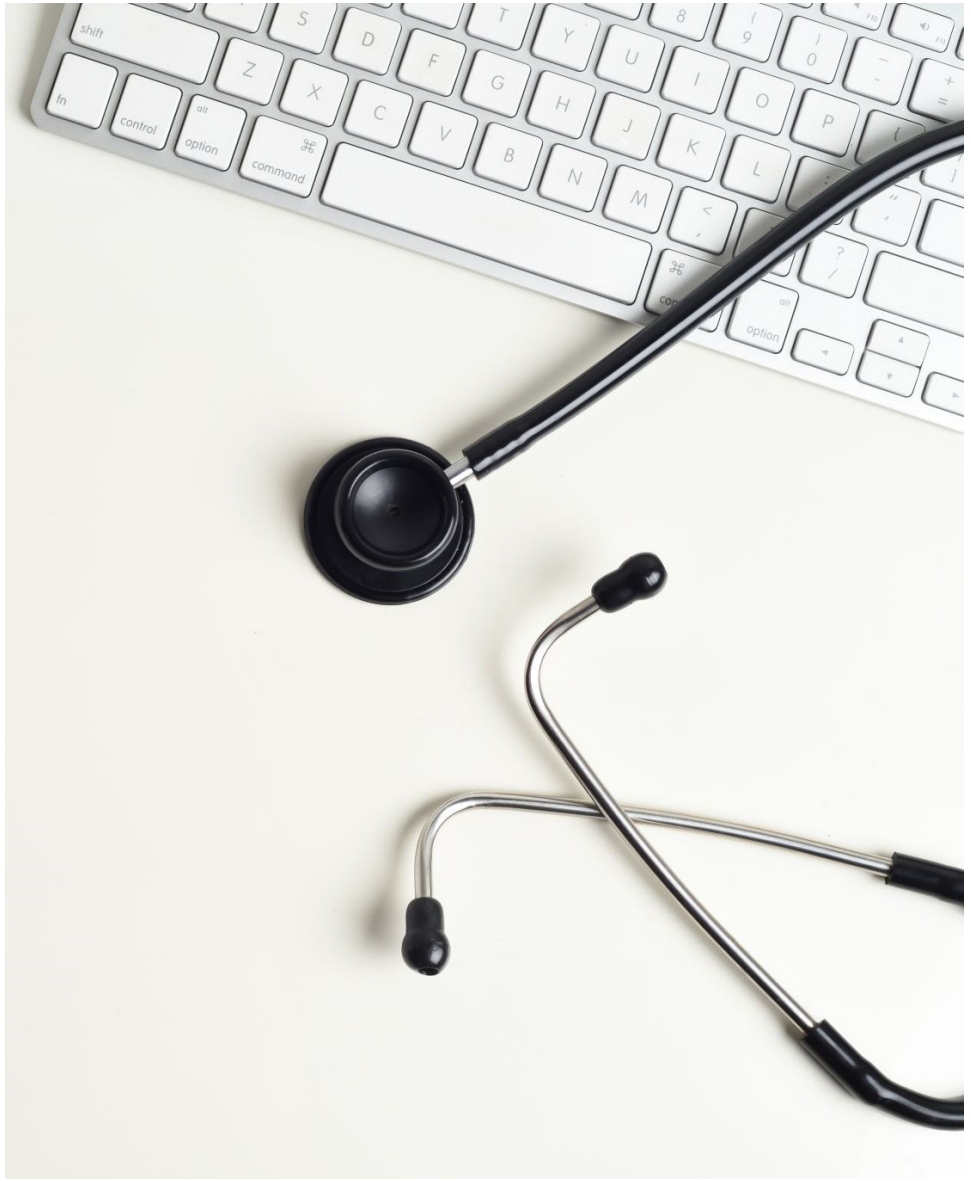
This review identified the need for:

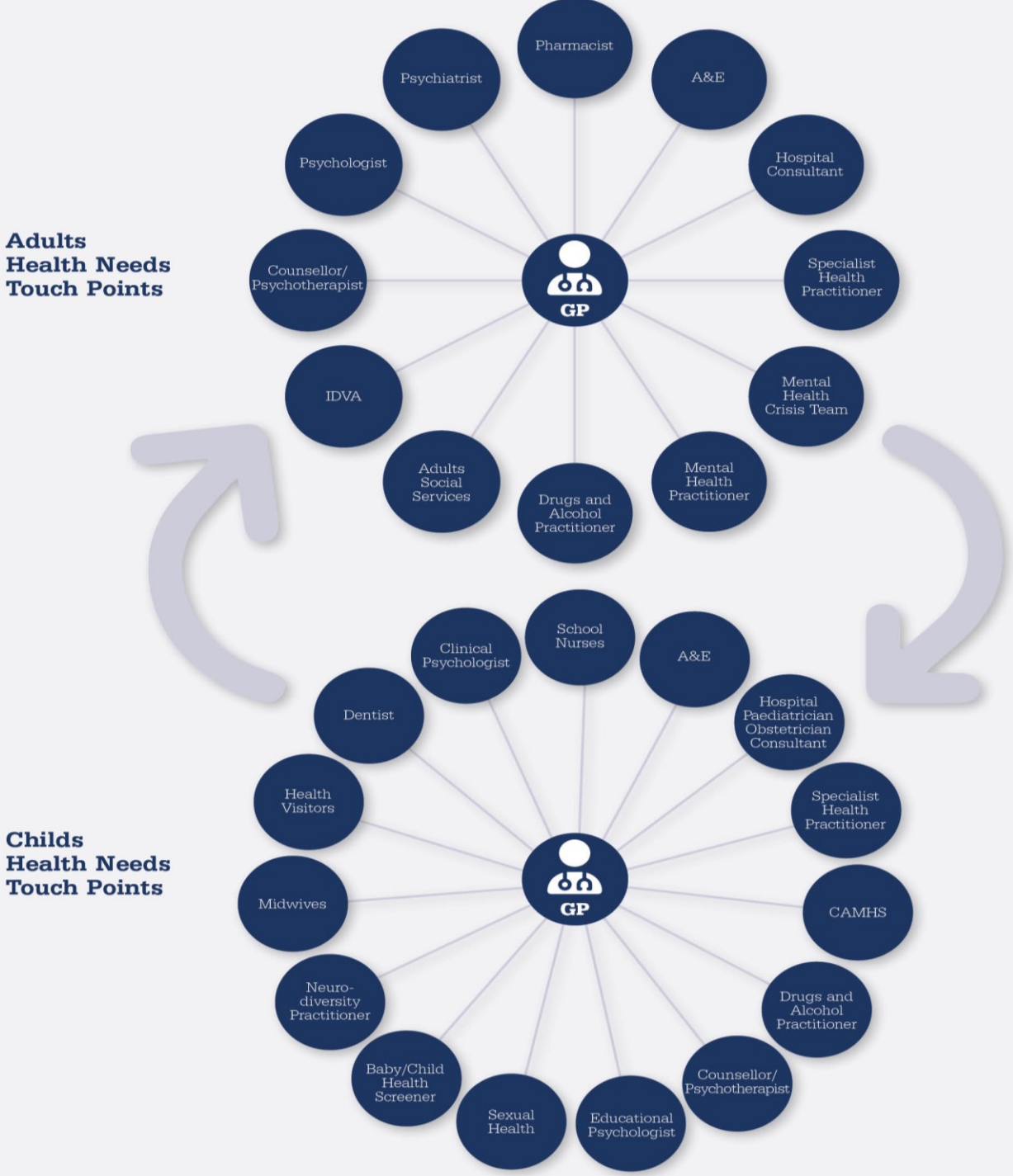
- **Multi-agency Thresholds Guidance** should be agreed regionally to clarify expectations and as a point of reference for practitioners when making safeguarding referrals.
- **Areas of concern, often subject to ambiguity** and different interpretations, for example neglect, should be addressed.
    - Include clear pathways for progressing concerns and challenging decisions should a safeguarding concern remain after a threshold decision has been reached.
- Local polices and protocols relating to managing emerging or escalating concerns and **resolving professional differences** should provide transparent and accessible pathways and processes.
    - This should be referenced in the Multi-agency Threshold Guidance and monitored as part of internal reviews.

2.2. Working towards a Unified Health Record

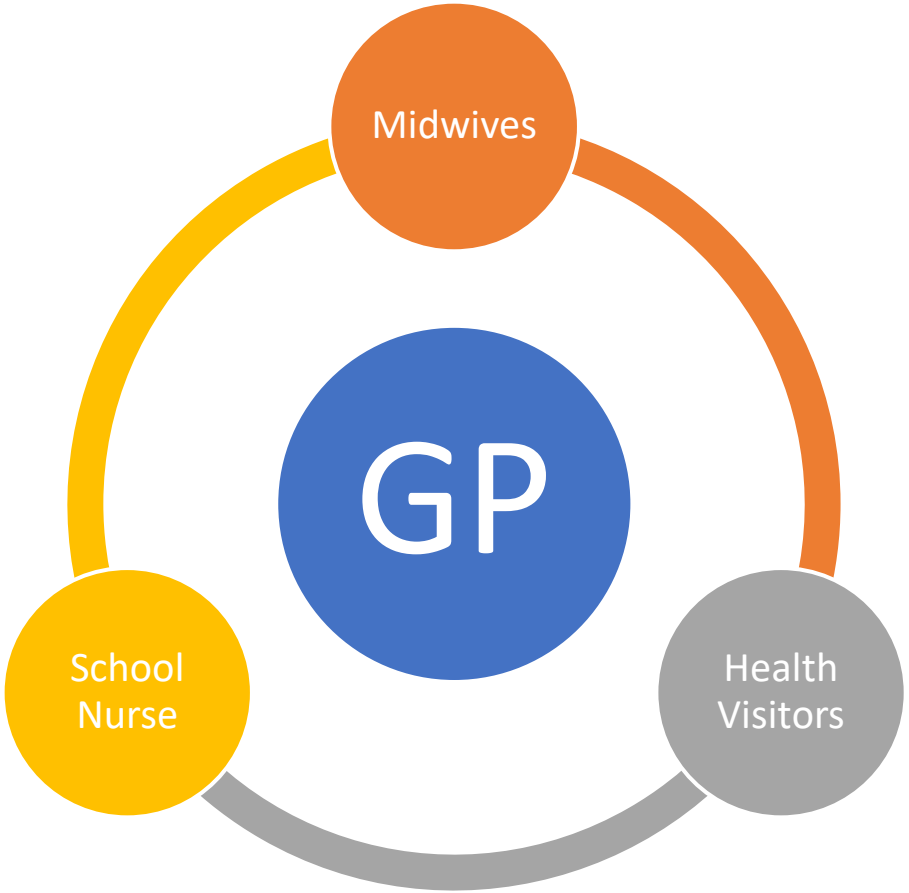
Key, but complex, nature of Health agencies within safeguarding. Whilst acknowledged as challenging, urgent work is required to further drive the facilitation of a unified health record:

- **GP surgeries, Midwifery Services and Health Visitors** information is particularly vital to enable a whole family focus, when identifying emerging safeguarding concerns.
- In the absence of shared IT systems, consideration must be given to **develop mechanisms which enable prompt routine information sharing** and which promote relationship development between these practitioners.
- **Nationally led Safeguarding Health Working Group**, with stakeholders to consider the barriers and opportunities for collaboration and effective information sharing of low level and emerging safeguarding concerns.



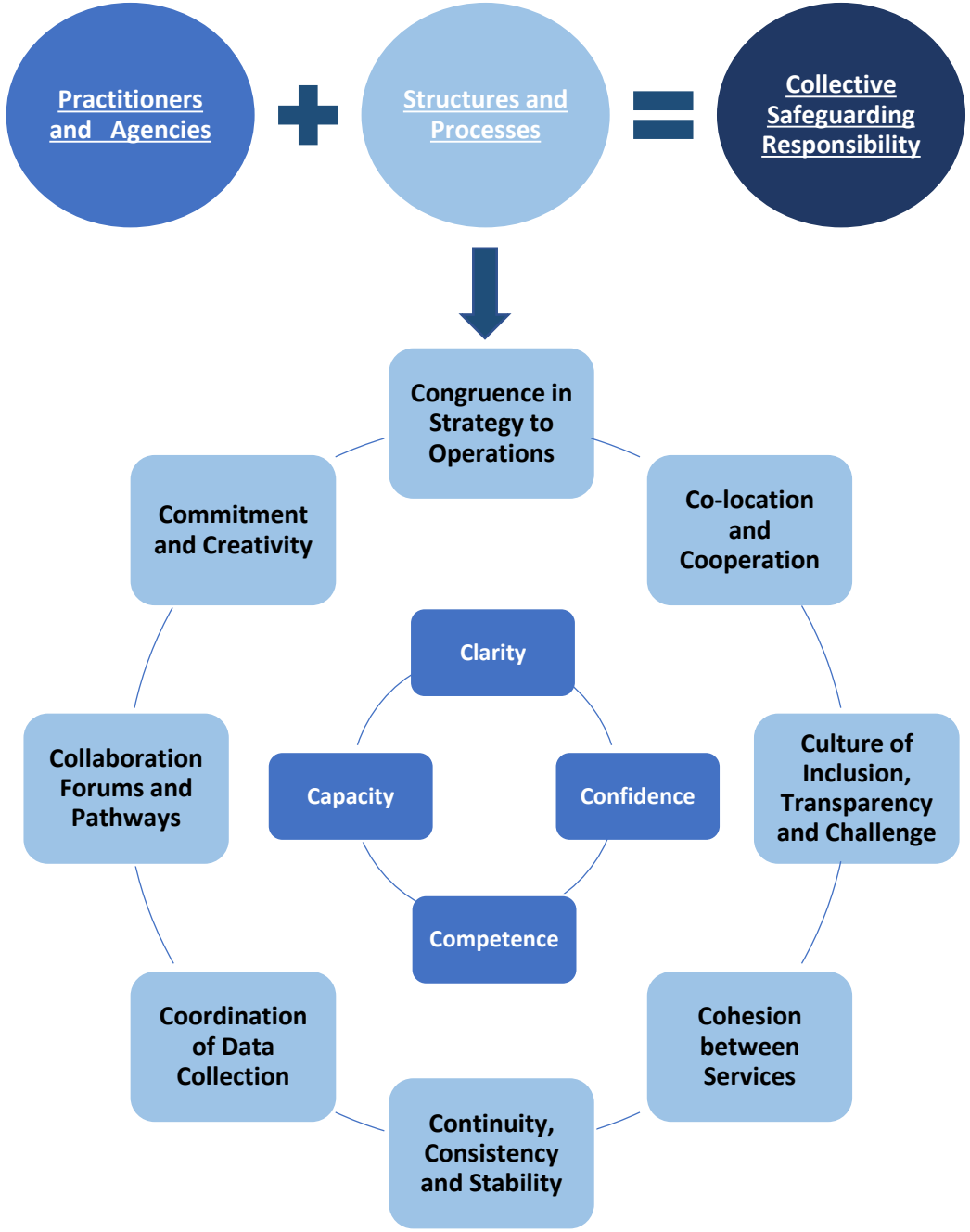


Health Complexity



2.3. Measuring Effectiveness within Safeguarding Arrangements

- Clearer evidence is required from RSBs/ LAs in **demonstrating the effectiveness** of their multi-agency safeguarding arrangements.
- RSBs and Local Authorities are encouraged to adopt the **Collective Safeguarding Responsibility Model: 12Cs** (Ball & McManus, 2023) as a toolkit.
    - 12Cs model details 12 components across “Practitioners and Agencies” as well as “Structures and Processes” to identify challenges and inform more targeted work, as well as identify best practice.



2.3. Measuring Effectiveness within Safeguarding Arrangements

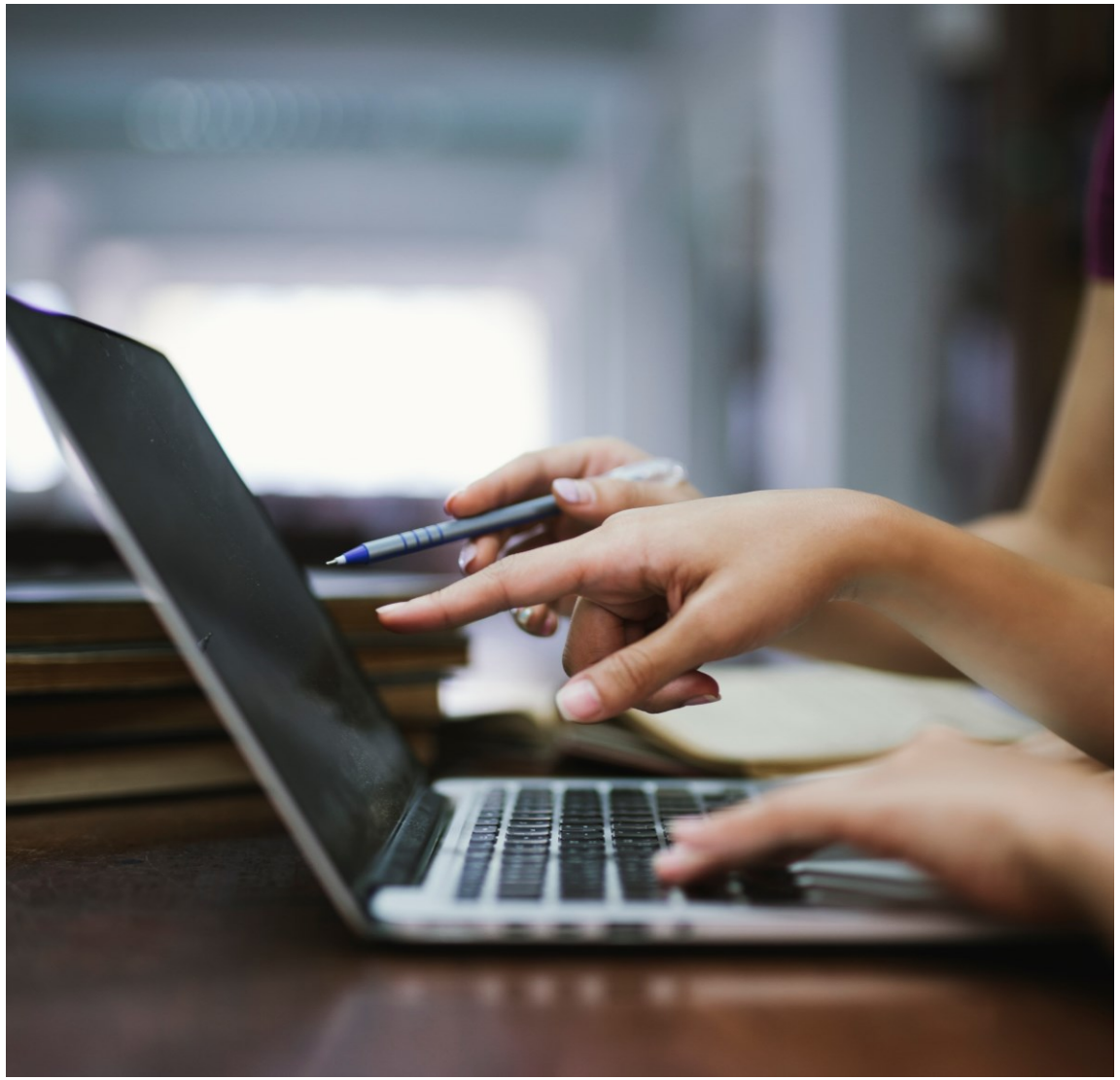
- Each RSB CPR should be included in **internal annual reviews** (e.g., as part of annual audits/corporate safeguarding reports). Given all CPRs provide a list of recommendations and required actions, the RSB should seek to collate all recommendations and actions required to improve safeguarding responses.
    - Identify common themes, share lessons and to better understand the improvements required across the region.



3. Recommendations for Policy Makers

3.2. Development of Automated Safeguarding Referral/Report Portals

- Prioritisation should focus on **building automated portals for professional safeguarding concerns to be received, reviewed and managed.** This would enable increased opportunities for effective information sharing of softer intelligence and concerns.
- In receiving notifications of submissions alongside unique referral reference numbers it would encourage follow-up from referrers regarding any decision making and feedback.
    - This would increase capabilities in searching and collating information on a child, wider family and household in determining a holistic picture of concerns raised.
- This would require additional resource to implement and would need to work within current systems and pathways, such as MASHs/ Safeguarding Hubs and Information, Advice and Assistance (IAA) front door processes.



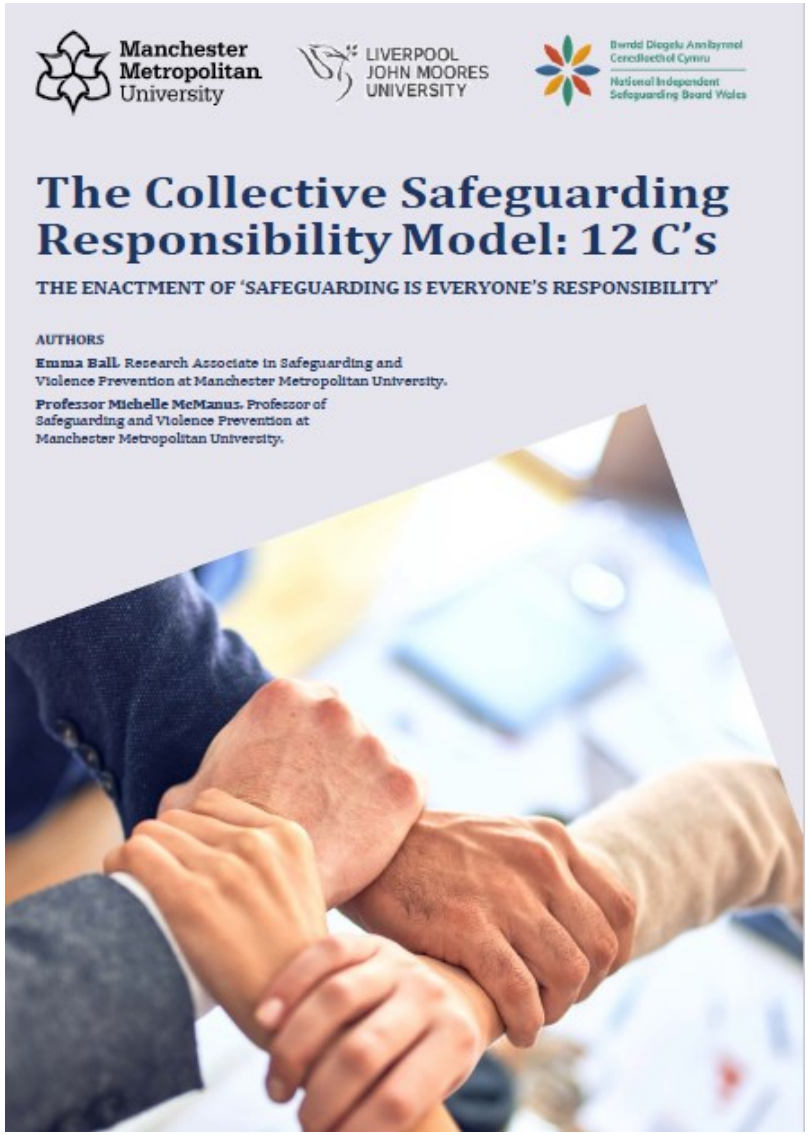
3.3. Review of the ‘Not Brought’ Protocol to maximise this policy into practice

- The ‘Not Brought’ Protocol was identified in many CPRs as requiring further implementation into practice, particularly regarding missed health appointments.
- A national ‘Not Brought’ protocol for all agencies needs to be developed to sit across RSBs - allow for a clear pathway of action, specifying the roles and responsibilities of each agency that is notified of information, should it require actioning.



3.4. Recording and Guidance relating to neglect and home conditions

- Issues with practitioners being unsure what detail was required to be reported to ensure accurate capturing of information - **the impact on all family members** needs to be considered in these assessments and recording.
- Record - Various, **cumulative, and continuing concerns** raised, what action was taken, and the longevity of any changes made (All-Wales Safeguarding Procedures; All-Wales Practice Guide on Safeguarding Children from Neglect, 2021).
- RSBs should seek **to review interacting risk factors such as how neglect and concerns regarding home conditions are recorded and who takes ownership and responsibility** for these concerns, using their ability to extract information identifying escalating and/or continuing lack of progress from relevant agencies.
- Authorities should seek to **develop multi-agency infrastructure nationally, to promote the sharing of softer safeguarding intelligence** and to build a more accurate understanding of harms being recorded.
- Wider and more consistent use of the Information Advice and Assistance system may also offer a route to develop this.



3.5. Implementation of the 12Cs as a Guidance Framework and Audit Toolkit

- How agencies can facilitate collaboration, joint-working and **instil a collective responsibility for safeguarding: The Collective Safeguarding Responsibility Model: 12Cs** (Ball & McManus, 2023).
- We recommended that this model be implemented to **support existing Guidance Frameworks, and Audit Toolkits** across RSBs and LAs to help demonstrate any measures adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.
- Implementing the 12C framework would require RSBs/ LAs to respond to each of the 12Cs in turn to evidence what has been put in place or is planned to be implemented, to address this area. There is also an option to grade progress made within each of the 12Cs, which can be reviewed annually and monitored.

C5: CONGRUENCE IN STRATEGY AND OPERATIONS:						
CIW Definitions	**1**	**2**	**3**	**4**	**5**	**6**
CIW Definitions	**Unsatisfactory**	**Weak**	**Adequate**	**Good**	**Very Good**	**Excellent**
CIW Definitions	**Major weaknesses - urgent remedial action required**	**Important weaknesses - priority action required**	**Strengths just outweigh weaknesses**	**Important strengths, with some areas for improvement**	**Major strengths**	**Outstanding or sector leading**
12Cs Progress	Practice/ Intervention/ Policy identified but not progressed	Practice/ Intervention/ Policy identified, key partners consulted, logistical requirements discussed	Practice/ Intervention/ Policy agreed by key partners, implementation plan finalised, start date agreed	Practice/ Intervention/ Policy implemented and in early stages of operation, undergoing review	Practice/ Intervention/ Policy implemented operating well, undergoing refinements where necessary	Practice/ Intervention/ Policy embedded, functioning optimally and sustainable
Self-assessment score			X			
Evidence for self-assessment score	*Narrative explaining the evidence for self-assessment score reached? Examples should specifically identify any Policy or Practice interventions/support*					
Accountability, Ownership and Governance	*Who is the lead person/people/ agency responsible for coordinating/driving action on this?*					
Stakeholder Partners	*Which stakeholders/partners are part of the delivery/achievement of this component and what is their role?*					
Specific Action Plan	*What is required to implement, improve, or sustain work on this component?*					
Implementation Timeframe	*Strategic Longer-term/ Operational Shorter-Term, Or for Police: Gold (Strategic, Long-term), Silver (Tactical, Mid-term), Bronze (Operational, Short-term)What are the timeframes and review points.*					

Concluding Remarks and Key Findings

- The reality of safeguarding is that it is not a linear journey. The number of potential agencies who are involved with any one young person, family member or their environment, is often **unclear and underestimated.**
- To optimise multi-agency learning from CPRs, the process of completing CPRs themselves must ensure **consistency in quality, clarity and adhering to terms of reference and guidelines**.
- Effective safeguarding **in practice** requires adequate resource to invest in a workforce who are supported to be **confident, competent** and have space and **capacity** to **implement recommendations** and deliver a quality service response.



Everyone's responsibility vs Collective Responsibility

- **'Safeguarding is everyone's responsibility'** has the **consensus** of practitioners, leaders and policy makers and has had for decades.
- But how does this translate into a **Collective Safeguarding Responsibility?**
- Collective Safeguarding Responsibility:
  - Must be promoted, enabled and enacted across all practitioners and agencies
  - Facilitators of instilling a collective safeguarding responsibility must be **identified, implemented and monitored** by senior leaders, authorities and boards.



Questions and Clarification

10 Minute Break resume at 11.10



Presentation: CIW Child Protection: Rapid Review

30 Minute Break resume at 12.35

Agenda

Afternoon Session:

- 12.30 National Safeguarding Training, Learning and Development Standards: Where are we now? Social Care Wales
- 13.20 Comfort Break
- 13.30 Activity: Taking Recommendations forward in practice across sectors. Interactive discussion with Padlet with all presenters
    - 13.35 Padlet 1: Sharing Good Practice
    - 14.00 Padlet 2: Challenges, Barriers and Gaps
    - 14.20 Padlet 3: Actions and Next Steps
    - 14.40 Padlet 4 Final Thoughts
- 14.55 Concluding remarks
- 15.00 Close of afternoon session



Presentation: Social Care Wales

10 Minute Break resume at 13.35

Panel Introductions

CPR Report:

- Emma Ball
- Michelle McManus

CiW:

- Lou Bushell-Bauers
- Mike Holding
- Vicky Poole
- Sian Roberts

SCW:

- Esyllt Crozier
- Cheryl Stevens

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