# MAKING SAFEGUARDING COUNT

# A BRIEFING PAPER

# MARCH 2018

This briefing arises from a Summit hosted by the National Independent Safeguarding Board on 27 March 2018. It was designed and facilitated by Simon Burch with assistance from Ruth Henke QC, Jan Pickles, Keith Towler, Arwel Hughes and Margaret Flynn. The impetus for the summit was a principal duty of the National Board as set out in the Social Services and Well-being Act 2014: "to report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales" (S.132 (2) (b). Participants were sent the regulations concerning the *Functions of Safeguarding Boards* before the Summit. To date, the variety and intricacy of safeguarding arrangements are reduced to referral information, numbers of trained staff and compliance with procedures.

**The purpose of the Summit** was to identify and consider information sources which will allow the Regional Safeguarding Boards and the National Board to reach stronger conclusions about the impact of safeguarding.

Simon introduced the event as an occasion to discuss ideas about information and measures which may provide a more rounded picture of safeguarding. Regional Safeguarding Boards bring together lead partners and managers from the local authority, the Local Health Board, the relevant NHS Trust, the police, the provider of probation services, education (at the Children's Safeguarding Boards) and others. The Summit's 40 or so participants[1] were encouraged to mix and share ideas in small groups - and were advised of the Chatham House rule.

Ruth asked if the participants who were members of Regional Safeguarding Boards had read *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*. She explained that the Social Services and Well-being Act and the Regulations set out the rationale for the existence of the Regional Safeguarding Boards and that they should, *inter alia*, gather information to demonstrate what they are achieving. The activities of the Regional Boards must increase the likelihood of them achieving specified goals and fulfilling their functions. The Act has determined that this is the best way to deliver and

[1] From local authorities, Welsh Government, the NHS, Cardiff University, training and consultancy organisations, the police, people championing the safeguarding of children and adults, inspectorates, the voluntary and private sectors

monitor safeguarding practice in Wales. The Regional Safeguarding Boards' first Annual Reports of 2017 did not fulfil the requirements of the Act.

Margaret invited participants to join the National Board in what occasionally resembles a back-seat driving role. The Regional Safeguarding Board Chairs are the drivers – they have a better view of the road and of the activities of the safeguarding practitioners. She proposed that the task of identifying credible measures for the Regional Boards required earnest attention and wondered if the discussion groups might identify some safeguarding equivalents to healthcare's vital signs: body temperature, pulse, blood pressure, respiratory rate and pain.

The early part of discussions reflected the surprise of some participants that there is **no evidence base**: *the annual reports are so different// I guess the Boards have never had their work scrutinised before// What's the point of agency-specific information when they are multi-agency boards?// What do we get for the money invested in the Regional Boards?// What are the outputs of the Regional Boards?// How do they add value?// Where is the evidence of local, partnership activities that have prevented or reduced harm?// Why not do things "once for Wales" by avoiding duplication and developing shared standards for safeguarding information? // Who is sighted on information about referral trends in terms of volume, timeliness and profiles?// Is there no aggregated data on organisations' referrals?// Is there an Information Board on what is collected as part of the delivery of care?// Data analysts would audit and triangulate information. At best, Chairs should be meeting to discuss data and establish a pattern for doing so// There should be a core national programme of audit, locally delivered// Is there no baseline data in terms of inspection and Adverse Childhood Experiences?// What happens between meetings?// We do not know the distance travelled in safeguarding// Why isn't the National Board holding the Regional Boards to account?*[2]

Other observations acknowledged **the importance of accountability**: *What do Regional Boards improve?// How transparent are the processes, decisions and priorities of the Regional Boards?// Who are the annual reports written for?// Is there confidence that there is clarity about the role of the Regional Safeguarding Boards across partners?// How compliant are individual agencies with the Act?// Is there data on organisational readiness with regard to duties and accountability?*

**Using existing data** from a range of disciplines, sectors and sources was suggested as a credible means of providing valuable contextual information. A question familiar to the members of one Board is *What are your "hot topics"?* This is transferable to the Regional Board Areas: *Where are the "hot spots"?// Why don't Boards use data maps of police "hotspots" and housing "hotspots"?// Can the origins of the referrals be mapped onto the Welsh Index of Multiple Deprivation? Welsh Audit information?// How do we know that*

[2] The quotations in this briefing paper have been copied verbatim from "post-its" which participants were invited to use and leave on their tables and from the discussions

*information from all localities is going to be reflected in the annual reports?// Is it possible to make use of comparable data within a Regional Board Area because the local authorities are so different?// Comparable data would enable "dives" to understand variation within and across an Area as well as across Regional Boards// collating and disseminating Coroners' Rule 43 which set out what would prevent deaths in similar circumstances// repeated safeguarding interventions concerning individuals, families, residential homes and wards// the homes subject to "Escalating procedures"// Where are the key findings from Child Practice Reviews and Adult Practice Reviews?// What is known about the rates of CPRs and APRs per population?// Is there any training compliance data?// The duration of police investigations is relevant because it impacts on safeguarding// Staff training data// social worker vacancies and turnover and the numbers of agency workers// Why no case tracking from the start to the conclusion of safeguarding interventions – perhaps using a "strengths and difficulties" questionnaire?// Where is the "safeguarding journey" going from the user's perspective? // Partners' cooperation may be reflected in the consistency of attendance at Regional Board meetings// Do busy partners use skype?// Is anyone asking referrers about their experience? Were their concerns effectively addressed?// What is known about the quality and levels of safeguarding training? Is it informing national learning and development programmes?// Are people with experience of safeguarding involved in safeguarding training?// What have we learned and how have we used what we have learned - are there thematic and emerging issues?// Where are the training statistics?// Where are the well-being outcomes?// Shouldn't we be concentrating on outcomes rather than numbers?// A National Safeguarding Outcomes Framework?// How is the learning from reviews feeding into training and practice?// Does safeguarding information tally with what's in the news?// Dashboards – at a glance indicators - are linked to different information levels.*

The weaknesses concerning **feedback** were considered. It was suggested that prevention and practice interventions should be explicit. The former should be attuned to the experiences of all communities and telling them about the changes which result from their experiences and ideas. In term of practice, the reviewers of Child/ Adult Practice Reviews should ensure that the child/ adult voices and/ or experiences are centre stage. Similarly, we must listen to the staff who are working with people who are at risk. *Would they want their loved ones to be referred to their service?//* [If they are willing to include their names] *Ask what the reason is if they give the service a low score// We have to use different methods with different users// What about the Regional Boards' subgroups? They are supposed to be the executive arm.*

**Using proxy measures** such as *admissions to hospital when neglect is suspected – and re-admissions// the successful prosecutions of people who have harmed others// domestic homicides// the use of restraint and seclusion in services for people with learning disabilities and people with mental health problems// the numbers of children, young people and adults placed outside Wales// numbers of placements experienced by the children, young people and adults subject to safeguarding interventions: 1-3; 4-6; 6-12; 12+// the school attendance and exclusions of young people in care/ known to safeguarding – and in the longer term –*

*examination results, those Not in Education, Employment or Training; those holding down their first tenancy for 12 months// Key findings from the reports of the inspectorates// residential homes closed after adverse inspections// failed attempts to identify secure accommodation for children and young people// anonymised interviews with foster parents – they have a sound grasp of what is missing in terms of the support available to children and young people. They are advocates able to add value// Court judgements are significant data// Agency health, e.g. use the Net Promoter Score[3] / exit interviews/ survey monkey – anything which provides useable feedback// What about domiciliary care visits which should have been made? The number of failed calls// The response time of safeguarding practitioners and the police?// Are the Regional Boards working together on any of these topics?// Couldn't the Regional Boards do some audits together?// Is there a basic measure of well-being that might be used?// Who is talking to the people using dementia cafes?//Evaluation// Perhaps where feasible, asking people "For how long did you live with the abuse/ neglect before you got help?"*

Keith invited participants to think about the information that is necessary **for Boards to be effective**. Information takes many forms – from people's own accounts of what has happened to them, to descriptions of processes, statistical data and "outcomes."

**Complementing people's voices/ interview information with information from a wide array of sources** is the starting point: *How are the Regional Boards engaging with people// Given the historical focus on children, what about adults at risk of harm?// Why don't we ask "What matters to you?"// "What makes you feel safe?"// How many people feel safe in their communities?// Where are the examples of people's voices and/ or experiences reflected in multi-agency interventions?// User-satisfaction surveys for qualitative feedback// Are we clear how we collect "voices" (qualitative) from how we use such information to shape/ change that means something and that they feel the change?// How much voice is evident?// Do all Regional Boards meet with Junior Safeguarding Boards?*

The question **What do the public know about safeguarding in Wales?** prompted such observations as: *The language of safeguarding isn't helpful// How are the Regional Boards engaging with the general public individually and collectively?// Are Regional Boards sharing information with the general public and if so, how?// Are the public even aware of the existence of Regional Boards in terms of their roles, functions, decisions and focus?// "Community Protective Factors" include awareness and/ or knowledge of child and adult protection// Do the Regional Boards audit the information provided to the public?// Are Regional Boards undertaking themed audits?// If we as a community were clear then our message would be clear// We should tell people what we do and be proud of what we do// A*

[3] A management tool used to calculate customer loyalty. People are asked "On a scale of 1-10, how likely is it that you will recommend your experience to family and friends?" A score of 6 or below are the "Detractors;" 7 or 8 are the "Passives" and 9 or 10 are the "Promoters." Take away the % of the Detractors from the % of the Promoters for the Net Promoter Score

*national safeguarding communications strategy?// A care national programme of safeguarding audit delivered regionally and nationally is required// Are Regional Safeguarding Boards using social media?*

Ruth asked the participant members of Regional Boards why they were not using Twitter. She cited "The Transparency Project"[4] which corrects, explains or comments on media reports of published judgements of family court cases, most particularly those which are sensationalised. Perhaps there is a case for an equivalent in safeguarding.

Paragraph 126 of the Part 7 Guidance states: "*A Safeguarding Board should ensure the effectiveness of the measures taken individually or as part of their shared responsibility as a Safeguarding Board partner…This enables a Board to gather data from its Board partners and other bodies about the nature and extent of need, abuse and harm with which they are working…It requires a system for agencies reporting to the Board on the measures they have in place and how they are working, and to be prepared to be challenged…"*

Two threads run through the topic of **challenging Regional Board members**:

(i) Why is the *burden of challenging so great?//* For example, *We can't get Public Health Wales to make any financial contribution*

(ii) *"Looking at any of our major institutions…homogeneity suddenly looks like a weakness and a risk. Diversity, in this context, isn't a form of political correctness but insurance against the internally generated blindness that leaves these institutions exposed and out of touch"* (p. 300).[5]

A **challenge register** or **challenge log** may counter the resistance to challenge: *In the last 12 months these are the challenges generated by members of the Regional Safeguarding Board. Topic X led to disputes and this is what was done to resolve them// Is there scope for providing case examples which illuminate the effectiveness of multi-agency working?// The Ombudsman receives complaints about safeguarding practice and arrangements, also the Children's Commissioner and the Older People's Commissioner. These are significant learning opportunities for Regional Boards// What about challenge partners/ Chairs who swap Regional Boards?// This should be reflected in Child and Adult Practice Reviews which let organisations off the hook// A role such as that associated with the Supporting People "Regional Development Coordinators" is pertinent, i.e. individuals who are skilled in collating, aggregating and presenting financial and strategic information would raise the game. Could money be directed to this role?// There is no meaningful challenge and analysis// Where are the different challenges between children's and adult safeguarding?//*

One participant cautioned that *Whatever measures are adopted there is a real danger that they will skew the task of child and adult protection. They will be fiddled!*

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[4] www.transparencyproject.org.uk/ (accessed on 30 March 2018)

[5] Hefferman, M. (2011) *Wilful Blindness: Why we ignore the obvious at our peril* London: Simon and Shuster UK

***How multi-agency are Strategy Meetings?*** *Checking the front page of recorded Strategy Meetings for attendance may indicate that these are not in fact multi-agency meetings. This may prompt the question: what is the Regional Board doing to enhance multi-agency working during this critical safeguarding task?// Do people attend using skype?*

Jan invited participants to rank their ideas and present these to all participants. She explained the merit in bringing new perspectives, debate and occasionally conflict to the task of addressing problems which reside in the "too difficult" pile.

It was proposed that the **360 degrees appraisal**[6] may explore the healthiness of relationships within Regional Safeguarding Boards - *and* the National Board – as well as how they are perceived.

*Start on a limited set of measures first// There's self-assessment vs the actual contribution of Regional Boards// What about survey fatigue?// A healthy organisation makes it possible for its employees to reveal that they are subject to harm// It's hard to critique if there is no relationship// Some members are in organisational turmoil// Sometimes membership is delegated down and that brings risks// A culture of honesty is required and that beings risks// Ask new Board members about their perception of the Board.*

Finally, participants considered which of the ideas they had heard about and discussed had particular promise. Although the resulting ideas have been cited in this paper – it was suggested that being attentive to people who have been harmed; triangulating information; gleaning insights from workforce data, including staff who are working with people who have been harmed; and analysing court judgements have a great deal of promise.

Margaret ended by thanking all participants for their valuable contributions, fresh perspectives and time.

## So what now?

The Summit was an important source of learning. It produced many ideas about how the adequacy of Wales' safeguarding arrangements may be assessed and it is envisaged that these will influence considerations of adequacy in the long term. In the meantime, the National Board suggests that the following ideas could inform discussions within Regional Boards and between the Chairs and the Welsh Government:

1. **Measures re the effectiveness of Regional Safeguarding Boards**

[6] Performance appraisal programmes, e.g. www.surveymonkey.co.uk/mp/360-degree-employee-evaluation-survey-template/ (accessed on 30 March 2018)

- The occasions recorded in a “Challenge Log” when the Chair/ Board members have challenged a partner – and the outcome of the challenge
- 360 degrees appraisal
- Examples of improvement actions taken by the Regional Board resulting from priorities or issues requiring attention
- Pooled information concerning “hotspots;” risks; safeguarding staff’s sickness rates; agencies’ sickness rates, vacancies and use of agency staff
- Progress against 2017-18 objectives
- Regional Safeguarding Board and subgroup attendance – seniority, stability and contribution

2. **Measures re Leadership and Safeguarding**
    - Events held to improve knowledge, skills and new safeguarding interventions
    - Learning and dissemination from CPRs and APRs
    - Evidence of Regional and National profile of the Regional Board via contact with the Welsh Government and National Board for example
3. **Measures re safeguarding performance and trends**
    - Survey data from frontline staff and foster carers
    - Stories capturing the voices and lived experience of children and adults at risk
    - [Proxy measures] the agencies involved in strategy meetings; individuals/ families/ services subject to repeat safeguarding referrals; numbers of children and adults placed out of county; staff recruitment, retention. Churn figures
    - Key messages from inspection reports
4. **Contextual data and research**
    - Comparative analyses within Wales and the UK
    - Evaluations
5. **Other intelligence**
    - Media reports of safeguarding matters within Regional Board Areas
    - Models from the accolades and other awards

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