LIVERPOOL JOHN MOORES UNIVERSITY

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

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

What does 'good' look like?

"What do we want to prove? What do we want to assurance on? If we were only allowed to have assurance on one thing, what would be the most important thing?"

Data Work-stream 3: Safeguarding Performance Frameworks.

November 2022

This is report 4 of 5. There are a series of reports in relation to the evaluation of 'Shaping the future of multi-agency safeguarding arrangements in Wales'.

Shaping the future of multi-agency safeguarding arrangements in Wales: What does 'good' look like?

Data Work-stream 3: Safeguarding Performance Frameworks.

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1. Introduction

Safeguarding involves both the protection of Children and Adults at risk from abuse, neglect or other kinds of harm and preventing them from becoming at risk of abuse, neglect or other kinds of harm. The National Independent Safeguarding Board (NISB) was set up under the Social Services and Well-being (Wales) Act 2014. Specifically, the National Board has three primary duties:

1. To provide support and advice to Safeguarding Boards with a view to ensuring that they are effective
2. To report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales
3. To make recommendations to the Welsh Ministers as to how those arrangements could be improved

A number of key reports, legislation and guidance have been critical in the development of multi-agency working within safeguarding. In Wales, a number of key initiatives have been developed to ensure equal statutory footing for Children and Adults and within the Wales Safeguarding procedures (known as Multi-Agency Operational Safeguarding Arrangements [MAOSA]). There are six regional safeguarding boards in place across Wales (North Wales, Mid and West Wales, Gwent, West Glamorgan, Cardiff and Vale, and Cwm Taf Morgannwg) to ensure that children, young people and adults are protected and prevented from becoming at risk of abuse, neglect or other kinds of harm.

Each safeguarding board is a multi-agency forum which brings together representatives of each of the main agencies and professionals who are responsible for helping to protect children and adults for abuse and neglect. The boards are responsible for agreeing on how the different services and professional groups should co-operate to safeguard children and adults, for making sure that arrangements work effectively in bringing about better outcomes for children and adults in Wales. The boards will engage with, listen to and hear the views of children, young people and adults.

Safeguarding arrangements are complex and work is required to understand how efficiently the system works. LJMU were commissioned to carry out research to identify 'what good looks like' across the whole safeguarding system and provide actionable recommendations to improve 'safeguarding' at every level in Wales. This research project follows findings from a previous study exploring the multiagency safeguarding response in Wales (McManus & Boulton, 2020[1]).

[1] https://safeguardingboard.wales/2021/01/06/national-evaluation-of-multi-agency-operational-safeguarding-arrangements-in-wales-phase-1/

This research provides evidence to inform 'Shaping the Future of Safeguarding in Wales' in evaluating three key areas that underpin safeguarding responses:

1. Safeguarding practitioner experience to identify key features of effective collaborative multi-agency safeguarding arrangements in relation to reports of safeguarding concerns.
2. Systems and data review to support the development of a national performance framework that enables safeguarding leaders and practitioners to measure and analyse the national statutory safeguarding risk profile and effectiveness of operational practice in mitigating risk.
3. User experiences of safeguarding processes to capture key common 'messages' about the personal impact and experience of individuals, including perceptions of the effectiveness of safeguarding processes in Wales.

This report focuses work-stream 2, reviewing the systems and data that seek to understand, capture and inform safeguarding practice across Wales. This was approached by reviewing the KPIs currently recorded by 7 LA areas in Wales, exploring any additional metrics that are not currently included within Welsh Government statistics. Additionally, 20 practitioners who held responsibility for data capture and performance management took part in either semi-structured interviews or focus group, providing additional context in achieving effective multi-agency safeguarding arrangements.

2. Rapid Review of Literature

2.1. Quality Standards

First issued in April 2016 by the Welsh Government under Section 145 of the Social Services and Well-being (Wales) Act (2014), the Code of practice in relation to measuring social services performance, states that local authorities must undertake activities and actions to secure well-being for people who need care and support and carers who need support (Welsh Government, 2016). Importantly, these activities have been outlined as a number of well-being outcomes and quality standards (see Appendix 4). Since April 2020, however, Welsh Government (2020a) have published a revised version of the Code of practice[2], in collaboration with local authorities and social care stakeholders in Wales. Crucially, it points to an ambition for sustained change in methodologies of how social services in Wales collect, analyse and understand data and evidence on the delivery of care and support (Welsh Government, 2020a).

The cornerstone of the 2020 Code of practice, are a revised set of quality standards (Table 1) in relation to Social Services and Well-being (Wales) Act (2014), which have been strengthened to ensure that both performance and improvement are equally weighted, designed to challenge local authorities to consistently strive towards improvement through best practice, and relate to expectations of the quality of support that local authorities must be providing (Welsh Government, 2020a; 2020b). Moreover, the standards are linked to the seven well-being goals as detailed in Section 4 of the Well-being of Future Generations (Wales) Act (2015)[3], to the definition of well-being in Section 2 of the Social Services and Well-being (Wales) Act (2014)[4], and have been designed in line with Care Inspectorate Wales' Code of practice for review of local authority social services (see CIW, 2019).

[2] This Code should be read in conjunction with all relevant codes of practice issued under the Social Services and Well-being (Wales) Act 2014.
[3] https://www.legislation.gov.uk/anaw/2015/2/section/4/enacted
[4] https://www.legislation.gov.uk/anaw/2014/4/section/2

Table 1. Quality Standards in relation to the performance and improvement of social services in Wales (Welsh Government, 2020b).

The Quality Standards			
People	**Prevention**	**Partnerships and Integration**	**Well-Being**
All people are equal partners who have voice, choice and control over their lives and are able to achieve what matters to them.	The need for care and support is minimised and the escalation of need is prevented, whilst ensuring that the best possible outcomes for people are achieved.	Effective partnerships are in place to commission and deliver fully integrated, high quality, sustainable outcomes for people.	People are protected and safeguarded from abuse and neglect, and any other types of harm.
Effective leadership is evident at all levels with a highly skilled, well qualified and supported workforce working towards a shared vision.	Resilience within our communities is promoted and people are supported to fulfil their potential by actively encouraging and supporting people who need care and support, including carers, to learn, develop and participate in society.	People are encouraged to be involved in the design and delivery of their care and support as equal partners.	People are supported to actively manage their well-being and make their own informed decisions so that they are able to achieve their full potential and live independently for as long as possible.

Keying into this are Care Inspectorate Wales (CIW), whose role alongside the Welsh Government is as an independent regulator of social care and childcare. Notably, CIW inspect and drive improvement of the quality and safety of regulated services and local authority social services for the well-being of the people of Wales. By undertaking thematic reviews of social care services, CIW provide independent quality assurance of social care in Wales to ensure that the rights of safeguarded adults and children are protected, and inform policy, standards and provide independent professional advice on a national level to those tasked with developing policy, as well as on a regional, local and individual level (CIW, 2019).

In returning to the expectations of the quality of support that local authorities must be providing, on the micro level, local authorities are expected to demonstrate their progress against the quality standards annually via the Local Authority Social Services Annual Report[5] (Welsh Government, 2020a; 2020b). Notably, this is evidenced through a combination of data

[5] As required by section 144A of the Social Services and Well-being (Wales) Act 2014.

and evidence gathered by the performance and improvement framework, alongside any local data or other approaches considered appropriate by local authorities (ibid.). For CIW (2019) and their role with local authorities, under section 149 of the Social Services and Well-being (Wales) Act (2014)[6], CIW has the power to review all local authority social services functions, and the specific legislation these functions relate to, as outlined within schedule 2 of the 2014 Act[7].

As regards consistency of approach, it is important to note that the headings of the quality standards detailed by the Welsh Government (see 2020b), have been deliberately formulated to align with those found within the Care Inspectorate Wales (CIW, 2019) Code of Practice for Review of Local Authority Social Services. In turn, this approach not only maintains importance consistency at a national level but provides local authority social services with a clear and consistent understanding of the shared language of both codes of practice.

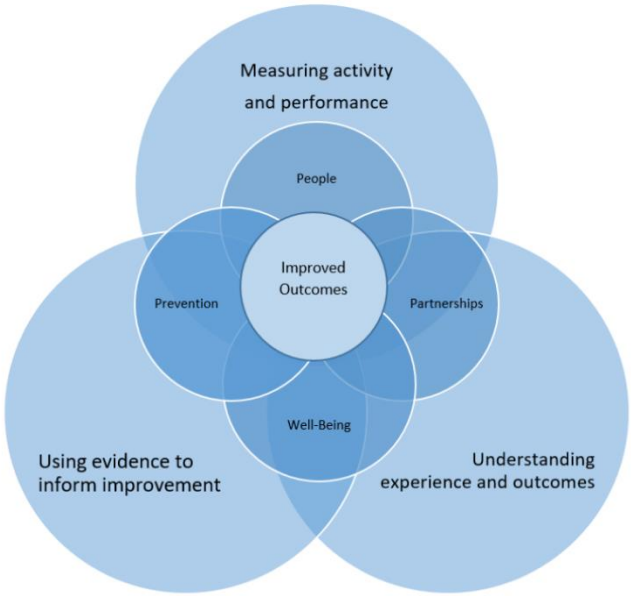
2.2. Performance and Improvement Framework

As previously mentioned, one of the main ways for local authorities to demonstrate their progress against the quality standards outlined by the Welsh Government and CIW, is through data and evidence gathered by using the performance and improvement framework. Indeed, the performance and improvement framework - first introduced in 2016 - is designed to support local authorities in understanding their performance in relation to the Social Services and Well-being (Wales) Act (2014), as well as inform their quality improvement activities at a corporate and organisational level (Welsh Government, 2020b). Recently, the performance and improvement framework has undergone a rigorous reworking, consisting now of the Code of practice as well as a series of separate guidance documents, which detail individual data requirements to enable local authorities to collect a wider range of data (Welsh Government, 2020a). Fundamentally, this has sought to subsume a number of key elements into a single 'toolkit', enabling local authorities understand how social care is delivered both locally and nationally (ibid.). To assist in this understanding of the different elements that constitute the performance and improvement framework, Welsh Government (2020b) have

[6] https://www.legislation.gov.uk/anaw/2014/4/section/149
[7] https://www.legislation.gov.uk/anaw/2014/4/schedule/2

created a diagram that illustrates how all of the components must align in order to achieve improved outcomes for individuals in need of care and support (Figure 1)

Figure 1. Performance and Improvement Framework (Welsh Government, 2020b).



Delving into the intricacies of the above diagram, the performance and improvement framework consists of three component parts:

- **Measuring activity and performance**

  Provides clear and accurate information on the number of individuals moving through the social care system of each local authority and subsequent identification of demand on services.

- **Understanding experience and outcomes**

  Provides local authorities with information on the quality of people's experiences of social care.

- **Using evidence to inform improvement**

  This enables local authorities to understand the wider context of social care and how their provision and practice can be improved at all levels in the social care system, to ensure consistent and sustainable improvement.

In relation to the last component on using evidence to inform improvement, it is also of importance to note that the guidance issued by the Welsh Government (see 2020b), outlines the roles and responsibilities on an individual, local, regional and national level. In short, on the individual level this equates to social care practitioners undertaking their own research or using evidence as part of a professional qualification to inform their own practice; local authorities using evidence to inform best practice; regional partnership boards using the Codes of practice from Welsh Government (2020b) and CIW (2019) to inform the routine use of data and evidence to complement both local and national priorities; and Welsh Government using evidence to understand the effectiveness of national policy and to inform future policy development.

Crucially, this data is to be gathered annually through a range of nationally prescribed metrics, with local authorities also gathering their own data to reflect locally defined priorities. Indeed, under the 2014 Act, the statutory director of social services for each local authority is required to publish an annual report[8] detailing their local authorities' functions during the financial year (CIW, 2019). Moreover, CIW aim to work in collaboration with local authorities by reviewing how each local authority supports and delivers its social services functions. At least one inspection is scheduled annually in each of the regional partnership footprints and are conducted first-hand through a combination of inspection and performance evaluation activities on an individual level (conversations with users about their experiences); operational level (observing practice and interviewing frontline staff), and a strategic level (leadership, planning and governance, through meetings with key stakeholders) (ibid.). The complete framework of inspection and performance evaluation came be found in Appendix 5.

As regards consistency of approach, in reviewing the performance of local authorities in Wales, CIW and the Welsh Government both take into account the Well-being of Future Generations (Wales) Act (2015). This is important to note, as the 2015 Act sets out a unique legislative framework to improve the social, economic, environmental and cultural well-being of the people of Wales (CIW, 2019). In addition, CIW facilitate in information and data sharing with Welsh Government policy colleagues of the themes arising from reviews of local authorities, which will in turn inform national policy.

[8] Guidance produced by Welsh Government for local authorities to assist in preparing their annual social services reports - https://socialcare.wales/hub/sswbact-factsheets

2.3 Measuring the Quality Standards & Performance and Improvement Framework

In measuring whether the quality standards are achieved, each local authority is required to have the necessary arrangements in place to collect and disseminate the data on performance measures as outlined in the Welsh Government's Code of practice (see Welsh Government, 2020b). In addition, local authorities must annually release this information publicly as an element of the Directors of Social Services Annual Report, which acts as an accessible tool for people to understand the effects of social services in their local area. This is of particular importance to note, given that in the financial year 2020-2021, £2.3 billion was spent on social services by local authorities in Wales, an increase of 12.7% from the previous year[9] (Welsh Government, 2021a).

In returning to measuring the performance and improvement framework, a number of metrics have been developed, with data obtained publicly released as Government official statistics. Notably, the metrics have been categorised into three groups: adults, children, and carers (adult and young carers), and consider the most significant aspects of activities that are delivered by local authorities in relation to authorities' exercise of their social services functions (Welsh Government, 2020a).

In addition to this, Welsh Government (2021b) have released some data in relation to the metrics for the performance and improvement framework for local authorities and their social services functions (Figure 2). In turn, Welsh Government have identified a number of data quality issues that they expect to improve over time, including missing data wherein it cannot be effectively captured or reported due to data system issues in local authorities, as well as inconsistencies in the way data is reported between local authorities, which has been put down to 'differing interpretations in how data should be recorded' (Welsh Government, 2021b). It is of particular importance to note, however, that this is the first instance in which data for the metrics has been collected and reported on and are to be considered as 'experimental statistics'. Indeed, of the notably 'brief' insight Welsh Government do provide, data has been published for 21 out of 43 metrics for adults (including adult carers) and data

[9] Full release: Local authority revenue and capital outturn expenditure: April 2020 to March 2021 - https://gov.wales/sites/default/files/statistics-and-research/2021-10/local-authority-revenue-and-capital-outturn-expenditure-april-2020-march-2021-673.pdf

for 23 out of 69 metrics for children (including young carers) including coverage from all 22 local authorities (ibid.).

Figure 2. Social Services activity: April 2020 to March 2021 (Welsh Government, 2021b).

Adults

During the year 1 April 2020 to 31 March 2021

- 149,591 contacts were received by statutory social services for information, advice and assistance (IAA) services for adults.
- 73,658 new assessments were completed for adults.
- 20,629 reports of an adult suspected of being at risk were received. 23% were from the police and 22% were from a provider of care and support or support services to carers. 34% of reports alleged abuse under the category of neglect (more than one category may be suspected in a report).
- 54% of reports of an adult suspected of being at risk resulted in enquiries being made. Of which, 39% determined that additional action should be taken.
- 6,841 contacts were received by statutory social services from adult carers or professionals contacting the IAA service on their behalf(a).
- 6,683 new assessments were completed for adult carers.

(a) One local authority was only able to provide data up until 23 November 2020 due to migration to a new ICT system.

At 31 March 2021

- 46,585 adults had a care and support plan, of which 11% had a care and support plan supported using a Direct Payment(b).
- 2,116 adult carers had a support plan(c).

(b) One local authority was unable to provide this data.
(c) Three local authorities were unable to provide this data.

Children and families

During the year 1 April 2020 to 31 March 2021

- 176,408 contacts were received by statutory social services for information, advice and assistance (IAA) services for children.
- 47,950 new assessments were completed for children.
- 3,868 children were placed on the child protection register. 41% were added under the category of emotional abuse. 4,065 children were removed from the child protection register.
- 1,163 contacts were received by statutory social services from young carers or professionals contacting the IAA service on their behalf(d).
- 806 new assessments were completed for young carers(e).

(d) Three local authorities were unable to provide this data.
(e) Two local authorities were unable to provide this data.

At 31 March 2021

- 18,827 children with a care and support plan, of which 7% had a care and support plan supported using a Direct Payment(f).
- 3,140 children were on the child protection register.

(f) Two local authorities were unable to provide this data.

3. Methodology

Local Authority (LA) areas included in the study were selected jointly by NISB and LJMU, considering findings from the Phase 1 report (McManus & Boulton, 2020). Areas selected ensured a representation of LAs across the 6 Regional Safeguarding board areas, those that used different IT systems, and collectively included those LA areas in rural areas and those in city locations.

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

For this work-stream there were 2 stages to the evaluation in being able to provide a deep dive review of LA safeguarding performance frameworks and management. This included:

1. Review and Development of Safeguarding Performance Indicators. This sought to gather data capture tools that provided details of any KPIs collected by each LA area to help them collect, understand and share their safeguarding arrangement processes and outcomes.
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 explore the strategic and operational aspects of data within the safeguarding arrangements.

Details of each approach are outlined below.

Stage 1 Methodology: Review and Development of Safeguarding Performance Indicators

This phase sought to identify any KPIs that were recorded and collected across the 6 LA areas in Wales (1 LA was unable to provide any information in time for the study). This was achieved by a nominated individual, usually within their performance team, sharing blank data capture tools (such as excel) with the listed variables (headers) included. No actual data was shared as part of this process. Six LA areas were able to share this data, with this sometimes provided in separate excel spreadsheets, such as those for children and those for adults.

The purpose of this review was to identify and potentially improve the existing request of Key Performance Indicators (KPIs) currently requested by Welsh Government to monitor and evaluate performance as regards safeguarding of Adults, Children and Carers. The existing and potential KPIs reviewed were considered in terms of:

- Depth, breadth and representativeness of current national reporting
- Fitness for purpose of the existing indicators

- How the KPIs potentially aligned with the themes and concepts of the Report 2 (practitioner report)

A review of all of the LA indicators across 6 LA areas yielded a list of more than 600 individual performance and information measures. Many of these duplicated Welsh Government KPIs, however, locally devised measures that supported or expanded on the standard KPIs were also identified. A thorough review of these 600+ measures was undertaken as follows:

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

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

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

Recruitment

The safeguarding manager for the local area then provided the research lead for their area a list of a names of those that have 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 (all in Welsh and English). From this, arrangements were made subject to availability of staff. This led to some LA areas including individual interviews as well as those with 2 or more staff members (focus groups). All, but one LA engaged in this phase of the evaluation. This resulted in a final data set broken down as below:

- 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, between June and July 2022. The interviews/focus groups ranged from 48 minutes to 1 hour and 16 minutes. Interview responses were transcribed by external transcription service and transcripts returned to LJMU, or were transcribed using Microsoft Teams. The interview data was analysed using a Template Analysis Framework, which considered the data inductively (being led by patterns in the dataset) and deductively (looking for specific concepts previously identified in the relevant literature).

Ethical Considerations

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

4. Analysis

4.1. Review of Safeguarding Performance Indicators at Local Level.

Overall, ***68 additional KPIs were reviewed as fulfilling the above criteria,*** which differ to the existing suite of National Measures. These sixty-eight measures are split into overall categories of Adult, Children, and a new category of Staff/Safe Workplace.

Additional Local Performance Indicators collected[10]:

The table below outlines each category, alongside the additional LA measures and the themes that they relate back to. Some notes are given as to the reason that the measure is required. Please note that no additional measures have been added to the National KPI categories of Young Carers or Adult Carers. For the most part, the wording of the additional measure is closely aligned with the Local Authority measure that it is based on, but in some cases the wording has been changed to better explain the measure or to better match the set of measures that the KPI complements. Every care has been taken to use the correct abbreviations or key words, but of course these may need to be reviewed by experienced staff. Codes have been created based on category (e.g., AD for adult), NEW, then a number. These are added simply to aid discussion and of course can be changed at any time.

It is important to note that the following section provides a list of the additional LA KPIs that were being collected at LA level that were not part of National KPIs. A further review is part of the next step in deciding whether these indicators indeed are capturing 'safeguarding', if their inclusion is required based on the evidence from qualitative findings within this report, and Data Report 1, and under what basis should these be collected (e., raw number, per 10k population, percentage, etc). Therefore, the following is simply a list of the additional LA KPIs identified.

[10] Appendix 1 includes the current Welsh Government KPIs along with the new KPIs. The new KPIs are highlighted in Green. Report refers to reporting frequency where FY is Financial Year.

Table 1. LA identified KPIs within safeguarding arrangements

category	Code	Measures added	Notes	Relevant concerns identified
Adults	ADNEW1	The percentage of adults who completed a period of re-ablement and had no package of care 6 months later	Measures improvement based on re-ablement - no further care	Joined- up Safeguarding Process, seamless service, Escalation of Risk, Increased Need and Service Adaption, Informing Practice: Trends, Demand and Gaps
	ADNEW2	The average length of time older people (aged 65 or over) are supported in residential care homes	Collect more info about those in care homes - develop trend data about length of care and average age needed.	

	ADNEW3	Average age of adults entering residential care homes		
	ADNEW4	Number of adults reported more than once for the same category of abuse or neglect during the year	Digging deeper into cases with multiple needs	
	ADNEW5	Number of adults reported for different categories of abuse or neglect during the year		
	ADNEW6	The total number of adults with a care and support plan where needs are met through a Direct Payment at 31 March	More monitoring on charging	
	ADNEW7	Number of urgent DoLS applications received	Deprivation of Liberty monitoring	
	ADNEW8	% of Urgent authorisations received that were completed within 7 days of receipt		
	ADNEW9	Number of Standard DoLS applications received		
	ADNEW10	% of Standard authorisations that were completed within 21 days of allocation		
	ADNEW11	Number of applications received that were withdrawn or inappropriate		
Category	**Code**	**Measures added**	**Notes**	**Relevant concerns identified**
Children	CHNEW1	The number of new assessments completed for children during the year that were completed within statutory timescales	To ensure assessment timescales are being met	Joined- up Safeguarding Process, seamless service, Escalation of Risk, Increased Need and Service Adaption, Informing Practice:
	CHNEW2	Number of assessments for children completed before child was born	To capture concerns for pre birth and new born children.	
	CHNEW3	The total number of assessments for children completed during the year for children who were born at the time the assessment concluded		
	CHNEW4	The number and % of reviews held with an up-to-date MYCSP	Capture MyCSP data	

	CHNEW5	The number and % of reviews held WITHOUT an up-to-date MYCSP		Trends, Demand and Gaps , Service Consistency, Resource and Accessibility, Holistic Safeguarding Responsibility: Thresholds, Consent, Confidence and Competence
	CHNEW6	Number of Foster Carer Reviews completed - Annual	Complete reviews of foster carers	
	CHNEW7	Number of Foster Carer Reviews completed - Independent		
	CHNEW8	Number of S.46 (Police Protection Orders) within the year	Capture s46 as well as s47	
	CHNEW9	Number of children on the CP Register for over two years as at the end of the period	Capture longer term CP activity	
	CHNEW10	Number of children who have had moderate or high SERAFs completed in the last period	Capture more info in children who may be at risk of sexual exploitation	
	CHNEW11	Of the above, what % are in receipt of a Care & Support Plan (NOT on the CPR)?		
	CHNEW12	Of the above, what % are subject to a Child Protection Plan?		
	CHNEW13	Of the above, what % are Looked After Children?		
	CHNEW14	Number of CSE priority perpetrators identified		
	CHNEW15	Number of Registered Sex Offenders (RSOs)		
	CHNEW16	Number of Missing Children in total	Missing children info recording	
	CHNEW17	Number of children missing on more than 3 occasions that have triggered a strategy meeting during the period		
	CHNEW18	The Number of Family Group Conferences that took place during the period	Family group conference recording	
	CHNEW19	The Number of Reviews of Family Group Conferences that took place during the period		
	CHNEW20	The Number of Special Guardianship Orders given during the period	Guardianship data recording	
Category	**Code**	**Measures added**	**Notes**	**Relevant concerns identified**
Children	CHNEW21	The average length of time for all children who were on the CPR during the year	Further data monitoring for looked after children	Joined- up Safeguarding Process, seamless service, Escalation of Risk, Increased Need and Service Adaption,
	CHNEW22	The percentage of looked after children returned home from care during the year		
	CHNEW23	The percentage of children supported to remain living within their family at 31 March		

	CHNEW24	Number of children subject to a Child Protection Plan at the end of this year	Specific ACES Monitoring	Informing Practice: Trends, Demand and Gaps , Service Consistency, Resource and Accessibility, Holistic Safeguarding Responsibility: Thresholds, Consent, Confidence and Competence
	CHNEW25	of these, number of children subject to a Child Protection Plan where Domestic Abuse features within the home		
	CHNEW26	of these, number of children subject to a Child Protection Plan where Parental Substance Misuse features		
	CHNEW27	of these, number of children subject to a Child Protection Plan where Parental Mental Health features		
	CHNEW28	Of these, number of children subject to a Child Protection Plan where all of the above 'Toxic Three' Risk Factors feature		
	CHNEW29	of these, number of children subject to a Child Protection Plan who have also experienced other household ACEs (for example, parental separation or incarceration of one or more household members)		
	CHNEW30	Number of Domestic Incidents involving children recorded		
	CHNEW31	No. of Young People Looked After Reunifications - in year	Capture more detail on residential placement	
	CHNEW32	No. of Young People Looked After Discharges of Care- in year		
	CHNEW33	Number of pre-birth child protection conferences convened during the year		
	CHNEW34	No. of Young People Looked After starting a residential placement		
	CHNEW35	No. of Young People Looked After ending a residential placement		

Category	Code	Measures added	Notes	Relevant concerns identified
Children	CHNEW36	Number of children that the Local Authority are aware of that are Electively Home Educated (EHE)	To capture safeguarding info around health and education.	Joined- up Safeguarding Process, seamless service, Escalation of Risk, Increased Need and Service
	CHNEW37	% of the above that have NOT received an annual visit in the last 12 months		
	CHNEW38	Number of EHE children that have received an annual visit in the last 12 months		

	CHNEW39	% of the above where the child was spoken to as part of the visit		Adaption, Informing Practice: Trends, Demand and Gaps , Service Consistency, Resource and Accessibility, Holistic Safeguarding Responsibility: Thresholds, Consent, Confidence and Competence
	CHNEW40	% of known EHE children who have deregistered in the last 12 months		
	CHNEW41	% of EHE children known to the Local Authority that have had contact with at least one other professional in the last 12 months		
	CHNEW42	Percentage of applicable children achieving the core subject indicator at Key Stage 2		
	CHNEW43	Percentage of applicable children achieving the core subject indicator at Key Stage 4		
	CHNEW44	The percentage of children seen by a registered dentist within 3 months of becoming looked after		
	CHNEW45	The percentage of children looked after at 31 March who were registered with a GP within 10 working days of the start of their placement		
	CHNEW46	Admissions to Hospital following deliberate Self-Harm (by gender) of looked after children		
Category	**Code**	**Measures added**	**Notes**	**Relevant concerns identified**
Staff/Safer Workplace	SWNEW1	The number of vacant posts that were advertised during the year	Service ineffective when not properly staffed. Staff and client wellbeing depends on effective and trained staff with manageable workloads	Multi-disciplinary Teams, Consultation and Training, Established Relationships and Workforce Stability, Professional Challenge and Reflection , Practitioner Wellbeing and Support
	SWNEW2	The number of vacant posts which were successfully recruited to		
	SWNEW3	% of staff and volunteers commencing in post with two references, a DBS check and professional registrations, where applicable in the year	Appropriately qualified staff employed	
	SWNEW4	% of relevant staff who have completed Safeguarding Children Training in the year	Top-up training essential for CPD	
	SWNEW5	% of relevant staff who have completed Safeguarding Adults Training in the year		
	SWNEW6	% of new starters who have completed Safeguarding Children & Adults Training in the year	Appropriately qualified staff employed	

	SWNEW7	Number of Professionals who have been identified in Safeguarding Children Part 4 or Safeguarding Enquiries	Staff performance monitoring	
	SWNEW8	% of the above allegations that were substantiated		
	SWNEW9	Number of Professionals who have been identified in Safeguarding Adults Professional Concern or Safeguarding Enquiries		
	SWNEW10	% of the above allegations that were substantiated		
	SWNEW11	Number of occasions the Resolution of Professional Differences Policy has been formally instigated		

4.1.1. Summary

The detailed additional LA metrics identified within Table 1 highlights the potential of some key metrics that might be missing from national indicator requests. However, given that these are mainly within Children (n = 46 additional KPIs), followed by Adult's (n = 11), with a whole new category of metrics that are being recorded at LA level that relate to staff and the workplace (n = 11). Clearly the addition of staffing indicators is something that is seen as an important consideration in monitoring the effectiveness of LA safeguarding arrangements and should certainly be considered for inclusion within any national metrics.

Whilst there were additional metrics provided within local areas, there were no metrics provided that referred to routinely capturing 'user voice', either quantitatively or qualitatively. Whilst this was felt to be an area most LA were keen to progress, the metrics to support this data collection were not yet in place. Similarly, whilst practitioners noted that the metrics were largely quantitative, there was a collective view that by not including qualitative measures the understanding of effectiveness is limited and that more qualitative measures are required to understand the safeguarding journey and context. Whilst most metrics document activity during the safeguarding process, which is a crucial part of understanding performance and is a key feature within the Social Services Performance Framework (Welsh Government 2020a), there was less clarity regarding how this activity informs LA on their effectiveness.

The volume of metrics already being requested by Welsh Government and provided by LA are already noted in requiring significant resource and effort to complete these within the timeframes. It is suggested that the additional metrics outlined here are a starting point of discussions about how to better align the KPIs, and not create additional burdens on already strained safeguarding teams. This should seek to ensure agreement on what is required to be collected and why, with this being prioritised and defined clearly across all LA areas in Wales. This is further addressed within Section 5. Key Findings and Recommendations.

4.2. Thematic Analysis of Interviews and Focus Groups responsible for Data and Performance Management

The main analysis thematically explores the views of 20 practitioners who had responsibility for safeguarding performance frameworks, data, quality assurance and audits across 7 Local Authority (LA) areas in Wales. The analyses of interviews identified 4 key themes, presented over the following pages. Each theme can be accessed directly through clicking on the hyperlink below.

Theme 1: Data utilisation

This theme explores how stakeholders discussed the utilisation of data. There were many ways in which data was used and understanding the data clarified what the *Aims of Performance Monitoring* were and why. Data utilisation also helped to understand patterns, themes and trends which in turn assisted in *Informing Practice* to ensure it was evidenced based and in addition to identify areas whereby *Training* would be beneficial. Data was also used to highlight *learning* and understand the full picture and to allow for a contribution to a wider range of *multi-agency safeguarding.*

1.1. Aims of Performance Monitoring

When describing the key aims of performance monitoring, audits and general data collection, all practitioners were clear about its necessity as part of the broader multi-agency safeguarding arrangements, with additional reference to the Social Services and Wellbeing Act. The quality assurance framework also undergoes audits and amendments as and when required to adhere to policies and procedures.

Key factors raised by practitioners within their roles and responsibilities on data management was around transparency and quality of data collection that can help inform the safeguarding response to communities and ultimately results in *"better outcomes for our children and families".* It was felt at the heart of data collection was providing a service to the community, so there is a duty to share what's working well and what is not.

It was stated that the development of performance management within safeguarding has progressed significantly over the years, and that in some instances these teams are led by those that have had frontline, professional experience with individuals and families at risk. This was seen to have a positive impact on how data was utilised and communicated throughout the safeguarding

arrangements, with a more practical perspective becoming embedded in ensuring that learning would be pushed through the systems and processes.

> *"I suppose, help bring in that kind of practice because I have a social work background, so that's where we link really well together and help her with what that means to practice on the grounds and obviously make recommendations"*

The importance when speaking about the utilisation of data was to ensure it achieved the aim of providing context to the more quantitative, and traditional number reporting, by including case studies and practice reviews and taking any findings into learning events. This was all about making sure that the data *"means something"* and are *"able to share it".* Managers across teams also stated the importance of regular data monitoring to be able to help identify issues and respond more efficiently.

Finally, in terms of the key aims within performance and data teams, they all discussed being a key part of business planning, and also aligning with the Code of Practice on Performance and Improvement (Welsh Government, 2021c). This most often involved pulling together annual reports and providing case studies[11]. These were seen as important public documents to help inform their communities about their safeguarding processes and how effective they were.

1.2. Inform Practice and Training

There was much discussion from practitioners across all LA areas regarding the crucial part of their role within performance management and monitoring and ensuring that this feeds directly into practice and the identification of training needs. It also provides evidence to understand if what is being out in place is having an impact and how to learn from previous examples to prepare for what can be put in place in the future to ensure effective working. This included exploring deep dives into specific areas such as Looked After Children or Referrals and even accounting for external factors such as extreme weather, to understand the impact and learn for future events.

> *"And just develop it a bit more so we understand if its those things are actually making a difference and currently it's being used and While the feedback I've got from I would say from our chief executive and higher up is very positive. And in terms of some of the actual hard figures, I guess because you know we link with the teams and we understand what's sticking points are, what's, any problems that are impacted on those figures and then have been there. And helping managers and senior managers prepare and think ahead based on that and you know, looking at how and we'll be asked often asked to do a piece of work".*

Some LAs discussed using their performance teams in identifying issues within information recording and sharing issues. An example was given around using their Quality Assurance (QA) audits to review

[11] We are unable to provide links to these as this would identify the LA included within the study.

cases due to issues identified in cases being closed without key information being received and *"their information could significantly change the outcome of an assessment"*. By reviewing the issues within this and the risk in closing cases without a full assessment, this check has become a regular QA audit feature. This was a positive example of where qualitative evaluation was utilised to understand the narrative and reasons behind certain quantitative metrics.

Others discussed the importance of performance dashboards in heling them with their day-to-day practice. Monitoring their cases and progress was initially seen as problematic, when dashboards flagged key indicators as red, amber of green. But a change in systems which has now removed this function seems to be causing more practitioners to struggle in keeping on top of their caseloads and admin requirements, as the day-to-day job is so busy. Therefore, desktop performance monitoring was seen as helpful in managing the day-to-day demand of the role.

Additional examples of how data was informing practice was the analysis of repeat referrals, which allowed processes to be introduced in helping to review decision making and responses to cases. One LA referral had introduced a policy around a trigger of 3 referrals in 6 months would automatically require a review of case. This allows further understanding around potential blockers within the safeguarding pathway, whether that be specific interventions of services, and also whether the correct decision was initially made around the referral and if any learning can be taken forward for future cases

Furthermore, other key aspects of informing day-to-day practice were centred on how data can inform resource allocations, whether that be in terms of specific services, interventions and teams, or whether this provides evidence around patterns of demand. For example, tracking the attendance of young people to a service that indicated a higher presence in the evenings subsequently informed and changed the shift patterns of the teams responding.

> *"So we've got our team working at the moment. 8 till four. Well, there's no point in working 8 till four because they need to work from 6 till 2"*

Similar to the mapping of demand on the service, data is being used regularly to monitor caseloads. This was seen to be extremely beneficial in identifying where additional support is needed and help social workers to manage, prioritise and complete their checks. It also helps to ensure the manager can prioritise their time and ensure appropriate supervision is available.

One LA area talked passionately about the use of data within reflective practice reviews. This was something that was embedded from the start of a practitioner's career and regularly throughout and stakeholders noted they *"built that into our supervision"*. It was seen as a positive, self-audit process, where practitioners selected one of their own cases and undertook a self-audit of it, which included family engagement. This was seen as a positive use of the quality assurance framework that

was implemented in a non-judgemental way to maximise learning and safeguarding effectiveness. This example illustrates how data can be utilised in practice at an operational level with practitioners, in addition to the data analysis and interpretation which often takes place at a strategic level.

1.3. Contributing to the Multi-agency Safeguarding Arrangements

It was clear that data and performance management teams were contributing significantly to the safeguarding arrangements within each LA area. Examples were given around responding to specific data peaks, such as suicides. By identifying and evidencing the escalation within the data, this resulted in joined up working group being set up as a "rapid response" (or incident reporting group) to this high-risk issue. This was seen to *"generate some data and information on the back of that about different things that are helpful outside of the personable and we are then able to get more higher helicopter data from a strategic point of view as well as supporting the operational kind of thinking".*

This was taken further in that when the LA data was compared to rest of Wales, it was noticeably higher, which led to the development of a model in response to increases in suicide. This was further agreed and rolled out across the region. This has also resulted in closer working relationships with organisations such as Public Health Wales in assisting with improved data collection and understanding of suicide risk.

Being prepared and forewarned on demand dips and spikes is something mostly seen as aspirational within many LAs, with this likely linked to changes in data recording system inhibiting the ability to look across their data over a number of years. However, one LA area certainly described how their understanding of data trends helped inform safeguarding responses. For example, not over-reacting to dips or spikes that were seen within *'normal limits'* for that time of year/day. Moreover, by having the data evidence of these trends, this can then be easily rationalised to senior stakeholders when concerns are raised by increasing numbers in a disproportionate way. This was seen as better preparing the service in what to expect in terms of trends of demand.

> *"So other things that we started looking at with our data is what's within normal limits? So because things fluctuate up and down, right, so things aren't static, but actually we've generally got an upper and a lower control limit in terms of what we're expecting to see. … So it enables us to not react to spikes in data"*

Service scrutiny and quality assurance audits were seen as a key feature of data performance management and monitoring. There was a keenness within interviews that these should be seen as a positive activity for the service to learn and continuously improve its safeguarding response. However, there was still concern around the specific creation of this role/service within the safeguarding arrangements out of fear of it being seen as a negative thing and that culture needs to change around how this process is seen. For the benefits of quality assurance and scrutiny to be maximised, it was seen that this should not be seen as an add-on role to someone's already full list of responsibilities

but should function as a team to ensure the expertise both analytical and practice based are part of that scrutiny process.

> *"And then leading to better conversation, it also means when he challenged about why things going up and down said well, it's in the normal parameters of what we would expect it to do and actually there may be seasonal reasons for it may be other reasons for it, but it is what we expect. So I was services built around expecting these things to happen"*

One LA area talked specifically about the merging of the data and reviews not just across their Adult's and Children's teams, but also across neighbouring LA areas and *"swapped homework".* This was seen as hugely beneficial in understanding their data and safeguarding response, but also in being able to evidence additional layers of scrutiny to their safeguarding processes, allowing further rigour in challenging and safety checking the pathways and processes. It was noted that a professional stance was required as the process could prompt feelings of defensiveness, however, it was a beneficial process for progress.

> *"Try not to get too defensive about their assumptions about our work and as we're trying to do in a friendly way and that was, well it can be painful, but it is ultimately very healthy thing to do if we really want to improve your service"*

Given the findings from Report 2 (Practitioner experiences of multi-agency safeguarding arrangements) the issue of variable thresholds was raised as a consistent challenge, particularly for those referring into safeguarding services. A key aspect in being able to buffer against this as an escalating issue was to ensure regular multi-agency discussions regarding threshold decision making. Reviewing those cases that have moved onto to various pathways to understand whether the right decision was made and ultimately whether the decision on threshold was correct, and reviewing these decisions at a 6 month review point too, ensuring there is continued learning. This continuous review process allowed for evidence to be generated which provided opportunities for improvements to be made in performance.

> *"I know we're saying this but where we right? You know, thinking because the data is telling us something different. And so we're trying to again"*

Furthermore, the wider Practitioner Report (Report 2) highlighted issues around the quality of referrals being received. Much was noted within the performance management teams around how they were consistently working to review and improve the quality of referrals received, with one area stating they were actually logging this within their KPIs. As this area uses an integrated referral form, it is possible to take every part of that form and out in through the database to monitor the quality of information recorded.

Given the difficulties of data sharing that was mentioned within Report 2 by many practitioners, particularly from Health, there were some great examples given across one LA area about how they were building their data networks wider by allowing different practitioners across

different agencies to bring their data to them. Subsequently this allowed for a fuller picture of the demand and trends to be developed and understood.

> *"They have a work, a violence worker within the hospital, a violence prevention worker in the custody suite. And they also have a worker that works with young people and families around preventing violence. They bring all of their data together to see how many young people they've seen the areas that they've worked with and from that, we are able to build a picture"*

The ability to combine data across the key safeguarding partners was seen as the most effective way in contributing to the safeguarding arrangements locally. For example, one LA area discussed the very pertinent issue of contextual safeguarding, where detached youth workers were targeted to specific areas within specific times to engage with young people using data provided by the police such as heat maps. Their multi-agency meetings often discussed individual cases and also sought to identify overlaps in places as part of this review to ensure that more contextual, place-based issues were also being identified and addressed. However, this required all agencies to have the space and ability to provide this data to see the bigger picture.

> *"It's bringing it all together all very different data all means very different things, different agency, but when you bring it together it shows the same bunch of young people with the same with one particular worry and we're able to combat the worry, rather than all of us, all doing our own, our own stuff and doing it as well as we can do, but bringing it all together, we have a combined plan and it just it just makes sense".*

A final key aspect of data and performance management being able to contribute to safeguarding arrangements was the ability of those frontline practitioners to run their own queries and see their own data as and when they need to. This requires the effective automation of reporting functions, rather than placing more burden on fairly small analytical teams (which are likely to have delays in any requests). But also allows the practitioner to have further understanding of data recording, collection and analysis – why it is required and what it is used for? By opening this up to ensure the data available is also up to date (daily updates) was also seen to have a positive impact on safeguarding practitioners in that they do not have to wait for the end of the month report to understand some of the key KPIs and whether they have been met and being able to monitor performance.

> *"And I think from a technical point of view, what's working well with our system at the moment because we use SSRS for our reporting functions is that we're looking more to automate our reporting. So rather than my team be the middle person in terms of sending out spreadsheet via an e-mail attachment, we're actually building reports to specification, which we would do anyway, but give the end user access to our reporting system. So that they can run that data whenever they want. "*

Theme 2: Key Safeguarding Indicators and Metrics

This theme explores the range of metrics, indicators and variables which were collected and collated nationally for Wales. In addition to the set national indicators, there were also *local developments* whereby local areas collected additional data that they felt were important to help understand their effectiveness. It was noted that in addition to set metrics, there was a requirement to understand, document and *measure the safeguarding journey* of individuals. This would assist understanding of what has happened at each stage of the process and highlight progress that has been made and what the impact of each intervention have been. Stakeholders noted their efforts in engaging and capturing *service user voice* in regards to young people, individuals and their families in being able to understand how to improve their safeguarding response. Key factors that were noted as *missing in data* collection and analysis were also highlighted.

2.1. Innovative Use of Data at Local Level

Across the LA areas, there were variations in how data was being collected, shared and used across the safeguarding arrangements. Often this started with the understanding of what exactly they were wanting to know from their data. This clear set of questions helped frame the performance management teams and united them clearly as a key part of the safeguarding arrangements and should feature as an agreed set of requirements across LA areas.

> *"So fundamental things for me to know are … children that are open and known to us being seen on a regular basis by the right people? Are the caseloads of our staff manageable? Are we able to therefore meet the demand as it's coming in? Is there a throughput to support the demand, or is 1 outweighed by the other and in which case why and what does that look like to have those conversations? Are we completing our statutory duties in the time scales that are set out for us? And if we're not, why not?"*

This may be slightly reframed as more practical goals for those frontline practitioners, but was still seen as a key consideration within the safeguarding arrangements.

> *"And we set the goals at the beginning of a case being allocated, so we agree the goals and we've got some set, some set goals. So we'll either be community, guardianship, building, building guardians in the community or it will be working on the physical environment or it will be young people themselves up, skill and young people themselves"*

Not only was the role of data and performance management seen as setting and agreeing an appropriate set of questions, but also about how the metrics are understood in relation to the safeguarding activity. The example of children looked after was discussed within one focus group. That currently this measure as a key KPI and the push for this to reduce is not helpful from a safeguarding perspective, in that decisions at court do not tend to reject removing a child from the family, with questions raised about whether the thresholds are actually too high. That what we may need within

this measure is to ensure that at local level it is understood that the right decision for that child is being made, regardless of the metric to reduce the LA Looked after Children population. It should be reassured at local level that if this decision is made, then it has been due to the right procedures being followed, with this being the best outcome for that child. Hence, for this LA it was about ensuring some of the required metrics did not make practitioners feel inhibited, or defensive in their decision making and actions. This links to the key concepts within Report 2 regarding the key competencies of individual and agencies within the safeguarding arrangements.

> *"It's not reducing the number and saying we've gotta have less children in care. You know, we can have an aspiration that we wanna do that, but there's a fundamental basis about world-wide children become looked after. And it isn't just because of knee jerk reactions of although it will be influenced by children who are living at home with, then get killed by their parents, and then the society not wanting to accept the fact that that could happen by not removing all children where there's a hint of risk. And so it swings like that pendulum without answering the question."*

Given the demand reported by practitioners, particularly those that were frontline, LA areas were attempting to ensure the referral forms that were being used across the various safeguarding pathways and agencies could be amalgamated to ensure consistent and accurate data. This encouraged key safeguarding agencies to agree the purpose of collecting certain information and key factors to be included, rather than collecting data, which was not utilised within these amalgamated forms, which ultimately then assist data input, extraction and analysis.

Some LA areas were seemingly more advanced in their analytical capacity and expertise, using platforms such as Power BI to be able to *"interrogate their data"*, with the system also providing the ability to run statistical analysis, mapping, as well as visually illustrate data. This is also a tool that is used within some Health organisations, with conversations within these partnerships about using Power BI to share and analyse both LA and Health data. This was all linked to the strength in being able to bring data together on key thematic areas, when required, from key partners in being able to agree strategies and response.

> *"So all of that data will be able to pull into one report. So it's not just gonna be social services data. It's gonna be relevant data from across the services, which is often we've all got our own set of data."*

Whilst there was a general consensus that collating multi-agency data is imperative to understanding safeguarding effectiveness and to understand the whole picture, it was acknowledged that currently, much of the data remains LA driven.

LA areas were asked about what indicators they were collecting and using that they saw as particularly important within their role that help them to be assured that things are working well, or conversely that there are issues that need addressing. Responses ranged from those that centred on

caseloads and workloads of staff, ensuring that cases were being closed, and if not *"what is the reason and are staff too stretched".*

Furthermore, one LA focus group talked about three key factors they look for within their safeguarding data. This was listed as scrutinising the threshold assessment, with the decision making about threshold seen as the most important assessment given the need to ensure that the safeguarding process is *"protecting people's rights, either the rights to private family life, or the rights to protect the child"*. With other factors mentioned such as *"have you identified the key changes that you are going to intervene on"* being clear on what needs to happen and why. Their third consideration was *"are you somehow assured that you are making focused progress"*, with this centred on continuous support, flexibility and monitoring of engagement. This was all linked to the idea of "ticking a box saying that a child protection plan is in place is not enough" and that these additional factors require recording and monitoring to make the safeguarding process effective and meaningful. Linked to this idea, other LA areas stated importance of logging their decision-making rationale within their data recording was seen as just as important as the key dates and numbers but was sometimes missing from cases. Understanding why a decision has been made and logging it within the data system was seen to provide essential narrative and context, particularly for when cases and decisions are reviewed.

Some LA areas talked about the limitations with some of the metrics at Welsh Government level and even at local level and were seeking to expand these to be *"more creative and get more meaningful data".* As part of this, rather than just collecting data on activities such as how many child protection conferences, but also collected and monitoring "*how many conference have there been where we've seen maybe an improved score for the families as part of that process".* Similarly linked to this was the recognition around key themes of data that required capturing and monitoring they may not be currently recorded, such as attempted suicides.

Other innovative use of data saw one LA area discuss collecting metrics in opposite to those asked for by Welsh Government. The example provided explored positive indicators of progress, such as children that have been removed from the register demonstrating that *"families have made enough progress to satisfy us that their children are no longer at risk or are no longer suffering harm".* The LA ensured that this was captured, shared and reflected on as a positive outcome for the child and family across the safeguarding partnership.

2.2. Capturing the Safeguarding Journey

In addition to specific outcomes which are standardised metrics including number of referrals, number of strategy meetings and so on, there has been evidence in some areas of capturing more incremental

progression-based outcomes that detail almost a road map of the safeguarding journey. These more incremental plans can relate to specific risks such as exploitation. Although it was mentioned that *"this system isn't based around any of that at all. It doesn't that mean from doesn't exist. We built it into the system ourselves".* It was suggested that documenting a child's journey, should be more fluid and include 'root maps' in line with child protection so that children do not become lost in the system. It was noted that professionals are working on a continuum of safeguarding.

It was also noted that as part of documenting this journey, these young people and families should be involved and part of the process in ascertaining which parts of interventions and support have been effective and what the impact of this is.

> *"We've got a measurement element there which you could say is an outcome measurements around individual changes, safety related changes for the child. We've got a scoring methodology that takes you from not good enough, which is a two, to good enough care which is an 8. And then we track that from case confidence to case conference"*

It was highlighted by some that there can be too much focus on figures and when measuring progress, the point of an intervention is to not mainly focus on 'getting a score' to illustrated change has been made but the crucial part is the discussion around what it would take to change the scores and the narrative surrounding that.

It was also felt that measuring can almost be like targets and as each situation is different, what means safety for one child may not for another and removing a child from parents under local authority care is complex and so to focus on numbers can be *"really frustrating in many ways because it feels again like a tick box".* There was an acknowledgement that logistically, although recording an individual's journey would be beneficial, it could be challenging to implement to measure such changes and which measures would best capture this and so it was felt *"it's a good idea but difficult".*

However, it was noted that this is a crucial part of the process and as well as documenting risk and changes made by the family, it was also important to consult for feedback on what has worked well and not just the huge outcomes such as whether a child has gone to university, but the other areas of success which have had an impact along the way and *"go back to I think when she was accommodated and talk about the journey through, you know, the system really and see what went well?"* There was a suggestion that there should be more conversations with families to understand what may have gone well and what families appreciated from a social work intervention along the journey to that this can support figures and provide a richer picture as to the overall impact of the social work journey.

2.3. User Voice

The partnership working between families and need for service user voice to be included in part of the process is accepted by practitioners and mandated within legislation and it was highlighted that the use of user voice within the context of performance management and data is paramount. To evidence that an intervention has been effective or had a significant impact, it is necessary to consult and record how this intervention has been experienced by service users and practitioners agreed the importance of this *"it's really important and it's much more powerful coming from the people that have been directly involved and impacted by because they are the ones that have lived through it you know*". It was also noted that data can be fairly numbers heavy and that this does not always reveal the full story.

> *"We currently collect this very quantitative really. So the fact that some enquiries are done in seven days doesn't mean that somebody's getting a better service than anybody else really. But I think in terms to get the qualitative information that we need, I think we delay on updates for that rather than the data. So it's about making direct contact with individuals who have been through the process"*

Some areas have begun to implement service user voice as standard and are exploring how technology can support embedding this process as they feel that it is key to understanding the impact of effective service use delivery and how this can be achieved through the use of meaningful data collection which goes beyond the set metrics and measurements and is considered to have *"soft outcomes"* that they have to report on. This also included ensuring that all forms have a section on the child's lived experience so this must be filled in as standard and that feedback is ascertained at different points of an intervention.

Other areas felt that there was still a long way to go in terms of prioritising user voice in measuring outcomes *"I don't really know if we, if the outcomes that we focus on per say, are really about lived experiences of the child as opposed to it being a minuet of data about what we do".* It was also highlighted that there must be resource and scope to be able to collect and action any feedback and data which is collected from service users and families and that *"most localities have somebody in place so they to pull data off of system, they don't have somebody in place who just speaks to families".*

2.4. What is missing - KPIs

Within focus groups and interviews it was noted that whilst there is an abundance of key measures and metrics collected that provide crucial insight into their safeguarding arrangements, there were also a number of key variables and processes not currently captured. Including these missing KPIs and processes was seen as enabling a fuller picture of their LA safeguarding demand, but also help identify

what is working well with these individuals, families and communities in keeping them safe.

One key aspect that was mentioned across all LA areas was the ability to see some of the more thematic demand across the LA areas and nationally as some areas found that trends in data "*likely to make its way up here at some point"* and so it can be helpful to see this in advance to prepare. There were concerns about being asked questions regarding increases in certain types of vulnerability, they are unable to understand if this is something that is being experienced regionally or nationally. Having more transparent access to this type of data will allow more informed responses to these issues to be formulated and actioned, providing a more detailed picture of fluctuations, with some also stating this would allow them to reach out to LA areas to seek advice on how to best respond. By capturing certain information at the point of referral, such as the *nature* of safeguarding concerns, as a common metric across areas, it could be that prevalence increases could be identified and in turn, practice shared about how to respond to certain trends and categories.

This was seen as particularly important for those LA areas that had much smaller numbers in regards to safeguarding demand, with interpreting some of the peaks and dips being *"quite dangerous"* without some wider context. This highlights the need for wider contextualisation and narrative than looking at raw numbers.

Furthering this need for LA data to be available, was the requirement of this to be available over a longer period of time. All LA areas had incurred some kind of change in their data recording systems, alongside some changes in metrics and definitions, etc that have been imposed by Welsh Government. This resulted in the inability to examine their data longitudinally, which is hugely important when interpreting your safeguarding demand. Therefore, when considering some of the requests around thematic demand and profiles, this data needs to be available over longer periods of time across Wales and the LA areas to help LAs to establish a baseline that is appropriate to their geographic profile. This may also help provide some consistency across the LA areas in regards to what they are reporting on outside of the Welsh Government metrics, and also bring that data together to review within their Regional Safeguarding Boards.

A final point on the data that is provided at LA level by Welsh Government, is that whilst some of the current metrics are available to explore on open, public websites, there does not seem to be any efforts to actually bring these together nationally within a report. This provides some issues regarding the purpose of data collection, explored within Theme 3.1. Therefore, a request from practitioners with responsibility for performance management and data was about ensuring these metrics are also brought together within a report to ensure there is some broader understanding and reflection on what the data is saying to help inform decision making, actions and policy going forwards. This may also help some inconsistences in data reporting that were discussed (within Theme 3.2) by

providing a national report that provides clear definitions and interpretations of the metrics across Wales. The role of the National Independent Safeguarding Board as a key partner in overseeing the national landscape of safeguarding could help to collate data measures and coordinate, provided funding was in place for analysing and reporting on data.

> *"A national report build could happen and be agreed and be, you know, right for all local authorities, but I think what came out of that was and why that didn't go any further is the fact that when you get back to a local level and practice, although you know practitioners are working to the Act in the way that they should be, the processes are ever so slightly different amongst each of the local authorities"*

Some LA areas highlighted the different attitude and culture to Quality Assurance (QA) activity with this most often present for Children's care management teams, rather than Adult's. Some LAs were seeking to re-address this imbalance to ensure that any agreed QA activity is equally addressed across the whole safeguarding system, with this being achieved by having a more holistic QA framework that speaks to both children and adults in the activities required to be completed.

> *"Historically, Children's Care Management Teams have contributed the most to quality assurance activity. This imbalance will be addressed within the revised QA framework"*

Alongside the resource and capacity issue in being able to engage practitioners in self-audits and reflection due to the day-to-day demand of the role (and requirement to actually be out doing the visits and assessments), issues around the skills-based deficit in qualitative auditing was also raised. It is often assumed that practitioners are able to undertake this important task with no training or knowledge of how to best approach this and questions were raised about capacity to carry out this work.

> *"How do you create a culture of learning reflection? How do you get stuff to do it? How do you create timing capacity? So we've got a real staffing crisis at the moment. So what am I gonna do, pull stuff away from visiting people so that they can sit down and review other people's work? Is that a good use of time? Potentially? But is that gonna happen in reality? Probably not. So actually we've got that real, the chicken and egg, but we wanna do more qualitative work, but we haven't got the boots on the ground to do it".*

When discussing what was missing, Health data was mentioned as a key part of the safeguarding system that was often missing or delayed. Issues ranged from key health workers such as Health visitors simply not having sufficient access to IT systems with *"three sharing a system"* which impacts upon them being able to update information in a timely way, through to data requests just going missing. It was noted that in some parts of health, *"they'll still be some non-computerised record collection".* This was seen as particularly concerning given the huge demands for mental health and wellbeing support.

> *"You asked Health to prove to you that they sent in a specific referral on a certain time. They find it quite difficult to find that data. They'll quite often quotes that they've got notes on the*

file, saying that they were supposed to have done something. We haven't had it, but they can't tell us whether it went well. All we know is that we've got no record that it arrived and just because some of the issues on the file that they intended to send, it isn't enough"

Final thoughts that were raised regarding missing KPIs within safeguarding was centred on ensuring that this did not result in 50 plus more metrics being added to the list. Certainly, LA areas mentioned the 'Covid-19' metrics that were seen to be a temporary request, which has subsequently continued (with no sign of this stopping). Therefore, questions were rightly raised when considering what is missing around the *"development of a performance set of rules"* including expectations of where the data should come from and from whom, as currently all data provided to Welsh Government is collected, analysed and produced by LA teams. There was agreement that there needs to be more challenge about what assurances are required to be captured, and simplifying this to allow other safeguarding partners to bring their data together as part of this.

"Like us to take a step back and ask ourselves, so what are we as a national safeguarding board? What do we want to prove? What do we want to assurance on? If we were only allowed to have assurance on one thing, what would be the most important thing we had assurance on? Or you're only allowed to have three things to be assured about? What would they be? So that you're trying to focus on not a wish list of all the things that would like to know""

Theme 3: Key Challenges within Data and Performance Management

This theme discusses challenges within the collection and analysis within performance management and data teams. Such challenges included questioning the *purpose of data collection*, what is being and requested, why and how is this being used to inform safeguarding decision making locally, regionally and nationally. In addition, it was also noted that there is often *inconsistency* within data requests and processes, making comparisons across Wales difficult. Challenges also included *limitations* within data and performance frameworks, whereby KPIs and processes were limited in their ability to provide a comprehensive understanding of a situation. Finally, the accessibility of data and logistical issues of recording, analysing and sharing safeguarding data was discussed, indicating a disparity in the intentions of data collection and use, versus the reality of this within a demanding, complex roles.

3.1. Purpose of Data Collection

"What's the purpose of collecting the data? They're always needs to be a purpose"

One of the key frustrations that was verbalised across LA performance framework teams centred on the metrics returned not reflecting the huge amount of work actually being undertaken within their safeguarding arrangements. This questioning of the purpose of this data collection was seen to feel like a "tick box exercise", with more needed to be measured and shared that captured the huge

pressures as well as efforts being made on the ground to support families in the way that they want and need to be and that *"data that may be kind of sent on doesn't reflect the level of work, the hours, the you know the commitment that work is on the ground are putting into their day-to-day jobs"*

This was linked to frustrations about what the aim of mainly quantitative data is at national level when all practitioners emphasised their reliance at local level to the *"back story"* in understanding the quantitative data, this includes the smaller details about what it is about support which is working, what are the nuances which are making a difference to a child, such as a child seeing their mum and dad at sports day and having someone cheer them on. This can be linked to ensuring 'quality' is captured, with this needing to be increasingly emphasised from national data collections.

> *"So the whole thing needs to think about quality, the discussion and the language we use and the drive from Welsh Government needs to be about what does this mean for that child?"*

This leaves people wondering what happens with this data when pooled together by Welsh Government, with a professional stating that "*I just got this send these numbers away. And we're not really sure what they know what happens with them".* This was furthered when commenting about the volume of returns that are also required, asking the questions *"does Welsh Government really need to know all of this?"*

The noted frustrations around some of the national KPI requests were seen to be worsened by the lack of feedback on these, specifically when questions are raised about the definition and therefore final numbers returned. Practitioners want to understand if data is helpful or not and noted that there is a lack of feedback and consensus around understanding of baselines within the metrics, "*there isn't a baseline, so we just all report and information"* and that this risks making these data collections less meaningful

Additional points raised regarding the purpose of data collection noted frustrations due to the complexities within the data systems being pushed by Welsh Government (WCCIS) with this requiring much local re-working to be operational within the safeguarding arrangements. Due to the local tweaking and building internally required, this subsequently creates *"anomalies … therefore we are not comparing apples for apples from one local authority to another".* In addition, definitions can differ according to agencies, for example, exploitation could mean one thing to the LA and something different to the Police which makes comparing data challenging.

> *"So we need to have some better universally agreed data sets and then who owns them? Is it the police that own that data in terms of the definitions or is it the local authority? Where does that mandate set to set those definitions and parameters? Because there are different stakeholders that need different data to tell them different things"*

This was furthered in regards to being able to understand the purpose of data requests given the huge efforts it takes for some LA to extract the required data due to the data recording system not having

these already built within them, thus creating multiple layers of reporting, extraction and validation.

> *"So every year there's an annual return. So this year it took six weeks for us to do the annual return because the database wasn't gathering the information that we need. You know, and it took two analysts, you know, and the manager. All of that time away from doing all the rest of work, just so we give the government the information that they needed on a system that they implemented"*

> *"We know what tech can provide, but it's seldom really delivers on what its promises. And then you look at the data set and then you ask, does this tell us whether the child protection action is effective or not?"*

Finally, the noted opposing role requirements on social workers due to those performance managements teams requiring them to ensure that their day-to-day activity includes *"being stuck behind a desk, as that the actual only way of getting some of this data inputted into a system nobody else can do it for you. You need some of that information in, puts it into systems in order for us to be able to report on".* This was seen to counter recommendations from the Monroe report after Baby P where it was stated that social workers need to be out visiting individuals and families.

3.2. Inconsistency

There were concerns that data collection and interpretation was inconsistent across different LA areas and that processes may be different and understandings of what the guidance requires can also differ. This may lead to different metrics being reported and can be problematic when comparing figures across areas. Examples included documentation of strategy meetings and how this can affect figures relating to whether a strategy date has been completed within a certain timeframe, with this depending on what approach is taken in counting the dates, which is open to interpretation.

> *"So what you find is that this variation in the way this has been audited and reported by authorities in Wales has been like this for at least 15 years. So we've told the government about this inconsistency on something as simple as that"*

It was noted that even in areas such as professional concerns, and individuals had a set pro-forma to follow, there were still difficulties in standardisation *"Everybody doing professional concerns had one blueprint to work from. You'd think that would produce consistency, wouldn't you? But strangely, it didn't. It just highlighted how everyone did things differently".* There were also concerns regarding different agencies understandings of different definitions, particularly within domestic abuse and what counts as domestic abuse in complex situations.

Whilst WCCIS has generated some consistency in that many LA areas are using the same database, there have been problems associated with different starting points for adopting the system leading to each LA then creating and adopting different processes. Whilst the standard Welsh Government metrics could be more consistent and embedded within WCCIS, there is more locally

derived data collection which has arisen from an operational need. This led to much talk about the need for the LA areas to align regionally, to further help provide consistency in the interpretation and reporting of key metrics.

Data entry can result in inconsistencies in data, and it was highlighted that a lack of training for example if there are staffing issues within a MASH and this can affect the recording of referrals and categories of abuse, for example, could be incorrect. This was felt to be of crucial importance within at the Front Door and Safeguarding Hub/MASH, because *"if you don't get it right there, it's gonna be wrong all the way along, so I think it's so important, all the QA work that we do just to make sure it is, it is right".* In addition to inaccurate recording of referrals, the actual decision of whether to make a referral was noted to be potentially challenging. Understanding the appropriateness of referrals can impact upon reporting on outcomes, because if individuals are referring to 'tick a box' this will produce a very high number of referrals *"which obviously have has an effect on statistics"* but it could be that many cases do not reach a safeguarding conclusion or action. Therefore, leading back to questions about within Theme 3.1 about the purpose of data collection.

Final inconsistency concerns were raised across the different safeguarding agencies such as Health and LA as they have different priorities of what is deemed as important data and information. It was noted though that collaboration here would be key and *"if we work together on that we collected the same data, so that you can run reports on them and you can see you better and analyse it".*

3.3. Data Limitations

Within the data itself, there were concerns that the measures and metrics did not allow for a full picture to be gathered and that the data had the potential to be limited in what it could be evidenced comprehensively, without raising the need for more questions and processes to be built. These data limitations tended to centre on the practitioner ability to record what was needed from mandated data returns whilst ensuring this was also "meaningful", the systems themselves being seen as not fit for purpose in its functionality for basic daily observations as well as the extraction and analysis of larger data sets. The result of these limitations often led to LA areas having to put huge amount of time and resources to find "workarounds" to get out of their data systems what is required for Welsh Government, but also to help inform whether the safeguarding arrangements are effective in protecting their communities.

Some LA areas actually talked about data limitations in regards to the capacity and emphasis on data recording. There were concerns that does not capture the essence of safeguarding work on the ground. For example, spending two minutes on a visit would quantitatively look the same as

someone who spent more time and had a much more meaningful engagement with the family. Therefore, raising questions about how can we encourage this as standard practice in recording their information, rather than trying to do as many visits as possible? Making each moment count was seen as particularly important, rather than consideration of whether the numbers were meeting the set targets.

> *"It's very easy, isn't it to say, yeah, I've seen that child. But as you've actually popped in for two minutes, you've spent three of those minutes speaking to the foster carer or the parent with a child, you know, the child may be up in the room or just in passing. Doesn't particularly want to engage or even if they do, we spend two minutes. "Yeah, yeah, everything's fine". Because actually you know if we're doing our job right, life is going better for them when we're involved. So it's those elements about actually what does that visit entail? What does it mean? How meaningful was that visit for that child?"*

This perspective of data limitations on capturing and encouraging frontline practitioners to *"do the work that actually keeps people safe"* was also furthered within another LA area. Frustrations were felt in regards to having to comply with *"tick boxes"* in recording the necessary KPIs whilst that 3 hour visit and engagement with that child, which may have had a huge impact, and resulted in less cases being dealt with that day and week, is not necessarily captured or acknowledged. This subsequently puts a lot of pressure too on managers who have the dual task of having to monitor and review the numbers to identify issues, whilst also acknowledging that sometimes cases require more time and resources, with outstanding questions of *"I don't know how you capture that".*

This led to many practitioners questioning how we can capture these staffing pressures, particularly given the additional challenges of sickness and vacancies across many LA frontline roles, to more accurately reflect the picture of safeguarding locally and nationally. Consideration of these related factors when reporting on any safeguarding KPIs, will allow LA areas to understand pressures on the ground and practitioners to feel that their efforts in the face of these pressures are being acknowledged, instead of just being solely focussed on the numbers passing through their systems.

> *"People will interpret that thinking of "God. They're not doing very well or, you know, that doesn't look very good". But there's always a reason behind that. And it's about being able to kind of share that in terms of making sure that we as managers are protecting our staff and sharing that information so that they that the wider audience for argument sake, knowing that these are the reasons"*

The data recording systems themselves were also limited across most LAs, this was particularly noted for those that had adopted the nationally accredited system of WCCIS. Some of these limitations were based on the pre-determined data parameters already embedded within these systems, with the example given of a "review box". This was supposed to be where the practitioner put in the review date. However, this was misinterpreted with people *"understandably though that the box is when they have a review".* This caused huge issues in terms of having to validate the data and then create *"work*

arounds" to then eventually "reconfigure" the requests on the system. For some LA that simply did not have the resources within their performance management teams, compared to other LA, this just created further work.

Again, final points raised the issue of all of the data requirements do need the professionals to be out there doing the visits and inputting the data. In times of reduced referrals, this is likely to be a reflection of practitioner absences or issues, rather than actually reduction in safeguarding concerns. Therefore, when interpreting any data at local or national level, this key limitation needs to be understood and acknowledged.

> *"So when we look at the referrals that we get into local authority in the Christmas period when there's no professionals at work, we see a massive decline. It doesn't mean that nobody's suffering, you know abuse or exploitation just means that the professionals are not there to acknowledge and refer in. So professions pay a massive role than they in and staff attention and having stuff that understand"*

3.4. Logistical Issues and Data Accessibility

It was noted that being able to access data from systems and extract information and data which need to be collated and analysed was sometimes logistically challenging, which could have an impact upon what could be reported upon.

> *"The Welsh Government backed WCCIS. So what data they need, but they don't match, doesn't do the job. So to me it was a bit like a bit like going to view a house that had two bathrooms and three bedrooms and a kitchen diner, and then you buy the house and then when you come to move in, it's got one bathroom and only two bedrooms and the kitchen diner is full of someone's old tissues. It just doesn't fit the thing that you bought. I didn't buy this. That's equivalent. Why would you? It's just not fit for purpose. It's about the amount of human effort that needs to go in, in order to make it work right is ridiculous"*

As mentioned across the various themes so far, the data recording system was seen as the main barrier in being able to effectively complete any performance management or data responsibilities. These challenges were seen particularly from WCCIS. Key concerns included "*the functionality and the sophistication of it is very limited"* and the system conditions within WCCIS not reflecting, or supporting practice, with further concerns that the system allows one to do things *"outside of the legal process".* Those that adopted WCCIS spent much time talking about these challenges, the significant resources and expertise needed to overcome these issues. This subsequently then created *"layers and layers of bureaucracy"* within the system, which given this is a Welsh Government backed system, it was expected that these parameters would be built in to aid consistency in reporting.

> *"It isn't reporting in a way that we can get anything back from, so we spent a lot of time looking at that. So everything from how we calculate visit, how we calculating time scales for conferences being held, you know literally basic core things that actually we have to report to*

Welsh Government that actually we have staff guidance that we've gotta be adhering to. All of that wasn't built into the system and isn't built into the system"

"Welsh Government database system and actually they didn't build in any of the parameters themselves about what they wanted in terms of just automating the data back out. So we have to do that and create that. I don't think it's been very sophisticatedly thought through by anybody. And then the other problem is it's trying to be a master to everybody and actually it doesn't deliver on any of the things that it's supposed to be doing. So from a data point of view, it's a real challenge to put data into it because it's not particularly intuitive. It's quite clunky and getting data back out of it is even more clunky and difficult. "

The consequences of the wide adoption of LA areas to WCCIS suggested that the ability for it to be *"built from the ground back up"* to fix the significant issues cannot be completed, as this would impact on all those currently using the system whilst this work is undertaken. Therefore, the LA level fixes that are being implemented across Wales to make it operational is resulting in differing parameters being created, including those around *"legal flow and processes"* which are nationally set. The urgent need to automate some of the key required KPIs was certainly seen as a requirement to be implemented across Wales.

"We can't just migrate all that information over because it won't fit. And then every local authority's been told they can do something slightly different and then some of the parameters of it have been told you can change locally and quite a lot of them. You can't. They gotta change nationally and quite a lot of the ones around following legal flow and process and nationally set and for whatever reason, other local authorities don't want to put them into concrete and all the statute and law"

Similar to the point previously raised within Theme 3.3 regarding data limitations, the key logistical issue that was raised by practitioners was the ability of staff to input the data. A practitioner clearly noted that any analysis or recommendations are based on the data inputted by frontline staff, and given the noted national issues being faced, particularly across social work, this logistical issue will inevitably impact on the quality assurance rigour that is able to be applied.

"I am not a qualified practitioner and, as such, I rely solely on practitioners completing audit tools to provide the base data to inform my analysis and recommendations within the reporting structure. There are well-documented capacity and staffing issues within Social Services both locally and nationally and this will inevitably influence the level of audit activity undertaken"

Furthering this, the logistical issues of WCCIS in terms of making it practical for frontline staff was also raised, given it is widely acknowledged that all data and performance indicators require the input by these frontline practitioners. Therefore, making the IT system as user-friendly as possible to those frontline staff to enable them to see clearly what their tasks are and what requires updating and inputting within the system should be a priority. However, it seems the basics of what is required for frontline practitioners is not provided within the current operating system and rather it was seen as *"really pulling us away from that really important work".*

> *"How do you create a meaningful dashboard for staff when the system won't allow you to do it? So you are then back to running manual reports and creating manual reports to tell people what they need to do, which is just seems bonkers! And then when you do produce the report, when you are producing dashboards for them, they're not accurate because they reliant on so many human factors that they're not gonna go well. So there's a lot of data validation, waste, waste of time, of validating data. There's a lot of time wasted of operational staff doing unnecessary data validation tasks that actually could be automated.*

Not only was this heavy burden of inputting on frontline staff noted, but also the continuous adding and changing of key metrics that were required to be returned to Welsh Government. This was seen as problematic as these metrics were always seen to be increasing, with no streamlining efforts to try and provide a more standardised set of metrics. The Covid monitoring was mentioned, with this first suggested to be a short-term requirement, but has since continued to be reported monthly. It just seemed to create more work, more reports and more resources within the safeguarding teams as a collective to achieve this within the required timeframes.

Further staff logistical issues were identified, such as being able to effectively contribute to the safeguarding arrangements within performance management teams, and also discussed was resourcing and expertise required within these roles. It was acknowledged across some LA areas that there was a deficit of skills to be able to maximise the analytical capabilities within the data. This was seen as an issue of time, due to the effort and resource needed to just manage the data, with a need for a more coordinated, dedicated role to help bring some rigour and consistency to LA performance teams in their use of safeguarding data.

> *"And we just started to have conversations in the safeguarding board about doing a very similar thing and having it (data) graphed. But we needed a data person to do it for us. We don't really have the skills, because we are a bit too busy doing our own data, let alone doing that"*

Theme 4: Good Practice and Future Recommendations

This theme identifies what stakeholders felt to be working well within data collection and performance management. These examples required for national data collection but also localised innovations such as different metrics and variables collected which were found to be useful for analysis, which may explain or contextualise the wider picture of safeguarding which existing data may not always highlight.

4.1. Working Well and Identified Good Practice

It was noted that some areas were seen to be achieving good practice by working closely with neighbouring LA areas in sharing of their data, audits and quality assurance frameworks. There were also various examples of how LA areas were applying their data collection and analysis, such as

incorporating data as a regular agenda item in meetings, not just strategically, but also operationally to ensure that congruence in leadership priorities and frontline delivery is continually progressed.

4.1.1. Geographical Data and Practice Sharing

It was clear that geographical data and practice sharing was not a commonly implemented approach across Wales. This was also detailed by one LA area that had established links into two other LA areas that they had made attempts to join their training departments and procurement departments in an attempt to better join-up their safeguarding approach. This approach at the strategic level was fed down into the safeguarding systems and processes, with this relationship seen as enabling the LA area to engage in more rigorous, challenging quality assurance and audit processes. Some LA areas also discussed how they actively looked outside of their LA and outside of Wales to help them understand their data and help support strategies to respond to specific types of demand, such as contextual safeguarding issues.

> *"Regarding contextual safeguarding, we've been in touch with a lot of other authorities that we're also trying to embed the same. So for example, there's a few London boroughs that werepart of the scale up and when we recently had an incident, a serious violence and involving aknife in (LA), we were able to call on those professionals like you know after this event what you do, what you put in place. I think the answers are out there"*

This collaborative working relationship across the LA areas was seen to have been developed over the last 2 to 3 years, with the managers of the safeguarding performance teams meeting every fortnightly to explore their data trends, with the ability to flag and discuss issues or concerns as they arise. This was joined up within their MASH quality assurance framework, with connections into the MASH operating quality assurance group. Reviewing the trends and data regularly allowed LA areas to better understand their baseline statistics by comparing with other LA areas. It also allowed for softer conversations that involved other key safeguarding agencies to understand why these differences might be occurring. For example, it was discussed by the practitioner below about a health representative explaining the different ways that Health were working across the LA areas, which may help explain any differences in outcomes.

> *"Well, yeah, it it's useful on a number of dimensions, isn't it? Especially when you look at structures, you don't want anything to go to a head of service before somebody realises there's a problem or a theme, but it's really useful for me to have that data. But because of the quality assurance group that sits under that, that has the team managers who oversee the respective MASHs and has a multi-agency aspect to it, so I will be able to see if there's any massive deviations and not just from a statistical perspective on the ones that we report on"*

4.1.2. Data as Agenda in Meetings

A key identified good practice that was seen to be an essential feature of effective multi-agency safeguarding arrangements, was the connection between the performance management teams and the safeguarding structures within the relevant hubs as well as with the frontline practitioners. This was mainly being achieved through dedicated efforts in providing reports, data and opportunities for discussion across these teams as part of the regularly, diarised multi-agency meetings.

> *"We've so we call this our weekly service health checks. But for us it is about the performance. Data is very, very important, for us as assets, as a pillar of our quality assurance framework, because actually things being done on time is a quality indicator. But it is not a quality indicator in itself. It needs another supporting soft data to show that we're doing it on time and we're doing it well, because actually in calling it a performance indicator can actually reduce quality, when people become too fixated with doing things within the time scale and then the priority is not on the quality that sits behind them"*

For some LA areas, there were clear processes in connecting their performance monitoring right from the front door to try and response to *"early alert data".* Some LA examples had processes in place to use data as a key part of weekly meetings, with key processes in place such as 100% compliance of referrals coming in being screened within 24 hrs, to enable quick responses to any concerns raised. The importance of these processes ensured regular feedback to teams, as well as the implementation of more qualitative reviews of decision making soon after decisions are made to ensure the compliance in time requirements (and numbers) were appropriately made.

Having these regular meetings and discussions about KPIs and metrics, allowed for softer data to be discussed, which helps the performance management teams contextualise the data. Also, for practitioners, this was seen to increase understanding regarding the rationale for the metrics, the *"importance of recording information"* in providing these metrics and importantly, how the data can help inform further learning, training and practice. The emphasis was seen as *"knowing that someone else external to it wouldn't know unless it's recorded"*

Another key approach that was used by a number of LA areas that linked performance teams and safeguarding teams was the use of self-audits to help staff understand the importance of performance data and quality assurance frameworks.

4.1.3. Working Well Within Data and Performance

Most LA areas discussed that within their safeguarding teams, including their performance management teams, that the ability to use their data to produce quarterly reports as part of their Local Operational Groups (LOG) and also the production of annual reports for wider public consumption were always well received.

Additionally, regardless of the issues that were discussed around their data recording systems, some LA areas stated that their capturing of quantitative data was now very good, with the inclusion of staff metrics included in helping them to interpret the data. These were said to help contribute to understanding caseload data held by staff, deep dive monthly reports, and also the creation of daily dashboards to assist with the daily tasks.

> *"I think that we're very good at being able to say how many things we are doing and in what times goals that we're doing. We can capture daily data tracking. We are able to look at all of the key areas that we are working and supporting people with, but we can also look at it from staffing point of view as well. So we can also look at our staff sickness kind of data we can use then. And caseload data. You know, there's a broad there's a very broad parameters and we've got well established"*

The importance of having a dedicated team of people, such as four key analysists for core areas, within performance management was seen as maximising the potential impact that could be made in understanding, sharing and learning from safeguarding data. This was seen to work particularly well when these performance management teams also included a principal social worker to ensure the data reports and processes always reflected the reality of practice. Having a dedicated team was felt to be more beneficial that viewing this quality assurance as an 'add-on' role. It also provides greater coordination and opportunities to drive that data analysis forward.

There was some progress being made with one LA area that were starting to embed peer auditing with colleagues from sectors, such as Health and Education, with data such as *"school exclusions"* part of this. This was being trialled as a monthly process, with an overarching aim for this to help bring multi-agency data sets together to inform strategic and risk management plans.

As mentioned in the previous subtheme, the use of weekly multi-agency meetings to review the decision making alongside the data allows for additional insight to be gathered, such as thematic areas. This is seen as being a reflective learning opportunity for new social workers to also engage in. The importance of these meetings is the recording of these discussions that result in a monthly performance report, which includes the qualitative auditing within them. The inclusivity of this meeting was seen to be a particularly positive approach, in that it allowed input and a voice to all those that are embedded within the system and those that may sit slightly outside of it.

> *"We have a weekly multi-agency review of child protection decision making. So every week we review all of the initial strategy discussions that have taken place. All of the section 47 outcomes that we've had and all of the children who have not been registered at initial conference and registered at first review. And that's multi-agency. And then it's also bringing in then across our service, then a range of different practitioners, not just the team that may be there, but other managers, social workers"*

Additional good practice was identified in some of the innovative tools that enabled LAs to capture aspects of the safeguarding process that are notably difficult to capture, such as the safeguarding

journey from the user/client's perspective. One LA discussed their 'Steps to Change' tool, which enabled families to understand and importantly for them to describe where they are at in their progress, and the agreed aspect of change that they were aiming to achieve. This enabled the communication to be much more *"transparent"* for the family and the worker. This was seen as a simple concept in gathering progress whilst also ensuring this spoke to the user as part of capturing their own thoughts on their progress. Thus, this was seen to make the data capture more accurate and meaningful around the LA safeguarding response.

> *"And having some kind of a documents that clarifies where the family are and what they what they're expected to be working on and they're trying to use their own words if we can. And we've had examples of children using them. So I've had quite nice examples and been quite touched really about how creative people have been using it to do 1 to one work, but that's the minority. You know most of the time workers are, you know, the running around the place. They've got no time. They've got massive pressures and they would wish to be doing this better"*

Those LA areas that have had their performance management systems, such as WCCIS, in place for a couple of years were noted to feel that they were now stable in their reporting, and as such were able to use data across a number of years to help answer key questions raised across the safeguarding arrangements.

Some more logistical examples were given in regards to what was working well, with this simply about giving frontline practitioners the ability to record their data in a more agile and flexible way that suits the demands and the requirements of their role. This ranged from providing staff with laptops to be able to input the data required in between visits. Additional work in reducing the duplication in forms and associated paperwork was also seen to be enabling best practice. By reviewing and amalgamating some of the data fields across key forms, it was seen to help *"enhance the amount of time people are able to spend with families".* This reduction in the admin burden was reported to have had a positive impact on *"recruitment and retention rates"* within one LA area.

One key aspect that was mentioned heavily within Theme 3 as challenges, was the ability to automate their data systems to enable practitioners to more actively engage in the data on a daily business to understand the demand, tasks and identify any issues as early as possible.

> *"So rather than my team be the middle person in terms of sending out spreadsheet via an e-mail attachment, we're actually building reports to specification, which we would do anyway, but give the end user access to our reporting system. So that they can run that data whenever they want. And we've actually used adult safeguarding as Guinea pigs with this and it's worked really well and we've had really good feedback, because rather than relying on a monthly report from my team, they're able to go in and monitor that on a weekly basis. If they want to"*

4.2. Future Recommendations

Stakeholders discussed ideas regarding data and performance management which they felt would be beneficial for future practice. Some of these ideas were linked to the use of a shared database and whilst it is considered helpful to be able to see a child can be open to another LA, there should also be more information that they can see rather than having to contact the LA for further information which can cause a barrier and delays. It was also noted that being able to have access to other LAs data would be useful to understand trends of what is happening in other areas and to create a national picture, to then ascertain the best ways of responding to challenges. Being able to liaise and work with other LA was also felt to be valuable and to ensure they shared their own methods of data reporting for more consistency and opportunities to learn. Being part of working groups in Children's and Adult's services also was perceived as helpful to learn from each other and *"have the opportunity to raise any early issues that we could foresee".*

The shared database itself was something which was felt to be supported by Welsh government and that has been invested into but that it is to be expected to have logistical issues with any IT system and having new systems being brought in does not always solve the problems which are being experienced.

> *"The risk is that we demonise WCCIS because it happens now to be a system that more and more people are using, so more and more people have high expectations of it"*

Whilst multi-agency working was felt to be going well overall, there were differences in reporting practices and it was highlighted that *"there is currently no formal structure for identified learning to be acted upon or for the wider workforce to take ownership of practice problems and suggest solutions"* and that this was being explored through a quality assurance framework. Linked to desire for consistency in processes was the idea that there should be a national pathway for children once they are involved in the system and that "*we get caught in subtleties of practice as opposed to broad parameters of things that are just things that we just have to do".*

There was a strong feeling that there should be more qualitative understandings of whether performance management is effective, as *"there's one thing doing them. There's another one doing them well"*. The details surrounding why a certain intervention may have been affective, for who and in what circumstances, needs to be understood, is learning to be actioned. This also affects resources and ensuring what is required is implemented appropriately. It was also mentioned that service user feedback should be a key part of this qualitative measure. It was acknowledged that this investment takes considerable resource and could be a job role in itself with some LA areas investing in this.

Whilst performance management is an area of interest in LA this can vary across areas and it was felt that *"to elevate the status of quality assurance"* ensuring it is mandatory with a designated

team and service rather than an add-on would be valuable as sometimes things can be '*hidden in the data"* and having time to explore smaller numbers which can have a significant impact such as children with complex needs which continue into adulthood *"and they sort of lost within that broad parameter of data"*.

It was noted that continuing to track data after an intervention would be beneficial to understand longer impact and to gain insight into a young person's journey and beyond the point of reaching adulthood. Bringing together multi-agency data which is more than just local authority data was felt to be something which would create greater clarity around safeguarding and understanding the bigger picture

> *"There are wider societal issues that you're gonna need to address with that that are not ours to do that are not in the data they're in a complex series of data's that are across a multidisciplinary things that need to be brought together and I would say that public health Wales need to do better and bringing the diversity of that data together to inform that and have better influence in Welsh Government"*

5. Key Findings and Recommendations

Key Findings

Data collection and performance management monitoring are clearly viewed as a valuable and essential tool by stakeholders across local authorities for evidencing what is occurring in practice, to learn from this and to facilitate effective safeguarding. There were national data metrics collected locally that are reported to Welsh government, however, LAs also collected and analysed additional metrics in order to understand demand of services and the determine the impact of safeguarding interventions. The aspiration yet to be achieved was to include adopting a multi-agency perspective whereby data is compared between agencies, between services and across neighbouring LA areas. Although some areas indicated good practice in sharing the LA owned safeguarding data across the regional area. Data was noted to help to create an evidence base that can inform training needs and inform practice so that the most effective action is taken to safeguard individuals and families.

Whilst it was felt that a substantial amount of metrics were collected, it was noted that the rationale and use of these performance indicators was not necessarily communicated, nor was it utilised in a way to help inform the national picture of safeguarding demand and practice. Therefore, practitioners wanted there to be some streamlining of these metrics and improved feedback from Welsh Government in regards to how their efforts in gathering and reporting this data was informing any changes in policy and practice. Simultaneously, it was also felt that some key metrics were missing from national collection. It was noted that service user voice should have an increased presence in data and performance management as feedback from service users' experiences is imperative to

understand the impact and effectiveness of safeguarding interventions. This raised the issue of understanding the nuances of a safeguarding journey and as well as the end outcome and understanding the longevity of impact. Moreover, this highlighted the additional need for a qualitative approach to data collection, which can contextualise and generate deeper understanding and clarity of quantitative data. This contextual narrative is fundamental in ascertaining not only what activities are carried out during the safeguarding process but also the 'so what' element, the impact, effectiveness and outcome of any such activities. Key challenges in data collection included a lack of resource to have the optimum number of analysists to embed data collection into services, a lack of consistency in data interpretation and reporting, a lack of feedback of national data to ascertain regional and national trends and themes as well as logistical challenges in retrieving data and utilising the information recorded.

There were areas of local innovation and practice regarding data and performance management with some areas investing in specific data management and performance teams across the LA area, and in one case across two LA areas, to ensure sufficient expertise and resource is dedicated to this responsibility. Additional good practice saw the use of analytical tools such as Power BI to be able to actively view and map their data in identifying peaks, geographical hot spots, as well as those areas that indicate absence of issues (which may indicate reporting/access issues to support). The advantage of Power BI also allowed other agencies to have access to data and utilise for their own activity monitoring.

Those performance teams that worked on a weekly basis with the safeguarding teams in helping to keep the dialogue between data recording, interpretation and practice continuous were those that reported effective mechanisms in responding to issues as they arose. They also engaged more effectively in activities such as self-audits in being able to contextualise the data for practitioners, emphasising the importance of their role as frontline practitioners and key data holders. Areas of innovation included Steps to Change model, whereby goals to work towards were determined in partnership with young people and families. Although metrics and scaling were a part of this process, measurements of achieving these goals were not viewed as the main objective, rather the discussions themselves that occurred as a result of conversations around the steps that needed to be taken, where the crucial focus and allowing that understanding of the journey to be discussed and understood. The Effective Child Protection Model (See Appendix 3) which has been adopted in a specific LA area also allows for this documentation and assessment of the nuances of the child protection process (see appendix). The process provides an opportunity for the Child Protection Chair to review case progression and assess to what extent change has been made when working with a family for example, and to what extent families have been involved and understood the changes which

need to be made to reduce significant harm. Where scores have changed in working towards goals, there is space to document if this has improved since the previous Child Protection conference, thus determining effectiveness of the intervention.

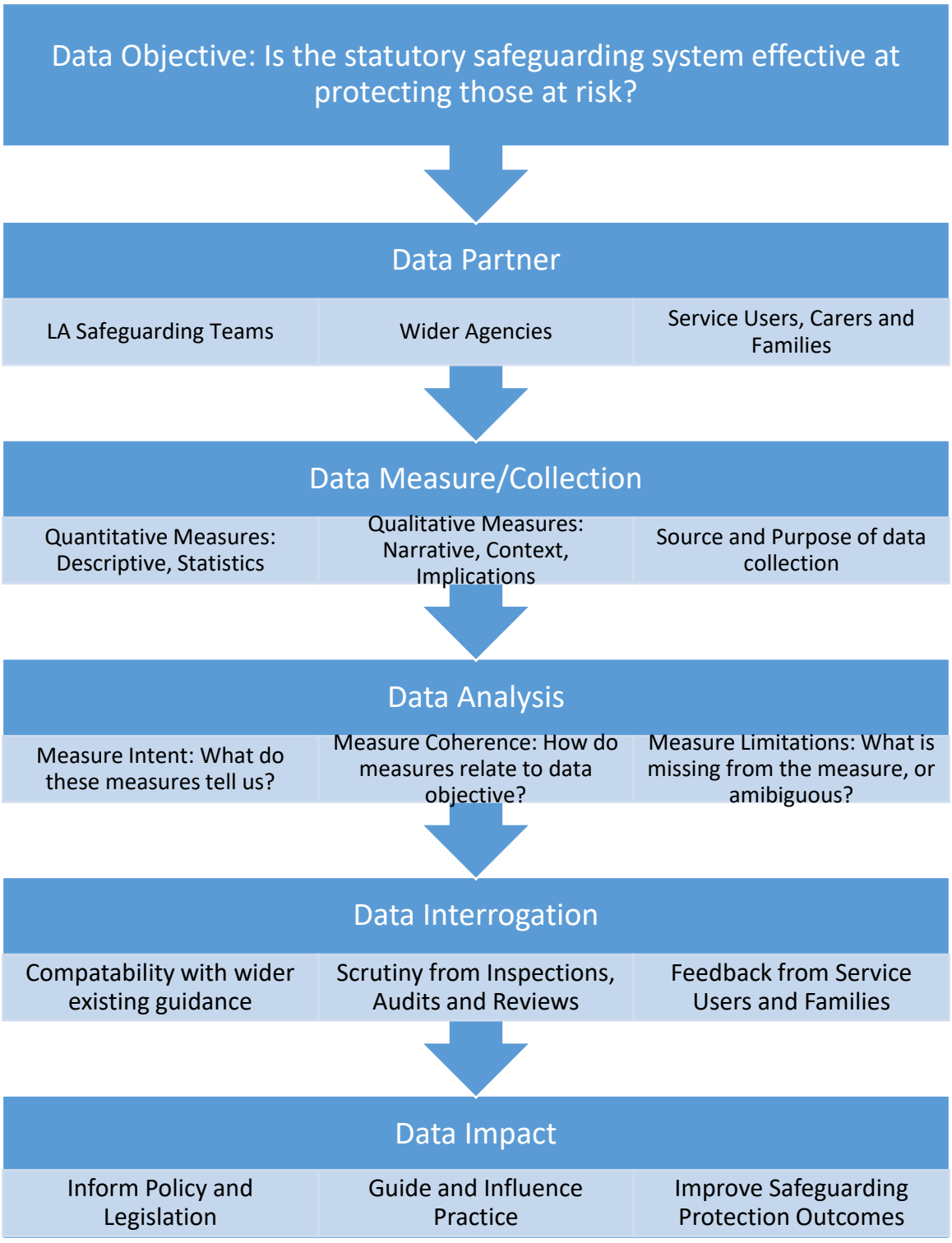
A key aspect of this evaluation was the ability to acknowledge, but also visibly see the operational variance across LA areas. This was important to practitioners in regards to being able to prepare and seek support for the varying types of demand to enable a proportionate, but effective response. This was seen as something that should be facilitated at national level and furthered within regional safeguarding boards. Final points noted that currently regarding the Welsh Government safeguarding metrics, these are currently captured, inputted and shared by LA practitioners. Whilst the multi-agency function clearly is working within the safeguarding arrangements, the data being captured and shared is LA driven. Therefore, certainly this was seen as an aspect of future aspirations for safeguarding arrangements in being able to include and report on other sector (Police and Health) within their safeguarding metrics.

The importance of data utilisation to understand performance management and to ultimately assess the effectiveness of safeguarding practice, is widely accepted as being essential. Whilst there are arguably an overwhelming amount of safeguarding metrics that are submitted to Welsh Government and even more which are collected locally, missing data metrics remain which are deemed to be helpful in determining effectiveness of the safeguarding process. These include firstly, incorporating user voice to understand the experiences of those individuals and families who have been through the safeguarding system. Secondly, given the importance of multi-agency working within safeguarding, it is crucial that data relating to safeguarding from a variety of agencies is incorporated into any data collection, allowing for a holistic understanding of the safeguarding process. In addition, it is beneficial to have a clear collective objective for which all data metrics relate to, such as whether safeguarding is effective. To answer this, it must be acknowledged that qualitative measures are required within data collection, which seek to build upon and explain the quantitative measures detailing safeguarding activities which have taken place and to go further, to explore the impact of any such activity.

In addition to the utilisation of data within the strategic arena of performance management, ensuring that data is integrated and embedded into operational practice, is felt to be advantageous. 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 this data clearly evidences what it needs to (through both quantitative and qualitative metrics), is key to evidencing best practice. In order for data to be succinct yet purposeful,

a set of quality performance indicators which take into account national multi-agency safeguarding data would be integral in determining how effective safeguarding processes are and to have a collective understanding of what 'good' looks like.

Data Utilisation Model



Key Recommendations:

1. LJMU, and the National Independent Safeguarding Board (NISB) should seek to work in partnership with Regional Safeguarding Boards to form a ***National Multi-agency Safeguarding Performance Framework (NMSPF) Working Group*** with the aim of co-producing a comprehensive set of data metrics (which include qualitative measures) to formulate a ***KPI Prototype***. This NMSPF should aims to evidence whether the safeguarding process is effective. This prototype can then be trialled across local authorities and evaluated to understand impact of whole system safeguarding effectiveness. This KPI Prototype would be submitted annually within an annual board report. In achieving this, it is suggested the following process be implemented:
    a. LJMU present their draft KPI Prototype for Children's Safeguarding (see Executive Summary report) to regional safeguarding leads as part of an initial co-production workshop. This should seek to understand what RSBs are currently collecting, along with their aspirations and challenges.
    b. Feedback to occur from this initial workshop on the 'KPI Prototype' developed for children's to understand which safeguarding metrics are currently operational and aspirational, and any additional feedback on the initial prototype.
    c. Next stage should seek agreement from RSBs/NISB/LJMU on the KPIs to be included and if any can be expanded to include multi-agency data indicators. This should utilise the **Data Utilisation Model** to interrogate this Prototype to ensure local good practice is reflected and incorporated as well as ensuring multi-agency data indicators are considered.
    d. The National Multi-agency Safeguarding Performance Framework (NMSPF) Working Group should meet regularly to review the Prototype with a view to produce a final KPI Prototype to be implemented to Local Authority areas by 1st April 2023.
2. Acknowledging the need for Mult-agency Data to evidence safeguarding activity and effectiveness, the National Multi-agency Safeguarding Performance Framework (NMSPF) Working Group must ensure there must be purposeful collaboration between (statutory) safeguarding partners to ensure that any safeguarding data is measured and collated coherently, with the aim of measuring whole system effectiveness. Such partners should include (as minimum):
    a. Local Authority
    b. Police
    c. Health

d. Education
e. Probation
f. Youth Justice

Additionally, there should be consideration of third sector partners (some of which are locally incorporated into LA structures or commissioned by LA's) such as Youth Services and Domestic Abuse Support Services.

Additional recommendations from this report also highlight the requirements of:

1. The production of a national annual report that brings all the KPIs across Wales (for example, those that are reported as quantitative measures on websites such as StatsWales) to help build better consistency and understanding of the metrics and the purpose of the request for them. Any new measures that are developed should seek to ensure these are pulled together in providing a National Picture of Safeguarding for Wales.
2. Review of the WCCIS system, to more transparently address challenges that have been made around:
    a. Its inflexibility to have built within the system the required metrics and processes, therefore, resulting in individual LA workarounds being created and causing variations in reporting across LA areas;
    b. Ability to see and access data across other LA areas that are using the system;
    c. Indication of other sectors that are seeking to join WCCIS, to understand its promised capability of bringing data together from different sector;
    d. Review of its ability to create performance dashboards that link to calendars, as was being done in some previous systems, to enable frontline practitioners to have access and ability to monitor their own caseload.
3. Thematic reporting on data to understand potential increases in certain types of risk areas such as suicides, criminal exploitation, etc. Knowing and seeing this across LA areas in Wales was seen to be beneficial in being able to have a more proportionate response to peaks and dips. Therefore, encouraging a more regional, or national agreed approach and response. Additionally, for those smaller or rural areas, it was also seen as an ability to go to those areas that have experienced the thematic surge and seek their guidance and support on how they have adapted their responses to deal with it.
4. There needs to be more emphasis on the requirement of Performance Management Teams as part of the safeguarding structure, with this not just an add-on role to a department. To be truly effective, this needs to run across the safeguarding arrangements and include a team

that has analytical expertise as well as practitioner experience, such as a principal social worker. This was seen to ensure the requirements on frontline practitioners in terms of what they are expected to record and how, as well as the interpretation of any data reports reflects the reality of safeguarding practice.

5. Within the safeguarding arrangements there needs to be a joined approach between the Safeguarding Hub/MASH and safeguarding teams with the Performance and Data teams. This should be a set agenda item occurring regularly (weekly/fortnightly/monthly). This was seen as enabling practitioners understanding of why data recording is important and how it is being used to feedback into the safeguarding response. Additionally, this allows any validation issues to be picked up as they occur, rather than creating a backlog of issues. Final benefits were seen in being able to discuss and agree approaches to any changes in the data as they occur, rather than waiting for monthly or quarterly reports that may indicate some peaks in data that then need to be retrospectively explained and responded to.

6. References

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7. Appendices

Appendix 1. National KPIs and newly identified LA KPIs

The final section of this document presents the current Welsh Government KPIs are currently specified, with the addition of the new KPIs presented above under the specific sub-sections where it is felt that they best fit. The new KPIs are highlighted in Green. Report refers to reporting frequency where FY is Financial Year.

Adults

Information, Advice and Assistance (Referrals)				
ADULTS	**Reference**	**Freq**	**Measure**	**Report**
IAA	AD/001	Year	The total number of packages of reablement completed during the year for support was reduced	FY
IAA	AD/002	Year	The number of new contacts for adults received by statutory social services during the year where advice and assistance was provided	FY
IAA	AD/003	Year	The number of contacts received by statutory adult services during the year received from	FY
IAA	AD/003a	Year	Self or family member	FY
IAA	AD/003b	Year	Friend or Neighbour	FY
IAA	AD/003c	Year	Health	FY
IAA	AD/003d	Year	Education	FY
IAA	AD/003e	Year	Police	FY
IAA	AD/003f	Year	Probation	FY
IAA	AD/003g	Year	Housing	FY
IAA	AD/003h	Year	Early intervention / Prevention Service (Step-up)	FY
IAA	AD/003j	Year	3rd Sector Organisation	FY
IAA	AD/003i	Year	Internal (social worker, other team)	FY
IAA	AD/003k	Year	Other	FY

Assessment				
ADULTS	**Reference**	**Freq**	**Measure**	**Report**
ASS	AD/004	Year	No. of New Assessments Completed for adults During the Year	FY
ASS	AD/005	Year	Of these, the total number where	FY
ASS	AD/005a	Year	Needs were only able to be met with a support plan	FY
ASS	AD/005b	Year	Needs were able to be met by other means	FY
ASS	AD/005c	Year	There were no eligible needs to meet	FY
ASS	AD/006	Year	The number of assessments during the year where	FY
ASS	AD/006a	Year	There was evidence of the Active offer of Welsh	FY
ASS	AD/006b	Year	The Active offer of Welsh was Accepted	FY
ASS	AD/006c	Year	The assessment was undertaken using the language of choice	FY
ASS	AD/007	Year	The number of new assessments completed for adults during the year undertaken in secure estate	FY
ASS	AD/008	Year	The number of new assessments that were requested by the adult or family during the year where the assessment had been completed in the previous 12 months.	FY
ASS	AD/009	Year	Of these, the total number where	FY
ASS	AD/009a	Year	Needs were only able to be met with a support plan	FY
ASS	AD/009b	Year	Needs were able to be met by other means	FY
ASS	AD/009c	Year	There were no eligible needs to meet	FY
Early Intervention and Prevention				
EIP	AD/010	Year	Total No. of Packages of Reablement Completed During the Year	FY
EIP	AD/011	Year	Of these, the total number where	FY
EIP	AD/011a	Year	Reduced the need for support	FY
EIP	AD/011b	Year	Maintained the need for the same level of support	FY
EIP	AD/011c	Year	Mitigated the need for support	FY
EIP	ADNEW01	Year	Had no further need for support	FY

Plans				
ADULTS	**Reference**	**Freq**	**Measure**	**Report**
PLA	AD/012	Year	The number of adults with a care and support plan at 31 March (AD/012)	FY
PLA	AD/013	Year	The total number of adults with a care and support plan where needs are met through a Direct Payment at 31 March (AD/013)	FY
Provision of services				
POS	AD/014	Year	For services started during the year, the total number of days adults have to wait between the completion of assessment and the start of a service identified within their care and support plan, where that service is:	FY
POS	AD/014a	Year	Residential Care	FY
POS	AD/014b	Year	Domiciliary Care	FY
POS	AD/014c	Year	Day Care	FY
POS	AD/015	Year	The total number of services for adults started during the year where that service is:	FY
POS	AD/015a	Year	Residential Care	FY
POS	AD/015b	Year	Domiciliary Care	FY
POS	AD/015c	Year	Day Care	FY
POS	AD/015d	Year	Respite care	FY
POS	ADNEW02	Year	The average length of time older people (aged 65 or over) are supported in residential care homes	FY
POS	ADNEW03	Year	Average age of adults entering residential care homes	FY

Reviews				
ADULTS	**Reference**	**Freq**	**Measure**	**Report**
REV	AD/020	Year	The total number of reports of an adult suspected of being at risk received during the year	FY
REV	AD/021	Year	Of those, the number received from	FY
REV	AD/021a	Year	Self	FY
REV	AD/021b	Year	Spouse or family member	FY
REV	AD/021c	Year	Friend or neighbour	FY
REV	AD/021d	Year	Health	FY
REV	AD/021e	Year	Police	FY
REV	AD/021f	Year	Probation	FY
REV	AD/021g	Year	Housing	FY
REV	AD/021h	Year	Early intervention / Prevention Service	FY
REV	AD/021i	Year	3rd Sector Organisation	FY
REV	AD/021j	Year	Internal (social worker, other team)	FY
REV	AD/021k	Year	Other	FY
REV	AD/022	Year	The total number of reports of an adult suspected of being at risk where it is necessary for enquires to be made	FY
REV	AD/023	Year	The total number of enquiries completed within 7 days from the receipt of the reported alleged abuse	FY
REV	AD/024	Year	The total number of enquiries where it was alleged there was abuse under the primary category of:	FY
REV	AD/024a	Year	Neglect	FY

REV	AD/024b	Year	Physical Abuse	FY
REV	AD/024c	Year	Sexual Abuse	FY
ADULTS	**Reference**	**Freq**	**Measure**	**Report**
REV	AD/024d	Year	Emotional or Psychological Abuse	FY
REV	AD/024e	Year	Financial Abuse	FY
REV	AD/025	Year	Of those enquiries, the number where the alleged perpetrator was:	FY
REV	AD/025a	Year	A child or spouse	FY
REV	AD/025b	Year	A family member who is not child or spouse	FY
REV	AD/025c	Year	A professional	FY
REV	AD/025d	Year	A friend or neighbour	FY
REV	AD/025e	Year	Other person	FY
REV	AD/025f	Year	Not known	FY
REV	AD/026	Year	The total number of enquiries that concluded that the action should be taken	FY
REV	AD/027	Year	Of those that proceeded, the total number where the individual at risk refused to participate in the identified action	FY
REV	AD/028	Year	The total number of confirmed allegations of abuse on 31st March under the following categories	FY
REV	AD/028a	Year	Neglect	FY
REV	AD/028b	Year	Physical Abuse	FY
REV	AD/028c	Year	Sexual Abuse	FY
REV	AD/028d	Year	Emotional or Psychological Abuse	FY
REV	AD/028e	Year	Financial Abuse	FY
REV	ADNEW04	Year	Number of adults reported more than once for the same category of abuse or neglect during the year	FY
REV	ADNEW05	Year	Number of adults reported for different categories of abuse or neglect during the year	FY

Charging				
ADULTS	**Reference**	**Freq**	**Measure**	**Report**
CHA	AD/029	Year	The number of adults who paid the maximum weekly charge towards the cost of care or support from carers during the year	FY
CHA	ADNEW06	Year	The total number of adults with a care and support plan where needs are met through a Direct Payment at 31 March	FY
Deprivation of Liberty				
DOL	ADNEW07	Year	Number of urgent DoLS applications received	FY
DOL	ADNEW08	Year	% of Urgent authorisations received that were completed within 7 days of receipt	FY
DOL	ADNEW9	Year	Number of Standard DoLS applications received	FY
DOL	ADNEW10	Year	% of Standard authorisations that were completed within 21 days of allocation	FY
DOL	ADNEW11	Year	Number of applications received that were withdrawn or inappropriate	FY

Children

Information, Advice and Assistance (Referrals)			
CHILDREN	**Reference**	**Measure**	**Report**
CHIAA	CH/001	The number of contacts for children received by statutory social services during the year	FY
CHIAA	CH/002	Of those identified: The number where advice and assistance was provided	FY
CHIAA	CH/003	The number of contacts received by statutory children's social services during the year where a decision was made by the end of the next working day	FY
CHIAA	CH/004	The number of contacts received by statutory children's social services during the year received from:	FY
CHIAA	CH/004a	Self or family member	FY
CHIAA	CH/004b	Friend or neighbour	FY
CHIAA	CH/004c	Health	FY
CHIAA	CH/004d	Education	FY
CHIAA	CH/004e	Police	FY

CHIAA	CH/004f	Probation	FY
CHIAA	CH/004g	Housing	FY
CHIAA	CH/004h	Early Intervention / Prevention Service (Step-Up)	FY
CHIAA	CH/004i	3rd Sector Organisation	FY
CHIAA	CH/004j	Internal (Social worker, other team)	FY
CHIAA	CH/004k	Other	FY
CHIAA	CH/005	Of those contacts received during the year	FY
CHIAA	CH/005a	The number where physical punishment by a parent or carer was a factor	FY
CHIAA	CH/005b	The number where physical punishment by a parent or carer was the only factor	FY

Assessments			
CHILDREN	**Reference**	**Measure**	**Report**
CHASS	CH/006	The total number of new assessments completed for children during the year	FY
CHASS	CHNEW1	The number of new assessments completed for children during the year that were completed within statutory timescales	FY
CHASS	CH/007	The total number of new assessments completed for children during the year where:	FY
CHASS	CH/007a	Needs were only able to be met with a care and support plan	FY
CHASS	CH/007b	Needs were able to be met by any other means	FY
CHASS	CH/007c	There were no eligible means to meet	FY
CHASS	CH/008	The total number of comprehensive assessments completed during the year where there is evidence that the child has been seen	FY
CHASS	CHNEW2	Number of assessments for children completed before child was born	FY
CHASS	CHNEW3	The total number of assessments for children completed during the year for children who were born at the time the assessment concluded	FY
CHASS	CH/009	The number of assessments completed during the year where:	FY
CHASS	CH/009a	There was evidence of the Active offer of Welsh	FY
CHASS	CH/009b	The Active Offer of Welsh was accepted	FY

CHASS	CH/009b	The assessment was undertaken using the language of choice	FY
CHASS	CH/010	The number of new assessments completed for children during the year undertaken in the secure estate	FY
CHASS	CH/011	Of those assessments completed during the year	FY
CHASS	CH/011a	The number where physical punishment by a parent or carer was a factor	FY
CHASS	CH/11b	The number where physical punishment by a parent or carer was the only factor.	FY
CHASS	CH/012	The number of assessments that were completed within statutory timescales	FY
CHILDREN	**Reference**	**Measure**	**Report**
CHASS	CH/013	The number of new assessments that were requested by the child or family during the year where a previous assessment had been completed in the previous 12 months	FY
CHASS	CH/014	Of those identified above, the number where:	FY
CHASS	CH/014a	Needs were able to be met with a care and support plan	FY
CHASS	CH/014b	Needs were able to be met by any other means	FY
CHASS	CH/014c	There were no eligible needs to be met	FY
Plans			
CHPLA	CH/015	The total number of children with a care and support plan at 31st March	FY
CHPLA	CH/016	The total number of children with a care and support plan where needs are met through a direct payment at 31st March	FY

Reviews			
CHILDREN	**Reference**	**Measure**	**Report**
CHREV	CH/017	The number of reviews of care and support plans that were due during the year	FY
CHREV	CH/018	The number of reviews of care and support plans that were due during the year that were:	FY
CHREV	CH/018a	Child protection reviews	FY
CHREV	CH/018b	Children looked after reviews (including pathway plan reviews and pre adoption reviews)	FY
CHREV	CH/018c	Reviews of children in need of care and support	FY
CHREV	CH/18d	Reviews of support plans (Special guardianship orders, direct payments etc.)	FY
CHREV	CH/019	The number of reviews completed within statutory timescales that were:	FY
CHREV	CH/019a	Child protection reviews	FY
CHREV	CH/019b	Children looked after reviews (including pathway plan reviews and pre adoption reviews)	FY
CHREV	CH/019c	Reviews of children in need of care and support	FY
CHREV	CH/019d	Reviews of support plans (Special guardianship orders, direct payments etc.)	FY
CHREV	CHNEW4	The number and % of reviews held with an up-to-date MYCSP	FY
CHREV	CHNEW5	The number and % of reviews held WITHOUT an up-to-date MYCSP	FY
CHREV	CHNEW6	Number of Foster Carer Reviews completed - Annual	FY
CHREV	CHNEW7	Number of Foster Carer Reviews completed - Independent	FY
CHREV	CH/019e	The total number of reviews due during the year that were not completed during the year	FY

Safeguarding			
CHSAF	CHNEW8	Number of S.46 (Police Protection Orders) within the year	FY
CHSAF	CH/020	The total number if initial strategy meetings held during the year	FY
CHSAF	CH/021	The total number of strategy discussions held during the year that progressed to section 47 enquiries	FY
CHSAF	CH/022	The total number of section 47 enquiries completed during the year that progressed to initial child protection conference	FY
CHSAF	CH023	The total number of children that were placed on the child protection register during the year under the category of	FY
CHSAF	CH/023a	Neglect	FY
CHSAF	CH/023b	Physical abuse	FY
CHSAF	CH/023c	Sexual abuse	FY
CHSAF	CH/023d	Emotional abuse	FY
CHSAF	CH/023e	Financial abuse	FY
CHSAF	CH/023f	Neglect and physical abuse	FY
CHSAF	CH/023g	Physical and sexual abuse	FY
CHSAF	CH/023h	Neglect and sexual abuse	FY
CHSAF	CH/023i	Neglect, physical and sexual abuse	FY
CHSAF	CH/023j	The number of children during the year not deemed to be at risk of significant harm at child protection conference but still have need for care and support	FY
CHSAF	CH/023k	The number of children during the year not deemed to be at risk of significant harm at child protection conference and no additional eligible need identified	FY
CHILDREN	**Reference**	**Measure**	**Report**

CHSAF	CH/024	Of those children who were placed on the child protection register during the year, the number that have been previously registered under any category at any time during the previous 12 months	FY
CHSAF	CH/025	The total number of initial child protection conferences held within statutory timescales	FY
CHSAF	CH/026	The total number of children on the child protection register at 31st March	FY
CHSAF	CHNEW9	Number of children on the CP Register for over two years as at the end of the period	FY
CHSAF	CH/027	The total number of initial core group meetings held during the year	FY
CHSAF	CH/028	The total number of initial core group meetings held during the year that were held within statutory timescales	FY
CHSAF	CH/029	The total number of visits to children placed on the child protection register that were due during the year	FY
CHSAF	CH/030	The total number of visits to children placed on the child protection register that were due during the year that were held within statutory guidelines	FY
CHSAF	CH/031	The total number of reports of children who go missing during the year	FY
CHSAF	CH/032	Of those the total number of children that these incidences relate to	FY
CHSAF	CH/033	The total number of reports of child exploitation received during the year	FY
CHSAF	CH/033a	The total number of reports of child exploitation received during the year that were:	FY
		Child Sexual Exploitation	FY
CHSAF	CH/033b	Child Criminal Exploitation	FY
CHSAF	CH/033c	Human Trafficking	FY
CHSAF	CHNEW10	Number of children who have had moderate or high SERAFs completed in the last period	FY
CHSAF	CHNEW11	Of the above, what % are in receipt of a Care & Support Plan (NOT on the CPR)?	FY
CHSAF	CHNEW12	Of the above, what % are subject to a Child Protection Plan?	FY
CHILDREN	**Reference**	**Measure**	**Report**
CHSAF	CHNEW13	Of the above, what % are Looked After Children?	FY

CHSAF	CHNEW14	Number of CSE priority perpetrators identified	FY
CHSAF	CHNEW15	Number of Registered Sex Offenders (RSOs)	FY
CHSAF	CH/035	The total number of days on the child protection register for children who were removed from the register during the year	FY
CHSAF	CH/036	The total number of children removed (de-registered) from the child protection register during the year	FY
CHSAF	CHNEW16	Number of Missing Children in total	FY
CHSAF	CHNEW17	Number of children missing on more than 3 occasions that have triggered a strategy meeting during the period	FY
CHSAF	CHNEW18	The Number of Family Group Conferences that took place during the period	FY
CHSAF	CHNEW19	The Number of Reviews of Family Group Conferences that took place during the period	FY
CHSAF	CHNEW20	The Number of Special Guardianship Orders given during the period	FY
CHSAF	CHNEW21	The average length of time for all children who were on the CPR during the year	FY
CHSAF	CHNEW22	The percentage of looked after children returned home from care during the year	FY
CHSAF	CHNEW23	The percentage of children supported to remain living within their family at 31 March	FY

ACES			
CHILDREN	**Reference**	**Measure**	**Report**
CHACE	CHNEW24	Number of children subject to a Child Protection Plan at the end of this year	FY
CHACE	CHNEW25	of these, number of children subject to a Child Protection Plan where Domestic Abuse features within the home	FY
CHACE	CHNEW26	of these, number of children subject to a Child Protection Plan where Parental Substance Misuse features	FY
CHACE	CHNEW27	of these, number of children subject to a Child Protection Plan where Parental Mental Health features	FY
CHACE	CHNEW28	Of these, number of children subject to a Child Protection Plan where all of the above 'Toxic Three' Risk Factors feature	FY
CHACE	CHNEW29	of these, number of children subject to a Child Protection Plan who have also experienced other household ACEs (for example, parental separation or incarceration of one or more household members)	FY
CHACE	CHNEW30	Number of Domestic Incidents involving children recorded	FY

Looked after children			
CHILDREN	**Reference**	**Measure**	**Report**
CHLAC	CH/037a	The number of children becoming looked after during the year	FY
CHLAC	CH/037b	The number of new episodes of children becoming looked after during the year	FY
CHLAC	CH/037c	The number of new episodes of children becoming looked after where the total concurrent time in care lasted 10 working days or more.	FY
CHLAC	CHNEW31	No. of Young People Looked After Reunifications - in year	FY
CHLAC	CHNEW32	No. of Young People Looked After Discharges of Care- in year	FY
CHLAC	CHNEW33	Number of pre-birth child protection conferences convened during the year	FY
CHLAC	CHNEW34	No. of Young People Looked After starting a residential placement	FY
CHLAC	CHNEW35	No. of Young People Looked After ending a residential placement	FY
CHLAC	CH/038	The number of part 6 care and support plans that were completed within 10 working days of the children becoming looked after	FY
CHLAC	CH/039	The number of children looked after at 31st March	FY
CHLAC	CH/040	The number of children receiving (S76) short breaks at 31st March	FY
CHLAC	CH/041	The number of statutory visits for children looked after that were due during the year	FY
CHILDREN	**Reference**	**Measure**	**Report**
CHLAC	CH/042	The number of visits to children looked after that were completed within statutory timescales	FY
CHLAC	CH/043	The total number of children looked after at 31st March who have experienced 3 or more placements during the year	FY

CHLAC	CH/044	The total number of children looked after on 31st March who have experienced one or more changes in school during the year (excluding transitional arrangements, moves associated with adoption or moving home)	FY
CHLAC	CH/045	The total number of children looked after who returned home during the year	FY
CHLAC	CH/046	The total number of children looked after who are not placed with parents family or friends	FY
CHLAC	CH/047	The total number of children looked after who are placed within Wales but outside of the responsible local authority	FY
CHLAC	CH/048	The total number of children looked after who are placed outside of Wales	FY
CHLAC	CH/049	The total number of initial pathway plans due to be completed during the year	FY
CHLAC	CH/050	The number of initial pathway plans completed during the year that were within the statutory timescales	FY
CHLAC	CH/051	The total number of young people that required allocated a personal advisor during the year	FY
CHLAC	CH/052	The total number of care leavers who experience homelessness during the year (As defined by the Housing (Wales) Act 2014 within 12 months of leaving care	FY
CHLAC	CH/053	The total number of care experienced young people in the following categories at 31st March	FY
CHLAC	CH/053a	Category 1	FY
CHLAC	CH/053b	Category 2	FY
CHLAC	CH/053c	Category 4	FY
CHILDREN	**Reference**	**Measure**	**Report**
CHLAC	CH/054	Of those, the total number who have completed at least 3 consecutive months of employment, education or training in	FY
CHLAC	CH/054a	The 12 months since leaving care	FY

CHLAC	CH/054b	The 13-24 months since leaving care	FY
CHLAC	CH/055	The number of young people leaving care who move into a 'when I am ready' placement	FY

Advocacy			
CHILDREN	**Reference**	**Measure**	**Report**
CHADV	CH/056	The total number of children during the year who receive the Active Offer of advocacy	FY
CHADV	CH/057	Of these, the total number where an independent advocate was provided.	FY

Health and Education			
CHILDREN	**Reference**	**Measure**	**Report**
CHHED	CHNEW36	Number of children that the Local Authority are aware of that are Electively Home Educated (EHE)	FY
CHHED	CHNEW37	% of the above that have NOT received an annual visit in the last 12 months	FY
CHHED	CHNEW38	Number of EHE children that have received an annual visit in the last 12 months	FY
CHHED	CHNEW39	% of the above where the child was spoken to as part of the visit	FY
CHHED	CHNEW40	% of known EHE children (P3.1) who have deregistered in the last 12 months	FY
CHHED	CHNEW41	% of EHE children known to the Local Authority that have had contact with at least one other professional in the last 12 months	FY
CHHED	CHNEW42	Percentage of applicable children achieving the core subject indicator at Key Stage 2	FY
CHHED	CHNEW43	Percentage of applicable children achieving the core subject indicator at Key Stage 4	FY
CHHED	CHNEW44	The percentage of children seen by a registered dentist within 3 months of becoming looked after (PMC30)	FY
CHHED	CHNEW45	The percentage of children looked after at 31 March who were registered with a GP within 10 working days of the start of their placement (PMC31)	FY
CHHED	CHNEW46	Admissions to Hospital following deliberate Self-Harm (by gender) of looked after children	FY

Staff/Safer Workplace:

Staff/Safer Workplace	Reference	Measure	Report
	SWNEW1	The number of vacant posts that were advertised during the year	FY
	SWNEW2	The number of vacant posts which were successfully recruited to	FY
	SWNEW3	% of staff and volunteers commencing in post with two references, a DBS check and professional registrations, where applicable in the year	FY
	SWNEW4	% of relevant staff who have completed Safeguarding Children Training in the year	FY
	SWNEW5	% of relevant staff who have completed Safeguarding Adults Training in the year	FY
	SWNEW6	% of new starters who have completed Safeguarding Children & Adults Training in the year	FY
	SWNEW7	Number of Professionals who have been identified in Safeguarding Children Part 4 or Safeguarding Enquiries	FY
	SWNEW8	% of the above allegations that were substantiated	FY
	SWNEW9	Number of Professionals who have been identified in Safeguarding Adults Professional Concern or Safeguarding Enquiries	FY
	SWNEW10	% of the above allegations that were substantiated	FY
	SWNEW11	Number of occasions the Resolution of Professional Differences Policy has been formally instigated	FY

Please note, established KPIs under the categories of Young Carer and Adult Carer are not reported here as no suggested changes have been made.

Appendix 2. LA (additional) KPIs matched across key thematic areas identified from Work-Stream 1 (Report 2).

Relevant thematic concerns identified	Measures added	Notes
Joined- up Safeguarding Process, seamless service, Escalation of Risk, Increased Need and Service Adaption, Informing Practice: Trends, Demand and Gaps	The percentage of adults who completed a period of reablement and had no package of care 6 months later	Measures improvement based on reablement - no further care
	The average length of time older people (aged 65 or over) are supported in residential care homes	Collect more info about those in care homes - develop trend data about length of care and average age needed.
	Average age of adults entering residential care homes	
	Number of adults reported more than once for the same category of abuse or neglect during the year	Digging deeper into cases with multiple needs
	Number of adults reported for different categories of abuse or neglect during the year	
	The total number of adults with a care and support plan where needs are met through a Direct Payment at 31 March	More monitoring on charging
	Number of urgent DoLS applications received	Deprivation of Liberty monitoring
	% of Urgent authorisations received that were completed within 7 days of receipt	
	Number of Standard DoLS applications received	
	% of Standard authorisations that were completed within 21 days of allocation	
	Number of applications received that were withdrawn or inappropriate	

Joined- up Safeguarding Process, seamless service, Escalation of Risk, Increased Need and Service Adaption, Informing Practice: Trends, Demand and Gaps, Service Consistency, Resource and Accessibility, Holistic Safeguarding Responsibility: Thresholds, Consent, Confidence and Competence	The number of new assessments completed for children during the year that were completed within statutory timescales	To ensure assessment timescales are being met
	Number of assessments for children completed before child was born	To capture concerns for pre-birth and new bord children.
	The total number of assessments for children completed during the year for children who were born at the time the assessment concluded	
	The number and % of reviews held with an up-to-date MYCSP	Capture MyCSP data
	The number and % of reviews held WITHOUT an up-to-date MYCSP	
	Number of Foster Carer Reviews completed - Annual	Complete reviews of foster carers
	Number of Foster Carer Reviews completed - Independent	
	Number of S.46 (Police Protection Orders) within the year	Capture s46 as well as s47
	Number of children on the CP Register for over two years as at the end of the period	Capture longer term CP activity
	Number of children who have had moderate or high SERAFs completed in the last period	Capture more info in children who may be at risk of sexual exploitation
	Of the above, what % are in receipt of a Care & Support Plan (NOT on the CPR)?	
	Of the above, what % are subject to a Child Protection Plan?	
	Of the above, what % are Looked After Children?	
	Number of CSE priority perpetrators identified	
	Number of Registered Sex Offenders (RSOs)	

	Number of Missing Children in total	Missing children info recording
	Number of children missing on more than 3 occasions that have triggered a strategy meeting during the period	
	The Number of Family Group Conferences that took place during the period	Family group conference recording
	The Number of Reviews of Family Group Conferences that took place during the period	
	The Number of Special Guardianship Orders given during the period	Guardianship data recording
	The average length of time for all children who were on the CPR during the year	Further data monitoring for looked after children
	The percentage of looked after children returned home from care during the year	
	The percentage of children supported to remain living within their family on 31 March	
	Number of children subject to a Child Protection Plan at the end of this year	Specific ACES Monitoring
	of these, number of children subject to a Child Protection Plan Where Domestic Abuse features within the home	
	of these, number of children subject to a Child Protection Plan Where Parental Substance Misuse features	
	of these, number of children subject to a Child Protection Plan Where Parental Mental Health features	

	Of these, number of children subject to a Child Protection Plan where all of the above 'Toxic Three' Risk Factors feature	
	of these, number of children subject to a Child Protection Plan who have also experienced other household ACEs (for example, parental separation or incarceration of one or more household members)	
	Number of Domestic Incidents involving children recorded	
	No. of Young People Looked After Reunifications - in year	Capture more detail on residential placement
	No. of Young People Looked After Discharges of Care- in year	
	Number of pre-birth child protection conferences convened during the year	
	No. of Young People Looked After starting a residential placement	
	No. of Young People Looked After ending a residential placement	
	Number of children that the Local Authority are aware of that are Electively Home Educated (EHE)	To capture safeguarding info around health and education.
	% of the above that have NOT received an annual visit in the last 12 months	
	Number of EHE children that have received an annual visit in the last 12 months	
	% of the above where the child was spoken to as part of the visit	
	% of known EHE children who have deregistered in the last 12 months	

	% of EHE children known to the Local Authority that have had contact with at least one other professional in the last 12 months	
	Percentage of applicable children achieving the core subject indicator at Key Stage 2	
	Percentage of applicable children achieving the core subject indicator at Key Stage 4	
	The percentage of children seen by a registered dentist within 3 months of becoming looked after	
	The percentage of children looked after at 31 March who were registered with a GP within 10 working days of the start of their placement	
	Admissions to Hospital following deliberate Self-Harm (by gender) of looked after children	
Multi-disciplinary Teams, Consultation and Training, Established Relationships and Workforce Stability, Professional Challenge and Reflection, Practitioner Wellbeing and Support	The number of vacant posts that were advertised during the year	Service ineffective when not properly staffed. Staff and client wellbeing depends on effective and trained staff with manageable workloads
	The number of vacant posts which were successfully recruited to	
	% of staff and volunteers commencing in post with two references, a DBS check and professional registrations, where applicable in the year	Appropriately qualified staff employed
	% of relevant staff who have completed Safeguarding Children Training in the year	Top up training essential for CPD

	% of relevant staff who have completed Safeguarding Adults Training in the year	
	% of new starters who have completed Safeguarding Children & Adults Training in the year	Appropriately qualified staff employed
	Number of Professionals who have been identified in Safeguarding Children Part 4 or Safeguarding Enquiries	Staff performance monitoring
	% of the above allegations that were substantiated	
	Number of Professionals who have been identified in Safeguarding Adults Professional Concern or Safeguarding Enquiries	
	% of the above allegations that were substantiated	
	Number of occasions the Resolution of Professional Differences Policy has been formally instigated	
Partnership Working with Service Users and Families, Service Consistency, Resource and Accessibility, Escalation of Risk, Increased Need and Service Adaption	No Additions	
Partnership Working with Service Users and Families, Service Consistency, Resource and Accessibility, Escalation of Risk, Increased Need and Service Adaption	No Additions	

Appendix 3. Effective Child Protection Model

ECP Project Evaluation

Data 2020/21 and 2021/22 (to December)

Introduction

The Chair in Case Conferences monitors several key performance matters. Of relevance to the ECP Evaluation there are two key data sets.

Data set 1 (Diogelu 1 and 2)

Data set 2 (ECP Monitoring data)

These have been in place and monitored over several years. We provide there fore the whole year performance figures.

Data set 1 (Diogelu 1 and 2)

Diogelu 1 is collected by getting sheets into the office after supervision from social workers/ managers, confirming which of a caseload were considered for risk screening. The purpose of the data is to encourage compliance. It is a slightly dubious method as we can only collect those received and whilst we do follow up, it proves difficult to get the whole dataset of supervisions in. it results in a slight 'halo bias.' Those who send in the sheet have done the risk screening as well. The out-turn has always been 100%.

Diogelu 2 is collected by Chair in Case Conferences and is their opinion about the quality of the risk assessment. Its purpose was to see effect of the implementation in general of the Risk Model and use of R2 in Case Conference Reports. This has exceeded 95% consistently.

Data set 2 (ECP Monitoring data)

More recently introduced and again part of the Chair's quality assurance role in Case Conferences. They fill in a Monitoring Report[12] in each Case Conference. There is whole year data for year 1 COVID (2020/21) and performance quarter Q1-Q3 of 2021/22. I think it shows general improvement and consistency.

However, the ECP project has been implemented in stages. Initially, focussed on Meirion/Dwyfor then Derwen (children with disabilities) then 16+. Finally, the two Arfon Teams. Derwen and 16+ do very little CP work in comparison to Meirion/Dwyfor and Arfon. The Arfon teams are interesting, being a mix of lukewarm welcome to the project at the beginning and staffing turmoil in the later period. As such, the project was gearing up to engaging those Teams and gaining momentum as COVID happened.

We've also had the revolving 'CP Chair' effect as Sue Adams retired in Sept 2020 and Non Davies helped us as interim Chair until December 2021. Delyth Davies was appointed but not released from her IRO role fully until recently.

There are two detailed ECP Monitoring spreadsheets[13] available that give a more granular breakdown of that data. In terms of how the project uses the data to manage the performance and implementation, we are very sighted on Diogelu 1 and 2 for several years. ECP Monitoring is less

[12] Copy of document attached to email.
[13] The spreadsheets are attached to the email

useful as a performance report. The detail leads to many questions. However, the effect of collecting the data is that it constantly draws the attention of the Chairs to what is considered important to be able to report on. Therefore, they will keep this foremost in mind. It enhances more than anything their governance effect on ECP matters in conferences and how they structure the discussions and challenge. That is the intention of the monitoring work; in addition, of course to provide some data for evaluation purposes.

Dafydd Paul

Senior Manager Safeguarding

16/02/2022

Data set 1 (Diogelu 1 and 2)

Diogelu 1

Proportion of children discussed in supervision, where consideration was given to risk of significant harm (and the answer recorded)/ *Cyfradd y plant a gafodd eu trafod mewn goruchwyliaeth, lle rhoddwyd ystyriaeth i niwed sylweddol (a'r ateb wedi ei gofnodi)*

	2017/18	2018/19	2019/20	2020/21	2021/22
Yes	100%	100%	100%	100%	100%
No	0%	0%	0%	0%	0%

Diogelu 2

Proportion of risk assessments presented to Case Conferences that were considered to indicate quality in decision making / Cyfradd yr asesiadau risg a gafodd eu cyflwyno i Gynadleddau Achos a oedd yn cael eu hystyried yn rhai a oedd yn dangos ansawdd wrth wneud penderfyniadau

	2017/18	2018/19	2019/20	2020/21	2021/22
Yes	96%	99%	99%	97%	99%
No	4%	1%	1%	3%	1%

Data set 2 (ECP Monitoring)

Initial Case Conferences	2020/21	2021/22
	Yes	Yes
In the opinion of the Chairperson has the conference identified the change(s) that the child/family need(s) to make	100%	94%
In the opinion of the Chairperson has the conference identified the 2 and 8 statements for each change?	86%	75%

In the opinion of the Chairperson had the conference worked in a collaborative way (for example, mutual respect, opportunity for all to contribute, constructive, recognition of family strengths)?	78%	67%
In the opinion of the Chairperson does the family/child understand the change (s) that need to happen	75%	69%
In the opinion of the chairperson does the child/family understand their part in this work	64%	62%
Review Case Conferences	2020/21	2021/22
	Yes	Yes
In the opinion of the Chairperson has the conference identified the change (s) that the child/family needs to make	86%	90%
In the opinion of the Chairperson has the risk of significant harm been reduced since the last conference?	68%	66%
In the opinion of the Chairperson has the conference identified the 2 and 8 statements for each change?	75%	71%
In the opinion of the Chairperson had the conference worked in a collaborative way (for example, mutual respect, opportunity for all to contribute, constructive, recognition of family strengths)?	84%	87%
In the opinion of the chairperson does the child/family understand the change(s) that need to happen	81%	86%
In the opinion of the chairperson does the child/family understand their part in this work	77%	75%
In the opinion of the chairperson is the child/family working on the change as part of the Core Group?	76%	85%
In the opinion of the chairperson is the child/family fully and effectively included in the Core Group	76%	85%
Progress checked in Review Case Conferences	2020/21	2021/22
	Yes	Yes

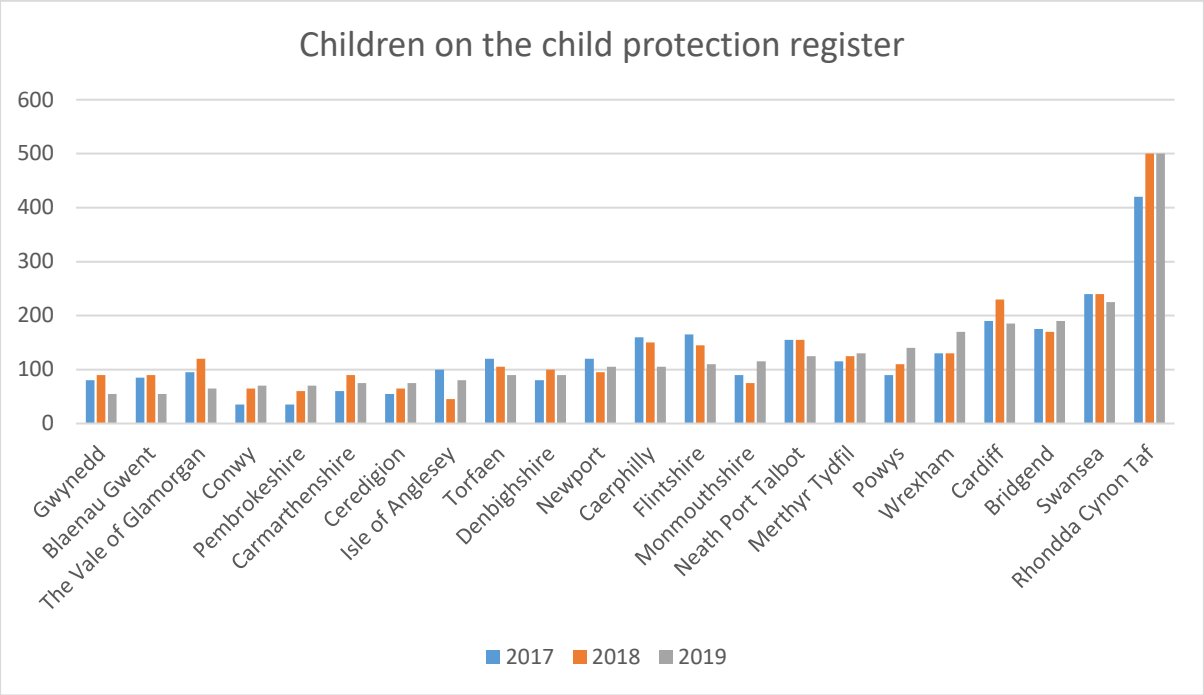
Has the Outcome/'Statement of change[14]' been recorded?	89%	98%
Score[15] has improved since previous conference - Arfon	66%	56%
Score has improved since previous conference - Dwyfor	70%	82%
Score has improved since previous conference - Meirionnydd	55%	67%
For information – where the scores have not been filled in the Social Worker's Report to Case Conference		
Blanks (score not filled) - Dwyfor	*26%*	*27%*
Blanks (score not filled) - Meirionnydd	*22%*	*6%*
Blanks (score not filled) - Arfon	*17%*	*2%*

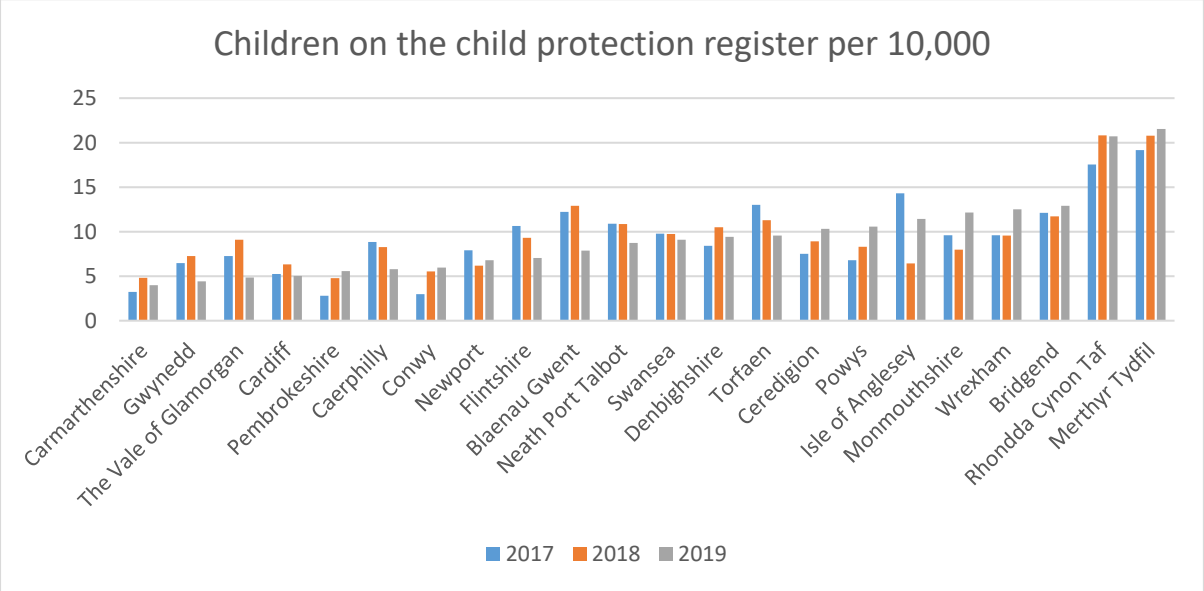
With thanks to Sharon Hughes and Yvonne Thomas Edwards for the data in this report.

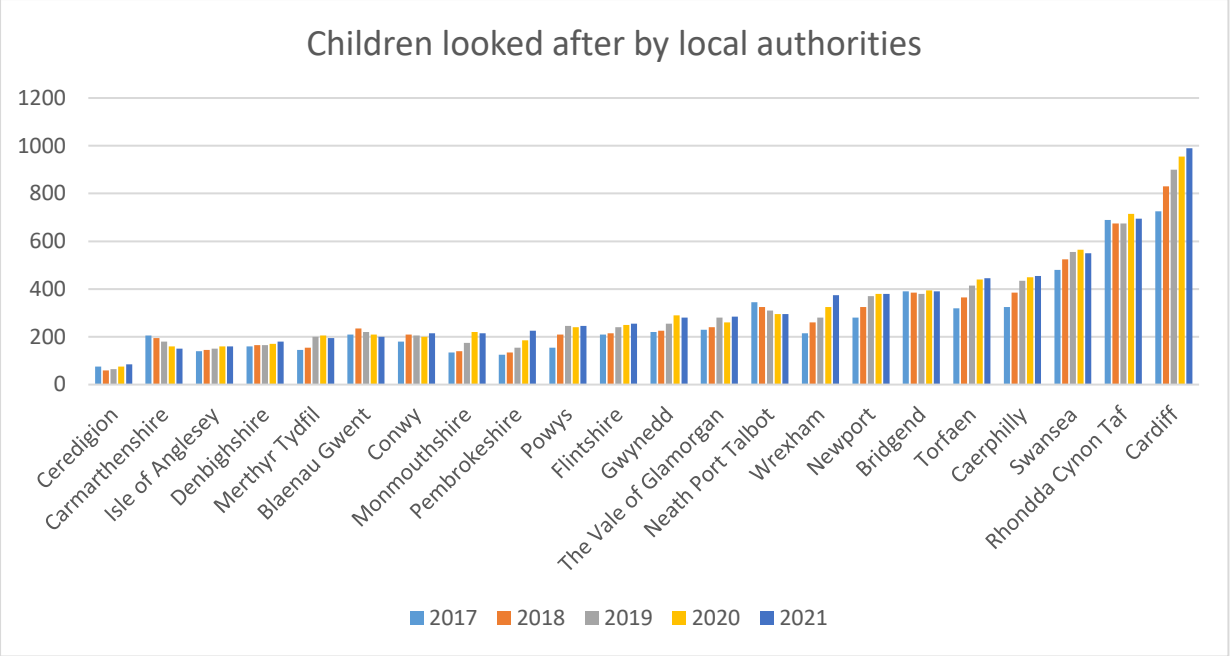
[14] The 'Statement of change' is what needs to change to keep the child safe.

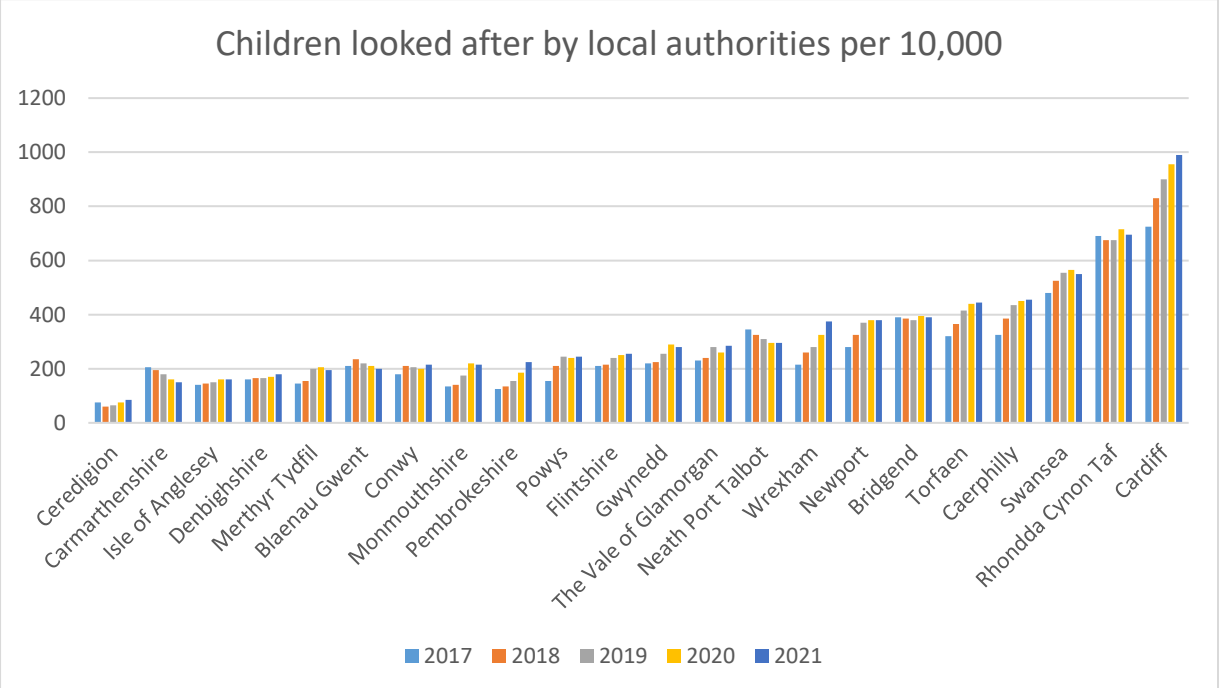
[15] 'Score' is the recording of scores of 2 to 8 in the Report.

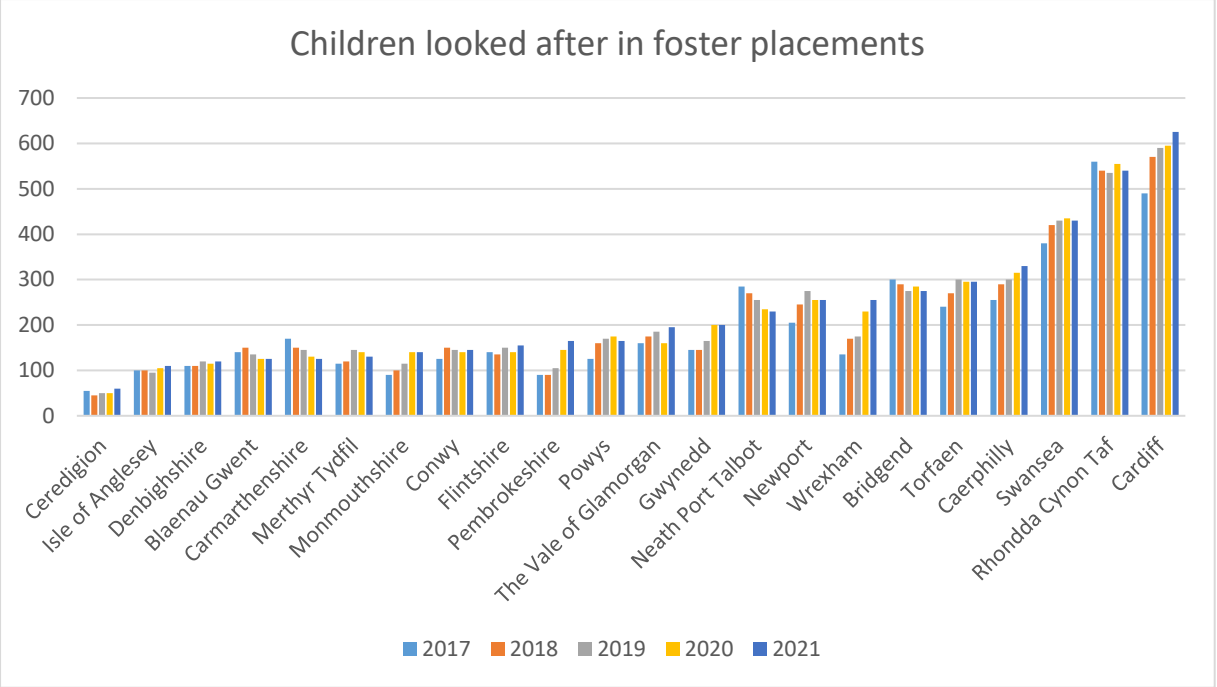
Appendix 4. National Safeguarding KPIs across each LA area

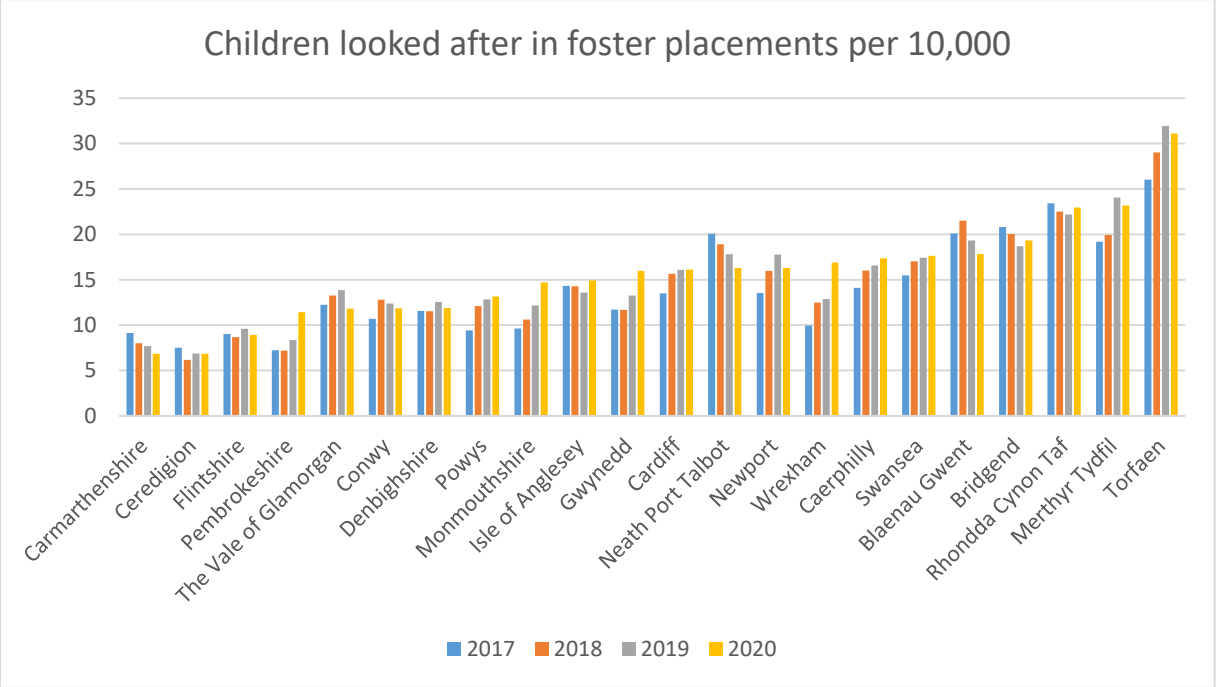


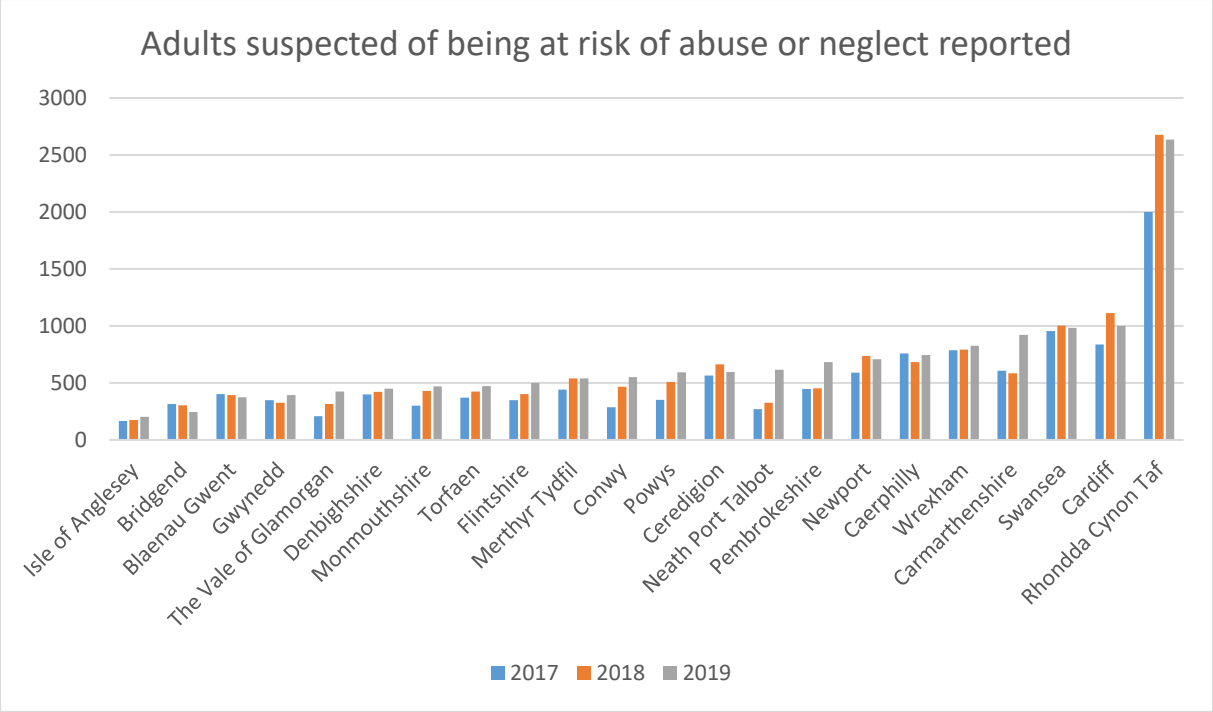


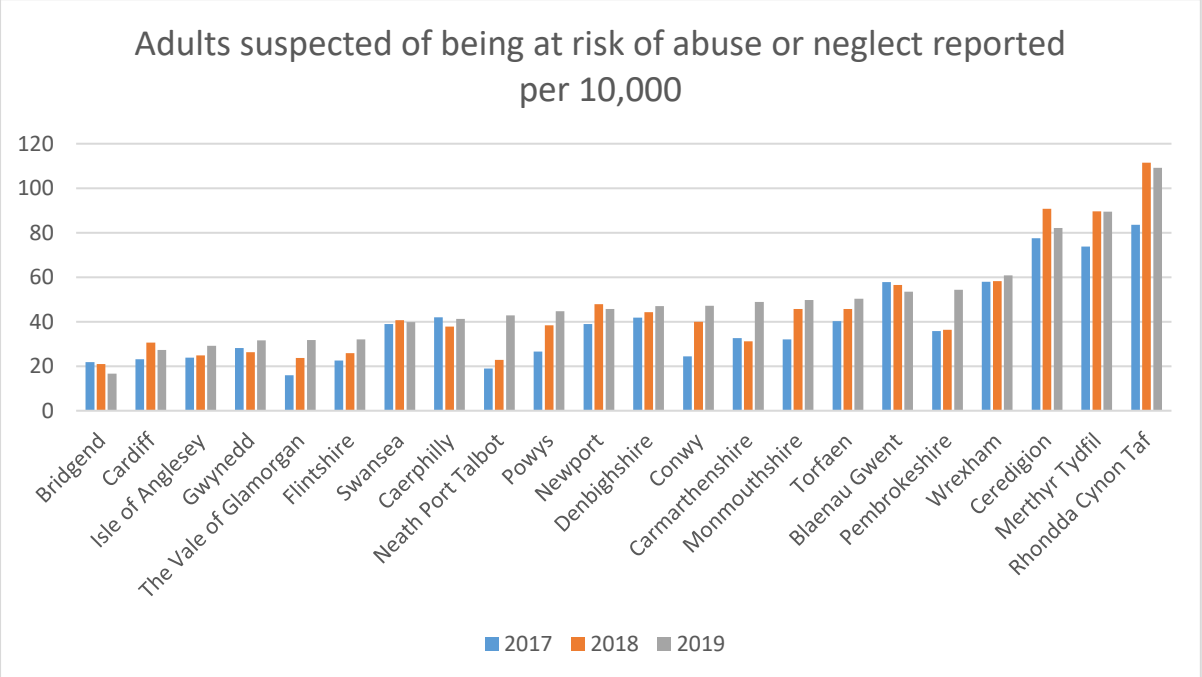

Children looked after by local authorities
1200
1000
800
600
400
200
0
Ceredigion
Carmarthenshire
Isle of Anglesey
Denbighshire
Merthyr Tydfil
Blaenau Gwent
Conwy
Monmouthshire
Pembrokeshire
Powys
Flintshire
Gwynedd
The Vale of Glamorgan
Neath Port Talbot
Wrexham
Newport
Bridgend
Torfaen
Caerphilly
Swansea
Rhondda Cynon Taf
Cardiff
2017
2018
2019
2020
2021

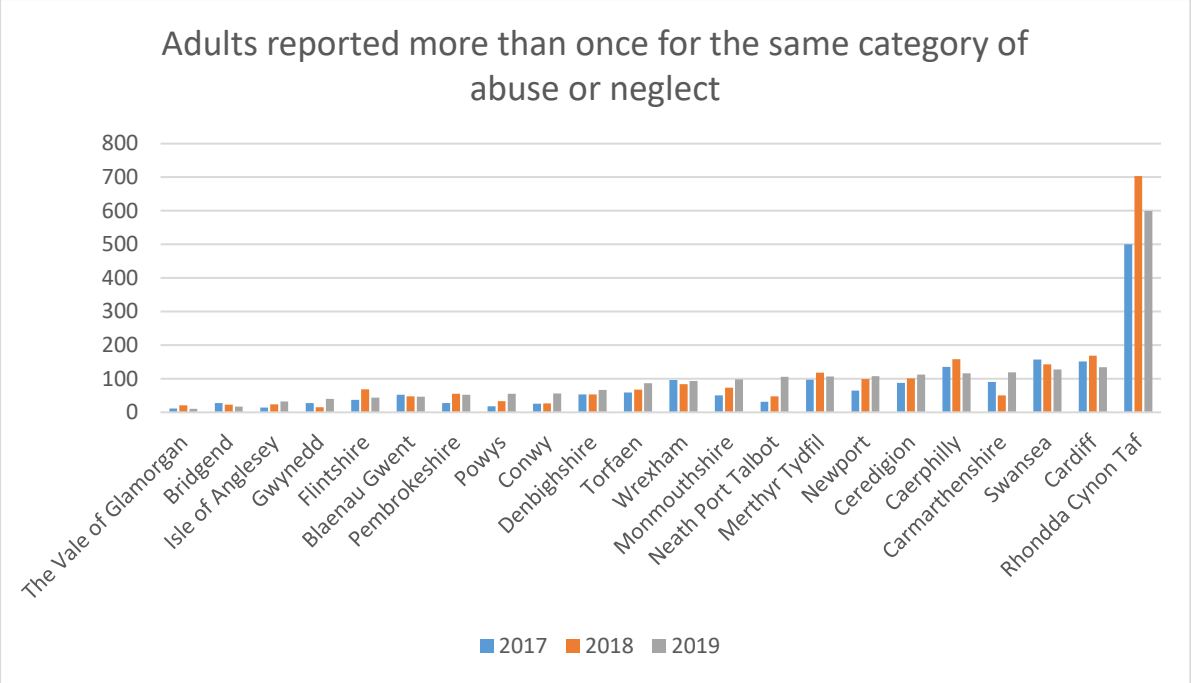

Children looked after by local authorities per 10,000
1200
1000
800
600
400
200
0
Ceredigion
Carmarthenshire
Isle of Anglesey
Denbighshire
Merthyr Tydfil
Blaenau Gwent
Conwy
Monmouthshire
Pembrokeshire
Powys
Flintshire
Gwynedd
The Vale of Glamorgan
Neath Port Talbot
Wrexham
Newport
Bridgend
Torfaen
Caerphilly
Swansea
Rhondda Cynon Taf
Cardiff
2017
2018
2019
2020
2021

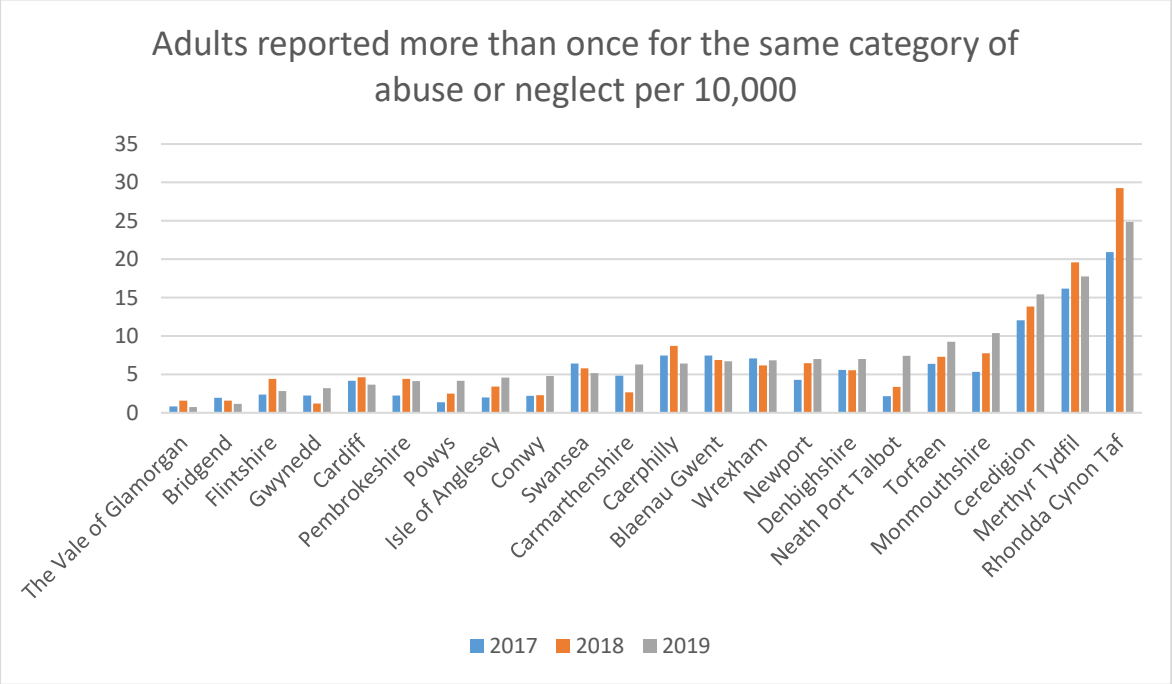

Children looked after in foster placements
700
600
500
400
300
200
100
0
Ceredigion
Isle of Anglesey
Denbighshire
Blaenau Gwent
Carmarthenshire
Merthyr Tydfil
Monmouthshire
Conwy
Flintshire
Pembrokeshire
Powys
The Vale of Glamorgan
Gwynedd
Neath Port Talbot
Newport
Wrexham
Bridgend
Torfaen
Caerphilly
Swansea
Rhondda Cynon Taf
Cardiff
2017
2018
2019
2020
2021

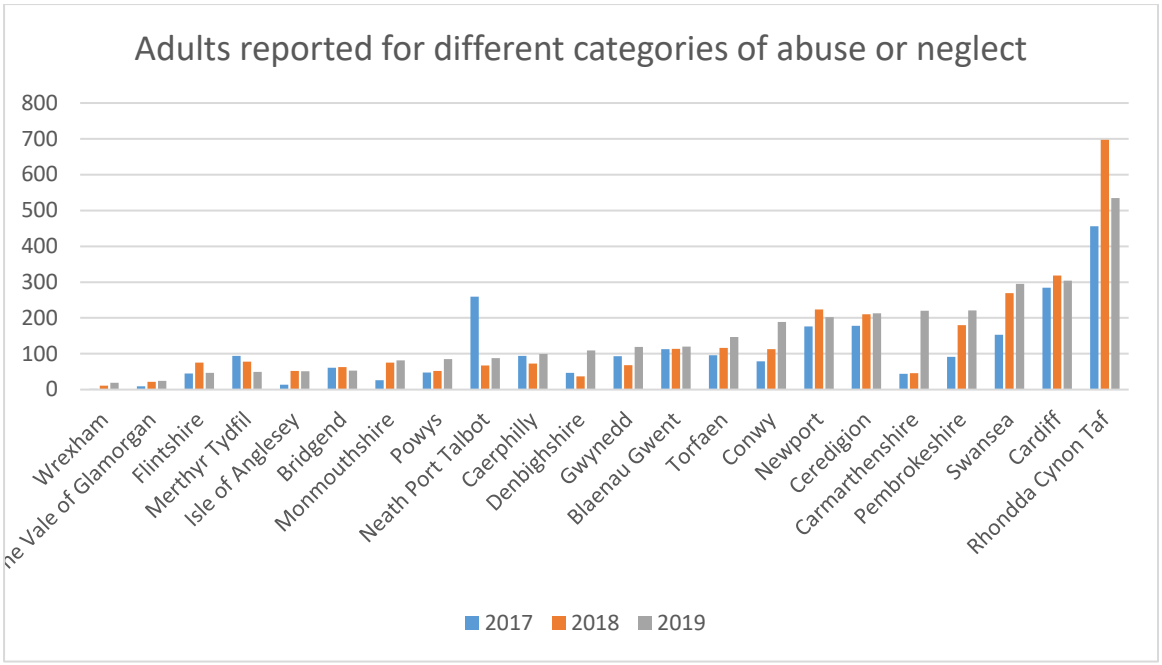

Children looked after in foster placements per 10,000
35
30
25
20
15
10
5
0
Carmarthenshire
Ceredigion
Flintshire
Pembrokeshire
The Vale of Glamorgan
Conwy
Denbighshire
Powys
Monmouthshire
Isle of Anglesey
Gwynedd
Cardiff
Neath Port Talbot
Newport
Wrexham
Caerphilly
Swansea
Blaenau Gwent
Bridgend
Rhondda Cynon Taf
Merthyr Tydfil
Torfaen
2017
2018
2019
2020

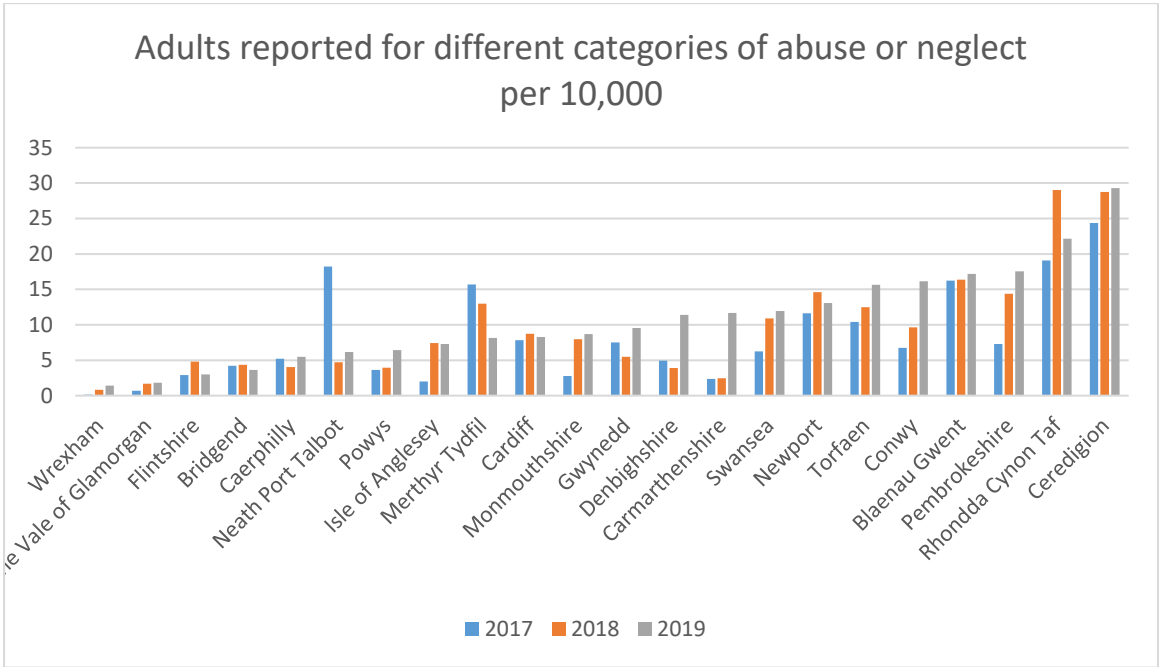

Adults suspected of being at risk of abuse or neglect reported
3000
2500
2000
1500
1000
500
0
Isle of Anglesey
Bridgend
Blaenau Gwent
Gwynedd
The Vale of Glamorgan
Denbighshire
Monmouthshire
Torfaen
Flintshire
Merthyr Tydfil
Conwy
Powys
Ceredigion
Neath Port Talbot
Pembrokeshire
Newport
Caerphilly
Wrexham
Carmarthenshire
Swansea
Cardiff
Rhondda Cynon Taf
2017
2018
2019

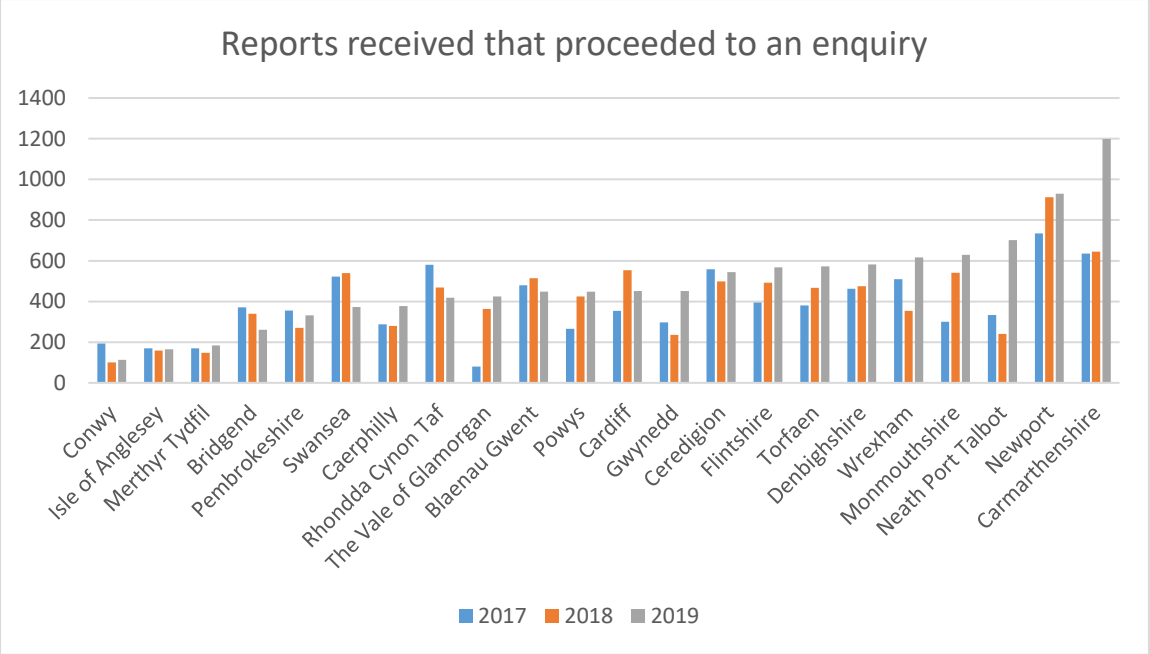

Adults suspected of being at risk of abuse or neglect reported per 10,000
120
100
80
60
40
20
0
Bridgend
Cardiff
Isle of Anglesey
Gwynedd
The Vale of Glamorgan
Flintshire
Swansea
Caerphilly
Neath Port Talbot
Powys
Newport
Denbighshire
Conwy
Carmarthenshire
Monmouthshire
Torfaen
Blaenau Gwent
Pembrokeshire
Wrexham
Ceredigion
Merthyr Tydfil
Rhondda Cynon Taf
2017
2018
2019

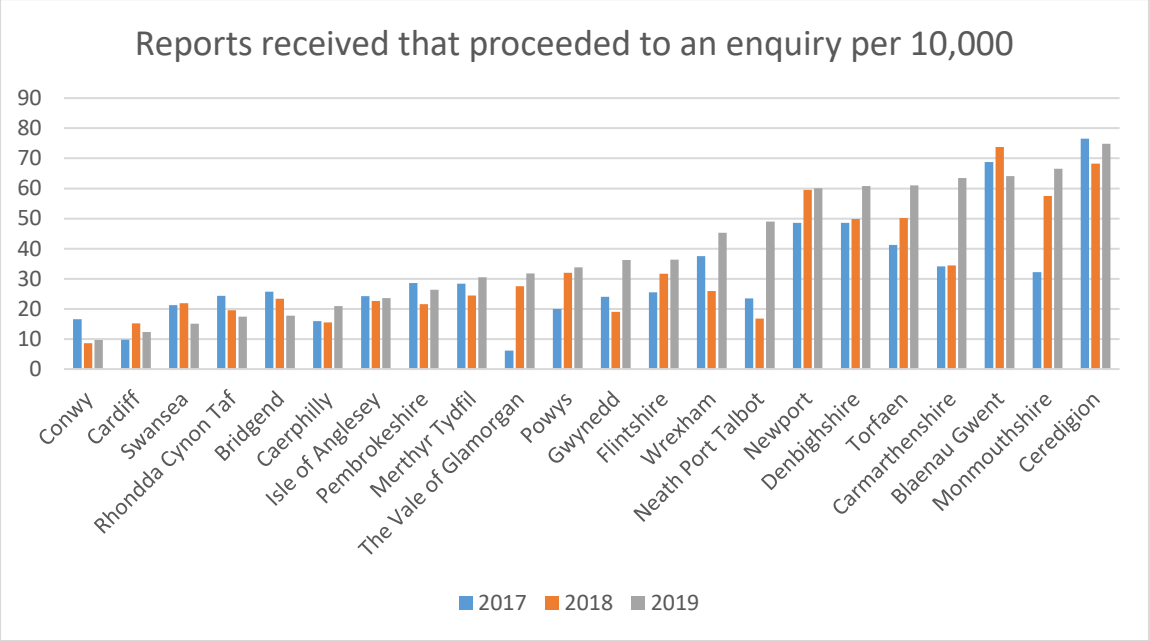

Adults reported more than once for the same category of abuse or neglect
800
700
600
500
400
300
200
100
0
The Vale of Glamorgan
Bridgend
Isle of Anglesey
Gwynedd
Flintshire
Blaenau Gwent
Pembrokeshire
Powys
Conwy
Denbighshire
Torfaen
Wrexham
Monmouthshire
Neath Port Talbot
Merthyr Tydfil
Newport
Ceredigion
Caerphilly
Carmarthenshire
Swansea
Cardiff
Rhondda Cynon Taf
2017
2018
2019

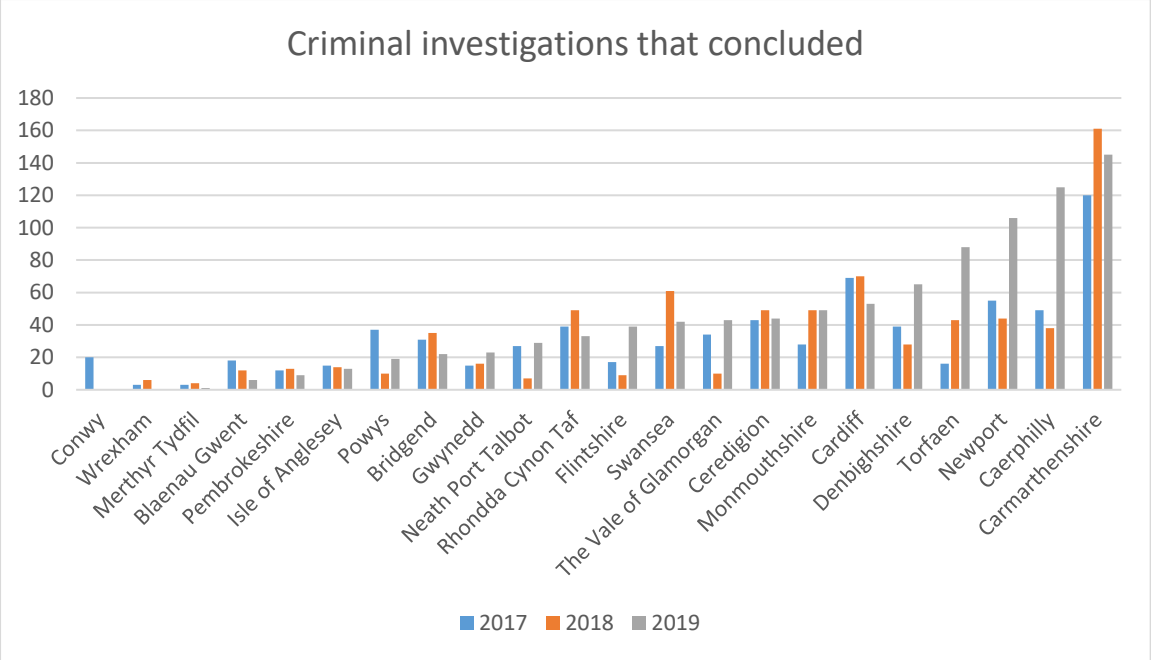

Adults reported more than once for the same category of abuse or neglect per 10,000
35
30
25
20
15
10
5
0
The Vale of Glamorgan
Bridgend
Flintshire
Gwynedd
Cardiff
Pembrokeshire
Powys
Isle of Anglesey
Conwy
Swansea
Carmarthenshire
Caerphilly
Blaenau Gwent
Wrexham
Newport
Denbighshire
Neath Port Talbot
Torfaen
Monmouthshire
Ceredigion
Merthyr Tydfil
Rhondda Cynon Taf
2017
2018
2019

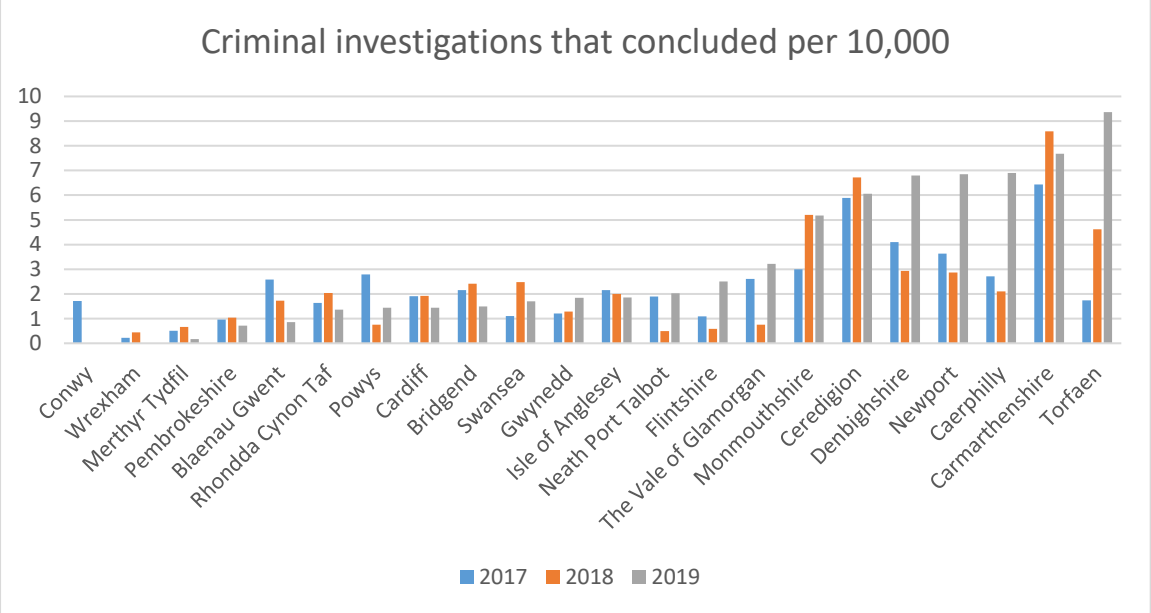

Adults reported for different categories of abuse or neglect
800
700
600
500
400
300
200
100
0
Wrexham
Vale of Glamorgan
Flintshire
Merthyr Tydfil
Isle of Anglesey
Bridgend
Monmouthshire
Powys
Neath Port Talbot
Caerphilly
Denbighshire
Gwynedd
Blaenau Gwent
Torfaen
Conwy
Newport
Ceredigion
Carmarthenshire
Pembrokeshire
Swansea
Cardiff
Rhondda Cynon Taf
2017
2018
2019

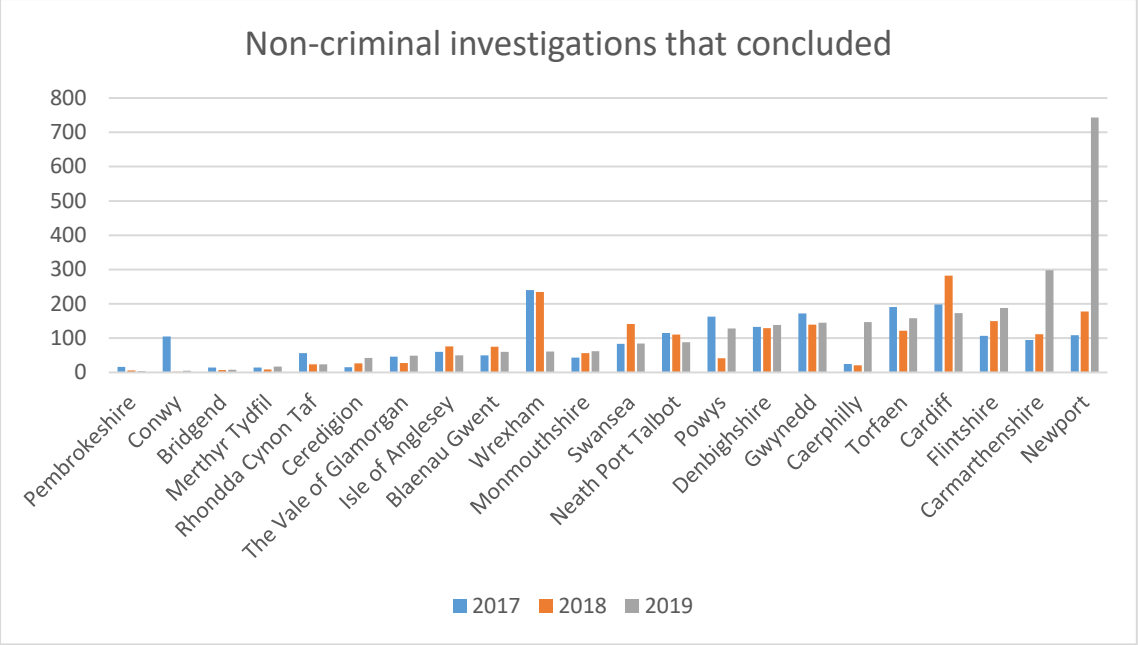

Adults reported for different categories of abuse or neglect per 10,000
35
30
25
20
15
10
5
0
Wrexham
Vale of Glamorgan
Flintshire
Bridgend
Caerphilly
Neath Port Talbot
Powys
Isle of Anglesey
Merthyr Tydfil
Cardiff
Monmouthshire
Gwynedd
Denbighshire
Carmarthenshire
Swansea
Newport
Torfaen
Conwy
Blaenau Gwent
Pembrokeshire
Rhondda Cynon Taf
Ceredigion
2017
2018
2019

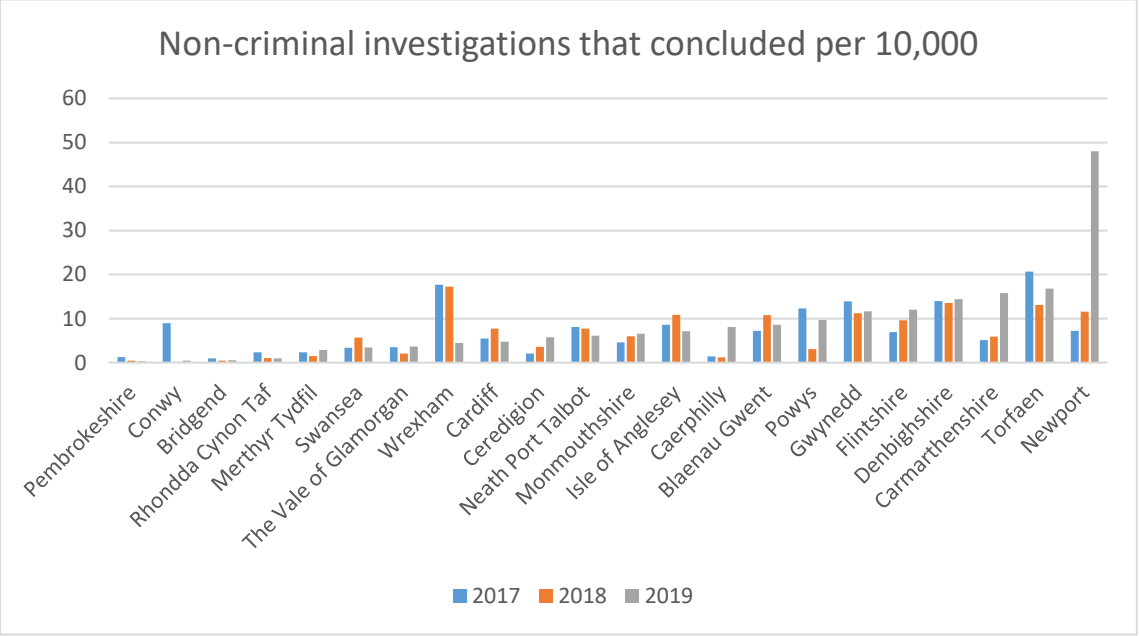

Reports received that proceeded to an enquiry
1400
1200
1000
800
600
400
200
0
Conwy
Isle of Anglesey
Merthyr Tydfil
Bridgend
Pembrokeshire
Swansea
Caerphilly
Rhondda Cynon Taf
The Vale of Glamorgan
Blaenau Gwent
Powys
Cardiff
Gwynedd
Ceredigion
Flintshire
Torfaen
Denbighshire
Wrexham
Monmouthshire
Neath Port Talbot
Newport
Carmarthenshire
2017
2018
2019


Reports received that proceeded to an enquiry per 10,000
90
80
70
60
50
40
30
20
10
0
Conwy
Cardiff
Swansea
Rhondda Cynon Taf
Bridgend
Caerphilly
Isle of Anglesey
Pembrokeshire
Merthyr Tydfil
The Vale of Glamorgan
Powys
Gwynedd
Flintshire
Wrexham
Neath Port Talbot
Newport
Denbighshire
Torfaen
Carmarthenshire
Blaenau Gwent
Monmouthshire
Ceredigion
2017
2018
2019


Criminal investigations that concluded
180
160
140
120
100
80
60
40
20
0
Conwy
Wrexham
Merthyr Tydfil
Blaenau Gwent
Pembrokeshire
Isle of Anglesey
Powys
Bridgend
Gwynedd
Neath Port Talbot
Rhondda Cynon Taf
Flintshire
Swansea
The Vale of Glamorgan
Ceredigion
Monmouthshire
Cardiff
Denbighshire
Torfaen
Newport
Caerphilly
Carmarthenshire
2017
2018
2019


Criminal investigations that concluded per 10,000
10
9
8
7
6
5
4
3
2
1
0
Conwy
Wrexham
Merthyr Tydfil
Pembrokeshire
Blaenau Gwent
Rhondda Cynon Taf
Powys
Cardiff
Bridgend
Swansea
Gwynedd
Isle of Anglesey
Neath Port Talbot
Flintshire
The Vale of Glamorgan
Monmouthshire
Ceredigion
Denbighshire
Newport
Caerphilly
Carmarthenshire
Torfaen
2017
2018
2019


Non-criminal investigations that concluded
800
700
600
500
400
300
200
100
0
Pembrokeshire
Conwy
Bridgend
Merthyr Tydfil
Rhondda Cynon Taf
Ceredigion
The Vale of Glamorgan
Isle of Anglesey
Blaenau Gwent
Wrexham
Monmouthshire
Swansea
Neath Port Talbot
Powys
Denbighshire
Gwynedd
Caerphilly
Torfaen
Cardiff
Flintshire
Carmarthenshire
Newport
2017
2018
2019


Non-criminal investigations that concluded per 10,000
60
50
40
30
20
10
0
Pembrokeshire
Conwy
Bridgend
Rhondda Cynon Taf
Merthyr Tydfil
Swansea
The Vale of Glamorgan
Wrexham
Cardiff
Ceredigion
Neath Port Talbot
Monmouthshire
Isle of Anglesey
Caerphilly
Blaenau Gwent
Powys
Gwynedd
Flintshire
Denbighshire
Carmarthenshire
Torfaen
Newport
2017
2018
2019

Appendix 5. Mapping of Well-being Outcomes, Quality Standards for Local Authorities and Measures (Welsh Gov, 2015).

National outcomes framework		**Performance measurement framework**	
Definition of well-being from the Social Services and Well-being (Wales) Act	**My well-being outcomes are informed by my rights and my responsibilities. When I co-produce my well-being with social services and their partners, the outcomes that I expect to achieve are:**	**Quality standard for local authorities**	**Measuring the quality standard**
Securing rights and entitlements **Also for adults: Control over day-to-day life**	I know and understand what care, support and opportunities are available and use these to help me achieve my well-being I can access the right information, when I need it, in the way I want it and use this to manage and improve my well-being I am treated with dignity and respect and treat others the same My voice is heard and listened to My individual circumstances are considered I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me	**1. Local authorities must work with people who need care and support and carers who need support to define and co-produce personal well-being outcomes that people wish to achieve.** In order to achieve this, in the exercise of their social services functions local authorities **must**: a) Work with partners to ensure access to clear and understandable information, advice and assistance to support people to actively manage their well-being and make informed decisions. b) Work with people, as partners, to prevent the need for care and support and with other partners to arrange services in a way that prevents or delays peoples need for care and support. c) Work with people as partners to undertake an assessment of personal well-being outcomes in a timely manner. d) Ensure decisions made have regard to a person's individual circumstances and the UN convention on the rights of children and the UN principles for older people and the UN convention on the rights of disabled people. e) Treat people with dignity and respect. f) Ensure people have control over the planning and delivery of their care. g) Arrange an independent advocate to facilitate the involvement of an individual where that person can only overcome the barrier(s) to fully participating in the process of determining, reviewing and meeting need, through the support of an advocate. h) Have in place suitable arrangements for assessing and determining need and eligibility. i) Ensure people who have a care and support plan have a named contact who shares relevant information with partners to allow a seamless transition of care and support across services. j) Ensure that the impact of the care and support on people's lives is measured, as well as the achievement of personal outcomes. k) Work with other professionals, including providers, to facilitate and lead a multi-disciplinary plan for care and support. l) Have in place suitable arrangements to make people aware of paying for care and charging arrangements.	• People reporting they have received the right information or advice when they needed it • People reporting they were treated with dignity and respect • People reporting that they felt involved in any decisions made about their care and support • People with a care and support plan reporting that they have been given written information of their named worker in social services • People who are satisfied with care and support that they received • The percentage of adults who have received support from the information, advice and assistance service and have not contacted the service again during the year • The percentage of assessments completed for children within statutory timescales

Physical and mental health and emotional well-being
 	
Also for children: Physical, intellectual, emotional, social and behavioural development
	I am healthy and active and do things to keep myself healthy
	I am happy and do the things that make me happy
	I get the right care and support, as early as possible
		2. Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.
		
		In order to achieve this, in the exercise of their social services functions local authorities **must**:
		
		a) Jointly develop with partners and people the means to promote and support people to maintain a healthy lifestyle.
		b) Support people to access services which enable them to maintain a good level of mental health and emotional well-being.
		c) Encourage and empower people to manage their own health and well-being, be active and benefit from proactive, preventative care and support.
			• The rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over
			• The percentage of adults who completed a period of reablement
			  ○ And have a reduced package of care and support 6 months later
			  ○ And have no package of care and support 6 months later
			• The average length of time older people (aged 65 or over) are supported in residential care homes
			• Average age of adults entering residential care homes
			• The percentage of children seen by a registered dentist within 3 months of becoming looked after
			• The percentage of looked after children registered with a GP

Protection from abuse and neglect	I am safe and protected from abuse and neglect I am supported to protect the people that matter to me from abuse and neglect I am informed about how to make my concerns known	**3. Local authorities must take appropriate steps to protect and safeguard people who need care and support and carers who need support from abuse and neglect or any other kinds of harm.** **Abuse, neglect and harm are defined in the Social Services and Well-being (Wales) Act 2014.** In order to achieve this, in the exercise of their social services functions local authorities **must**: a) Respond effectively to changing circumstances and regularly review achievement of personal well-being outcomes. b) Provide care and support to people where it is necessary to meet their assessed needs in order to protect them from abuse or neglect or a risk of abuse or neglect or to protect a child from harm or a risk of harm. c) Develop suitable arrangements for people who put their own safety or that of others at risk to prevent abuse and neglect. d) Support people to protect the people that matter to them from abuse and neglect. e) Manage risk in ways which empower people to feel in control of their life, consistent with safeguarding needs. f) Work in partnership with others to investigate allegations of abuse and neglect to ensure that people are protected from harm.	• People reporting that they feel safe • The percentage of adult protection enquiries completed within statutory timescales • The percentage of re-registrations of children on local authority Child Protection Registers (CPR) • The average length of time for all children who were on the CPR during the year
Education, training and recreation **Contribution made to society**	I can learn and develop to my full potential I do the things that matter to me I engage and make a contribution to my community I feel valued in society	**4. Local authorities must actively encourage and support people who need care and support and carers who need support to learn and develop and participate in society.** In order to achieve this, in the exercise of their social services functions local authorities **must**: a) Support people to do the things that matter to them to achieve their personal well-being outcomes. b) Help people to gain the skills and educational attainment they need to engage in things that matter to them. c) Encourage people to be active members of their communities, and to support each other in reducing social isolation.	• People reporting they can do what matters to them • People reporting they feel satisfied with their social networks • The percentage of children achieving the core subject indicator at key stage 2 and 4 • The percentage of looked after children who have experienced (1) or more changes of school, during a period or periods of being looked after, which were not due to transitional arrangements, in the year to 31 March
Domestic, family and personal relationships	I belong I contribute to and enjoy safe and healthy relationships	**5. Local authorities must support people who need care and support and carers who need support to safely develop and maintain healthy domestic, family and personal relationships.** In order to achieve this, in the exercise of their social services functions local authorities **must**: a) Work in partnership with people to investigate allegations of abuse and neglect and take action to ensure that people are protected from harm. b) Support people to maintain the relationships that matter to them, consistent with safeguarding needs. c) Help people to recognise unsafe relationships and protect themselves from abuse and neglect. d) Take the views of people's families, carers and other personal relationships into consideration when assessing their care and support needs, if appropriate. e) Provide people with stable and consistent care and support placements.	• People reporting that they feel a part of their community • The percentage of looked after children on 31 March who have had three or more placements during the year • Carers reporting they feel supported to continue in their caring role • Carers reporting they felt involved in designing the care and support plan for the person that they care for • Parents reporting that they felt involved in any decisions made about their child's care and support • The percentage of children supported to remain living within their family • The percentage of looked after children returned home from care during the year
Social and economic well-being **Also for adults: Participation in work** **Suitability of living accommodation**	I contribute towards my social life and can be with the people that I choose I do not live in poverty I am supported to work I get the help I need to grow up and be independent I get care and support through the Welsh language if I need it I live in a home that best supports me to achieve my well-being	**6. Local authorities must work with and support people who need care and support and carers who need support to achieve greater economic well-being, have a social life and live in suitable accommodation that meets their needs.** In order to achieve this, in the exercise of their social services functions local authorities **must**: a) Support people to participate as active citizens both economically and socially. b) Support people to access and sustain the ability to engage in meaningful work. c) Support people in accessing financial advice and help with benefits and grants. d) Provide access to services through the medium of Welsh, in line with the Welsh Governments' framework for Welsh Language, 'More Than Just Words' or in other languages of choice where necessary. e) Support people to access living accommodation that meets their needs and facilitates independent living.	• People reporting they have received care and support through their language of choice • People reporting that they live in the right home for them • People reporting they chose to live in a residential care home • Children and young people reporting that they are happy with who they live with • Young adults reporting they received advice, help and support to prepare them for adulthood • The percentage of all care leavers who are in education, training or employment at 12 months and 24 months after leaving care • The percentage of care leavers who have experienced homelessness during the year

Appendix 6. Framework of Inspection and Performance Evaluation (CIW, 2019)