Catholic Safeguarding Standards Agency

Diocesan Baseline Audit Programme 2022 – 2024

Overview Report

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1. Introduction

1.1 This is an overview report of the Catholic Safeguarding Standards Agency's (CSSA) baseline audit programme of the then 22 dioceses of the Catholic Church in England and Wales, completed between 2022 and 2024. As an overview report, it does not contain new findings or specific actions for dioceses but collates learning from the overall programme in order to identify systemic strengths and areas for development.

1.2 The report is intended to enhance public transparency and accountability of safeguarding in the Catholic Church in England and Wales. In turn, trustees of dioceses are encouraged to use the report as a prompt for discussions about the continuous improvement of their own safeguarding arrangements. A number of areas that require national attention are identified and should be considered by the CSSA or Strategic Council for Catholic Safeguarding, as appropriate.

2. Background

2.1 The *Independent Review of Safeguarding Structures and Arrangements in the Catholic Church in England and Wales* (hereafter the Elliott Review)[1] proposed the introduction of a standards based model for safeguarding in which compliance is assessed and promoted through a national audit and review programme. This programme was to be delivered by the newly created CSSA.

2.2 Through their acceptance of this Review, the bishops of the then 22 dioceses of England and Wales committed to work toward the delivery of the eight national

[1] The Elliott Review, published in October 2020, was commissioned to review and make proposals for future safeguarding structures and arrangements in the Catholic Church in England and Wales. Its final report is available here: Independent Review Safeguarding Report 2020 Re-Format 4

safeguarding standards[2] throughout their organisations and ministries. The CSSA came into operational existence in June 2021 and, following a period of recruitment and the development of the audit model, the diocesan baseline audit programme began in May 2022.

2.3 So as to promote a consistent 'One Church' approach to safeguarding, the eight national safeguarding standards have also been adopted by religious life groups within England and Wales. They are subject to a separate audit programme, so not further considered within this report. Likewise, the two eparchies within England and Wales have been audited but are not included within this report due to their distinct circumstances.

3. Overview of the baseline audit programme

3.1 The Elliott Review proposed a rolling audit programme in which dioceses' ongoing compliance with the national safeguarding standards and the continuous development of their safeguarding arrangements is tested. The initial round of audits are referred to as baseline audits, due to their deliberate focus on compliance with elements of the standards relating to safeguarding structures and policies. By assuring that they are in place, the CSSA will subsequently be able to assess progress from this point of reference and place a greater emphasis on the quality and impact of practice.

3.2 The initial baseline audits were completed on a pilot basis, in order to allow the CSSA to develop and refine its audit model. These seven audits were completed at the invitation of the involved dioceses and the CSSA's appreciation of their role in the development of the audit programme is noted. The pilot phase was completed between May 2022 and May 2023, with the remaining 15 dioceses audited, in

[2] The eight national safeguarding standards are referenced later in this report and available, together with the substandards, here: The Eight National Safeguarding Standards Minor amendments were made to the substandards following the initial diocesan pilot audits.

accordance with the terms of their contracts, between September 2023 and September 2024. The timescale for re-audits is determined by a diocese's baseline audit grade. Two dioceses were consequently re-audited during the baseline audit period and one shortly thereafter, using the same methodology. For the purposes of this report only their initial audit outcomes are included.

3.3 Public transparency is provided to the CSSA's audit programme through the publication of, in the case of the diocesan baseline audits, executive summaries of the full reports on the CSSA website.[3] Participation in the pilot audit phase was agreed to be on the basis that reports or executive summaries would not be published by the CSSA.[4] Information subsequently included in this report in respect of the grading of the pilot audits is already within the public domain due to either self-publication of the reports by the involved dioceses or CSSA publication of re-audit reports.

4. Audit methodology

4.1 Baseline audits were completed in accordance with the Audit and Review Framework[5] for dioceses, a final version of which was published at the conclusion of the pilot phase of audits. Audits are intended to be of current practice and therefore consider evidence relating to the last 12 months. It is acknowledged that this can cause a degree of dissonance for those whose primary, and sometimes negative experience, of diocesan safeguarding practice occurred during an earlier timeframe.

4.2 Put briefly, the baseline audit process consisted of a self-assessment by the diocese, followed by a week (or more) of CSSA audit activity, including a review of

[3] Audit Reports of Dioceses

[4] The one exception to this was for a diocese whose baseline audit formed part of a broader safeguarding review. This was published, in its entirety, on the CSSA website.

[5] DIOCESAN-AUDIT-FRAMEWORK-23-July.docx

all written evidence provided, interviews with key personnel, focus groups and surveys of clergy and Parish Safeguarding Representatives,[6] and audits of safeguarding casework. Where possible, the CSSA auditors, known as analysts, spoke to survivors of abuse. A mix of in-person and virtual interviews and meetings were used throughout the process. Later audits tended to include a greater proportion of in-person activity, which was the preference of both dioceses and the CSSA analysts, however the content of discussions remained consistent and therefore comparable throughout.

4.3 Dioceses were graded using a Maturity Matrix,[7] which provides a brief description of the practice necessary to achieve each of the seven possible grades[8] for each substandard. Grades for each substandard are averaged to provide a grade for each standard and an overall grade.

4.4 Baseline audits were completed by Quality Assurance Analysts employed by the CSSA. All are experienced safeguarding professionals and offer expertise from a range of backgrounds. A lead and second analyst were appointed to each audit, with additional team members involved where necessary to complete individual tasks, particularly in larger dioceses. Consistency was provided through the moderation of reports by the Quality Assurance Manager, with final sign off provided by the CSSA Chief Executive Officer.

[6] Parish Safeguarding Representatives are volunteers who hold lead responsibility for practical safeguarding arrangements with a parish.

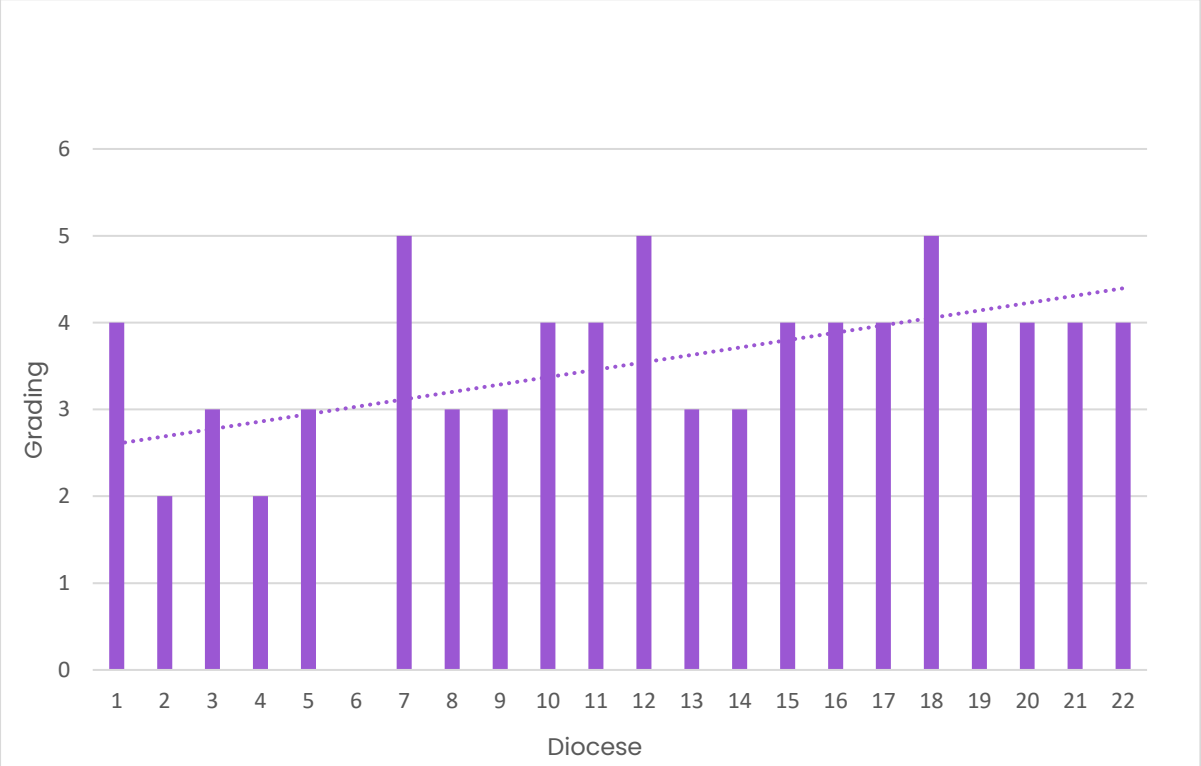
[7] APPENDIX-5-LEVEL-3-MATURITY-MATRIX-FINAL.docx

[8] The seven possible grade, in descending order, are Exemplary, Comprehensive Assurance, Results Being Achieved, Firm Progress, Early Progress, Basic, and Below Basic. The latter grade is reserved for situations in which expected practice is not being met to the extent that unsafe situations are created.

5. Audit outcomes

5.1 The purpose of this report is to provide an overview of outcomes and learning from the baseline audits of dioceses in the Catholic Church in England and Wales. In view of the focus on the dioceses as a whole, individual dioceses referred to are not named, other than in the good practice examples boxes.

Overall grades attained by dioceses, in order of audit completion, were as follows:



Key to Grading: 0 = Below Basic, 1 = Basic, 2 = Early Progress, 3 = Firm Progress, 4 = Results Being Achieved, 5 = Comprehensive Assurance, 6 = Exemplary

5.2 All dioceses, with one exception, were therefore able to provide evidence of some progress toward meeting the national safeguarding standards. There was clear evidence of an improving trend in audit grades during the course of the programme, with those completed in 2022 and 2023 averaging a underpinning score of 3.2 and those completed in 2024 averaging 4.0 (providing an overall average of 3.5, midway between Firm Progress and Results Being Achieved).

5.3 The number of dioceses attaining each grade overall and by standard were as follows:

	Overall	Standard 1	Standard 2	Standard 3	Standard 4	Standard 5	Standard 6	Standard 7	Standard 8
Exemplary	0	0	0	1	0	0	0	1	0
Comprehensive assurance	3	7	5	2	4	4	4	4	0
Results being achieved	10	6	7	11	9	11	9	9	7
Firm progress	6	5	6	5	7	3	5	3	11
Early progress	2	3	3	2	1	3	3	3	3
Basic	0	0	0	0	0	0	0	2	0
Below Basic	1	1	1	1	1	1	1	0	1
Average score	3.50	3.64	3.50	3.59	3.59	3.59	3.50	3.59	3.05

5.4 Average grades for individual standards are therefore relatively consistent, with the exception of Standard 8, the reasons for which are explored below. Putting Standard 8 aside, the standard with the fewest occurrences of the top two grades was Standard 3, relating to those who report harm. This would suggest that this is area of solid performance, but one that few dioceses excel at. The CSSA intends to undertake a thematic review of work with survivors to better understand this issue and will provide greater opportunity for survivors to contribute to future audits to enable a more nuanced assessment of practice (see section 8 below).

5.5 A proportion of a diocese's safeguarding casework is assessed as part of each audit, with grades assigned to each of the six practice domains and the overall response in accordance with a case audit matrix.[9] Of the 198 case audits completed, 19 were assigned an overall grade of Insufficient, 62 a grade of Requires Improvement, 90 a grade of Good and 27 a grade of Outstanding. Where practice

[9] The case audit matrix, which includes descriptions of the subsequently referenced grading system for case audits is available here: APPENDIX-4-CASE-WORK-AUDIT-MATRIX-FINAL.docx

in an individual audit domain falls short of basic expectations, for example in the timeliness of reporting of allegations or the completion of a risk assessment, the domain is graded as Does Not Meet Requirements. Twenty domains received this grade, with required actions either escalated to the diocese for an immediate response or outlined with expected timeframes for completion within the case audit report.

6. Summary of findings by standard

6.0 The following section provides an overview of findings by standard drawing on commonly found strengths and areas for development, together with examples of individual good practice and questions that trustees of dioceses are recommended to ask themselves. As can be seen from the tables above, one diocese scored Below Basic overall and in seven individual standards. References to 'all' dioceses should be taken to exclude this one diocese.

Standard 1: Safeguarding is embedded in the Church body's leadership, governance, ministry and culture

6.1.1 Standard 1 is the broadest ranging standard and critical to underpinning a diocese's overall safeguarding response. It was also (marginally) the highest scoring of the eight standards. By hearing from a range of stakeholders during the audit, analysts were able to assess where safeguarding leadership was perceived to originate from. In some dioceses this was unequivocally seen to sit with the bishop and other senior clergy or lay leaders, however in others the safeguarding team were seen to be responsible for leading on safeguarding. Relatively straightforward means of addressing this were seen in introductions to safeguarding website pages being personally authored or videoed by the bishop. Similarly, bishops' personal attendance at masses for survivors or training events were cited as examples of visible personal leadership of safeguarding. In strongly scoring dioceses everyone spoken to was able to articulate their individual safeguarding role, although this should be more widely supported through the use

of role descriptions. Specific safeguarding training should also be provided for those in leadership roles, including trustees.

6.1.2 The Elliott Review proposed that dioceses should establish safeguarding subcommittees of trustees, in place of previous commission arrangements. All dioceses had expected arrangements in place, albeit with a degree of variation in the use of other subgroups particularly for casework oversight, which was often provided through a separate panel.[10] Variations in arrangements primarily reflected the size of the diocese and it is accepted that there can be no one model that will fit all dioceses. All dioceses attempted to make use of independent professional expertise on their subcommittees and case review panels, although securing membership and attendance was a universal challenge. Some dioceses were attempting to formalise their engagement with statutory agencies and it may be that this approach can serve to secure longer term arrangements, less dependent on the goodwill of individuals.

6.1.3 Greater variability was found in the application of governance arrangements. In better scoring dioceses, the subcommittee and other groups were seen to operate according to their Terms of Reference, with decisions taken in the expected forum and information flowing productively between the groups. Records of decision making and challenge in minutes were a regularly identified area for development though. While most dioceses attempted to use key performance indicators (KPI) to inform the work of their subcommittee, these were often inconsistent over time and members were not always confident in their accuracy. There was furthermore little consistency between dioceses, for example as to how caseloads are counted, suggesting that this is an area that would benefit from further work.

6.1.4 Ultimately, the role of governance arrangements is to drive improvement in the delivery of safeguarding. The standards expect that this will be achieved

[10] A range of names are used by dioceses for both the subcommittee and case review panels. These terms are used throughout this report though for the sake of consistency.

through a safeguarding implementation (or action) plan. All dioceses either had a plan in place, or in development, with the more successful able to demonstrate how the plan was being actively used and reviewed to shape their safeguarding arrangements. As an aside, longer term strategies or plans for the overall development or ministry of dioceses were an often missed opportunity to embed safeguarding within the wider mission of the Church. Practice in respect of managing organisational risks was less well developed, with few holding a safeguarding risk register or using one as an active means of assessing and mitigating risks (this is a wider issue, with many dioceses not holding an overall risk register).

6.1.5 The nature of a diocese is such that practical arrangements to create safe environments are largely delivered in parishes and other ministries, outside the direct oversight of the diocesan leadership and safeguarding team. Trustees should therefore seek assurance that safeguarding policies are being applied throughout the full range of diocesan activities. Good practice was seen in attempts to use visits and audits to assess safeguarding arrangements in these contexts, but these were either in their infancy or needed systematising to enable complete and ongoing coverage.

6.1.6 A consistently identified risk was the operation of other organisations under the Catholic banner. These range from closely associated charities, for example delivering diocesan pilgrimages or youth ministry, to those with no structural link to the diocese, but providing a ministry presented to be of the Church. Many provide valuable services to vulnerable people who will not necessarily distinguish between the Church bodies providing the ministry. Furthermore, any organisation presenting itself as Catholic requires the permission of the bishop to operate within a diocese. A bishop could therefore be held publicly accountable for any safeguarding failings in organisations that he has given permission to minister in his diocese. It is therefore critical that trustees understand the range of organisations present in their diocese and assure themselves of their safeguarding arrangements on an ongoing basis.

6.1.7 A wide range of safeguarding staffing complements and structures was seen, not always obviously related to the size of the diocese. Dioceses with smaller staffing complements tended to place greater expectations on volunteers in parishes, particularly for safer recruitment tasks. While this may prove to be effective in terms of service delivery, it does raise a question in terms of where dioceses are happy to hold risks in their structures. Trustees should therefore consider whether they have sufficient oversight of safeguarding arrangements delegated to individual parishes and the implications of their level of reliance on volunteers. Greater staffing resources tended to enable safeguarding team members to be more visible through the diocese, which was often reflected in survey returns and focus groups. While it was not possible to prove a cause and effect, it would seem to follow that more visible safeguarding teams would encourage greater reporting of concerns. The physical location of the safeguarding team and their presence in wider diocesan meetings and activities was similarly critical to promoting their role. A commonly identified need was to ensure sufficient resilience in safeguarding provision. This is a genuinely difficult issue for smaller dioceses, with limited staffing. However, the planned or unexpected absence of the safeguarding coordinator[11] is an identifiable risk that requires mitigating. This was most commonly achieved through arrangements with neighbouring dioceses, where not possible within the diocese.

6.1.8 Dioceses are relatively small organisations and the success, or otherwise, of safeguarding arrangements relies on a few key individuals. Aside from the resilience issue, noted above, this raises the issue of the continuity of practice when one or more individual in a key role changes. In a small number of dioceses it was evident that a recent change of safeguarding coordinator had resulted in the loss of operational knowledge, although the opportunity had also been taken to re-assess and invigorate practice. Trustees should nevertheless ensure that

[11] The term 'safeguarding coordinator' is used throughout this report for the sake of clarity, although it is acknowledged that some dioceses have different titles for this role.

arrangements are in place to provide for continuity during periods in which key personnel change.

6.1.9 Finally, the standards expect dioceses to be transparent about their safeguarding arrangements and practice. For some this only extended to the publication of policies, others went beyond this to place action plans, annual reports, meeting minutes or externally commissioned reviews in the public domain. This is an area that dioceses would benefit from taking a more systematic approach to, to ensure that they have an agreed approach and that it is maintained over time.

Good practice examples

The Bishop of Leeds, in his personal introduction to the safeguarding pages of the diocesan website, places safeguarding within the context of the ministry of the Church, sharing his sorrow about past abuse and saying "This was not – and is not – Christ's way".

Caring Safely for Others[12] was evidenced to have been embedded by East Anglia diocese through its provision to all clergy, input in training and through discussion of its application in Deanery meetings. In casework, it was seen to be provided to complainants and respondents, and used to inform decision making.

Questions for trustees to ask

- Who is seen, by lay people and the public, to lead on safeguarding in our diocese?
- Do all our diocesan role descriptors include safeguarding responsibilities?
- Do we have consistent and meaningful KPIs that enable us to provide effective oversight of safeguarding?

[12] Caring Safely for Others Pastoral Standards and Safe Conduct in Ministry was produced by the Catholic Bishops' Conference of England and Wales in 2020.

- Do we use our risk register to actively manage and mitigate safeguarding risks?
- How do know that our parishes and other ministries are safe places for all?
- Do we know which catholic organisations are in our diocese and whether they have effective safeguarding arrangements?
- Is our safeguarding staffing complement sufficient to provide an effective and resilient service?

Standard 2: Communicating the Church's safeguarding message

6.2.1 The overall trend of dioceses later in the audit cycle scoring more positively was mirrored in this standard, largely due to the increasing likelihood of a communication plan having been agreed. It was also evident that larger dioceses, who were likely to have more sophisticated communications arrangements, were more likely to score well on this standard.

6.2.2 When used effectively, the communication plan formed the basis of all safeguarding communications. It defined their purpose, target audiences and channels to be used. In one diocese a series of agreed messages were used to underpin all communications, whether planned or reactive. Good communication plans reflected their diocesan context, with consideration given to the full range of audiences, including those who are harder to reach. Good examples were seen of the use of Makaton and British Sign Language, although it is clear that the production of messages and materials in languages other than English remains an area for development, not least when considered against the range of languages that masses are celebrated in in many dioceses. Similarly, a broad range of communication channels should be utilised to maximise engagement. Consideration should also be given to internal audiences, with a view to encouraging the inclusion of safeguarding in all diocesan activities. Processes for dealing with expected or reactive responses to adverse publicity should have been routinely included in communication plans or as standalone documents, but were rarely seen to have been formalised.

6.2.3 Most dioceses had held services or events for survivors of abuse, both as a means of providing care for those present and demonstrating to the wider community their desire to engage with survivors yet to make contact. Attendees and those otherwise involved often spoke positively of their impact, however there is a need to ensure that they are not one-off events, and that differing types of event and locations are used in order to maximise engagement.

6.2.4 Standard 2 also covers links to other Church bodies and organisations for the purpose of developing a safer environment. Dioceses were generally able to evidence links to a range of church, voluntary and statutory agencies in their area, on which they were able to draw for both individual casework and wider initiatives. Dioceses should, however, ensure that they have established links throughout the geographical extent of their diocese. The most productive arrangements, particularly with other denominations, were seen where some form of network meeting had been established, with one notable example seen in an island community. Dioceses should therefore consider how they can contribute to the establishment of networks, where they are not already in place.

6.2.5 The most common areas for development in Standard 2 were related to engagement with stakeholders and the evaluation of communication activities. There was limited evidence of any engagement with target audiences (which should include survivors) in the development of individual messages or campaigns. Similarly, communication activities were not routinely evaluated, either through feedback from target audiences or through assessment of, for example, website views or interactions. It is acknowledged that many dioceses had not reached a formal review point for their communication plan and that greater evidence of evaluation may therefore be seen in the forthcoming re-audit cycle. Finally, dioceses are encouraged to follow the example of some who have begun to audit and promote consistent content on individual parish websites.

Good practice example

Liverpool archdiocese made a decision to shift its narrative about safeguarding away from a reactive response to abuse to the need to respond to low level concerns as a means of creating a safe environment. Bespoke materials were

produced and existing communications channels utilised to promote this message. To support this campaign, multiple means of reporting concerns were provided, including through the diocesan website, which is linked to via QR codes in campaign materials. Those spoken to during the audit had a strong awareness of the campaign and welcomed its change in emphasis, demonstrating both its reach and effectiveness.

Questions for trustees to ask

- Do we communicate about safeguarding in ways that are accessible for the whole diocesan community?
- What would our key messages be when publicly commenting on safeguarding within the diocese?
- Who do we need to ask whether our communications are effective? What might be the best ways to actively engage with people?

Standard 3: Engaging with and caring for those who report having been harmed

6.3.1 This standard encompasses the overall framework for responding to those who report harm, however the experience of individuals in this position will always be the most important lens for considering its implementation. As has been previously detailed (para. 5.5), individual case audits provided a range of outcomes. There were a number of outstanding examples of practice of relevance for this standard, in which case workers had gone above and beyond what might be expected to meet the needs of survivors. Factors seen to be critical in this response were ensuring that what is promised is delivered, particularly in terms of maintaining contact. More successful responses were reflective, with thought given to the reasons for a person's actions, anticipation of forthcoming times and events, and the consequences of actions taken. Conversely, in some individual case audits disclosures or indications of abuse encountered in what might be termed less expected circumstances (for example, passed on by a third party to the Parish Safeguarding Representative, or observed by a member of clergy in a visit to an

elderly parishioner) did not always receive the expected recognition or speed of response.

6.3.2 Better scoring dioceses were able to evidence a degree of forethought and planning in their response to survivors, using strategies to set out exactly what they were looking to provide to anyone reporting having been harmed. Clarity was also provided in terms of expected responses to those reporting abuse that had taken place within a Church context and those whose experiences of abuse occurred outside the Church. During the course of the audit programme, it increasingly became the norm for dioceses to have some form of survivor charter or commitment that was made publicly available. Good examples clearly set out what a person disclosing abuse should expect to happen, were seen to be provided to survivors and delivered on in practice. Expected responses to families of survivors and others affected by abuse (for example, the parish in which an abusing priest ministered) were often missing from these documents though and less evident in practice.

6.3.3 Disclosures of abuse may be received by a wide range of people within a diocese. Good practice was seen where thought had been given to who amongst their employees, volunteers and office holders may receive a disclosure, with appropriate training and means for them to report the information provided. Support and debriefing arrangements for those receiving a disclosure should also be available. For those in more specialist roles, a thorough understanding of local service provision, with formal arrangements made where appropriate, is critical for on-the-spot signposting and longer term provision. Much of the training provided (and responses to individuals seen) was trauma-informed, although not necessarily badged as such.

6.3.4 Bishops universally expressed a willingness to meet survivors of abuse and most had done so in practice. This was seen to be most effective when the number and nature of meetings was clearly steered by the survivor and when meetings were offered proactively. Other examples were seen of bishops personally advocating on behalf of survivors. While the primary purpose of meetings of this nature is to meet the needs of the survivor, it was clear that they were often

impactful for bishops (and others involved) and represented an untapped reservoir of learning that could be utilised for training and service development.

6.3.5 There are two levels to receiving and responding to feedback from survivors. At an individual case level this should consist of regular checks to ensure that individual needs are being met. Most dioceses were able to evidence doing so, with more innovative methods to encourage feedback including the use of open ended surveys available on the diocesan website and linked to in email signatures of safeguarding team members. There was a need for more formal consideration of feedback and learning from individual survivor's experiences by case review panels though. Secondly, dioceses should seek to learn from survivors collectively in order to inform the development of service provision. Positive examples were seen of dioceses working with small groups or individual survivors or in order to inform their overall approach, influence specific areas of work or policies, and to develop training. A simple message in this respect is that it is not always necessary to develop a panel of survivors, with all that this entails, as individuals may be happy to be called on to assist with discreet tasks on an ad hoc basis. For some dioceses it is genuinely not possible, due to having no ongoing contact with survivors who would be willing or able to assist. In these circumstances consideration should be given to accessing learning from other organisations or dioceses.

6.3.6 CSSA analysts have spoken to individual survivors during the course of a number of baseline audits having either been approached directly or as arranged by the diocese. A range of views have been heard in these contacts and, for some, It has been apparent that their lived experience of diocesan responses may not always tally with the CSSA's conclusions about overall service provision. This is an important dichotomy and one that the CSSA will continue to seek to understand and explore in future work.

Good practice example

A 'Healing and Reconciliation' subgroup of the safeguarding subcommittee of Northampton diocese has been established to work to improve engagement with and support for survivors. Its members include survivors and other stakeholders, such as Parish Safeguarding Representatives. The group has been

pivotal in organising a survivor masses, days of prayer, other events and a diocesan healing garden.

Questions for trustees to ask

- Would a survivor receive a consistently compassionate and speedy response whoever they made a disclosure to in the diocese?
- Do we know what we want to achieve for survivors? Is this information publicly available?
- How do we listen to and learn from survivors to shape the response that they receive as an individual and our overall approach? How do we know that this response is effective?

Standard 4: Effective management of allegations and concerns

6.4.1 More so than any other standard, evidence for compliance with Standard 4 is drawn from audits of individual casework. That said, dioceses, as a whole, had agreed appropriate policies and procedures for the management of allegations. Fewer had specific policies for managing lower level concerns though and this is an expected area of future development and important means by which dioceses can ensure a consistent response and mitigate the risk of lower level concerns escalating.

6.4.2 Case audit findings indicate that the vast majority of allegations and concerns are reported to statutory authorities within the one working day required by the Catholic Church in England and Wales. When present, delays tended to occur in the reporting from parishes to diocesan safeguarding teams rather than in the subsequent reporting to statutory agencies. This is therefore a training issue for dioceses, who must be confident that their clergy, volunteers and employees will identify and report allegations and concerns in accordance with policy expectations. It is acknowledged that dioceses can struggle to secure the engagement of and information from statutory agencies and the role of formal information sharing agreements, as referenced in Standard 1, should be explored.

6.4.3 The primary areas of development in terms of the management and investigation of allegations were in respect of structures for management oversight and decision making. While all dioceses provided oversight to some or all cases through a case review panel, or equivalent structure, formalised arrangements for types of case to be reported and the expected junctures were less frequently seen. Similarly, few dioceses had formal schemes of delegated decision making (for example, what person or body is able to take a decision to close a clergy safeguarding plan, or a lay safeguarding plan). These should not be viewed as questions of the professional competence of safeguarding staff, but one of where a diocese is happy for risk to sit. The majority of safeguarding coordinators and caseworkers had individual professional supervision arrangements in place, which represents an important further check and balance.

6.4.4 The recording domain of case audits tended to be less well scored, with the comprehensiveness of records a frequent issue. Recording is not an end in itself, but shortcomings in this respect can cause difficulties in evidencing actions taken to statutory authorities, or responding to a complaint or subject access request from those concerned. Similarly, there is a need to create records that another practitioner could readily use in the event that they were required to provide cover during a short term absence or following the receipt of another concern or allegation a number of years hence. The importance of structured management oversight has already been explored, with the linked expectation in this context being that this is also recorded on case files as a means of evidencing decision making. Recording should include all forms of management oversight and decision making, including that of the bishop and any other senior clergy or leaders consulted. Dioceses should also ensure that they have robust arrangements for the recording of lower level concerns, that will enable practitioners to 'join the dots' in the event of linked concerns being received.

6.4.5 The CSSA respects the ultimate right of trustees to make decisions about reportable serious incident notifications to the Chairty Commission and therefore focuses on the application of decision making processes in this respect. These were generally applied as expected, although areas for development were sometimes

found in the timeliness of notifications, feedback from decision makers to the safeguarding team, provision of updates and the recording thereof.

6.4.6 Appropriate levels of confidentiality were seen to be maintained throughout dioceses, both in terms of who information was shared with and how. Similarly all dioceses had appropriate information security arrangements. There were fewer examples of practitioners explaining how information would be stored and used (or at least recording that this was done). Good practice was seen in one dioceses though, where a person disclosing harm and the respondent would both be provided with a physical copy of the diocesan privacy notice at their first contact, with reference made to it thereafter to explain actions.

6.4.7 Dioceses had varying arrangements for safeguarding team access to and use of clergy files during the course of safeguarding investigations, and issues in this respect were rarely found. Most dioceses had also undertaken some form of review of clergy and safeguarding files prior to the Independent Inquiry into Child Sexual Abuse (IICSA), however for others there remains ongoing work to be completed to review all safeguarding and/ or clergy files. In doing so there is a linked question of future accessibility and the potential value of digitising records. Trustees should therefore assure themselves that all potential sources of information about past concerns have been checked (records potentially held by previous clergy safeguarding coordinators included) and that information is accessible for any future investigations.

6.4.8 Finally, it would be expected that trustees of dioceses seek to learn from their responses to allegations and concerns, both to build on good practice and to secure improvement where gaps are evident. There were successful examples of this at in individual case level, including through the commissioning of formal reviews. Most dioceses would benefit from further systematisation of arrangements for learning though, which can be achieved relatively easily, for example by introducing standing agenda items to consider learning at case review panels and as a question within case closure documentation.

Good practice example

Immediate senior management oversight is provided to significant allegations in Nottingham diocese through formal arrangements for a 'Response Group'. This group ensures that appropriate referrals and notifications are made, confidentiality and communications matters discussed, and that both complainants and respondents are provided with appropriate support and risk management.

Questions for trustees to ask

- How do we promote the reporting of low level concerns and provide a response that reduces the risk of escalation?
- Are we confident that all allegations, however received, are reported to statutory authorities within one working day?
- Do we have a case management system in place which is maintained and updated as necessary, with information recorded in an easily accessible format? How do we monitor and address any gaps?
- Do we have a clear scheme for delegated decision making covering all types of case and decision?
- Is our decision making and application of processes for Charity Commission Reportable Serious Incidents consistent?
- Have all files and potential sources of information about previously received safeguarding concerns been reviewed to ensure that they were appropriately acted on?

Standard 5: Management and support of subjects of allegations and concerns

6.5.1 This standard covers both the management of those within the Church who become the subject of an allegation or concern and those who are otherwise identified as presenting a risk and managed through a safeguarding plan, most commonly lay registered sex offenders.

6.5.2 A critically important element to the management of any respondent is a thorough understanding of the risk that they present. It was therefore disappointing

to encounter a number of examples within case audits of safeguarding plans being put in place without, or prior to, the completion of a risk assessment. It is acknowledged that information may be limited during the initial response however, if there is sufficient information available to suggest the need for a plan, this also indicates that a risk assessment can and should be completed. Trustees should therefore assure themselves that all individuals who are known to present a safeguarding risk have been rigorously assessed. There were also good examples of thorough assessments, drawing on a range of sources of information, including professional and statutory agency assessments.

6.5.3 Safeguarding plans were seen to be used and reviewed on the vast majority of occasions when they would be expected. Some required a more comprehensive approach though, particularly for lay registered sex offenders. Plans of this nature typically delineated the church and particular mass to be attended, together with seating arrangements (usually based on a physical visit). However, the need for subsequent amendments could be avoided through the inclusion of arrangements for Holy Days, confession, other parish activities and so on. Providing comprehensive expectations adds a further layer of protection against those that would seek to exploit weaknesses in plans. Greater consideration was also required of monitoring arrangements to ensure that they are robust. It cannot be realistic to expect a priest, who is also celebrating mass, to be solely responsible for monitoring a member of the congregation throughout their time in the building. Consideration likewise needs to be given to expectations for when those routinely expected to monitor are not present. The majority of dioceses used the CSSA safeguarding plan template and it is acknowledged that this does not always support the expected standard of practice. Revised risk assessment and safeguarding plan templates will therefore be provided in 2025.

6.5.4 Clergy subjects of allegations were typically provided with substantial packages of support, with good use being made of diocesan clergy welfare officers (although care should be taken to ensure that they are aware of any pertinent risks). The coordination and delivery of support tended to be less well evidenced in case records, although some good examples were seen of the use of multi-disciplinary meetings to support coordination. Case audits also indicated the

importance of providing clarity of expectations, with a particular need to emphasise that the conclusion of a police investigation with no further action would not necessarily result in an immediate return to ministry, due to the need to assess and mitigate any ongoing risks. Clarity of role should also be provided, with the safeguarding case worker maintaining a co-ordinating role and not getting drawn into providing support services, even if they are qualified to do so. Similarly, dioceses should ensure that different people work with the person making the disclosure and the respondent to maintain boundaries and manage workloads. One (larger) diocese was able to do this through the creation of a role specifically to work with respondents.

6.5.5 For clergy subjects of allegations, statutory investigation processes often take place alongside canonical processes. While this area is ultimately outwith the safeguarding team's control, there was a striking discrepancy in the number of laicisations reported by dioceses. Inconsistencies tended to reflect differing approaches to situations in which there had been a substantiated allegation, but no conviction. In some dioceses laicisation was not pursued in these circumstances, whereas in others, when considered appropriate, it was. An overall point of learning in this area though is the need for those involved in the safeguarding response to maintain clarity about canonical activity and for both to be coordinated. The formation of the National Tribunal Service[13] came too late in the baseline audit programme for any learning to be derived in this respect, but should provide for greater consistency between dioceses.

6.5.6 Similar conclusions were also drawn from situations in which there was an initial or ongoing lack of clarity as to whether a concern was a safeguarding issue or a clergy discipline matter. Dioceses benefit from having clear arrangements for such circumstances, with close ongoing working from parties involved in each

[13] The National Tribunal Service was launched in November 2023 and is responsible for undertaking judicial canonical trials that were previously completed by dioceses. This will provide for greater consistency, although individual dioceses will still determine which cases are referred into canonical processes. More information is available here: NTS-Information-110123.pdf

process. Clear safeguarding records should also be maintained to evidence decision making, even when the matter was ultimately determined to be one of clergy discipline.

6.5.7 In practice, the vast majority of members of the clergy will provide a lifetime of ministry without being the subject of an allegation. However, clergy surveys and focus groups consistently revealed a distinct degree of nervousness in this respect, together with a lack of certainty about the support that they would receive from the diocese in the event of their being the subject of an allegation. Attempts to mitigate this were seen through the content of training, the production of leaflets and other materials, and discussions in deanery meetings and other contexts. It is clear that persistence is required in these approaches.

Good practice example

A comprehensive, whole diocese approach to managing respondents was evidenced in Brentwood. This includes senior clergy and lay leaders writing to respondents to ensure that they meaningfully with their safeguarding plans. Risk management is balanced with support through the role of the Clergy Advisor for Safeguarding, who is a qualified therapist, and the use of an Amicus Clero.[14] The clergy have been provided with canon law input at annual safeguarding events to ensure that they understand their canonical rights should they be the subject of an allegation.

Questions for trustees to ask

- How do we seek assurance that every safeguarding plan is based on a good quality and up to date risk assessment?
- What steps do we take to identify and address gaps in the assessment of risk, or implementation of safeguarding plans?

[14] An Amicus Clero is a role performed by a clergy member, in which he acts as a 'friend of the clergy' by listening to the personal or pastoral concerns of other clergy members.

- Do we provide consistent and coordinated safeguarding and canonical responses to the subjects of allegations?
- Is there sufficient provision in place to provide a suitable pastoral response to those accused of harm?
- How do we develop the confidence of the clergy in respect of the actions that would follow them being the subject of an allegation?

Standard 6: Robust human resource management

6.6.1 This standard covers a disparate number of areas, albeit all concerned with the recruitment and management of clergy, volunteers and employees of the diocese. Dioceses tended to have the expected policies in place for this standard, particularly for the safer recruitment element, although their practical application was a greater issue. Most also had complaints and whistleblowing policies, although the inclusion of a final recourse to the CSSA, in the former, was often lacking. Policies were usually available on diocesan website, but more could be done to promote them, particularly through the routine provision of the complaints policy to people who receive a safeguarding service. A few dioceses had developed volunteer policies and the provision of this framework is viewed as good practice.

6.6.2 Safer recruitment processes are expected to be applied to a wide range of situations, although the greatest demand numerically, will come from parish based volunteers. While safeguarding teams are responsible for and will oversee this process, it is largely delivered by other volunteers in the parish. The provision of support to parishes is therefore critical and good practice was seen in the employment of officers specifically for this role, who were able to visit and spend time in parishes, and through the provision of comprehensive documentation to support volunteers administering recruitment processes. It is accepted that maintaining accurate records of volunteers throughout the diocese is a far from straightforward task, the practice of one diocese in which Parish Safeguarding Representatives were sent lists of their volunteers to check every three months, with a minimum expectation of a return every six months, was seen to work well though. Effective safer recruitment is supported by safeguarding teams remaining alert to

all diocesan activities and ensuring that they are able to contribute to the recruitment of any volunteers or employees. Increasingly robust processes for school governor recruitment were evidenced during the course of the baseline audit programme and should continue to be developed.

6.6.3 The completion of Disclosure and Barring Service (DBS) checks remains a key part of the safer recruitment process, and while dioceses tended to be able to consistently provide checks prior to commencement in role, many had accrued significant backlogs of re-checks, relative to their overall size, during and after Covid lockdowns. More recent audits suggest that this issue is being addressed and it is clear that where this is the case that active trustee oversight has been a critical component of the response. Trustees did not always have the expected ongoing oversight of DBS checks or the broader safer recruitment process though and should ensure routine reporting in this respect. A number of dioceses had provided additional resources to address backlogs in DBS checks. Routine reporting to trustees should enable informed decision making about the resourcing necessary to prevent a recurrence in the backlog. Finally, audits identified inconsistencies in the application of DBS checks, most notably in terms of the Parish Safeguarding Representative role. This has occurred due to variations in advice provided by different regions of the Disclosure and Barring Service and therefore requires a national resolution, which the CSSA will seek to provide.

6.6.4 A small number of DBS checks inevitably reveal information about previous convictions or other adverse intelligence. Good practice was seen in dioceses with clear systems to risk assess this information and take decisions about proceeding with the recruitment process in a forum appropriate to the level of risk involved, whether that be within the safeguarding team or at a panel with trustee oversight.

6.6.5 Surveys and focus groups indicated a range of views about overall safer recruitment processes, from those who viewed them as functioning effectively to others who considered them to be excessively bureaucratic. This is an area that dioceses are encouraged to explore, as it may be that specific concerns can be ameliorated.

6.6.6 Safeguarding teams are expected to have a role in processes for clergy coming into dioceses, although this was often seen to be in need of formalisation and too often reliant on personal relationships and ad hoc exchanges of information within the curia. This points to a broader issue for dioceses though, as there is also a need to ensure that senior clergy are aware of everyone ministering in their diocese. Processes for overseas clergy tended to be more formalised and examples of good practice were seen in individual cases where applications had been refused on safeguarding grounds, in requirements to complete online training prior to arriving in the UK, early safeguarding team contact and broader enculturation programmes. In one diocese newly arrived overseas clergy are initially placed in the cathedral where they can be closely supported while they become familiar with the diocese. There remains a clear need for the ongoing national work to develop consistent overall practice for clergy arriving from overseas though.

6.6.7 Without exception, dioceses had an expectation that clergy would only be issued with their celebret, required to minister in other dioceses, should they have an in date DBS check and have completed expected safeguarding training. Despite very few dioceses having achieved 100 per cent training compliance, no examples were seen of a celebret being withheld. (Restrictions on the issuing of celebrets do not address expected actions in respect of ministry within a priest's own diocese, should he fail to comply with safeguarding expectations.) This requirement was nevertheless viewed, if not positively, as being reasonable by almost all members of clergy spoken to. The recently published *The Cross of the Moment* report[15] does emphasise the need for dioceses to understand reasons for non-compliance with training, rather than simply take a punitive response and achieving this balance is one that the CSSA will expect to see dioceses working toward.

[15] Pat Jones, Marcus Pound and Catherine Sexton, *The Cross of the Moment A Report from the Boundary Breaking Project*, (Durham: Durham University Centre for Catholic Studies, 2024)

6.6.8 Standard 6 does also include an assessment of complaints and whistleblowing practice, however these were sufficiently rare for there to be no generalisable learning. Dioceses may legitimately view the limited occasions on which these policies are being utilised as evidence of a positive culture and practice, however they should balance this by ensuring that they are readily available to all who might have cause to make use of them.

Good practice examples

A formal document produced by the safeguarding team and senior clergy in Shrewsbury diocese, sets out expectations for clergy coming into the diocese under a range of scenarios, including from within England and Wales, from overseas and new vocations, and for different lengths of time. Who is to be notified is clearly set out, alongside safeguarding expectations. The completion of each step in the process is recorded on IT systems.

Clifton diocese is exploring the addition of a QR code to celebret cards that would enable a 'receiving' diocese to check that the priest's DBS check and safeguarding training remains in date.

Questions for trustees to ask

- How do we obtain assurance that all diocesan roles are safely recruited to?
- Do we know that all of those recruited within the diocese have had necessary checks? What risk mitigations are in place if this is not the case?
- Are we adequately sighted and involved in decision making about blemished DBS checks?
- How do we balance the need to have robust safer recruitment processes while making them manageable for clergy and volunteers?
- Are we confident that we are aware of all clergy ministering the diocese, that they are of good standing and have sufficient knowledge of safeguarding expectations?

- Are expectations that clergy have an in date DBS check and have completed expected safeguarding training for them to receive a celebret applied in practice? What is our policy for issuing celebrets for clergy who are subject to a safeguarding plan?

Standard 7: Training and support for safeguarding

6.7.1 All dioceses audited had well established safeguarding training expectations for clergy members and tended to have been delivering against them typically for five to eight years. Most required two yearly face to face training, with a minority providing annual input. Only one diocese relied on online learning. Attendance was mandatory in all and bishops typically took an active role in its good promotion, with good practice seen in some dioceses of the bishop attending, for at least some of the day, on all training courses. With the exception of a small number of dioceses who were unable to provide accurate compliance rates, all reported over 90 per cent compliance and a handful achieved 100 per cent, which tallied with clergy survey returns received in the course of audits.

6.7.2 Safeguarding teams typically provided one-to-one or small group mandatory inductions for new Parish Safeguarding Representatives, with training offered after this point being on a voluntary basis. Some longer standing Parish Safeguarding Representatives, seen in focus groups, had consequently undertaken no recent church-based safeguarding training, which is an issue that should be addressed in training needs analyses.

6.7.3 The substandards require dioceses to have completed a training needs analysis as a means of planning their ongoing training provision. Where present, these were more commonly badged as training strategies or plans. Better quality examples provided comprehensive coverage with consideration of all clergy, lay employee and volunteer roles within the diocese, with distinctions drawn for those with particular areas of responsibility or in leadership roles. Others focussed on who was most likely to receive a disclosure, leading to the inclusion of cathedral guides and social club employees in some. The delivery of training can be a resource intensive part of safeguarding arrangements and there were a number of dioceses

who had chosen to invest in this area of practice through the creation of training roles, others based training provision on existing available resources.

6.7.4 The bulk of dioceses chose to make use of CSSA provided face to face training for clergy and online provision for others, with a small number preferring to provide their own training. This provision will become the responsibility of the Strategic Council for Catholic Safeguarding, although there will be an ongoing need for the CSSA audit programme to provide assurance that all participants receive the same message, irrespective of who delivers the training. A number of examples were also seen of dioceses providing topic specific safeguarding training at a local level or throughout the diocese and there is a need for dioceses to have the capacity to deliver subject specific training that is responsive to local or diocesan needs. Most dioceses made some use of locally provided safeguarding training, usually through safeguarding partnerships. Dioceses would benefit from taking a more structured approach to this, to promote wider attendance and make full use of training available throughout the geographical extent of the diocese. There is also a role for commissioned training, with input by a local sexual violence victims' service having been particularly well received in one diocese.

6.7.5 Clergy and Parish Safeguarding Representative survey respondents and focus group participants generally provided favourable feedback about the diocesan training offer, although the need for more flexibility in location and timing was a consistently voiced area for development. Parish Safeguarding Representatives generally requested more opportunities to meet and form more local networks. Both groups welcomed the support provided by safeguarding teams and appreciated the provision of practical materials (for example, checklists) to support them in their role.

6.7.6 The most commonly found area for development for this standard was that of the evaluation of the training programme. Only a minority of dioceses requested that participants provide on the day evaluations of training provision and no systematic attempts to ascertain the longer term impact of training were seen. Similarly, there were few examples of attempts to measure training needs. In addition to monitoring training compliance, trustees should therefore seek

assurance that they deliver a high quality and impactful training programme, based on properly understood need.

Good practice examples

A particularly comprehensive approach to promoting safeguarding training was seen in East Anglia diocese which involved the use of promotional material on safeguarding team email signatures, the diocesan website and in the yearbook. The latter two also featured news stories designed to promote safeguarding training. The bishop attended the annual training day for Parish Safeguarding Representatives to personally thank them for their work and to promote the importance of safeguarding within the Church.

In order to better understand their training needs, Northampton diocese analyses advice calls received from parishes to understand themes in the nature of concerns being dealt with and any gaps in knowledge that are prompting calls. This information is then used to develop the training programme for clergy, volunteers and parish based employees.

Questions for trustees to ask

- Do we have a training needs analysis that establishes expectations for all roles and the overall volume of training necessary to deliver?
- How do we decide what training is important within our diocese?
- What is our training offer for more experienced parish safeguarding representatives?
- How do we provide effective oversight to all training compliance?
- How do we ensure that commissioned training is of sufficient quality?
- What impact does our training provision have?
- How do we provide support to clergy and volunteers in their safeguarding roles beyond the provision of training?

Standard 8: Quality assurance and continuous improvement

6.8.1 As had been anticipated, Standard 8 proved the to be the lowest scoring of the eight standards. This was due to the need for dioceses to ensure that arrangements were in place for the initial seven standards, before quality assurance and continuous improvement activity could be fully implemented. Having said that, a wide range of learning activities were seen, including past case reviews, commissioned reviews of specific areas of practice, interviews with previous safeguarding postholders, participation in statutory reviews, audits and quality assurance of casework practice, peer audit arrangements, audits of parishes and other areas of ministry, SWOT analyses, feedback forms for service users and the use of the CSSA audit reports of other dioceses. With a readily available range of learning activities to hand, trustees should look to use them in a structured manner to test whether their diocese is a safe place for all, to continuously improve practice and to close the loop on learning by testing the outcomes of this activity.

6.8.2 Dioceses should also look to how they can make learning a routine activity in their existing governance arrangements or, as some have done, through the creation of an audit subcommittee. An alternative approach, seen in some dioceses, is for the safeguarding subcommittee chair to assume a quality assurance role rather than simply acting as a meeting chair. This could be through quality assurance of broad areas of practice or in casework, although care should be taken that they do not to stray into an operational remit.

6.8.3 Trustees are responsible for promoting their diocese's compliance with the national safeguarding standards. As such, it is logical for their safeguarding implementation plan to be structured around the eight standards, as was done in the majority of dioceses. Where this is not the case, care should be taken to ensure that all elements are covered. Better quality plans were completed on a whole diocese basis and did not rest responsibility for actions solely with the safeguarding coordinator. This is significant both in terms of the message of safeguarding being everyone's responsibility and in providing realistic workloads.

6.8.4 Transparency has been touched on under Standard 1 and is again relevant to the substandard relating to the production of an annual report in Standard 8. Few

dioceses had attempted to produce a safeguarding specific annual report (safeguarding would be expected to be included in the annual report and accounts submitted to the Charity Commission). Those that had done so had taken differing views as to the intended audience and it is accepted that annual reports could legitimately serve different purposes, for example a report of the safeguarding team to its trustees or of the diocese to its public. The latter does provide an additional means of providing transparency.

6.8.5 The CSSA does have a follow-up role with dioceses, on the conclusion of their audits.[16] It has been encouraging to see the quality of the action plans produced by some dioceses following their baseline audit and this will serve as a good foundation for the continuous improvement of their safeguarding arrangements.

Good practice examples

Westminster archdiocese's audit subcommittee has, amongst other workstreams, developed a mechanism to seek feedback from survivors and is responsible for overseeing recommendations from any reviews that are undertaken. The group is also responsible for the rolling parish audit programme, in which they work collaboratively with parishes to ensure that a culture of safeguarding is instilled at a local level. Audits involve a subcommittee member and safeguarding team representative visiting the parish to meet with clergy, Parish Safeguarding Representatives and others, while also checking practical arrangements. A report is provided from each audit and any follow-up support necessary for the parish.

Safeguarding coordinators from group of northern dioceses (and one religious life group) have formed a peer support network to learn from each other, share good practice and undertake case audits. By auditing each other's cases they

[16] The nature of follow-up activity varies depending on the grade achieved, further detail is provided on pages 10-13 of the Diocesan Audit and Review Framework DIOCESAN-AUDIT-FRAMEWORK-23-July.docx

benefit from having a second opinion and can share perspectives from differing professional backgrounds.

Questions for trustees to ask

- How do we ensure that we routinely learn from our safeguarding casework?
- What role should our subcommittee chair have in quality assurance and continuous improvement arrangements?
- Does our safeguarding implementation plan encompass the whole diocese and not just the safeguarding team?
- How do we demonstrate that we are a transparent organisation?
- How do we use learning from others' audits and external sources to improve our own safeguarding practice?
- Do we have long term mechanisms in place to measure our quality and effectiveness?

7. Conclusions

7.1 This summary report of the diocesan baseline audit programme presents an emerging picture of compliance with the national safeguarding standards and, in some dioceses, of a level of robustness and quality in arrangements; there nevertheless remains much work to be done. It is encouraging that it has been possible to draw the good practice examples included above from a range of dioceses rather than being reliant on one or two. Where there have been concerns in respect of specific areas of practice, the CSSA have escalated them to dioceses during the course of audits and reached resolutions on all occasions. Broader issues in two dioceses should not be ignored though and both have been the subject of safeguarding reviews, one alongside its baseline audit and the second as a follow-up. The former was due to specific issues relating to the episcopal leadership of safeguarding, while the latter was more wide-ranging. While outside the scope of this report, re-audits of each have evidenced improvements in each

since the time of the reviews. The findings of this audit cycle therefore provide a degree of confidence that dioceses are willing to work with the CSSA to promote the safety of all who have contact with the Catholic Church in England and Wales.

7.2 As previously noted, there was a trend of dioceses scoring increasingly well during the audit programme. It was evident that those audited later in the programme had benefited from the additional time available to them to secure compliance with the safeguarding standards. They were therefore more likely to have a comprehensive suite of policies and procedures, a communications plan, charter or offer for survivors, training needs analysis and other strategies in place. Similarly, learning disseminated from earlier audits was more likely to have been acted on, with more general improvements seen in management oversight for casework and safer recruitment practices. These improvements should be celebrated and do demonstrate the potential of ongoing audit to drive practice improvement.

7.3 Dioceses will already be aware of the recommendations of their own audits and are also encouraged to make use of this overview of overall learning. A small number of issues that require national consideration have also emerged from the baseline audit programme:

- The production and use of key performance indicators for safeguarding oversight, linked to which is how caseloads are counted.
- How assurance is obtained for safeguarding arrangements in other Catholic organisations operating within dioceses.
- Arrangements for incoming overseas clergy.
- Consistency in practice regarding the issuing of celebrets.
- DBS expectations for Parish Safeguarding Representatives.

The CSSA will raise these issues with the appropriate organisations and hold them to account for their response. An update on progress against each will be published by the 30th September 2025.

8. Next steps

8.1 The baseline audit programme has been delivered, as intended, with a purpose of assessing compliance with the safeguarding standards. The focus of analysts has therefore been whether the diocese has the expected policy and governance structures in place and if they are applied in practice. This was reflected in audit tools used and in activity undertaken. Having satisfied itself that dioceses, by and large, do have the underpinning structural and policy framework to deliver effective safeguarding arrangements, the CSSA will now increasingly focus on the quality and continuous improvement of practice. Greater emphasis will also be placed on the delivery of practical safeguarding measures to create a safe environment for all who the diocese ministers to. To recognise this change in emphasis the CSSA will be moving away from the terminology of audit to one of inspection.

8.2 Building on feedback from survivors and the quality assurance team's own reflections, the forthcoming inspection programme will include opportunities for survivors and others who wish to do so to provide feedback about their experiences. The primary means of doing so will be through a public call-out for information. Dioceses will be asked to promote these as widely as possible and to those whom the safeguarding team are working with. The CSSA will utilise its own communication channels, including survivor networks, to support this process. Call-outs have been trialled during the final four baseline audits and were successful in both the volume and range of feedback received. Analysts will continue to take any opportunity to meet survivors or respondents that becomes available.

8.3 Inspections will also include visits to parishes and other ministries provided by the diocese, with a view to speaking to those involved and observing practical safeguarding arrangements. A greater emphasis will be provided to casework audits, as a critical indicator of the quality of practice. The inspection programme will take place between the summer of 2025 and early 2028. The timing and sequence of inspections will be risk based, with the primary factors being length of time since the baseline (or follow-on) audit and the grade received then, although a broader based and more sophisticated measure of risk will be introduced in due course.

8.4 Full information about the inspection programme is available in the published Inspection and Review Framework. Trustees are encouraged to consider how they will evidence the quality and continuous improvement of their safeguarding arrangements and to ask themselves the fundamental question, how do they know that their diocese is a safe place to be?