Adult Safeguarding **Peer Challenge**

Warrington Borough Council
September 2014

Feedback report

Table of contents

Executive summary

Warrington Borough Council (WBC) asked the Local Government Association to run an Adult Safeguarding Peer Challenge as part of sector led improvement. Through a process of internal and external stakeholder engagement WBC asked for the scope to focus upon:

- The quality of front-line practice and management, in particular the difference this makes to the lives of adults who have experienced safeguarding services
- Decision-making at all key stages of the safeguarding process including referral and assessment; protection planning; the use of the mental capacity act; the Deprivation of Liberty Safeguards; and advocacy for people without capacity
- The work of the Adult Safeguarding Board and the broad business of the council and its partners, in particular the concept of 'safeguarding is everybody's business'.

The Team made a number of recommendations that are covered in the detail of this report and which are based on conversations with more than 187 people attending 40 meetings, reviewing 15 case files, visiting partners in a variety of sites across the borough and reading a range of documents. Staff told us that the process of preparing for the Challenge was helpful in itself as it focused on what needed to be done and actions were already being taken as a result.

The findings from this Peer Challenge of Adult Safeguarding at Warrington Borough Council are that:

The Team noted a number of achievements, these included; that there was clearly recognisable, strong leadership across the partnership and this enabled strong partnership working at all levels. Leadership was demonstrated through the Safeguarding Adults Board (SAB), which functioned well and helped ensure there was an impressively high level of self-awareness in the partnership, as demonstrated in the production of a self-assessment document that the peer team's findings broadly agreed with. People spoke openly and honestly with the peers. The partnership has committed, skilled staff with the right values and integrity and the team recognised that these were important cultural traits in the journey to ensuring safeguarding was every body's business and this was demonstrated in the reflection that was brought to bear in the serious case reviews.

However, the Team also noted that it was hard to see where outcomes for individuals were clearly demonstrated. It was recognised that Warrington is on the journey to Making Safeguarding Personal (MSP) but that this was in its infancy and more needs to be done to evidence that people set their safeguarding interventions and get what they want to achieve from these. Referrals from the general public are low and more needs to be done to raise awareness of what safeguarding means and how people can access interventions, particularly amongst those traditionally hard to reach groups of vulnerable people. Market development desperately needs strengthening, particularly in light of the Care Act's implications. From the

documents reviewed and the people met by the Team the voice of the individual was beginning to come through, although this is not embedded in everything that the partnership does and more needs to be done to build on the existing notable practice.

Other recommendations and comments are detailed in the report.

Report
Background

1. The senior management of WBC's Adult Social Care services commissioned an LGA Adults Safeguarding Peer Challenge to gain an external perspective of how they and partners were undertaking their roles to safeguard vulnerable adults in the borough. The Challenge was undertaken at a time of change for the Council with a new Executive Director having recently taken up post, the appointment of a new Independent Chair of the Safeguarding Adults Board (SAB) who also chaired the Local Safeguarding Children Board (LSCB) and the appointment of a new interim Director of Adult Social Care. There were other recent changes that the Team were made aware of, not least the local impact of NHS reforms. The Team was also aware that Warrington were preparing for a Peer Challenge on their Children's Services to follow the Adults' Challenge.

2. A peer challenge is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer challenge is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.

3. The basis for this challenge is the LGA Standards for Adult Safeguarding (Appendix 1). A range of guidance, tools and other materials has been produced by national and local government, the NHS, police and justice system in recent years. The LGA Standards reflect this. The headline themes are:

    - Outcomes
    - Experiences of people who use services
    - Leadership
    - Service delivery and effective practice
    - Performance and resource management
    - Safeguarding Adults Board - Working together

4. The members of the Peer Challenge Team were:

    - **Joy Hollister –** Director of Children's, Adults and Housing Services, London Borough of Havering
    - **Cllr Mike Connolly –** Leader, Bury Metropolitan Borough Council
    - **Ros Keeton -** Chief Executive, Birmingham Women's NHS Foundation Trust
    - **Emily White –** Head of Safeguarding & Quality Improvement (Adult Services), Central Bedfordshire Council

- **Caroline Barlow –** Assistant Director - Contracting & Business Support, St Helens Metropolitan Borough Council

- **Michael Laing –** Service Director, Social Care and Housing - Gateshead Council

- **Luke Nightingale –** National Graduate Programme, London Borough of Waltham Forest

- **Jonathan Trubshaw –** Peer Challenge Manager, Local Government Association

5. The Team was on-site from 15th – 19th September 2014. The programme for the on-site phase included activities designed to enable members of the Team to meet and talk to a range of internal and external stakeholders. These activities included:

    - interviews and discussions with councillors, officers and partners

    - focus groups with managers, practitioners, frontline staff and people using services / carers

    - reading documents provided by the council, including a self-assessment of progress, strengths and areas for improvement against the LGA Standards for Adult Safeguarding

    - A comprehensive review of a select number of case files

6. The Peer Challenge Team would like to thank staff, people using services, carers and councillors for their open and constructive responses during the Challenge process. The Team was made welcome and would like to thank the Executive Director of Families & Wellbeing, Steve Reddy and his team, particularly Kellie Williams and the Challenge preparation team, for their invaluable assistance in planning and undertaking the Challenge.

7. Our feedback to the Council and partners on the last day of the Challenge gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the Challenge. The report is structured around the main areas of the Standards for Adult Safeguarding listed above.

8. 'No Secrets' (DoH 2000) provides the statutory framework and guidance for adult safeguarding. This defines 'a vulnerable adult' as 'a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'. The previous Government published a Challenge of No Secrets with the following key messages for safeguarding:

    - safeguarding must be empowering (listening to the victim's voice)

    - everyone must help empower individuals so they can retain control and make their choices

- safeguarding adults is not like child protection – vulnerable adults need to be able to make informed choices

- participation / representation of people who lack capacity and the use of the Mental Capacity Act are important.

The Care Act has now gone through Parliament and puts Safeguarding Adults Boards on a statutory footing. Safeguarding remains a complex area of work and case law continues to test the basis on which it is undertaken.

Outcomes

Strengths

- Good practice evident on the ground
- Early planning in transition impacting positively
- Case studies used to consider outcomes achieved and reflect on practice
- Seeing good examples of person-centred approaches
- Work on dignity in Prisons
- Good use of advocacy to improve outcomes
- Good ambition for MSP

Areas for consideration

- Feedback loops – you said, we did
- Thresholds inconsistent
- Timely feedback on outcomes from Safeguarding investigations
- Need to define what you mean by an outcomes focused approach – refer to LGA/ADASS outcome measures and embed in practice
- Develop an agreed approach to positive risk taking

9. The Team was impressed by the case study examples of good practice that Warrington was able to use and the level of reflection that went into these. Of particular notable practice was the way in which the Transitions team were able to identify the complex cases for transition from Children's to Adults and were working well across both services. The benefits of having both services in one place meant that an individual's life journey was being recognised and beginning to be recorded. The inclusion of the Child Sexual Exploitation team in transition discussions was innovative and noteworthy in that it allowed young people, who may not realise they were being exploited, to have their risks identified with the potential of having harmful behaviours addressed before they go into adulthood. There was also noteworthy practice around engagement with the two prisons, including a focus on prisoner to prisoner advocacy, with a view to the prisoners who are caring being able to access an NVQ which would potentially reduce recidivism and improve their life chances.

10. Advocacy appeared to be used well with examples of the individual's wishes being identified and respected. Examples the Team were made aware of

included a mother and daughter who could not agree on whether the daughter was at risk, on how to help her or whether to let her take the risk. Advocacy was put in place for both the mother and daughter, both of whom were then heard and the risks identified.

11. There is ambition to Make Safeguarding Personal (MSP). However, this now needs to be translated in to effective practice that can be seen to be done through evidence from case file records, as well as in recognised practice through feedback from service users.

12. The Team heard from service users, carers and health professionals that they gave what they perceived to be safeguarding information to the Council but that they then were not always kept informed as to what the next steps or outcomes of this were. The Council needs to make sure that timely feedback is given to those who provide information and especially on the outcomes of any safeguarding investigation that may result; whatever that outcome may be.

13. While the introduction of a triage system in the Access Social Care team had brought about improvements to responses to alerts relating to older peoples services, the Team became aware that there were inconsistencies in the application of thresholds across the department. The Council needs to be firm in ensuring that thresholds are applied consistently and this will become increasingly important as austerity measures have a deepening impact across the partnership.

14. There was a lack of clarity from the people the Team spoke to about what they considered to be an Outcomes Focussed Approach. The Council needs to be very clear on what it means by this and ensure that this ties in with your work on MSP. The LGA/ADASS guidance may be of help in reaching a commonly agreed definition across the partnership. The Council also needs to be clear on the approach adopted towards positive risk taking, both in regard to individuals and their behaviour and in the Council's approach with providers.

Suggested Actions:

1. Develop a system to record outcomes and service user involvement and to ensure service users receive copies of their safeguarding plans, with an associated audit process to monitor how these are achieved.

2. Train social care workers in person centred and outcome focused practice.

3. Develop a system to feed back results and outcomes to the referrer and to monitor that this is being consistently undertaken.

4. Operational staff are involved in routine audit work.

5. Ensure that there is a consistent model of triaging safeguarding alerts across adult social care

People's experience of safeguarding

Strengths

- Learning disability advocacy
- Residents surgeries held by care quality officers
- 'Speak Up' do peer reviews
- Safeguarding feedback form showing positive experiences but low levels of participation
- CSP gather views from Area Boards and can evidence outcomes
- Evidence of willingness to work outside eligibility to improve outcomes

Areas for consideration

- Some people not knowing they were in a process
- Some inconsistency in the safeguarding process
- Some inconsistency in MCA
- Started to collate feedback but small numbers so far – consider other methods
- Nothing about us without us
- Audits could routinely feature feedback loops
- People alleged to be causing harm perceive they wait a long time for outcome

15. Warrington has developed some effective mechanisms for engaging with people. The way in which the independent advocacy service (Speak Up) engaged with people with learning disabilities was of particular notable practice, both in their one to one and group work as well as conducting commissioned pieces of research. The Team was impressed with the use of drawings and words that were meaningful to the participants as an easily understandable and engaging way of capturing what people wanted to be said. The residents' surgeries, held by the Care Quality Officers, were another way of actively engaging with people and the feedback about these was positive. The Safeguarding Feedback Form appeared to be another useful initiative to acquire information and what people were saying about their experience was also broadly positive. However participation and response rates were disappointingly low with only 17 completed at the time of the Challenge and the Council will want to ensure that data from a

small base is not relied upon to provide a whole system perspective. This has the potential to provide a rich source of information in the future and the Council needs to promote its use and agree how the information gathered will be used in conjunction with other feedback mechanisms, for example smart-phone apps, to demonstrate outcomes and inform service improvements. The Council needs to consider how to enhance the quantity and quality of people's feedback so that it can be included in everything that you do.

16. The Community Safety Partnership (CSP) is linked to the area boards and is monitoring the impact of the work it undertakes. This is a strong and established partnership with robust relationships between members, especially with the Police. The Council should build on this existing practice and link with other safeguarding work to help evidence outcomes.

17. The Team noted that there was some flexibility in the way that thresholds were applied and that this enabled a people focused approach that helped deliver targeted outcomes for individuals. The Council needs to consider if this is a sustainable model and determine what its core business is. In an environment of austerity more needs to be done to develop the voluntary sector and improve signposting to where support can be obtained. This will help ensure greater consistency in the safeguarding and Mental Capacity Act (MCA) work.

18. While there was evidence of good practice with the AMPH and BIA roles embedded in the front line teams, use of the MCA and HRA was inconsistent. Strengthening a focus on good practice in these areas at the start of safeguarding interventions would strengthen the basis for intervention, improve consistency, reduce potential for over reliance on third party information, provide an evidence base for decision making and ensure that the wishes and feelings of people are central to the process.

19. Some of the people that the Team spoke with, when asked about their experiences of the Safeguarding process, said that at the time they were not aware that they were in fact within the process. From the people the Team spoke with involvement in safeguarding meetings by people and their representatives was rare. Professionals need to contact people as soon as they enter the safeguarding process and keep them informed all the way through, involving them in meetings wherever practically possible. Where and when handovers occur between professionals it needs to be part of process that the people involved are kept informed and that this is clearly evidenced in the records.

20. Evidence that the Team heard from the Providers' Forum meeting and also from the Police indicated that some people who were alleged to have been causing harm perceived that they waited a long time to hear of an outcome. The Team was aware that the Council is tracking waiting times on a weekly basis. More needs to be done to counteract people's misperceptions and where waiting times are slipping to keep people informed of the reasons for a delay (such as police investigations of alleged criminal activity) and what action is being taken.

Suggested actions:

1. Ring and speak with people when undertaking case file audits and include their feedback on the file and elsewhere in the evidence gathering and monitoring systems.

2. Ensure people are notified if and when they are brought into the safeguarding process and make sure they receive regular and timely information on the outcome of the process.

3. Review the approach to safeguarding meetings so that people and their representatives are fully involved in decision making.

Leadership

Strengths

- New Executive Director starting to drive change
- Council commitment to safeguarding - Pledge
- Lots of ambition
- Very impressive partnerships
- Centralised safeguarding unit and co-location with quality assurance and contract management
- Self-awareness
- Well-resourced department
- Independent Chair of Safeguarding Board
- Links across CSP, HWBB and SAB
- Learning organisation

Areas for Consideration

- Strengthen member awareness to improve assurance
- Consider the priority given to democratic scrutiny of safeguarding
- Plethora of plans and initiatives – consider prioritisation and critical path
- Strategic Commissioning structure fragmented and confused
- Unclear accountability of commissioning to DASS
- Need for coherent prevention strategy

21. From the people that the Team talked with, the view was that Adult Services was well led with good, visible leadership from the recently appointed Executive Director. The Team was impressed that the Council had Safeguarding as one of its core 'pledges' and this gives the mandate for the ambitious focus that the leadership is giving to this area of work.

22. The self-assessment, undertaken in preparation for the Peer Challenge, identified partnership working as a strength and the Team found good evidence to support this assertion. Partnerships were well developed, supportive and mature enough to engage in more robust challenge. It was clear that there is a high level of self-

awareness with learning being gained not only through this Peer Challenge but also from other Challenges commissioned for Children's inspections and reviews. The focus needs to be on using that learning and not continually undergoing the reflective process. The appointment of the Independent Chair of the Safeguarding Adults Board (SAB) was considered to be a good move by many of the people contributing to the Peer Challenge, as were the links across the CSP, the Health and Wellbeing Board and the SAB.

23. The centralised safeguarding unit and the co-location of quality assurance and contract monitoring is enabling high value information to be gathered, interpreted and used to inform continuing service improvements. There was an example of notable practice in having social work link workers with care homes, who also fed into the quality intelligence mechanisms. The Team recognised that it was "early days" in the combining of Children's and Adults systems and that the Council would want to continue to focus on the this area of work to ensure that it is fully embedded.

24. In the opinion of the Team, Adult Social Care appears to be well resourced with managers. This is a strength, in that this provides an opportunity for maintaining good relationships with partners through meetings. However, the Council may wish to consider how this capacity can be sustained in the future.

25. Elected member awareness needs to be strengthened so that they are able to effectively scrutinise safeguarding measures and outcomes. The Council needs to be assured that people are safe and may want to consider how robust the existing mechanisms, including receiving the annual report at Policy Committee, are for informing elected members that this is the case. At the time of the Challenge the Team understood that 18 members had been through initial safeguarding training but that since then no further activity had been undertaken.

26. It appeared that a lot of policies and associated documentation have recently been brought in, some since June 2014. Whilst this demonstrates an ambition to establish good practice the Team was concerned that they did not see a clear prioritisation or critical path for implementing and embedding these across the partnership; without which there is potential for duplicated effort, putting further strain on resources. With the preparations for the Care Act and the Children and Families Act the partnership will need to ensure it is clear what needs doing first and that there is the capacity to deliver. A clear, overarching plan would help all those involved in safeguarding to understand the influences and partnership's response to these.

27. The Team found that strategic commissioning was fragmented and confused. The commissioning cycle of identifying needs, having a clearly defined commissioning strategy, delivering on the plan by managing the market and then using the intelligence from the quality hub to reshape the loop on an on-going basis was not in place. The market strategy for older people had recently been put in place and at the time of the Challenge there was not one for Learning Disability or other sections of the community and these need to be developed as a matter of urgency to ensure there are clear lines of accountability of how the commissioning links to the person with statutory responsibility.

Suggested actions:

1. Raise the profile and understanding of adult safeguarding with elected members by amongst other things, launching *corporate carers* (based on the concept of *corporate parents* for looked after children).

   "Councillors' Briefing: Safeguarding Adults" LGA 2013 is a useful guide *http://www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/3510589/ARTICLE*

2. Decide on and implement an effective commissioning structure that influences and is informed by the local market so that policy outcomes are delivered; the accountability is with the DASS therefore so should be the commissioning responsibilities.

Service Delivery and Effective Practice

Strengths

- Effective practice is keeping people safe across the partnership
- Good partnership working e.g. Emblem and home checks
- RSL's engaged and focused on vulnerable adults
- Public health conscious of their role in safeguarding
- Good intelligence sharing across partners
- Evident benefits of co-locating safeguarding in care quality
- Training seen as good and budgets protected
- Proactive quality management

Areas for Consideration

- Consider the operation of the Out of Hours team
- Need for proactive action on quality issues
- Consistency in safeguarding response
- Audit process needs aligning to MSP and ask 'what difference we made'
- Consider the capacity of the IMCA service
- Consistency of thresholds – NFA 27%
- Need for workforce plan
- Strengthen the role of the PSW in safeguarding assurance

28. The Team found that there were a number of partnership initiatives that were being well delivered to keep people safe. These included notable practice through Emblem and Aqua (home checks with a pharmacist to check on the appropriate use of medications). Registered social landlords were well engaged and displayed a willingness to identify and work with their vulnerable adult tenants, increasing capacity within the wider social care workforce. Health were providing support and resources into the care home sector including; specialist services and equipment and a fixed-term appointment of a GP lead.

29. Public health partners are aware of their role in the safeguarding agenda and have trained their staff in the relevant issues. In the wider partnership the Team

found that the people they spoke with valued and appreciated the training that was offered to them. Partners also appreciated the open access to training with no or limited cost to them for attending. The Council will need to consider if this model is sustainable in the future (the Team was aware that the budget was currently protected) and to explore with partners how they can contribute to the development of the workforce. The SAB training sub-group was in its infancy with an ambitious agenda. Consideration of a competency framework for safeguarding may assist in developing the approach to training. Additionally, the training offer did not appear to sit within a clear workforce plan for the wider social care workforce. Any workforce strategy will need to take into account the demands of the Care Act and MSP.

30. From discussion with frontline staff the Team heard that the out-of-hours service was putting pressure on the Approved Mental Health Practitioners (AMPs), with people being on call and then being in work the next day as normal. The Council may wish to consider how this is addressed as a capacity issue, although this may be covered through the existing budget strategy.

31. The social care audit process needs aligning to your approach to MSP. The existing process appeared to be relatively robust although the attention to outcomes was not as strong as it could be and will need refocusing. Alongside this, themes and learning from audit should be used to inform the SAB, rather than a focus on the audit process itself.

32. In the Team's view the Independent Mental Capacity Advocate (IMCA) service appeared 'light', with 1.8 IMCAs covering four boroughs. Although the Team were not able to comment on whether the service was adequate for the needs of Warrington's residents the Council may wish to undertake its own assessment, particularly in light of the recent Supreme Court ruling and the impact that that may have on the demand for services.

33. There appeared to be some inconsistency in the application of thresholds with 19% of safeguarding alerts deemed to require no further action, once they had gone through the initial screening. By agreeing thresholds with partners and raising general awareness throughout the partnership and particularly with those undertaking the initial gatekeeping role, a more consistent use of thresholds would be enacted, saving time and resource.

34. The role of the Principal Social Worker (PSW), although relatively recently appointed to, needs reviewing and strengthening in order to deliver adequate safeguarding assurance. At present the PSW role is undertaken as an additional set of duties to an existing role and the Council will need to consider how resources are moved around the department so that the PSW can have a greater impact on improving day-to-day social work practice.

Suggested actions:

1. Develop a comprehensive Workforce Strategy for the wider social care workforce that takes into account current and potential changes in service provision. Plans should include scenarios for at least the next five years including training and development of the workforce to meet these foreseen changes.

2. Further strengthen the audit process by developing a system to ensure referrers are given feedback, a focus on making safeguarding personal and that learning and themes are fed into the SAB and its sub groups.

3. Consider review of the content and format of the adults safeguarding policy and procedures to combine these into one more easily accessible and navigable document that is more reflective of current and developing practice.

Performance and Resource Management

Strengths

- Partnership contract monitoring impacting positively
- Combined unit for Safeguarding and QA making a difference – intelligence in one place
- Robust and cascaded case file audits is improving practice
- Developing performance sub-group on SAB
- Safeguarding and social work activity appears to be well resourced

Areas for Consideration

- Focus on outcomes not activities, inputs or outputs
- Measuring but missing the point. Need to revise the performance dashboard to include key outcome measures
- Ensure new CCG approaches are embedded into the multi-agency approach
- Make sure people are spending the most time on the most important things
- Consider how form follows function
- Safeguarding and DoLS not identified in corporate risk register

35. The Team thought that contract monitoring was impacting positively on the partnership's performance. There was notable practice in the multi-agency way in which information was used including intelligence being taken from health and used across the partnership, demonstrating good links between agencies. The Team was also impressed with the way in which case file audit information was cascade and used to improve performance.

36. As with a range of practice that the Team observed that there was a newly re-formed Performance sub-group. Again this demonstrates the Council's ambition to make progress on a number of areas relating to safeguarding and it will need to consider how this fits within the overarching strategy and what prominence and resource it can dedicate to the sub-group's work.

37. The Team considered that the focus of departmental activity was on processes and ensuring that documentation and document systems were robustly in place. Although the Team acknowledged that these were important, the focus on outcomes did not seem to be sufficiently well developed. More needs to be done to be clear about what makes a difference (and what that difference is) for the

individual. At the time of the Challenge it was not clear to the Team that what was being measured enabled senior managers and elected members to determine the impact of the activities being undertaken. The dashboard indicators may need reviewing so that the information is relevant and more easily used to effect change.

38. The Team saw evidence that the Clinical Commissioning Group (CCG) were endeavouring to lead the integration of health information from a wide range of sources in their performance monitoring of the care home sector and this should be built upon. However, it appeared that this sat parallel to the multi-agency approach being undertaken by other partners. It is therefore incumbent on the CCG to consider how their approaches can integrate further into the wider partnership process and for the Council to consider if their processes are suitable for all partners because partners will develop their own processes if the partnership wide process does not work for all.

39. The Team thought that it was important for the Council to consider what was most important for it to work on and then to put structures in place to ensure that these were delivered. This methodology is of particular significance in the approach undertaken to commissioning. The desired outcomes for developing the domiciliary care market should dictate how commissioning is structured so that it is ready to provide for the requirements of the Care Act.

Suggested actions:

1. Consider implementing the LGA Making Safeguarding Personal outcomes measures so as to drive the necessary change in culture and practice.

Working together – Safeguarding Adults Board

Strengths

- Independent chair across both adults and children's is making a difference
- Right people, right level, right relationships
- Sighted on and prepared for the Care Act
- Clear link to HWBB and CSP
- Not afraid to bring challenge to the partnership and recognise the need to challenge more
- Use of BCF to give capacity
- "Independent chair is really making a difference, it feels like it's a real partnership now and not a Local Authority board"

Areas for consideration

- Lead Member for adults to consider joining the Board
- Push on with Member training
- Capacity and resources for the Board
- Further development and use of Healthwatch
- Engagement strategy to be developed
- How are the Board sighted on provider quality issues?
- How to demonstrate outcomes for people?
- Themes and actions from audits to feed into Board

40. The Team found that the arrival of the Independent Chair of the SAB was very widely welcomed and that she was respected across the partnership. There was an appreciation of the potential to learn across Children's and Adults and links to other boards could also provide strengths and reduce duplication of effort. There was a culture of challenge in the partnership and a willingness amongst partners to challenge each other even more robustly in the future, which when developed will bring even greater strength and depth to the Board. The Team felt that the culture within the Warrington SAB was more inclusive than other safeguarding boards that the Team members were familiar with and that this was a significant

strength. However, as the lead elected member for adults, the portfolio holder should be on the SAB to ensure democratic representation.

41. To continue to function well the Board needs to be adequately supported and chaired. More thought needs to be given to ensuring the independent chair has sufficient time and resources to conduct the work that the partnership members require, particularly as the SAB moves to a statutory board in the not too distant future.

42. The SAB need to develop an engagement strategy so that the voice of service users is adequately and appropriately heard. This is not about tokenism with a service user representative sitting on the board but about developing a sustainable mechanism for engaging with people so that their voices and stories are heard. The strategy should also include a feedback mechanism so that when people provide information they are made aware of subsequent outcomes and what has changed as a result.

43. The Board needs to be clear on how it demonstrated that it is making a difference. Partners will need to be aware of what return they are getting for supporting the SAB, as well.as showing how the work of the Board is making people safer.

44. The Team received conflicting evidence as to how themes and actions of audits and provider quality issues were fed into the Board. The Board needs to make partners aware of what is and is not its business and how areas of concern are picked up and dealt with, both at a partner and individual level. This needs to form part of the Board's communication strategy, which in turn needs to fit with the partner organisations' communication strategies.

Suggested actions:

1. Have a service user case study presented by a user, carer or family member at the start of every Board meeting to ground and make relevant subsequent discussions and decision. Also, find other ways of gathering users' and carers' views and feeding them into the Boards planning.

   The SCIE guide "User involvement in adult safeguarding" attached is a useful resource:
   http://www.scie.org.uk/publications/reports/report47/files/report47.pdf

2. Build a 3-5 year strategy with the Board members that they can own. Deliver it with an annual business plan, which you review at the year end with a published SAB annual report, (every action in the business plan must be tied in to the delivery of the strategic objectives).

   A lot of Boards now have a published strategy on their website. here are two examples (also attached)
   http://ersab.eastriding.gov.uk/easysiteweb/getresource.axd?assetid=260528&type=0&servicetype=1
   https://www.newcastle.gov.uk/sites/drupalncc.newcastle.gov.uk/files/wwwfileroot/health-and-social-

care/newcastle_safeguarding_adults_board_vision_and_prirotieis_2014-2016_-_final.pdf

3. Review sub-groups to ensure they will facilitate delivery of the strategy and consider sub-strategies such as; workforce planning, communication, etc.

4. Develop a dashboard of outcome measures (mixture of outputs, outcomes and subjective measures) that really will tell them how they are making a difference. Make it a standing agenda item and drive up performance through it.

   Nottingham City Council is in the design stage of developing a real time cloud based browser, which will hold all contractual and regulatory information from the Council, health partners and CQC in relation to regulated providers. The aim of the 'Dashboard' is to share information in relation to the current status of providers, to which practitioners can refer. It is anticipated the pilot will go live in autumn 2014. For more details contact: Julie.Sanderson@nottinghamcity.gov.uk .

   The LGA/ADASS report "Making effective use of data and information to improve safety and quality in adult safeguarding" is also a useful resource: http://www.local.gov.uk/c/document_library/get_file?uuid=92848e3c-50a8-4ac3-8110-da12c793c90f&groupId=10180

5. Plan for how the Board will meet new statutory status under the Care Act ensuring adequate support and chairing resources.

Summary

- Is Safeguarding everybody's business?

  Yes

- What is the quality of frontline practice?

  Good – overall

- What is the quality of decision making at all key stages?

  Variable – inconsistent involvement of people and Members

- Decide what is important and deliver it

45. In response to the three key questions the Council asked the Team to consider, the Team's view was that from the evidence that they gathered safeguarding did appear to be everybody's business. The Partnership takes safeguarding seriously and it is embedded across the partners. There are areas for further development and on the whole the partnership displays a high level of self-awareness as to where these areas and what specific issues are.

46. Overall the frontline practice observed by the Team was good. There was variability in some practice and steps are being taken to address this. However, a lot of these steps have been started recently and clear impact evidence has yet to be gathered or disseminated.

47. The Team found that the quality of decision making was variable with inconsistent involvement of people at key stages, including not being given information on outcomes of processes or decisions. The voice of people and members not only needs to be heard but needs to be demonstrated that it has been heard through clear and consistent reporting and record keeping.

48. There has been considerable recent change both in the Council and within the partnership, including in key leadership positions. In line with these changes a range of initiatives have been started and the Council, with its partners, need to prioritise which actions to lead with and ensure that these are delivered. There also needs to be a clear mechanism for reporting what has been done and what lessons have been learnt from undertaking them.

Contact details

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For more information on Adult Safeguarding and Adult Social Care Peer Challenges and Peer Challenges or the work of the Local Government Association please see our website www.local.gov.uk/peer-challenges

Appendix 1 - LGA Standards for Adult Safeguarding Peer Challenge

The standards are derived from:

- CQC performance and board reports
- The No Secrets Review
- LGA engagement with safeguarding developments
- Broader local government and NHS developments

The standards are grouped into four main themes which are further divided into sub themes:

Themes	**Outcomes for and the experiences of people who use services**	**Leadership, Strategy and Commissioning**	**Service Delivery, Effective Practice and Performance and Resource Management**	**Working together**
Elements	**1 Outcomes** **2 People's experiences of safeguarding** This theme looks at what difference to outcomes for people there has been in relation to Adult Safeguarding and the quality of experience of people who have used the services provided	**3 Leadership** **4.Strategy and** **5. Commissioning** This theme looks at the overall vision for adult safeguarding, the strategy that is used to achieve that vision and how this is led and commissioned	**6. Service Delivery and effective practice** **7. Performance and resource management** This theme looks service delivery, the effectiveness of practice and how the performance and resources of the service, including its people, are managed	**8. Local Safeguarding Board** This theme looks at the role and performance of the Local Safeguarding Board and how all partners work together to ensure high quality services and outcomes

For the complete, detailed version of the LGA Standards for Adult Safeguarding please go to:

http://www.local.gov.uk/web/guest/peer-challenges/-/journal_content/56/10171/3510407/ARTICLE-TEMPLATE