

Bath & North East
Somerset
Adult Safeguarding
Peer Review Report

March 2015

Executive Summary

As part of the South West ADASS programme of sector led improvement quality assurance and improvement Bath & North East Somerset Council (B&NES) requested the Local Government Association undertake an Adult Safeguarding Peer Review. B&NES was seeking an external view on the quality, processes and procedures of Adult Safeguarding in the context of B&NES local integrated arrangements and the delivery of key adult safeguarding functions by Sirona and Avon and Wiltshire Mental Health Partnership Trust (AWP). The scope of the peer review is to review and “test” the clarity of accountability and the associated assurance systems, processes and mechanisms with particular emphasis on context-specific learning and improvement.

After due consideration across the variety and complexity of the adult safeguarding business of B&NES, the Peer Review Team made a number of recommendations covered in the detail of this report. Participants in the peer review process told us that the process of participating in the review was helpful in itself as it focused on what needs to be done and actions were already being taken as a result.

Headline messages

Bath & North East Somerset Council and the Clinical Commissioning Group (CCG) have shown real system leadership in the way integration has been progressed over a period of four years. The development of Sirona as a community interest company providing a wide range of publicly-funded care and support services, including community healthcare, children’s healthcare, public health services and adult social care services and generic social work, put you ahead of the curve. A strong focus has been maintained on assurance and development of robust processes to support this.

There is strong recognition by the Council and CCG of the need to continue the journey of integration. This is evident in the creation of a new post across both organisations to progress joint commissioning and the vision of integrated services through the ‘*your care, your way*’ two year project to review, design and deliver integrated community services in partnership with local people. All of the partners, managers and staff the Peer Review Team met are clearly committed and enthusiastic to ‘get things right’ in relation to adult safeguarding, thus providing an opportunity to progress integration at all levels - and with some pace.

There is a real importance to ensure the safeguarding prevention and early intervention narrative is ‘live’ for citizens and practitioners. This would include being clear for those trying to implement it what is understood by ‘prevention and early intervention’ within the context of your aim to empower people to remain in control of their own lives. Making Safeguarding Personal is starting to offer solutions that will be evaluated to help in understanding the effectiveness of interventions, complement your renewed focus on outcomes and provide a platform for best practice sharing.

The Council and its partners have identified a desire to improve engagement and co-production. Co-production needs to become your new ‘norm’ so that you not only retain assurance but can unleash further your potential for creativity and innovation. As co-production goes further than engagement there needs to be a plan as to how

service users, and carers, will be involved in the design preparation and implementation of changes in order to demonstrate true co-production.

Whilst it took a strong commitment to get to the front with integration and the creation of Sirona you now need to use your strong partnerships and four years of learning as a basis to consider how you move forward together with focus and pace to stay 'ahead of the game'.

Report

Background

1. As part of the South West ADASS programme of sector led improvement quality assurance and improvement Bath & North East Somerset requested the Local Government Association undertake an Adult Safeguarding Peer Review.
2. The Council intends to use the findings of this Peer Review as a marker on its improvement journey. The specific scope of the work was:
 - a) The quality, processes and procedures of Adult Safeguarding in the context of B&NES local integrated arrangements and the delivery of key adult safeguarding functions by Sirona and Avon and Wiltshire Mental Health Partnership Trust (AWP).
 - b) Review and “test” the clarity of accountability and the associated assurance systems, processes and mechanisms with particular emphasis on context-specific learning and improvement
3. A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review 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.
4. The basis for the context of the review was 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 contextual themes used were:
 - Outcomes for and experiences of people who use services
 - Leadership, Strategy and Commissioning
 - Service delivery and effective practice, performance and resource management
 - Working together – the Safeguarding Adults Board

The main focus of the review was the following questions:

- Is it clear and understood by all where accountability sits?
 - How do the individuals/bodies/organisations with accountability get assurance and provide upwards assurance?
 - Are assurance mechanisms and processes robust, providing genuine *assurance* rather than *reassurance*?
5. The members of the Peer Review Team were:
 - Stephen Chandler, Director for Adult Services, Shropshire Council

- Fran Leddra, Strategic Lead, Safeguarding, Complex Care and Social Work, Thurrock Borough Council
 - Councillor Ruth Dombey, Leader of the Council, London Borough of Sutton
 - Kay Burkett, Challenge Manager, Local Government Association
6. The team was on-site from 23rd – 25th March 2015. 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 and partners
 - reading documents provided by the council, including a self-assessment of progress, strengths and areas for improvement against the three main questions

The review did not include looking at case files.

7. The Peer Review Team would like to thank staff, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made welcome and would in particular like to thank Jane Shayler, Director Adult Care & Health Strategy and Commissioning, Lesley Hutchinson, Head of Safeguarding & Quality Assurance and Clare Tozer for their invaluable assistance in planning the review.
8. Our feedback to the Council and partners on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review. The report is structured around the main areas listed above.
9. The Care Act puts safeguarding adults on a statutory footing. Safeguarding remains a complex area of work and case law continues to test the basis on which it is undertaken.

Leadership, Strategy and Commissioning

Strengths

- Joint Health & Wellbeing Strategy (JHWS) sets out a clear vision for prevention, integration and care tailored to meet the needs of individuals
- Good understanding of adult safeguarding and universal commitment in wanting to get it right
- Sirona as a community interest company is an innovative model
- Commissioners and providers work well together with clear expectations and reporting requirements in place
- Commissioning and contracting sets out quality assurance and service standards for safeguarding

Areas for consideration

- Develop the views and experiences of people who have used services so they are incorporated further into strategies, plans and commissioning processes
 - Pushing integration much further e.g. pooled budgets, dashboards
10. The JHWS, Better Care Fund plan and the '*your care, your way*' project set a clear commitment to prevention, integration and care tailored to meet the needs of individuals. There has been a focus on strengthening the long term financial sustainability of the health and wellbeing system through a shift in investment to prevention and there is a desire to make use of new opportunities for patients, service users and carers.
 11. The procedures and processes for safeguarding are widely understood and universal commitment in wanting to get it right. There are many suggestions from practitioners and providers about ways of improving the response to adults experiencing abuse, as well as ways of supporting carers and wider family members. Ways of harnessing these suggestions whilst Making Safeguarding Personal (MSP) is being piloted should be a consideration, including for those adults not entering the safeguarding process.
 12. Sirona Care and Health was created in October 2011 as a Community Interest Company (CIC) to provide integrated health and social care and was one of the first in the country to include both health and social care practitioners. Creating the CIC demonstrates positively the strength of political and strategic management leadership in this endeavour. As an innovative model it has provided a wide range of care and support services, including community care and community, health services, mental health support and children's health care.
 13. Health and social care providers spoke positively of their experience of working with commissioners and there are many examples of the benefits for service users resulting from these strong working relationships. Collaboration rather than 'blame' has enabled an open learning culture where honest conversations take place on a regular basis to complement the formal reporting structure.
 14. There are clear benefits of improved and integrated commissioning, including specifications for safeguarding which are also integral in the procurement frameworks for social care services. There are quality standards in place and contract and commissioning officers are part of the quality reviews looking at safeguarding and report back to the safeguarding team any areas of concern.
 15. There is a commitment to considering feedback from patients, service users and carers in the design and commissioning of safe services that can be developed further in line with your vision for person centred care.
 16. In developing and implementing your 'Making it Real' action plan to embed the principles of personalisation, co-production and integration of adult health and social care commissioning there is an opportunity to consider ways of pushing integration much further. The pooled budgets for mental health and learning disability from April 2015 will also help to progress intervention. The Better Care Fund (BCF) also provides an opportunity to streamline performance reporting to

reflect integration by bringing together aspects of the dashboards that currently duplicate each other.

Outcomes for and the experiences of people who use services

Strengths

- The four 'test beds' provide a really strong framework to make safeguarding personalised and truly involve people
- There are services available to support carers that could be developed further to ensure their voices shape services
- Good examples in commissioning for People with Learning Disabilities

Areas for consideration

- Consider how the voice of Users and Carers can be listened to in a comprehensive and systematic way, particularly in relation to safeguarding procedures & processes
- Develop more qualitative understanding of safeguarding to inform regular reviews of your processes
- How do boards know if they are making a difference?

17. The four 'test beds' for Making Safeguarding Personal (MSP) are being implemented with enthusiasm and energy by practitioners and they are already providing case studies to evidence how this approach is making a difference in relation to defining and achieving clear outcomes for people (victims, perpetrators and families). Use MSP to help you consider how to respond to low level alerts that do not enter the safeguarding process and identify ways of managing less repeat referrals and/or stopping them going so far into the process.
18. There is a joint Carers Strategy in place, a Carers Centre, LSAB consultation and open sessions and signposting to information and services via the Carers' Gateway. Services and processes for carers are monitored but there is currently less emphasis on understanding and responding to the experiences of carers in relation to safeguarding.
19. Learning Disability outcome based commissioning is well established with combined responsibility for social care, specialist health and complex health needs. There is evidence of reshaping the market to provide independent living, shared lives and some employment opportunities. This approach could be used as a model for other commissioning areas e.g. older people and safeguarding. Commissioning development should ensure that the Council and CCG are able to influence commissioning decisions in a timely way, particularly in relation to continuing healthcare.
20. A more systematic way of ensuring the voice of service users and carers in relation to safeguarding is required. Supporting people to develop their capacity for decision making will need to be demonstrated to fulfil your commitment to increasing prevention, self-care and personal responsibility as well as in meeting

Care Act requirements. Mapping existing methods for capturing the voice of individuals e.g. The 'Friends & Family Test' currently used in relation to care homes and patient experience surveys could help inform what could be co-ordinated better across the health and care system so you are assured that people's experiences are not lost within often complex and multiple processes

21. The LSAB and LSCB are committed to making a difference and are keen to put extra impetus into taking safeguarding messages out to wider communities and to develop a more qualitative understanding of safeguarding. A case study was presented at the last LSAB meeting and this approach, if adopted in a more systematic way, could provide valuable information to inform reviews of processes and services.

Service Delivery and Effective Practice, Performance, Resource Management

Strengths

- Strong focus on performance of processes and procedures
- People are clear about how to make a safeguarding alert
- Learning is shared at practitioner level
- GP email account and the use of IRIS software is innovative

Areas for consideration

- Use the people at the frontline to redesign the system with individuals and carers
 - Are language and processes restricting creativity and innovation?
 - Keep the perspective on helping people and families to be more resilient
 - Consider to what degree risk management enables people to take more responsibility for themselves
22. There is a strong focus on performance and processes supported by lots of data informing regular reports to the LSAB and Health and Wellbeing Board (HWB). Resources have been put in place to enable the safeguarding process to be enhanced following monitoring of processes and data trends e.g. the introduction of safeguarding chairs and in respond to an increase in referrals and re-referrals.
23. A stronger focus on outcomes rather than outputs will be the next stage of developing your performance management framework to help evaluate the impact of interventions and inform reviews of the safeguarding system. Enhance this by using people at the frontline to shape the system going forward putting the experience of people and their stories at the heart of redesign.
24. People are clear about how to make a safeguarding alert and are keen to work together to make the system work. There is a universal pride in wanting to get it

right for people and are likely to be supportive of any changes made to improve the efficiency and effectiveness of procedures and processes.

25. The use of the GP email reporting system and the use of IRIS demonstrates the progress being made in embedding safeguarding within partners at both a system and service level.
26. Your clear focus on the development of strong systems and progresses has many strengths, but also risks restricting creativity and innovation. You should seek to use more “test and learn environments’ to both support innovation yet providing reassurance.
27. In the next reiteration of your safeguarding system be assured that commissioning specifications help people to be resilient and there is a strengthened core relating to people taking more responsibility for themselves and the management of risk. Reflect these changes in the information and training provided by the LSAB.

Working together – Safeguarding Adults Board

Strengths

- Strong and well established partnerships have enabled closer working and the development of services
- Children’s and Adults working increasingly closer e.g. safeguarding boards and creation of Head of Safeguarding & Quality Assurance
- LSAB has engaged partners and good participation at the board and sub groups

Areas for consideration

- There is scope to develop the capacity of the voluntary sector to help with prevention and shaping future direction of travel
 - Consider how to reduce barriers to engagement and influence at the LSAB e.g. volume of paperwork and use of jargon/acronyms
 - Volume of bureaucracy
 - Utilise existing methods for safeguarding engagement e.g. ‘your care, your way’ and Area Forums
28. There are well established partnerships in B&NES with many strong and productive working relationships. These include the Council and CCG, commissioners, contract teams and providers, and the local safeguarding boards. Regular meetings mean there are forums to discuss issues and monitor processes.
 29. Children’s and Adults are working increasingly closer with the safeguarding boards planning to share and/or integrate their business support & co-ordination, quality assurance and training. The appointment of the current LSCB Chair as the new Chair of the LSAB will provides an opportunity to raise further the profile and visibility of the LSAB in its new statutory role.

30. You have a strong and committed voluntary and community sector in B&NES who want to be part of shaping the development of services. Enabling more capacity in the third sector will help increase safeguarding awareness and contribute to your prevention and early intervention ambitions. Consider ways of involving the voluntary sector more in assurance e.g. by ensuring everyone new to the LSAB has an induction and is supported to contribute fully and in timely way to discussions and developments.
31. The LSAB has proactively engaged all partners and the right people are at the board. Going forward consider how to reduce barriers to engagement and influence at the LSAB e.g. by reducing the volume of paperwork and use of jargon/acronyms. To further support participation ensure good ideas are encouraged to be brought forward for discussion at the board and sub groups and be clear about how they will be taken forward.
32. Every opportunity must be taken for taking safeguarding messages out into the wider community and to non-traditional audiences, even where it is not the primary focus on the agenda, e.g. Area Forums. The role of elected members and frontline staff can be enhanced by supporting all of them to champion safeguarding in their communities and services through training and briefing sessions. This will add value to your commitment to 'Making Every Contact Count'.

Is it clear and understood by all where accountability sits?

Strengths

- Processes are in place to ensure that safeguarding procedures are applied consistently
- The Quality Assurance Framework is clear and widely understood
- Safeguarding Chairs are adding value to the case management work

Areas for consideration

- Review how accountability is shared e.g. give more autonomy to Sirona
 - Do people going through safeguarding process understand where accountability sits?
33. The concentrated focus in developing and implementing the Quality Assurance Framework has succeeded in providing assurance that safeguarding procedures and processes are applied consistently. The role of the Safeguarding Chairs has been widely welcomed and there are examples of where they are adding value to the case management work and in the application of the procedures.
 34. As the strength of the Quality Assurance Framework has been established the time is right to continue to build the confidence in your processes and procedures by considering how more autonomy could be given to Sirona in relation to safeguarding. 'Walk through' your processes with Sirona and other partners with a fresh look at where accountability could lie e.g. would a straightforward

safeguarding investigation need to be taken back into the Council and might there be a different way to respond to low level incidences?

How do the individuals/bodies/organisations with accountability get assurance and provide upwards assurance?

Strengths

- Lead member has regular meetings with senior officers and provides strong challenge
- Strong partnership with children's will lead to good outcomes
- Use of case studies at the LSAB a good way to know if it is making a difference
- LSAB Chair is inclusive and encourages participation
- LSAB Annual Report goes to HWB and Wellbeing Policy Development & Scrutiny Panel for challenge
- Wide range of methods used to gather data and intelligence regarding risks in services for the risk register e.g. staff feedback forms, service reviews, CQC reports and whistleblowing

Areas for consideration

- Be assured about your outputs and timescales but make it proportionate to a revitalised emphasis on outcomes
- Quarterly Domiciliary Care Strategic Partnership meeting with providers could be utilised better to look at progress in implementing learning & recommendations from safeguarding
- Build on strong commitment from Wellbeing Policy Development & Scrutiny to identify further opportunities to undertake 'deep dives' e.g. in relation to safeguarding prevention and review of procedures and processes to further develop a personalised approach
- CSE/ASE - develop work post 18 to ensure young child is not lost in the system
- Do all alerts have to follow the process – might there be a different way to respond to low level incidences?
- Involve voluntary sector more in assurance e.g. LSAB induction
- Improve feedback to referrers the outcome from an alert e.g. what activity if it doesn't meet the threshold

35. The Cabinet Member for Wellbeing and Co-chair of the Health and Wellbeing Board (HWB) has been proactive in ensuring he is well informed about the adult safeguarding agenda. He attends the LSAB and has been supported well by the Council, CCG and Sirona senior officers with planned meetings established to enable information sharing and challenge to be provided on a regular basis. A newly formed HWB sub group, the Transformation Group, will provide a forum

where challenging issues and opportunities from across the health and wellbeing system can be raised; this is intended to facilitate wider ownership of the safeguarding agenda.

36. Strategic oversight of safeguarding arrangements is provided by the Local Safeguarding Adults Board, the Council, CCG and HWB. Strategic oversight of social care is through the integrated commissioning arrangement and HWB
37. Strong partnership with children's safeguarding processes places you in a great position to support good outcomes. It is important that the opportunities for greater effectiveness and efficiencies through the review of LSAB subgroups gives a place to start the next stage in safeguarding development.
38. Governance arrangements are established with regards to adult safeguarding demonstrated by LSAB annual reports going to the HWB and Wellbeing Policy Development & Scrutiny Panel. The Scrutiny Panel Chair and the Cabinet Member for Wellbeing meet on a regular basis. There is an opportunity for the LSAB to build on the strong commitment from the Scrutiny Panel to identify further opportunities to undertake 'deep dives' e.g. in relation to safeguarding prevention and review of procedures and processes to further develop a personalised approach
39. In relation to Child Sexual Exploitation (CSE) and Adult Sexual Exploitation (ASE) develop work post 18 to ensure young child is not lost in the system.
40. There are a wide range of methods used to gather and triangulate data and intelligence regarding risks in services for the risk register e.g. staff feedback forms, service reviews, CQC reports and whistleblowing. Commissioning teams consult with providers, meet with service users and have developed a stronger focus on prevention in relation to supported housing e.g. by working with providers on ways to avoid hospital admissions.
41. The services that both Sirona and AWP deliver are quality assured through the integrated commissioning performance management arrangement. Service specifications are in place and there is a specific one for safeguarding.
42. During the peer review process it was widely acknowledged that a focus on getting processes and procedures right within the Quality Assurance Framework meant there is further opportunity to ensure that the voice of people is heard through the design of the safeguarding system. Continue to be assured about your outputs and timescales but make it proportionate to a revitalised emphasis on outcomes.
43. Quarterly Domiciliary Care Strategic Partnership meeting with providers could be utilised better to look at progress in implementing learning & recommendations from safeguarding. Other forums might also benefit from an emphasis on shared learning, and look at ways of capturing and scaling up the informal practitioner to practitioner learning.
44. Improve feedback to referrers the outcome from an alert e.g. what activity has been taken if it doesn't meet the threshold.

Are assurance mechanisms and processes robust, providing genuine *assurance* rather than reassurance?

Strengths

- Regular safeguarding audits take place with quality and safeguarding high on the agenda e.g care and nursing home commissioning
- Quality Checkers – very focused and inspiring who feel valued, utilise them more and develop beyond LD
- Transition Assessment has strong safeguarding element

Areas for consideration

- How do people living in B&NES contribute to the LSAB agenda?
 - Focus on process and structure rather than outcomes, more needed to understand the impact on people's lives from safeguarding processes
 - Consider ways of streamlining audits across partners (self-assessments, case file audits)
45. Regular safeguarding audits take place with quality and safeguarding high on the agenda e.g. care and nursing home commissioning and there are examples of pragmatic responses to potential issues e.g. putting an interim registered manager in place in a care home and provision of specific training for a domiciliary care provider. Consider ways of streamlining audits and join up where this is possible.
46. You are starting to put Quality Checkers at the heart of quality assuring learning disability services by listening to what they are telling you and being clear about what has changed as result of their findings. Utilise them more and take the principle of the 'lived experience' across to other areas to add value to more traditional assurance processes.
47. Transition Assessment has a strong safeguarding element with transition planning commencing from age 14 and having a strong risk management focus.
48. More focus is needed to understand the impact on people's lives from safeguarding processes. There is a growing recognition by service users about needing to be more involved helped by MSP. Consider ways of service users being supported to attend strategy meeting, where is possible and appropriate, and ensure the professionals who attend them can add real value. The focus is not everything to do with the person's life it should be those people who are relevant to the safeguarding aspect.
49. The LSAB has reaffirmed for itself the need to raise its profile and continue to reach out to the wider community to enable people living in B&NES to contribute to the agenda.

Key Recommendations

- Progress at pace the implementation of Making Safeguarding Personal (MSP)
- The Quality Assurance, Audit and Performance Management Sub Group – in line with MSP, could develop more qualitative ways of auditing safeguarding
- Revise the 2 day decision rule in relation to MSP
- Consider how you reaffirm the citizen at the centre of everything you do

Next Steps

After due consideration of the issues and recommendations in this summary report the Peer Review Team assume you will take forward aspects of this report in your future plans. We suggest you disseminate the key messages to staff and partners and seek to publish the report.

In due course LGA and South West Regional ADASS will evaluate the progress of this work in line with the wider regional sector led improvement work.

Contact details

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For more information on peer reviews and peer reviews or the work of the Local Government Association please see our website www.local.gov.uk/peer-reviews

Adults Safeguarding resources

1. LGA Adult Safeguarding resources web page

http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/3877757/ARTICLE

2. Safeguarding Adults Board resources including the Independent Chairs Network, Governance arrangements of SABs and a framework to support improving effectiveness of SABs

http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/5650175/ARTICLE

3. LGA Adult Safeguarding Knowledge Hub Community of Practice – contains relevant documents and discussion threads

<https://knowledgehub.local.gov.uk/home>

4. LGA Report on Learning from Adult Safeguarding Peer Review

http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/4036117/ARTICLE

5. Making links between adult safeguarding and domestic abuse

http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/3973526/ARTICLE

6. Making Safeguarding Personal Guide 2014 – the guide is intended to support councils and their partners to develop outcomes-focused, person-centred safeguarding practice.

http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/6098641/PUBLICATION

Appendix 1 - LGA Standards for Adult Safeguarding Peer Review

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	<p>1 Outcomes</p> <p>2 People's experiences of safeguarding</p> <p>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</p>	<p>3 Leadership</p> <p>4.Strategy and</p> <p>5. Commissioning</p> <p>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</p>	<p>6. Service Delivery and effective practice</p> <p>7. Performance and resource management</p> <p>This theme looks service delivery, the effectiveness of practice and how the performance and resources of the service, including its people, are managed</p>	<p>8. Local Safeguarding Board</p> <p>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</p>

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

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