Bournemouth Borough Council Safeguarding Adults' **Peer Review Report**

September 2016

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Executive Summary

Bournemouth Borough Council requested that the Local Government Association undertake an Adult Safeguarding Peer Review at the Council and with partners. The work was commissioned by Jane Portman, Executive Director Adult and Children's Services, Deputy Chief Executive and she was the client for this work. She was seeking an external view on the progress made within the safeguarding adults' arrangements at Bournemouth Borough Council since the last peer review in 2013. 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:

- To test out progress since the 2013 review and have a strong focus on practice
- How has 'Making Safeguarding Personal' been applied in practice and
- How this is strategically progressing against the agenda and how the service is managed and the budget that goes with it.

After due consideration of the documents read and the people seen the peer review team believe that Bournemouth Borough Council have a very clear commitment to keeping people safe, both operationally and strategically. All the elected members, staff and partners that the peer review team met across all organisations were clearly committed to safeguarding vulnerable adults and were passionate about its importance. This is a real strength.

There has been significant progress since the 2013 review. Service users and carers reported that they were supported by people who were kind, who listened to them and who were able to respond flexibly to meet their needs. There was clear evidence from across the partnership that practitioners took a person centred approach to safeguarding. There are opportunities to further develop coproduction with service users and between partners, which may help extend the understanding of outcome definitions for individuals. There was a clear appetite to engage in the safeguarding process and once involved people would welcome more information on the status of the enquiries that they raise.

There was strong leadership both from elected members and officers. The portfolio holder and executive director were able to articulate a clear strategy for safeguarding vulnerable adults and to form effective relationships across the partnership. The principal social worker is respected, both within Adult Social Care and by partners and has formed solid relationships to ensure individuals' needs are met. There are opportunities to strengthen inter-departmental working so that safeguarding is truly everybody's business, including deepening the relationship with housing.

Adult Social Care has a stable workforce that is responsive, knowledgeable and caring. Service users appreciated the continuity of service that they received from staff who were aware of their needs and able to provide flexible solutions. Staff were well supported to manage enquires in a timely fashion and this could be supported further by increasing the access between Care Direct and locality

teams. There was an awareness that the predictions are for an increasing number of older people in Bournemouth and the implications this has for resourcing the future support that they will need.

The relationships between partners at the Safeguarding Adults Board were mature and robust. Colleagues were able to challenge each other with the understanding that this was to improve services. Where partners recognised that more needed to be done, they took action themselves to refocus resources and engaged more fully in the partnership. There were positive links with the Children's Safeguarding Board and learning was shared where appropriate. Partners developed a 'Line of Sight' with service users through the case studies and this helped ground their work. More could be done to more directly engage with service users and cares, building on the Making Safeguarding Personal approach that is clearly evident throughout the partnership.

Report
Background

1. Bournemouth Borough Council requested that the Local Government Association undertake an Adult Safeguarding Peer Review at the Council and with partners. The work was commissioned by Jane Portman, Executive Director Adult and Children's Services, Deputy Chief Executive and she was the client for this work. She was seeking an external view on the progress made within the safeguarding adults' arrangements at Bournemouth Borough Council (BBC) since the last peer review in 2013. 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:

- To test out progress since the 2013 review and have a strong focus on practice
- How has 'Making Safeguarding Personal' been applied in practice and
- How this is strategically progressing against the agenda and how the service is managed and the budget that goes with it.

Peer Review Context:

2. Over the past few years BBC has undertaken a significant transformation. Adult Social Care has undertaken significant change to ensure the implementation of the Care Act 2014, including the introduction of a Principle Social Worker with significant focus on Making Safeguarding Personal. There has been strong managerial and elected member leadership to put the necessary resources in place to address the needs of vulnerable adults. The Council recognises that further work is required to embed the changes brought about by the Care Act, and also seeks an opportunity to reflect on and celebrate positive partnership working and good practice.

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 benchmark for this peer review was the Safeguarding Adults Improvement Tool (Appendix 1). As part of the reason for the review was to monitor progress since the 2013 review this report follows the headings used in the original report. The headings in the feedback took into account the scoping questions outlined above. The headline themes were therefore:

    - Outcomes for, and the experiences of, people who use services

- Leadership, Strategy and Commissioning
- Service Delivery, Effective Practice, Performance and Resource Management
- Local Safeguarding Board

5. The members of the peer review team were:

- **Margaret Willcox OBE**, Commissioning Director and Director of Adult Social Care Services, Gloucestershire County Council
- **Councillor Philip Corthorne**, (Conservative), Cabinet Member for Social Services, Housing , Health and Wellbeing, London Borough of Hillingdon
- **Vicky Allonby**, Senior Manager, Adult Care and Support, Cornwall Council
- **Bryan Stephenson**, Team Manager, Safeguarding, Adult Social Care, Portsmouth City Council
- **Jonathan Trubshaw**, Review Manager, Local Government Association

6. The team were on-site for three and a half days from Tuesday 6th to Friday 4th September 2016. 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 and interviews with managers, practitioners, frontline staff and people using services and their carers
- reading documents provided by the Council, including a self-assessment of progress, strengths and areas for improvement
- A review of a select number of case files (undertaken before the team was on site).

7. The peer review team would like to thank staff, people using services, carers, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made very welcome and would in particular like to thank Bev Turpin, Service Development Office and her peer review team and Sarah Webb, Safeguarding Lead & Statutory & Principal Social Worker for their invaluable assistance in planning and undertaking this review.

8. Our feedback to the Council 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.

9. The Care Act has put safeguarding adults on a statutory footing. The Care and Support Statutory Guidance defines adult safeguarding as “protecting a person’s right to live in safety, free from abuse and neglect”. The Care Act requires that each local authority must:

    - make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to other appropriate adult to help them.
    - cooperate with each of its relevant partners (as set out in section 6 of the Care Act) in order to protect adults experiencing or at risk of abuse or neglect

10. The aims of adult safeguarding are:

    - To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
    - To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives.
    - To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible.
    - To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

11. There are six key principles that underpin all adult safeguarding work:

    - **Empowerment** – Personalisation and the presumption of person-led decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”
    - **Prevention** – It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”
    - **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented. “I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed.”
    - **Protection** – Support and representation for those in greatest need. “I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”
    - **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me.”

- **Accountability** – Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life.”

Key Messages: Achievements and Challenges

Achievements:

- Re-shaped the Safeguarding Board
- Doubled the capacity of Overview and Scrutiny and re-focused it
- Improved partnerships – "*We're in it together*"
- Established the Statutory Services Team
- Earned staff and Members respect for Leaders
- Improved transparency of reporting
- Increased and improved training for Members and officers
- Available resources are well managed
- MSP is universally embedded – an enviable position

Challenges:

- Securing more evidence of outcomes
- Enhancing engagement with service users and carers to improve feedback
- Further developing co-production
- Assist CQC to engage more with SAB
- Linking commissioning to the operational front line

- Reinstating the equivalent of a safeguarding plan on a page
- Section 42 enquiries – there's a need to get back to partners with information more quickly
- Developing consistent commissioning intentions to shape the market
- Rationalise the data

12. The peer review team was made very welcome by everyone that they met during the on-site work and during the preparations for the review. When moving around the building and in other locations staff respectfully and in a friendly manner checked peers' names, the reason for them being in a particular location and the visibility of security passes; all key elements in making sure that safeguarding was demonstrably everybody's business.

13. It was clear to the team that there was a definite partnership approach to ensuring that safeguarding was everybody's business. The phrase, "We're in it together" was used by a variety of partners operating at all levels within their organisations. Relationships were robust and there was evidence of respectful challenge at the Safeguarding Adults Board (SAB) that allowed partners to hear difficult messages, collectively find solutions and continue working together. The SAB and its sub-groups appeared to work well and partners recognised the improvements that had been made and that are continuing to be made, to its structure, which helped it work effectively across both Bournemouth and Poole. A member of the team was able to attend a SAB meeting and saw that partners worked well together, reported back on actions taken to address previously identified issues and where necessary challenged each other to ensure further action was agreed.

14. The restructuring of Adult Social Care (ASC) that BBC has undertaken, combined with the focus elected members have placed on safeguarding, has helped ensure that Making Safeguarding Personal (MSP) is embedded in the Council. This in turn has helped ensure that it is also embedded across the partnership. In the team's view this is not the case in all partnerships and one that Bournemouth should be rightfully proud. The team received evidence from staff and through the case files that service users wishes were taken into consideration when planning and undertaking interventions. The team believed that Bournemouth was a good place to be if you were someone with a safeguarding need.

15. The team heard evidence that the establishment of the Statutory Services Team (SST) was widely regarded as positive, providing a single point of access to services that ensured clarity, consistency and approachability. Safeguarding alerts /concerns were allocated to individual Safeguarding Adult Practitioners (SAPS) so that there was an allocated worker who had responsibility for

the issue raised and was a constant point of contact for others who may be involved in any enquiry. This approach also ensured that the authority's statutory responsibility under Section 42 of the Care Act was fulfilled; control and responsibility in enquiries was maintained as required. The Deprivation of Liberty Safeguards (DoLS) team was located within the SST, which helped minimise any potential delays by ensuring the necessary specialist skills and knowledge were readily available. The SST staff reported that having ready access to other specialists gave them a level of control and accountability over the work they undertook.

16. The team received strong evidence from staff, elected members and partners that there was clear leadership in taking forward the safeguarding agenda. There was also evidence in the documentation that the team reviewed and in the changes that had been made to the policies and procedures. The appointment of a Principal Social Worker (PSW) has helped reinforce the link between the strategy setting mechanisms and frontline practice.

17. Elected member commitment to the safeguarding agenda was strong. The portfolio holder was able to articulate the vision as well as demonstrating an understanding of how this was being applied by practitioners across the partnership. Leadership of the scrutiny function has been strengthened and this is beginning to provide robust and constructive challenge, which was evidenced through the panel's minutes and examples from meetings. There is a Members' training programme in place which has helped raise awareness of safeguarding. This could be further strengthened to build on the contribution that non-executive members make at these meetings and equip them to encourage others on the council to avail themselves of regular safeguarding up-dates.

18. From the information presented to the team the available resources within BBC appeared to be well managed. Elected members had agreed a 2% precept to further support the work of adult social care and the workforce in general was becoming more stable. The benefits of this were that service users reported to the team that they were more often staying with one social worker, with whom they could build an empowering relationship.

19. The team recognised that securing evidence of outcomes for individuals is difficult and that other authorities were also struggling in this area. The team did see evidence of increased involvement with service users and more could be done with them to determine how this might be obtained in a systematic way. Finding enhanced methods of engaging with service users could also be helpful in further coproduction of strategy and policies. The team was aware that other authorities use feedback forms at the end of the safeguarding process and a similar methodology could be considered to collate outcomes and improve their service delivery. An additional suggestion is to use the contract and commissioning process to gather feedback regarding services and interventions requested and provided.

20. The team was impressed with the progress that had been made in streamlining procedures and systems. Some of the staff who the team spoke with requested a quick and simple form to provide an overview of a case. BBC may wish to consider reinstating a

safeguarding ‘plan on a page’ to provide those reviewing case files with an overview of the services users issues and the actions that have been taken. Evidence from carers, partners and those raising Section 42 enquiries was that once the form had been accepted into the system they did not always hear as to the outcome of their enquiry. More could be done to keep those raising enquiries informed, especially when cases may continue for a long time. Examples from the team’s experience include; Cornwall Council have a monthly meeting with their partners to provide a feedback session and update all concerned on progress and outcomes of the safeguarding process. Portsmouth City Council use closure forms that include evidence that the enquiry outcome has been fed back by the worker before the manager can sign off the enquiry.

21. Some of the practitioners that the team spoke with were unable to articulate the role of commissioners and how this linked to frontline practice. Commissioners could be more visible, attending team meetings holding briefing sessions, specifically highlighting where commissioning decisions will impact on service users. Further work could be done to demonstrate how the commissioning process is used, including how commissioners interact with providers and service users, to shape the market.

22. In the team’s view BBC was able to collect a lot of data. However, a lot of data requires a lot of analysis to make it relevant. It may be beneficial in saving time and money, in both collection and analysis, if the data requirement was rationalised and focused on those areas which were of greatest importance in demonstrating outcomes for individuals and performance monitoring.

23. There may be benefits to encouraging CQC to become more engaged in the work of the SAB. In the team’s view CQC could offer more consolidated support, working with the SAB rather than waiting to see what actions are taken and then deciding whether to respond or not. In Portsmouth, regular meetings are held with the CQC South Coast area manager, so that a robust relationship is maintained, which ensures any challenges regarding the CQC’s work are explored through frank discussion and resolved.

Your Scope and our Response

You presented the peer review team with a clear scope and related questions, which we answer here.

- To test out progress since the 2013 review and have a strong focus on practice
  There has been significant progress since the 2013 review with clear engagement and support from elected members and a restructuring of the directorate to ensure there is a strong focus on practice. Not least this has included the establishment of the Principal Social Worker role, who has earned a position of professional respect. The Care Act legislation has been embedded and adhered to well across all the locality teams.

- How has 'Making Safeguarding Personal' been applied in practice
  People across the partnership and at all levels are aware of their roles and responsibilities and actively identify safeguarding issues. Elected members, officers and partners consistently referred to safeguarding as a priority, regardless of their formal role. The safeguarding process has changed in line with making safeguarding personal and outcome based practice is evident in all the work. Safeguarding Strategy meetings and conferences are held in locations of choice with all partners supporting the process.

- How this is strategically progressing against the agenda and how the service is managed and the budget that goes with it.
  The partnership is seen to be "mature" with agencies being able to respectfully challenge each other to stimulate and take forward necessary and agreed actions. There is a healthy balance between being able to have difficult conversations whilst being supportive.

Outcomes and People's Experiences of Safeguarding

Strengths

- The word 'kindness' was used by many
- Service users reported a positive experience, trusted the staff and no longer felt at risk
- The arrangements are flexible so that safeguarding meetings can be held where service users want them
- The inclusion of perpetrators is seen as beneficial
- Service users and carers reported they were listened to and believed solutions were actioned and delivered
- Service users confirmed a person centred approach in which they were fully involved

Areas for Consideration

- Some service users and carers did not understand the safeguarding system and felt confused and frustrated
- There is an appetite for more co-production, especially in commissioning alternative services
- The definition of outcomes is not well understood by some
- Service users with learning disabilities would benefit from more creative solutions
- There is a need to improve service user and carer engagement in feedback about safeguarding experiences
- Communications about the safeguarding process could be simplified

24. The team received evidence from across the partnership of how people perceived that they engaged with and took responsibility for the welfare of vulnerable people. Service users and people who cared for them reported feeling that people who provided

services were “kind” to them. Staff also reported that colleagues were kind to each other and that Bournemouth was a good place to work. In the team’s experience this was not always the case in other areas and again is something that Bournemouth should be rightfully proud.

25. Service users and carers that the team met reported having a positive experience when engaged in the safeguarding process. They spoke highly of the staff that supported them and recognised the benefits of a stable workforce in that they appreciated working with one person over long periods of time. Service users and carers reported that they were listened to and that their views and needs were taken into consideration.

26. Meetings with practitioners were held where service users wanted them, which was not necessarily in their home and staff were flexible in meeting individual requests. There was flexibility in arrangements to meet the service user’s individual needs and effort had been made to ensure that there was a positive outcome from meetings that were held. Where appropriate and with the agreement of those concerned some cases involved the inclusion of perpetrators, not just in meetings but right the way through the process. In the team’s view this inclusive approach to MSP is another strong example of Bournemouth implementing practice that is not widely seen in other areas.

27. Service users reported a person centred approach and increased opportunities to work together with staff to create the support package that they wanted to meet their particular needs. Staff also reported that they had more opportunity to engage with service users and to do things together. There was an acknowledgement that service users did not always feedback what staff wanted to hear and that there was a culture of using this information positively to improve the individual’s experience.

28. Not all service users and carers that the team spoke with were clear about the safeguarding system and reported that this led them to feel confused and frustrated. This was understandable given the complex and long-term nature of some individuals’ needs and in follow-up conversations with staff evidence was provided that procedures had been followed and explanations offered. For some vulnerable people, who may include carers, information may need to be provided in a non-standard way so that they can more fully understand what is happening to them. Even greater clarity on what actions are being taken by staff and when the safeguarding process has come to an end will lead to individuals having greater confidence about their role in the safeguarding system.

29. Not all the staff that the team spoke with were able to easily describe what an outcome was for service users. This in turn meant that they were not easily able to record when an outcome had been achieved. An area to consider is how might there be a more universal understanding and approach to recording that will enable the partnership to further demonstrate that they are making a difference to individuals’ lives. Further work on understanding outcomes could be undertaken; this could include service users

who have been through the safeguarding process. Often the outcomes a person wants to achieve are difficult to evaluate, using a safeguarding plan that identifies levels of happiness could provide the data to analyse. In Portsmouth, service users are contacted after any alert/concern is raised and their outcome wishes clearly documented. The original wishes are reviewed on closure to record and monitor whether the outcomes have been achieved.

30. The challenges facing Bournemouth, along with many other areas is how to increase co-production, communicate the safeguarding system in a way that is both simple and provides sufficient information for those who need to become involved with it and then to provide feedback on their experience. There appeared to be an appetite for greater co-production from the service users, providers and carers that the team met with. However, evidence from the SAB showed that when opportunities were provided these were not always widely taken up. The National Co-production Advisory Group has information that may be useful in devolving ways in which to further engage those who are impacted by the services offered by Bournemouth, see: http://www.thinklocalactpersonal.org.uk/Browse/Co-production/National_Co-production_Advisory_Group/

Leadership, Strategy and Commissioning

Strengths

- Role and leadership behaviour of Cabinet Portfolio Holder
- Role and leadership behaviour of Executive Director and Principal Social Worker
- Informed and constructive Chairing of Overview and Scrutiny
- Increased capacity in the Police Safeguarding Team with individual portfolio priorities
- Joint contract management and monitoring with NHS colleagues
- Robust strategies in commissioning for people who may been trafficked as part of the national referral mechanism pilot
- Leadership across the partnership delivers Care Act compliance

Areas for consideration

- Enable frontline contribution to commissioning intentions
- Take a consistent approach to strategic intentions across all care groups
- Review process in Care Direct to ensure appropriate and timely decision making
- Improve connections with housing, especially floating support
- Develop the relationship with Healthwatch
- Vulnerable adults, regardless of residency, must be treated equally and supported through the safeguarding process
- All departments of the Borough Council must work collaboratively to achieve personalised outcomes for all

31. From the initial presentation to the team at outset of the peer review it was clear to the team that there was strong elected member involvement in safeguarding vulnerable adults. The Portfolio Holder demonstrated a wide knowledge of the subject and communicated this with eloquence and passion. At a corporate level this commitment is seen in a 2% precept being raised to help support service delivery.

32. The team received evidence from staff at all levels and from colleagues across the partnership of the strong leadership provided by senior BBC officers. It was clear that the Executive Director took time to engage with staff on a personal level; staff reported that this was appreciated and contributed to the effective communication, through all levels of the organisation, that safeguarding was everybody's business. The PSW was seen to take a pragmatic role in ensuring that policies and procedures were implemented, building relationships across agencies and ensuring obstacles to joint working were overcome.

33. It was reported to the team that there had been a notable change in the leadership of Overview and Scrutiny. Evidence from the minutes showed that there had been a change in the panel's structure and that more robust and constructive challenge was being given. The process of due diligence had been increased with more frequent meetings and ensuring that items had been fully dealt with before moving on.

34. The police recognised that they needed to increase their involvement in the safeguarding agenda and have taken action over the last year to develop the strength of the resource they have available. There are now senior officers with individual policy area responsibilities and these individuals are building relationships with other partners. There is also an increased willingness to undertake more in terms of strategic joint working through the SAB and in ensuring effective operational relationships.

35. Relationships with health are well developed with joint contract monitoring and management in place. The team saw evidence of information being shared and where concerns were identified joint action was then taken. Providers were supported and where this did not promote sufficient improvement jointly agreed solutions were implemented.

36. The partnership has developed clear and strong strategies in commissioning for people who may have been trafficked; this was undertaken as part of the national referral mechanism pilot. The team believes that there is an opportunity to promote this work more widely and the partnership should consider where this work could be presented.

37. From the evidence that the team saw, their conclusion was that BBC was Care Act compliant. There was robust leadership across the partnership and people understood the strategic priorities. It was clear to the team that service user wishes and

contact with them, was a key part of any intervention undertaken. A view expressed by some of the practitioners that the team spoke with was that the Care Act had freed them up to work as they had been trained to do and "*not just follow all the processes*".

38. Frontline staff that team spoke with expressed an interest in becoming more involved in the commissioning process, so that they could better express what they saw as beneficial options for the service users with whom they worked. There is an opportunity to support co-production, particularly if staff could work with service users on specific issues.

39. Evidence from providers and staff in Care Direct indicated that in some cases there was a delay in decisions being made. It was recognised by practitioners that generally the decisions were seen to have been appropriate and the concern raised was in the hand-off and whether the response could be swifter. The team was aware that BBC was addressing how assessments were made and recorded; currently staff have to look for information on a different system and this layered approach may be contributing to the delay.

40. In the team's view, connections with housing, especially floating support could be improved. There is an opportunity for those involved in floating support to spend time out with frontline practitioners to gain a fuller and more person centred understanding of each other's roles. This could be built into a wider programme of shadowing and joint working.

41. The team noted that discussions were already underway with Healthwatch to consider how to improve the gathering of service user voice and perceptions. BBC may wish to consider if Healthwatch's involvement could be broadened further to include participation at the SAB and also offer observations at an operational and commissioning level. The team recognised that Healthwatch observations may not fully represent all the various needs of Bournemouth residents and their views will need to be considered alongside other sources of user information.

42. There is a challenge for all councils to ensure that staff across departments understand their role in safeguarding vulnerable adults, regardless of any competing operational priorities. The team recognised the work already undertaken to ensure that safeguarding is everybody's business. This is an on-going commitment to remind staff and keep the message foremost in people's minds. The partnership has strong policies and robust relationships to enable these to be implemented so that personalised outcomes are delivered for everyone in Bournemouth who needs them.

Service Delivery, Effective Practice, Performance and Resource Management

Strengths

- Having a dedicated Statutory Services Team
- Positive reporting of OT interventions
- Good frontline working relationships with partner agencies
- Section 42 enquiry meetings well led and usually timely
- Responsive frontline service
- Low turnover of staff providing a stable workforce and continuity for service users
- Good peer support within teams
- Recognition of need in adult social care by Members' investment since 2013 and ongoing resources
- Data confirms that safeguarding referrals are appropriately being managed

Areas for consideration

- Enable access to localities by Care Direct
- Reduce layers of IT to enable efficient and effective transfer of care information
- Have confidence in the data and reduce the range collected
- Review the process for closing down referrals when risks remain
- Reinstate a one page safeguarding plan that draws the key pieces of information

- Improve communication to referrers on receipt and outcomes of Section 42 enquiries
- Recognition that the demographics will put pressure on the resources of the Council and all partners

43. The evidence from practitioners was that creation of the Statutory Services Team (SST) was seen as positive. The SST was able to respond quickly to requests for support and individual members of the SST were seen to be approachable. The SST was regarded as being well led and appropriately focussed.

44. The team was impressed with the positive view of Occupational Therapists (OT), with carers and service users reporting the beneficial outcomes of their interventions. OTs were able to meet with clients relatively quickly (average waiting time for an OT appointment in other parts of the country is 45 weeks) and undertake a course of individually specified treatment that enabled them to use their creativity for the benefit of the client. In appropriate cases OTs worked alongside social work professionals to devise a joint assessment rather than focus solely on health cases and this was seen to be a positive model. In the team's experience this is not the case in other areas and BBC should continue with their approach to OTs and consider whether learning could be shared with other professional groups.

45. Evidence from partners was that frontline social work staff were seen to be responsive and ready to engage with colleagues in other organisations. The team experienced staff as being involved in the process of safeguarding, motivated and passionate about providing a good service for the people of Bournemouth.

46. It was clear that BBC have worked hard to create a stable workforce. Carers and service users reported positively that they often had the same social worker for a long period of time, which enabled them to build up a meaningful relationship built on trust and understanding of the individual's needs. They also recounted their experiences of other local authorities where this had not been the case. The stability of the workforce also meant that relationships could be developed with staff in other agencies so that an understanding of how procedures worked in practice was developed and worked well. Staff reported that they were supported in their work and that this included support from their peers and managers.

47. The team saw evidence that elected members had recognised the need to allocate resources and financial support for adult social care. These resources appear to have been well managed and staff have been appropriately developed to provide the current level of service. The resources available will need to be constantly reassessed to take into account the growing demographic demands of a population that is aging. The team heard evidence of the links with Bournemouth University and the work they are undertaking to model the cost implications of future adult social care demands. These relationships place BBC in a strong

position to consider forward planning of provision at a partnership level and understand the associated resource implications and how these will be met.

48. The evidence for the files and the staff met was that section 42 enquiries were generally well led and conducted in a timely manner. Staff responded quickly and information was brought together efficiently. However, there was evidence from some practitioners that they were not always informed of the outcome of the enquiries that they submitted. The team recognised that staff were aware of the need to respond to new enquiries and this was where their attention was focussed. More could be done to keep referrers up to date with how their enquiry is progressing through the system and particularly when an enquiry is closed, as referrers were keen to know if they had a further role to play and what might be required of them.

49. Data confirms that safeguarding referrals are appropriately being managed. From the information that the team received it appeared that approximately 28% of referrals and alerts that were accepted were then taken through the safeguarding process. This indicates that the approach taken in Bournemouth ensures that an appropriate level of risk and case management is being undertaken to bring cases into the system.

50. Some of the Care Direct (CD) staff that the team met said that they could only get access to locality teams via email. These staff expressed a desire to get more direct communication, by telephone, so that they could speed up how they obtained relevant information and therefore process client enquiries more efficiently and in a more personally focussed way. A suggestion from CD staff was that more direct contact with qualified social workers at the front line would be beneficial in helping inform decisions and access the necessary recording systems. Another suggestion was that if CD staff were trained to a higher level this could increase the decisions they were able to make. However, any increase in decision making would need to be fully risk assessed.

51. The team noted the large amount of data that was collected by BBC. This may be because information is relatively easy to collect due to the size of the authority and the good relationships that have been developed, which enables pertinent questions to be asked and responses readily given. An area to consider is whether all the data collection is necessary. There is an opportunity to ask the questions; where is the resource to analyse and investigate further best invested and what is the most relevant information that continues the drive for ongoing improvement? A refocussing on what is needed to demonstrate the outcomes that have been identified may help to rationalise the investment made in data collection and reporting.

52. Frontline staff told the team that they would value having a document that would give an overview of a service user's safeguarding plan, summarising the issues and the information that had been obtained. Although the reinstating of a 'Plan on a Page' would create an additional document to be completed, staff recognised the benefit of being able to see an individual's requirements and the actions being undertaken to meet these set out in one place. BBC recognised that this would be relatively easy to introduce,

as well as the benefits this would offer in terms of information sharing when case meetings were convened. The case file audit showed that information was contained in several different places within the file. An overview document would greatly streamline this process and provide consistency in where case file information is held.

Safeguarding Adults Board

Strengths

- Partnership is mature, experienced and collaborative
- Balance between co-operation and challenge
- Strength of policy and procedures sub group
- Effective use of Quality Assurance sub group to affect change
- “Line of sight” using case studies is valued by SAB
- Evidence of commitment and step change from partners
- Financial support from key partners
- Positive opportunities arising from working across the two authorities
- Developing links with Children’s Boards

Areas for Consideration

- Clarify the relationship(s) between Safeguarding Board, Health and Wellbeing Board and Criminal Justice and Community Safety Board.
- Address skills gap (NHS) of Nominated Enquirer
- Request CQC to raise their contribution to SAB
- Explore alternative ways of engaging carers and services users and hearing their voices

- Seek evidence that training is effective and learning is embedded

53. From the evidence seen in the minutes, the people that the team met and observation of a Board meeting, it was clear that significant progress had been made with the Safeguarding Adults Board (SAB). Partners described the SAB as being made up of a cohesive group of senior officers who knew each other well, had a deep understanding of safeguarding vulnerable adults and who were not afraid to challenge each other to prompt even greater improvements. The team saw challenge being offered in a respectful and informed way, which was received and acknowledged with a commitment to undertake action on the points raised. When challenge was received explanations and reasons were offered as a way of providing information and not in a defensive or blocking manner. This demonstrated a sophistication and experience in the partnership. The team recognised the complexities of working across both Bournemouth and Poole and that partners were accomplished in working effectively with these.

54. The SAB has strong sub-groups that appear to be working well. In particular the Policy and Procedures sub-group and the Quality Assurance sub-group have been able to affect real change. Policies are now sharper and more easy to use and the staff whom the team spoke with reported that they were relatively easy to follow. The quality assurance process has driven change with people understanding why their work is being looked at. There is a clear focus on provider quality and the team was aware that appropriate action was taken as a result of regular monitoring, which included the provision of improvement support and where necessary the application of sanctions.

55. The phrase “Line of sight” was used to describe to the team how the partners made sure that their considerations and decisions were grounded and were relevant to service users. The use of case study evidence was an important part of this process and gave the Board as a whole a chance to reflect on the work they were undertaking. There may be opportunities to take this further with presentations, in person or through video reports, from service users as a grounding mechanism at the start of each Board meeting. This and other approaches for engaging service users will provide very clear evidence that their voice is being heard and show how that then leads directly through to decisions on policy and strategy development.

56. The team was impressed with the level of financial support that was given to the Board from across the partnership and not just the statutory partners. This is not the case for all SAB’s and was thought to be an enviable position that demonstrated the commitment to the Board process.

57. In the team’s view the partnership was making the most of the close relationship between the SAB and Children’s Board and this was helping young people transition into adult services. The work on capturing the voice of the child and the approach to considering the family as a whole that is taken within Children’s, was also seen to be benefitting the approaches being taken when

working with adults. There will be more benefits to come as learning from both approaches continues to be shared through the Boards.

58. There is an opportunity to clarify the relationships between the SAB, the Health and Wellbeing Board and the recently established Criminal Justice Board (CJB). Some of the people that the team met with, particularly at a practitioner level, found these relationships difficult to articulate. There may be some benefit in restating which Board has responsibility for what and where these follow through into the other Boards. The Team was aware that the SAB independent chair also sat on the CJB so that there was already an established link. It may therefore be a case of maintaining an awareness of the structures through the staff briefing mechanisms, especially as the CJB had only very recently been convened and any differences between Boards may therefore have been magnified.

59. Health representatives told the team that there was a skills gap which was preventing them putting forward a Nominated Enquirer. This appeared to be a training requirement that once highlighted should be relatively swiftly addressed. Health partners were aware of the situation and were putting training in place to support the role. However, the team recognised that the skills to undertake enquiries and write the subsequent reports to the required standards was not necessarily easy to find and that a skills audit of existing suitable staff should be undertaken. This role will be particularly important for contributing to Serious Adult Reviews (SAR) and the Nominated Enquirer will need to be competent to operate at this level to prevent any returns of reports. The Nominated Enquirer will therefore need to be in place before a SAR is identified.

60. In the team's view CQC could be invited to make more of a contribution to the SAB. This should be done to enhance the Board's work with CQC working alongside partners, providing intelligence and signposting to good practice and not only reporting on activity undertaken. In Gloucestershire there are regular and frank discussions with the CQC representative leading to a greater understanding of each other's role and an enhanced problem solving relationship that helps prevent issues escalating and becoming adversarial.

Summary

- Commitment of Members and Officers across the partnership to MSP is tangible
- Members understand the needs and advocate for their residents, including the ongoing dedication of resources
- Leadership is dynamic, visible and appreciated
- Partnerships are strong and getting stronger
- The service is no longer driven by process
- Generally service users and carers feel supported and safe
- The process is Care Act compliant
- The work with Bournemouth University is a valuable asset
- There is clear evidence of significant progress since the 2013 Review and of the drive to further improve services for vulnerable adults

61. The people that the team spoke with, from frontline practitioners to senior management and elected members, used a vocabulary when describing their work that demonstrated that they were making safeguarding personal. People were able to describe what they had done for an individual that took into account their personal circumstances and wants. Frontline staff talked about MSP and that the approach had been beneficial for them and that it enriched their work.

62. The elected members that the team met were clear in their role as advocates for their residents. They were passionate about making sure safeguards were being upheld and there was a programme in place to keep members informed and aware of safeguarding issues. Members had made recourses available to support the changes that have been made to create a stable workforce however; these will need to be refreshed to keep pace with the changing demands of an expanding older population.

63. The team was impressed with the leadership of the service. Staff reported that they appreciated senior managers being visible and approachable, particularly the Executive Director. There is clear direction and understanding of the issues from the senior team and this was also seen in partner organisations, including the police, which had made changes to their structures to better meet partnership arrangements and residents' needs.

64. The team recognised the changes in the SAB since the 2013 review. This is a mature and stimulating partnership with a clear understanding of what they are working to achieve in a complex environment. There was an awareness of the needs for the future and plans on how these could be addressed.

65. There was recognition from staff that policies had been significantly improved, with stream-lined documentation. Social workers reported to the team that they were now more able to focus on doing "Real social work" rather than being process driven. The request for a 'Plan on a Page' to be reintroduced demonstrated the frontline staff's on-going commitment to engaging with the process reform to provide a focus on outcomes for the services user.

66. The team heard positive evidence from service users about how they were treated as individuals and that practitioners treated them with "kindness". There were examples of service users saying that they now felt safe and of carers who reported that their experience in Bournemouth was more positive than it had been elsewhere. There were some concerns that information was not always fed back to those who initiated or who were involved in the safeguarding process in a way that they understood what was happing. There will always be more that could be done to keep those participating informed.

67. The partnership's work with Bournemouth University on the concerns for the future raised by an expanding older population was seen as valuable and thought provoking. The work and issues that were highlighted were seen as significant and have been forwarded to ADASS colleagues in the South West for their consideration and discussion at a future meeting.

68. In the team's view the processes that were seen were Care Act compliant. The people that the team spoke with were knowledgeable about safeguarding and reflected on this and their practice. They were able to articulate what changes were being made and why these were happening.

69. In conclusion, the team was convinced that significant progress had been made since the 2013 review. There is a high level of awareness that this is a continuing process and momentum is being maintained to ensure that action is being undertaken to address predicted issues. The right level of resources will need to be allocated to continue work. The partnership approach is strong with recognition that safeguarding is not one agency's responsibility but that it is everybody's business.

Case File Audit

The Case File Audit process completed in this safeguarding adults peer review follows the methodology outlined in the LGA Guidance Manual for Adult Safeguarding Peer Reviews. The cases considered represented a mix of ages and include adults with mental health problems, people with learning and physical disabilities. A total of twenty eight case records numbers were made available to the peer review team and fourteen were randomly selected, two from each category. The feedback given here is based on the files the peer review have read and seen.

Strengths

- Making Safeguarding personal is deeply embedded and working really well.
- Clear evidence of recording outcomes in a personalised way, this was recorded clearly when the outcomes had been achieved.
- Evident that partner agencies work well together, good attendance and support at strategy meetings.
- Good use of both the IMCA and Care Act Advocacy during safeguarding processes.

Areas for Consideration

- Section 42 enquiries – there is a need to get back to partners with information more quickly
- The Safeguarding Adults plan reinstated; this could support workers and ensure all information is stored in one place.
- Organisational abuse, need the data to analyse and manage whole service investigations.
- Hospital safeguarding could be improved with a deeper focus on outcomes and personalisation.

Narrative Response

Of the 14 cases we audited six people had a learning disability, two people had mental health problems, two people had physical disabilities , one person was working age adult and three were older people.

- One person was not known to services
- Five of those people were living at home
- Six people were living in residential establishments
- Four people were in hospital at the time of investigation

- Two people had personal assistants
- Two people were adults with children in the household
- Four people had been referred through domestic abuse services, hate crime or other community routes.

All the cases managed by the locality teams were thoroughly written up and although information was difficult to find it was available. There was a very clear outcome gained at the start of the safeguarding process which was continuingly reviewed throughout the safeguarding process. One of the hospital cases did not include the consultation of either the person involved or a family member until the investigation had been completed.
The use of advocates was fully explored with the locality teams was clearly evidenced, this could be extended to the hospital teams.
The reinstatement of the safeguarding plan would resolve some of the time taken to find information on a safeguarding case; this currently is a risk on ensuring the most up to date information is available.

Safeguarding Adults 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

7. **Social Care Institute for Excellence (SCIE)** website pages on safeguarding.

http://www.scie.org.uk/adults/safeguarding/index.asp

Contact details

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For more information on adults peer challenges and peer reviews and the work of the Local Government Association please see our website http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/3511083/ARTICLE

Appendix 1 – Safeguarding Adults Improvement Tool

Overview
There are four key themes for the standards, with a number of sub-headings as follows:

Themes	**Outcomes for, and the experiences of, people who use services**	**Leadership, Strategy and Working Together**	**Commissioning, Service Delivery and Effective Practice**	**Performance and Resource Management**
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 Collective Leadership** **4.Strategy** **5 Local Safeguarding Board** This theme looks at: • the overall vision for Adult Safeguarding • the strategy that is used to achieve that vision • how this is led • the role and performance of the Local Safeguarding Board • how all partners work together to ensure high quality services and outcomes	**6. Commissioning** **7. Service Delivery and effective practice** This theme looks the role of commissioning in shaping services, and the effectiveness of service delivery and practice in securing better outcomes for people	**8. Performance and resource management** This theme looks at how the performance and resources of the service, including its people, are managed

Download the Safeguarding Adults Improvement Tool from this page:
http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/3510407/ARTICLE