Local Government Association

Peterborough City Council Safeguarding Adults' **Peer Review Report**

September 2016

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Executive Summary

1. Peterborough City Council requested that the Local Government Association undertake a Safeguarding Adults Peer Review at the Council and with partners. The work was commissioned by Wendi Ogle-Welbourn, Executive Director People and Communities and was the client for this work. She was seeking an external view on the effectiveness of the safeguarding adults' arrangements at Peterborough City Council (PCC), which included adult safeguarding practice. 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:

Impacts and outcomes – from a practice perspective, NOT from a user perspective (there are other ways of assessing service user experience; the focus should be on our approach to service delivery – is it able to evidence positive impacts and outcomes). How embedded is practice, are we able to demonstrate continuous improvement etc.?

Strategic leadership and governance – is our internal leadership model robust and safe, and is the interface between us and PSAB and vice versa clear and effective?

Commissioning/QA/QI – are our strategies and procedures robust and effective (even if only in principle – it may be too early to evidence anything practical), are joint commissioning arrangements with health effective and the effectiveness of the S75 with CPFT.

2. The peer review team went through an interesting journey to understand the context of adult safeguarding, prevention and early intervention in Peterborough. This was important to be able to make accurate observations and recommendations that can be heard by the Council and partners involved in keeping adults from harm. Therefore this part of the report outlines our understanding of the context at Peterborough, which frames our feedback.

3. During the on-site work the team heard from a range of stakeholders who confirmed that Peterborough had been undergoing a sustained period of change. They also confirmed that through this time staff at PCC had remained focused on their work. The team met with enthusiastic practitioners from across the partnership who wanted to do their best for the people of Peterborough.

4. Although the team did not undertake a full financial analysis the documents that they did see indicated that budgets were being well managed. Given the demographic changes that are predicted to affect Peterborough, including an almost one third rise in dementia cases in the next ten years, there will continue to be significant budgetary pressures that will need to be addressed in order to satisfy future demand forecasting across all health and social care services.

5. .The team acknowledged PCC's assessment that adult safeguarding was at a low point in 2012 and that measures had been put in place to address this situation. Although there will always be more to do to further improve safeguarding there have been significant developments over the past 18 months and this should be applauded.

6. The development of policies to provide a robust framework for the safeguarding activity has been very rapid. There has been strong leadership and drive from the senior management team to ensure that these are in place.

7. The team saw some innovative and excellent structures that have been designed to improve safeguarding vulnerable adults. The Prevention and Enforcement Team (PET) is ambitious in that it brings together staff from a number of organisations and functions within PCC and the police. The PET had very recently gone live at the time of the team's visit and so there was not a large evidence trail to demonstrate impact. The team was impressed with the organisation of the PET and what it is aiming to achieve.

8. The Safeguarding Adults Board (SAB) appeared to working well at a strategic level. However, the team heard evidence that more needs to be done to dovetail the understanding of operational issues with the strategic direction. The Independent Chair is aware of these issues and was preparing to address them in the context of different stakeholders wanting different things.

9. PCC is clearly aware of the continuing and rapid population growth of Peterborough. The team was not aware of a sophisticated approach to forecasting the demand on adult services. In the team's view this will help facilitate the partnership to create different responses to meeting the rising demand within the context of changing demographics and challenging resources.

10. PCC is in the process of reviewing policies to ensure that a consistent style is applied across Adult Social Care. The team heard evidence from frontline staff that they did not see themselves as having been involved in the co-production of the policy documents. There was a "lack of ownership" that in the team's view if left unresolved could mean that the policies were not being fully implemented.

11. The team recognised that there was a strong strategic vision at a senior level within PCC. More could be done to engage and oversee that the delivery of the strategic vision is translated to those working at an operational level, so that they clearly understand and buy into the vision.

Report
Background

12. Peterborough City Council requested that the Local Government Association undertake a Safeguarding Adults Peer Review at the Council and with their partners. The work was commissioned by Wendi Ogle-Welbourn, Executive Director People and Communities and was the client for this work. She was seeking an external view on the effectiveness of the safeguarding adults' arrangements at Peterborough City Council (PCC), which included adult safeguarding practice. 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:

Peer Review Context:

Between 2004 and 2012 Adult Social Care was delivered and commissioned via the Health system with the Primary Care Group and subsequently the Primary Care Trust and Community Services Trust. Over time the focus on Adult Social Care was eroded and oversight of the safeguarding responsibilities suffered as a result. Following transfer of Adult Social Care back to the Council in February 2012, it became apparent a particular focus on safeguarding was required as there was no clear strategic overview in relation to the number of safeguarding referrals demonstrating there was no real understanding of the referrals received and what had been or was being investigated. In addition a safeguarding report generated indicated there were in excess of 600 safeguarding open referrals across Adult Social Care and the Mental Health Trust (CPFT). A plan was agreed to address the concerns as a matter of urgency as potentially vulnerable adults remained at risk as Adult Social Care could not evidence that the department had or was actively investigating or that protection plans were in place to reduce further risk. By the end of March 2013 the backlog had been addressed however, concerns remained around the quality and the skills of staff and the Council commenced a quality improvement programme, 'Raising The Bar'.

In 2013/14 Adult Social Care began to transform its service delivery in preparation for the implementation of the Care Act from April 2015. Russell Wate, Independent Chair of the Peterborough Safeguarding Adults Board (PSAB), commissioned an independent review of how Peterborough City Council deals with safeguarding concerns, providing a report highlighting findings, conclusions and recommendations (please refer to the review report contained within the evidence library 022). Transformation across the department has continued throughout 2015/16 to ensure Adult Social Care meets statutory requirements and delivers continuous improvement for local people. The Care Act sets out a clear legal framework of how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. PCC was keen to measure their response to the Care Act.

During the last couple of years PCC has undergone significant change with the movement to a People and Communities Directorate and related changes in personnel and structures. The Corporate Director of People and Communities, the Service Director for Adults and Communities and the Service Director for Children's and Safeguarding have been in post since February 2015.

The People and Communities Directorate is responsible for ensuring the needs of residents are met, particularly those that are most vulnerable. The directorate ensures the right services are provided to the right people, by the right people, at the right time, in the right place and at the right cost. The work of the directorate includes working with adults, children, families and communities, including schools and primary care. It supports adults and communities through the commissioning and delivery of targeted services to meet needs and ensures the delivery of services that build confidence, capacity and resilience within our communities.

Scope:

Impacts and outcomes – from a practice perspective, NOT from a user perspective (there are other ways of assessing service user experience; the focus should be on our approach to service delivery – is it able to evidence positive impacts and outcomes). How embedded is practice, are we able to demonstrate continuous improvement etc.?

Strategic leadership and governance – is our internal leadership model robust and safe, and is the interface between us and PSAB and vice versa clear and effective?

Commissioning/QA/QI – are our strategies and procedures robust and effective (even if only in principle – it may be too early to evidence anything practical), are joint commissioning arrangements with health effective and the effectiveness of the S75 with CPFT.

13. 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.

14. The benchmark for this peer review was the Safeguarding Adults Improvement Tool (Appendix 2). These were used as headings in the feedback with an addition of the scoping questions outlined above. The headline themes were therefore:

    - 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

15. The members of the peer review team were:

- **Wendy Fabbro** – Director Adult Care and Health, Reading Council
- **Cllr Dale Birch** – Executive Member for Adult Services, Health and Housing, Bracknell Forest Borough Council
- **Tracy Keats** – Assistant Director of Safeguarding, NHS Nene and NHS Corby CCG's
- **Claire Crawley** – Senior Policy Manager Adult Safeguarding, DoH
- **Nick Presmeg** – Director for Commissioning Vulnerable Adults, Essex County Council
- **Phil Shire** – Independent Safeguarding Consultant

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

16. The team were on-site for four days from Tuesday 27th September to Friday 30th 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

17. 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 Helen Gregg, Commissioner, People & Communities Directorate and Debbie McQuade, Assistant Director Adult Operations for their invaluable assistance in planning and undertaking this review.

18. 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.

19. The Care Act 2014 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

20. 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.

21. 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."

Your Scope and our Response

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

Impacts and outcomes – from a practice perspective, NOT from a user perspective (there are other ways of assessing service user experience; the focus should be on our approach to service delivery – is it able to evidence positive impacts and outcomes). How embedded is practice, are we able to demonstrate continuous improvement etc.?

The team saw strong examples of user focused practice that demonstrated positive impact and achievement of agreed outcomes. However the evidencing of impacts and outcomes was inconsistent and this was demonstrated within the case file audit. Staff reported that Framework-i does not adequately provide all the data necessary and so staff are finding ways of working round the system leading to information being held in a number of different places.

Strategic leadership and governance – is our internal leadership model robust and safe, and is the interface between us and PSAB and vice versa clear and effective?

The senior leadership is strong. Elected members are informed and supportive. There have been a number of changes in structure over the past two years and these are now creating a strong leadership model. The development of the Principal Social Worker was seen as providing a strong link between strategic and operational leadership. Given the pace of change more now needs to be done to ensure that these relationships are embedded throughout the directorate. The PSAB and the independent chair work well and the partnership is maturing.

Commissioning/QA/QI – are our strategies and procedures robust and effective (even if only in principle – it may be too early to evidence anything practical), are joint commissioning arrangements with health effective and the effectiveness of the S75 with CPFT.

There is a strong suite of policies in place, which are being revised and standardised. However, some of these had only recently been developed at the time of this review and more work needs to be done to ensure that the strategic vision and direction is fully operationalised. As policies are further developed more coproduction with practitioners would facilitate their adoption by frontline staff.

Outcomes

Strengths

- Senior management focused on QA and outcomes via the QA team structure
- Stronger SAB actively promoting MSP amongst all partners
- Healthwatch projects e.g. Wellbeing champions in Prisons
- Some staff articulated person centred and outcome focussed approaches

Areas for Consideration

- Promote wider public awareness of safeguarding
- Consider impact of changing profile of the population and future demand forecasting to influence market shaping
- Ensuring quality of MSP through reflective practice and supervision to ensure that the philosophy is being embedded and making a difference
- Proportionate responses clearly communicated to referrers

22. The senior management team had a strong focus on quality assurance (QA). The Principal Social Worker (PSW) has a clear remit and is driving improvements in the (QA) arrangements through the QA team structure. In the team's view there could be benefits in including the PSW as part of the senior management team. This would strengthen the link between strategic direction and operational delivery as well as continuing the increased grip on QA.

23. The team was impressed with the way the SAB had undertaken an audit of Making Safeguarding Personal (MSP); this was noteworthy and innovative practice. The process had ensured that all partners had reflected on their practice and how they took accountability for MSP. This has given the partnership a valuable basis to build on.

24. The projects undertaken with Healthwatch showed good practice and helped identify safeguarding at an early stage. The team particularly noted the work of the prisoner engagement project, which acknowledged and addressed a hard to reach local demographic with significant health and wellbeing issues.

25. The frontline social work staff that the team met were clearly focussed on the individual and their needs. Staff openly articulated what MSP meant and how they were delivering this. They also described the change in working practices away from a process driven approach to a focus on the service user and how to meet their identified outcomes. The team observed interactions between staff and service users that were highly effective and very respectful. Other staff who the team met, including those in Financial Assessment and Reablement, were also impressive in the way they explained their highly individualised work and approach to MSP.

26. The team heard from a number of sources, including a strong request from the Older People's Partnership Board, to increase public awareness of safeguarding issues. More information could be made available to the public about when safeguarding is happening and knowing what to do about it when a resident becomes concerned. The team was aware that information, such as leaflets, is already available; more could be done with community bodies, including further co-production, to increase ownership and help promotion to the wider public.

27. PCC is aware that there is an expected change in the population of Peterborough. The team was not aware of work to address the challenges that these changes will bring, including cultural challenges and how the partnership will meet these. Further work on demand forecasting could help Peterborough to specify the services and market offer that will be needed, and also to review the most effective way to engage with customers and communities to continually enhance wellbeing. In particular, other local authorities have acknowledged a preferred point of contact at hospital and amended service design (see Oxfordshire) , or engaged 'buddy' and social capital options to support and maintain independence (see Silverlinks example from C&RE) and '3 conversations' model from Partners in Change.

28. The team saw evidence that the management team received assurance, through audits, that MSP was taking place. However, the connection between the audit process and the line management process for assuring frontline practice was less clear. This needs to be more explicitly stated to enable clear instruction to be given to frontline staff.

29. More needs to be done to ensure a clear understanding of what becomes a safeguarding issue is clearly communicated to all those involved in the process. An example given to the team was that a referral had been made because of a flippant sign-in at a residential home, which may have required a management or QA response but did not on the presenting evidence justify a safeguarding response. There was a clear need to ensure a consistent and effective response to a safeguarding concern which includes pre-investigatory discussion with agencies rather than heading directly into a Section 42 enquiry.

People's experiences of safeguarding

Strengths

- The Older People's Partnership Board is a valuable resource; vibrant, enthusiastic
- The Registered Managers forum is a vanguard
- Availability of advocacy, (contract expectations could be clearer in terms of response times)
- Language line is available for the wealth of diversity in the community (translators harder to access)
- Community connectors recognised as innovative

Areas for Consideration

- The 'front line' and contact process / pathway is not clear, and could benefit from mapping and reordering
- Home from Hospital pathway requires a systemic review
- More and accessible information to the public
- Some perceptions of risk averse approach to safeguarding from legal services
- Limited application of the threshold presents a large number of referrals to MASH which affects their capacity to prioritise

30. The team was impressed by the members of the Older People's Partnership Board that they met. The individuals were enthusiastic and willing to engage with PCC and represent a significant resource to help deliver agreed activities. In the team's view this partnership was an asset that could be further built upon.

31. In the team's view the Registered Managers (RM) forum represented vanguard activity. This forum provides for those with statutory duties in the care provider market to share interpretation of quality expectations and best practice, and drive improvement in market quality systems. All registered managers are invited to attend the forum, which offers training and opportunities to network and obtain peer support. The council has funded a facilitator/trainer and there are guest speakers. The RMs who the team met valued the forum, which benefited from focusing on practice rather than contract and fee issues.

32. Advocates were said to be generally available for those that needed them and attention has been given to how this should be arranged with a new contract being introduced. The team received mixed evidence with regards to the new contract with some interviewees stating that they were pleased and could use advocacy, whilst others stated that some customers were not well served giving examples of having to wait weeks for an advocate to become available. There

is a need to ensure that operational staff within PCC know what the service specification is in terms of response times.

33. Some interviewees considered Language Line to be an asset in communicating with a range of people from different language backgrounds. Given the predicted increase in people, both in terms of numbers and from diverse geographical areas, Language Line is likely to become an even more important way of communicating with those who do not understand or speak English. Some participants also stated that access to translators was harder to arrange and this might present problems in the future if not planned for and addressed now.

34. The team was impressed with the use of Community Connectors (CCs), who were appointed from some of the harder to reach communities and helped police and others in community safety work. An example was given of how the CCs had been used to proactively work with their communities, following the Brexit vote to help prevent hate crime. A real strength of this initiative is that the people come from and are rooted in the communities with which they work.

35. The team was uncertain as to how the processes were set out for new contacts coming into the system. This would benefit from being clearly mapped out so that a person coming new to the system, both customers and staff would readily understand the various stages, what the triggers were and where any filters were applied. A clear map would also provide assurance that the right people are getting to the right services as has been set out in the mission statement.

36. In the team's view the Home from Hospital pathway needs a systemic review. Partners should consider together how they can better work to ensure that staff involved in transfers of care are fully aware of the requirements on the other agencies and that the focus is on the individual receiving the right care at the right time. Although there was a good record on levels of Delayed Transfer of Care (DTOC) there needs to be a high level of assurance that any early discharges are safe. The team heard examples of some patients being discharged who were not fully weight bearing and this might lead to increasing numbers of readmissions. The team recommends benchmarking readmission rates to see how these compare and where further action might need to be targeted.

37. The team heard from a number of participants that they would welcome more and more accessible documentation being made available to the public. The team was not aware of Easy Read information that was already available and it may be worthwhile for the partnership to consider what might readily be promoted in an Easy Read format. There may also be an opportunity to engage in coproduction with selected community groups where additional information is identified as being required.

38. The team considered that more understanding may be required between the case work and contract work, particularly where lawyers are involved. The triggers around removing people from their own home due to safeguarding concerns may need to be more fully appreciated by both legal and social work staff to ensure that risk is appropriately assessed.

39. In the team’s view the significant number of referrals going through the Multi-Agency Safeguarding Hub (MASH) has the potential to overwhelm the system with inappropriate referrals. Further work on describing thresholds may need to be undertaken so that referrers are clear as to what an appropriate referral is and where best to take concerns of they are unsure.

Leadership

Strengths

- Political leaders supportive and informed
- Wendi and team seen as strong and create principle and direction
- Very impressive financial assessment and income team
- Rapid delivery of a whole suite of policy and guidance
- Strong leadership from the statutory partners
- Strong professional leadership from PSW
- Home Services structure working well

Areas for consideration

- Is the leadership embedding its strategic direction throughout the organisation?
- Leadership needs to offer a narrative to explain and facilitate - it would be useful to review the style, channels and effectiveness of the communications
- The multiple restructurings have left some staff confused about accountability for safeguarding
- Some political leaders could improve their visibility to operational staff
- There is more to be done to reassure staff and bring together the strengths from both Adults and Children's safeguarding models
- Some concern about Partners' consultation and involvement e.g. MASH

40. The team received evidence from across the wide range of interviews conducted that the Executive Director People and Communities and her management team have clearly provided strategic direction and created a set of principles to guide the directorate's work. There was support from elected members who were well briefed and who took an active interest in the adult social care agenda. There was also evidence of strong leadership from statutory partners that facilitate working together.

41. The team saw effective leadership within teams. Examples included the financial assessment and income team where staff were supported and encouraged to work with individuals to find the most appropriate solutions to meet their needs. Team members effectively led their cases and managers provided support, challenge and direction within the framework of the strategic principles.

42. The team saw evidence that there had been clear leadership in the rapid delivery of a large number of policies and guidance. This is on-going work that is being addressed with pace and grip. The PSW is providing strong leadership in ensuring that policies are being revised and operationalised, so that a consistent message is being provided to all staff.

43. It was clear to the team that a considerable amount of work had been undertaken in the months leading up to the review. The challenge is now to ensure that the strategic messages are embedded at all levels within the organisation. Senior manages already go out and meet staff and building on this informal practice as well as using established mechanisms, such as supervision, will provide opportunities to test the consistent application of strategic messages. Reviewing the multi-channel approach, using different ways of communicating with people will help people understand and apply the strategies to their day to day practice. It may be useful to engage further with staff and involve them more in the coproduction of the information they receive.

44. The team was impressed with the Home Services; the people participating in the review took a strong position on the delivery of their work, with a focus on the individual and convinced the team that they knew their strategic direction and what they were doing to achieve this. The representatives from Axiom expressed clearly how they are applying MSP and were well informed on a wide range of safeguarding issues.

45. The team received a small number of comments from some front-line staff that there had been a number of organisational restructures in a relatively short period of time and that this had left them uncertain as to where the accountability for safeguarding was held. In the team's view this will be addressed through the consistent application of the arrangements that have been put in place and the on-going engagement with staff, not least through the work of the PSW.

46. The team received a couple of comments that some operational staff would welcome more visibility from their politicians. Some staff said that they would find it helpful to hear the vision and direction directly from their political leaders.

47. Some of the interviewees expressed a concern that the coming together of Children's and Adults under one People and Communities Directorate have resulted in the perception that one department's delivery model is favoured over another. These perception issues will need to be addressed to help closer working and learning about best practice, wherever it originates, to create a single model that works well.

48. The current model of the MASH requires consideration as this does not appear to be working within a national framework in terms of multi-agency working. Good engagement from health is crucial as often their information underpins effective decision making on risk assessments.

Strategy

Strengths

- Good suite of strategies and policies that will take you in the right direction
- Some bold innovative structures starting to deliver, e.g. Home Services, QA
- Some innovative policies e.g. Self-neglect and 'Hoarding'
- Partners are becoming more involved with strategy creation

Areas for consideration

- Status of some strategies not yet clear
- We have not had sight of the implementation plans for new strategies
- It would help staff if these were co-created and easily accessible
- MSP is clear in the policy and strategy, but some staff unable to describe what this means to them
- The first contact / triage appears confusing and needs review
- Thresholds for Section 42 enquires is unclear
- Joining the dots - right time for a systemic review of how the policies fit, and how they are embedded

49. There was a clear link with the strengths in leadership and the creation of a good set of strategies and policies that are being standardised and form the basis for a well-defined strategic direction. There were examples of innovative strategies, including those to address self-neglect and the issues of hoarding. From the strategy documents and through discussions it was evident that partners are becoming more involved in the development of strategies, which creates a more joined up and consistent approach to issues. Given that there is now a strong suite of policies there may be an opportunity to set out how these all work together to deliver the strategic vision; to 'join the dots'.

50. Strategic decisions to put some structures in place are beginning to prove their worth. Home Services were well regarded by the people that the team interviewed and the QA arrangements are becoming more robust and providing useful feedback.

51. Some of the frontline staff that the team met with said that they were unclear as to the status of the multi-agency policy and procedures. With the recent rapid development and dissemination of some policies it would be helpful if managers made sure staff knew and felt confident in applying the current ones.

52. The team saw no evidence of an implementation plan for the strategies that had been developed. There is a concern that without a clear understanding of the implementation requirements staff will not be able to apply the strategy through their day to day work.

53. In the team's view, more co-creation of strategies with staff would help ensure a whole system understanding and application of the strategic intentions. Practitioner involvement in the design of strategies would help gain buy-in and ensure validity with other frontline staff.

54. Although some staff were very clear on what MSP and being person centred meant for them this was not universally understood. Some staff the team met with were not able to say what MSP meant. Managers need to ensure that all their staff are able to articulate what MSP means and how they deliver this for individuals through their work.

55. The pathway through First Contact and Triage was confusing for some of the staff that the team met. It would be helpful to have this clearly mapped out so that there is a consistent understanding of how the process works. The pathway should also set out how the strategy is being delivered.

56. Some of the providers that the team met with stated that they sometimes were unclear as to when or why an enquiry was being started. The thresholds for Section 42 (S42) enquiries needs to be firmly set out and communicated to all those involved in the process so that is a consistent understanding and approach.

Commissioning

Strengths

- Appear to be focused on achieving savings
- Clear view of the market and the MPS is well written, and indicates next steps
- Contracts in Health and Social Care are clear on safeguarding responsibilities
- Registered managers forum an important asset to understand the market

Areas for consideration

- The Commissioning ‘philosophy’ needs to be clarified and the ‘target operating model’ defined
- Senior management team respected, but commissioning response and process slow
- Co-commissioning with service users and third sector involvement needs to be clearly demonstrated
- Commissioning intentions - MPS could say more on market analysis re: capacity, volume, quality and competency
- QA, informatics and contract monitoring information could be more joined-up
- Roles and responsibilities with respect to S117 and CHC could be further developed
- Where is Transforming Care Programme on the radar?
- Legal services need to be more joined up between case work and contract approval

57. In the team’s view there was a focus in the commissioning work on achieving savings. Given the financial pressures faced by local government this should be seen as a strength.

58. The Market Position Statement (MPS) was well written with a clear view of the market. “Hot spots” were identified along with the action required to address these.

59. The contracts in health and social care issued to providers were clear on safeguarding responsibilities. This was seen to be a particularly important aspect in maintaining the relationship with providers to ensure that they work with the council. When providers enter into a relationship with the council they are clear on their duties and what is expected of them.

60. The Registered Managers’ forum is an important asset. The information from this group helps develop the understanding of the market. This intelligence is then used to develop contracting intentions and future iterations of the MPS. The team received positive comments from providers regarding the senior management team and this is a strong foundation for working together with the market place going forward.

61. In the team’s view there needs to be a clearer understanding of the council’s commissioning philosophy; setting out what is it that commissioning will achieve. The target operating model also needs to be defined so that there is an understanding of what success looks like and how progress towards this is being monitored. This will need to take into account predicted demographic changes and changes in the market and therefore how commissioning will take account of these and help shape future developments. More definition could also be given to the commissioning intentions for addressing the Hot Spots identified within the MPS, as well as more detailed intelligence as to why the Hot Spots occur. This would lead to more sophistication as to what needs to be purchased in the coming years.

62. The team received comments from some providers that the commissioning process could be slow to respond to issues raised. However, the team did not receive evidence one way or the other.

63. The team did not see evidence of co-commissioning with service users. Where this does occur this could be presented as a strength and used as a basis for developing service user engagement and feedback.

64. The team was unclear as to how the QA intelligence, informatics and contract monitoring information all came together to provide a coherent picture to inform future decision making. These need to be brought together in one information set that ensures coordination and avoids any duplication of data collection.

65. Roles and responsibilities with respect to Section117 and Continuing Health Care (CHC) could be further developed. The team understood that there was a dispute between PCC and the CCG regarding Section 117 responsibilities. In addition there was a poor perception of CHC across the partnership, which included poor recruitment to posts and a delay or reluctance to carry out assessments. These need to be discussed and clarified at a strategic level to ensure robust partnership working.

66. In the team’s view there appeared to be little evidence of attention being given to the Transforming Care for learning disability services. The strategic vision and delivery programme was not discussed or shared with the team. There also needs to be a clear set of expectations regarding what the council wants to get from the programme.

67. The team was concerned that some of the legal staff that they spoke with, who were working on cases relating to safeguarding, did not appear to be fully familiar with the safeguarding clauses within the major and framework contracts and how these requirements could be interpreted within the context of other legislation. The team was aware that solicitors provide advice on individual cases and are neither involved in the contracting side nor necessarily consulted at a policy level. Social workers can only seek legal advice with their manager's agreement. This could present difficulties when working with providers to ensure they are clear on what is expected of them.

Safeguarding Adults Board

Strengths

- The independent chair is very highly regarded and respected, willing to learn and develop
- SAB is working well with good attendance from partners with an improving strategic focus
- It is clear there is collaborative planning
- SAR subgroup is working well (clear policy, procedures, attendance and focused)
- Some good projects undertaken by Healthwatch (hydrotherapy, prison, cancer centre)
- Constructive feedback from providers regarding audit tool kit

Areas for Consideration

- It might be helpful to re-launch a statement on Local Authority accountability and all other roles e.g. involvement of health leaders. Would be useful to map process and roles, set up an executive group of statutory partners
- Improve the learning between SAB and practitioners
- Further work to embed MSP across the partnership e.g. recording outcomes appears to be inconsistent and incomplete
- Reissue template and agenda for strategy meetings to clarify purpose and outcome

68. The team heard wide ranging support and appreciation for the SAB's independent chair. He was held in high regard and his role in developing the partnership was recognised by those participating in the review.

69. The team heard evidence that the SAB worked well, both in the way meetings were conducted with members attending regularly and in the way partners worked collaboratively to achieve objectives. There was an appreciation that arrangements at the Board had improved and there was a greater strategic focus for the work undertaken. The Safeguarding Adult Review (SAR) sub-group was recognised as being effective and useful mechanism for learning when issues were referred.

70. The projects undertaken with Heathwatch were noted in a number of interviews. It may be worth reflecting on the reasons why the Healthwatch work received such levels of recognition and considering how these factors could be transferred to help projects with other organisations across the partnership.

71. In the team’s view it may be worthwhile relaunching a statement about local authority accountability in the context of accountabilities for all other partners. This should reiterate that safeguarding is not just the council’s responsibility and one that the whole partnership shares. To support this it would also be useful to map partners’ roles and responsibilities. This should identify any gaps or overlaps and action could then be taken to address these.

72. The team heard about plans to establish an executive group. In the team’s view this would be a useful way of ensuring statutory partners develop and drive the strategic business plan on behalf of the SAB and to ensure that the work of the Board is clearly understood and actively implemented.

73. More could be done to strengthen the relationship between the strategic SAB and how the decisions taken there relate to the operational work undertaken by practitioners. In other SABs each board meeting is preceded by a presentation, in person or via video, from a service user, carer or practitioner to help ground the decision makers. This or other approaches to demonstrate the connection between the Board and front line work may be useful.

74. The team saw evidence from the file audit of inconsistent and in some cases incomplete recording of outcomes. There were examples of very good work with service users in some files and if other work is not being fully recorded then tracking to see if agreed outcomes are being achieved is not going to be possible. Although case file auditing is carried out as part of the QA process, managers could undertake a similar file audit exercise on a regular basis, which would then help reinforce the culture of appropriate recording to demonstrate that MSP is taking place and outcomes are being achieved.

75. It is the team’s opinion that there would be benefits in reissuing the template for case-based safeguarding strategy meetings so that those attending are aware of the purpose, style and appropriate membership. This would confirm to providers and others what the practice for these meetings is.

Service Delivery and Effective Practice

Strengths

- Strong partnerships with Police, Health and Housing that share good practice and lessons learnt
- Prevention and Enforcement Team has potential to provide more effective safeguarding
- Financial assessment team (would like to bottle and take home)
- MASH – phone advice re appropriate referrals appreciated
- Contract Monitoring team has potential, but need to avoid duplication
- Home Services embedding MCA
- Effective management of DoLS service

Areas for consideration

- Thresholds - over recording/volumes presenting risk of swamping real concerns. Could be strengthened at the first contact
- First point of contact needs to be appropriately skilled to filter
- Hospital discharge – we have heard that some cases could be unsafe leading to unnecessary readmissions
- MASH or ASH? Variable quality in responses
- QA should dovetail with Contract Quality monitoring function, and coordination could be clearer (e.g. LSE)
- Need for reflective practice in supervision to dovetail with QA
- First contact needs review, re: target led, fragmented
- Is the process for closing cases embedded and clear enough? E.g. MSP as reason for nfa
- CHC awareness of MCA, and completion of MCA assessment

76. There are strong partnerships with police, health and housing where staff work effectively to resolve issues. There are good relationships and people know who to contact when they need information. Good practice and learning is shared and there is a ‘can do’ attitude, which results in better services being offered to service users.

77. The review team was impressed with the enthusiasm and action orientated approaches displayed in a number of teams that they met. The innovative approach taken in creating the PET, bringing together the enforcement functions with the police to agree on areas of focus and to share information should result in improved safeguarding activity. The financial assessment team were really focussed on the individual and their needs and went to great lengths to ensure a person centred solution was provided. The telephone advice

provided by the MASH was highly valued and more could be done to ensure that this is developed further.

78. The Contract Monitoring team has great potential to help raise standards. However, there is a danger in over-burdening providers by having different sets of monitoring processes applied to them. There are opportunities to work with health colleagues to consider how monitoring arrangement could be aligned or combined. Also, to work closely with the Care Quality Commission and consider any dovetailing with their monitoring regime.

79. In the team's view there is a need to strengthen thresholds, particularly at the point of first contact. Those providing this service need to be appropriately skilled and with the right degree of knowledge to filter cases. There is a danger that there may currently be a level over-referring, resulting in a high volume of relatively low risk cases and this presents a risk of swamping more significant concerns. Referrers may have been sending concerns in that could have been managed outside safeguarding. This requires a wider approach to educating partner agencies; and asking them to revisit their internal management systems around safeguarding.

80. The team considered the MASH to be somewhat of a misnomer as there was little colocation of specialist staff. Although social work staff had telephone access to colleagues this did not fully embrace the possibilities that close working offers. The team heard evidence that the social workers had experienced some slow responses to enquiries and that on occasion calls went unanswered. Discussions with health and police should be revisited so that a truly multi-agency approach can be adopted, accepting that at the time of the review the police operated on a force wide basis.

81. Feedback from a provider suggested that the triggers and criteria used when undertaking a Large Scale Enquiry were not easily understandable. There may need to be greater clarity when communicating the purpose of any interventions undertaken with providers.

82. There is an opportunity to dovetail the way in which reflective supervision could use the information from the QA process. Individual cases and themes identified through QA could give the social workers and their managers a framework to consider other cases they are involved in.

83. The team found variable information from CHC staff in regard to the levels of understanding of the Mental Capacity Act 2005 and the way in which assessments were carried out whilst patients were still in hospital. There needs to be a clear understanding as to when and by whom assessments are carried out, particularly at times of transfer from hospital to care homes.

Performance and Resource Management

Strengths

- Innovative QA function designed to provide rigor and management confidence
- Stable management team
- DTOC data assertively managed
- MASH resolve a high % of cases
- Police have been independently inspected for their service to vulnerable people and found to be performing well

Areas for consideration

- No evidence of a comprehensive data picture of S42 activity and referrals
- Front line teams not getting useful ‘dashboard’ of business intelligence
- Growing reliance on the QA function, but staff need to understand the line management audit function and how it complements and works with QA
- Risk of not delivering next tranche of savings
- Fwki !! And ‘workarounds’ are a problem

84. The team was impressed by the way in which DTOC was assertively managed. The definitions that have been agreed are of clear benefit to the authority. However, this might not always be the case and steps should be taken with health to collaboratively manage the situation into the future.

85. The MASH is resolving a high number of the cases that they receive. However, as presented earlier, are thresholds being sufficiently rigorously applied to ensure the right type of case is being allocated to the MASH? If the MASH is resolving relatively straight forward cases that could have perhaps been dealt with elsewhere, is the data presented a true reflection of the level of safeguarding?

86. The team wanted to acknowledge the positive outcome of the recent inspection of the police’s services to vulnerable people. Where one partner is recognised as performing well this can have a constructive impact on the rest of the partnership, with learning being shared and built on.

87. The team understood that S42 referrals coming in on existing cases were not being recorded in the same way as S42 on new cases. If a service user already has an existing social worker, the social worker will undertake the necessary work but will not record this as a new S42 referral. This approach maintains continuity and causes the least disruption for the service user, facilitates a swift response and avoids additional bureaucracy. However, this may also be leading to an underreporting of the safeguarding activity being undertaken.

88. Frontline teams need to have information on their performance presented in a digestible and palatable way. An example of how this might be done is Reading's Dashboard, which is sent out on a weekly basis to all frontline managers. This is a two page document with graphs showing current performance measured against benchmarks and highlighting where further action needs to be taken.

89. The team recognised that the council was aware that Framework-i was not able to deliver what was wanted in terms of data at present. The team heard from a range of practitioners that they had independently developed ways of recording and presenting information, away from Framework-i. The question is therefore, how much confidence is there that there is a comprehensive performance data set?

Summary

- People are working hard and generally make it work. Some very impressive teams
- We have a "Swag bag" to take away, of good practice
- Leadership is ambitious and innovative
- Commitment to being agile and fleet of foot - but is the pace preventing robust implementation?
- …and will the high level concept of anticipated savings materialise?
- Some concerns re: resilience of MH service and safeguarding
- Multi-agency partnership is strong at a senior level and needs to be consistently embedded though all levels across the partnership
- Market, strong work to improve relationships and the shaping function improving

90. The team was impressed with the enthusiasm of the people that they met. There were noteworthy examples of teams that were doing good work and the review team members recognised learning that they could take back to their own authorities.

91. There was clear evidence that the leadership is setting out an ambitious vision and encouraging innovative ways of working together to support a MSP approach. There have been a number of recent policy and structural developments and the desire to deliver these quickly may now need to be matched with a focus on ensuring the changes are rigorously implemented throughout the organisation. At the same time, consideration needs to be given to the longer-term impact of budgetary constraints across the public sector and how these will affect how the partnership delivers services in the future. Specific attention may need to be given to the resilience of the mental health service and their ability to undertake safeguarding activities.

92. There is a strong approach to multi-agency working, particularly at a senior level. There are also good examples of inter-agency working at an operational level with staff building up good relationships to ensure that when issues arise they work proactively together to resolve them. However, more needs to be done to ensure that there is a consistency of approach and that this is embedded through all levels of the organisations across the partnership. There has been a strong approach taken to improve relationships, particularly with providers so that the market is developing and the market shaping function is improving.

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 thirty case record numbers were made available to the peer review team and fourteen were selected (there were no cases identified in category E). The feedback given here is based on the files the peer review team have read and seen.

Strengths

- Generally safeguarding is timely and cases are not drifting.
- There are good examples of effective safeguarding that protects people from further abuse, although there are some cases where this has not been achieved.
- Positive examples of multi-agency working which have contributed to effective safeguarding.
- The QA forms that are completed after triage (by MASH) and after the s42 enquiry stage (by the lead worker) are a very useful QA device, which, if properly completed, will help raise practice standards.

Areas for Consideration

- Look at the latest multi-agency policy and procedures (just released) and what these require in relation to areas identified above, for example -
  - In what circumstances safeguarding meetings are expected to take place
  - MSP and how procedures embed this approach in order to ensure more meaningful involvement of the adult at risk and their representatives in formulating outcomes and being involved in decision-making.
  - Issues re assessing mental capacity and use of advocates
  - Safeguarding planning and review post the s42 enquiry
- Consider the role of MASH and triage and their approach to risk and resolving cases at an early stage. Consider how the police are involved in the MASH.
- How safeguarding is carried out in the C&PFT mental health service (operating under a Section 75 agreement), given some of problem areas identified in audited cases.

Findings from case file audit

- There is some way to go in embedding Making Safeguarding Personal and outcome-focused practice into safeguarding in Peterborough, with none of the audit areas in outcomes or people's experience of safeguarding scoring higher than 50%.

- Scores are much better on service delivery and effective practice; however the score for support methodologies should be treated with caution, as in many cases it would not have been appropriate to use these methods, even if they had been available.

- A brief description of each case and issues identified by the audit has been sent separately.

Key issues arising from the audit

- Few of the cases audited can demonstrate that MSP is embedded or that there is a focus on the adult at risk deciding what outcomes they want and being part of decision making.
- We need to understand what the MASH does, as many of the audited cases did not have much apparent input at the triage stage before being moved to other teams to carry out S42 enquiries. I have looked at two cases that were dealt with primarily at the MASH stage and more actively managed in the team.
- How consideration is given to the involvement of advocates and the process to be followed where the adult at risk lacks capacity or cannot meaningfully engage in safeguarding.
- Duplication of same information in different parts of reports making it difficult to follow the narrative.
- Low number of safeguarding meetings taking place, which are no longer embedded as part of the process.
- It is sometimes evident that key agencies are not part of information sharing and planning.
- In some instances, practice looks rather risk averse and cases have been brought into safeguarding that could have been dealt with in other ways.

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

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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