East Riding of Yorkshire Council

Adults Safeguarding **Peer Challenge Report**

March 2017

Final Report

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Executive Summary

East Riding of Yorkshire Council requested that the Yorkshire and Humber ADASS undertake an Adult Safeguarding Peer Challenge at the Council and with partners. The work was commissioned by Rosy Pope, Head of Adult Services & Director of Adult Social Care who was the client for this work. She was seeking an external view on East Riding Council and partners' ability to safeguard people in the East Riding of Yorkshire.

The Council intends to use the findings of this peer challenge as a marker on its improvement journey. The specific scope of the work was:

- How effective is the Board in assuring itself that partners are working to deliver the SAB's strategy?
- How effective is the Council in engaging and hearing the voice of people at risk of harm and their carers?
- How robust are the safeguarding enquiries that are undertaken?
- How far is Making Safeguarding Personal (MSP) embedded in practice, culture and systems?

East Riding of Yorkshire Council and partners can be justifiably proud of the strengths that have been identified with regard to leadership of the Safeguarding Adults Board (SAB) working across organisations and developing and renewing the Safeguarding Strategy. The achievements for safeguarding adults has been the culmination of years of work and engagement activity coupled with the utilisation of individual people's skills, expertise and knowledge, and demonstrates huge levels of commitment to all who are part of and delivering on behalf of the SAB This is a very strong foundation to build upon.

The peer team found the passion for safeguarding people was articulated at all levels of the organisation and included a clear commitment from the Chief Executive, the Chair of the SAB, Members and the Head of Adult Services & Director of Adult Social Services, and that passion for safeguarding filtered through the organisation. This was evidenced by the people that the peer team met.

The SAB is a mature partnership, which we found had a wide reach and involvement, informed the work of all the partners we met and supported front line staff. We heard of good challenge at Board level, for example to embed MSP across organisations.

Individuals using care services are best placed to articulate their own preferred outcomes and there is recognition that this is a complex area of work. The Council recognises and understands that Making Safeguarding Personal (MSP) is critical activity and must be central across every agency and in every activity. We acknowledge there is a good deal of progress with the Council and partners working toward Making Safeguarding Personal, and that an outcomes based performance dashboard is in development.

There is good evidence of clarity, certainty and priority setting in the commissioning cycle. Council officers have a good understanding of the services commissioned by them and providers have a good understanding of how commissioning and contracting work together. "Respect" and "excellent" are words heard from providers in relation to Quality Development and Monitoring Officers (QDMOs),in particular their training and workshop delivery on subjects such as nutrition and fluids and manual handling. Of note is the work delivered on "Do Not Attempt Cardio Pulmonary Resuscitation", and the frequently asked questions document.

There are some occasions where messages and information exchanges are not as fluid as they could be, this is particularly the case for large organisations where strategic messages could become diluted and potentially lose their impact and challenge as they progress through communication channels. There may be a need for the SAB to clarify the communication of priorities and work with partners and communities to develop processes that help deliver strategic priorities.

A key question posed by the peer challenge team is does the East Riding Safeguarding Board have confidence in their engagement with individuals and in their engagement networks, and is it being doing it alongside service users? The infrastructure for user engagement is evident and carers were familiar with the networks in place. Carers recognised that development was needed in the LD Partnership Board and in the membership and for this reason some meetings had been suspended pending a review of the LD Partnership Board. This is work in progress and there is recognition by Adult Social Care of the need to review and reform some of the user engagement infrastructure.

There may be some blurring of roles and responsibilities between safeguarding staff and QDMOs and officers working in domestic violence where roles and responsibilities aren't clearly defined which is leading to some tensions at the interface. There is recognition that there have been a number of personnel changes recently in the safeguarding team and there may a need to build new relationships and redefine responsibilities between teams. Officers are keen for this to happen, recognising the experience and value that safeguarding colleagues can bring to working relationships and strengthening the service provided to individuals.

There is a good amount of soft intelligence gathering from QDMOs and at CQC, Safeguarding Adults Team (SAT) and Commissioning level the information sharing is working very well. However, there are further opportunities to gather soft intelligence from other areas. This is a task the SAB could consider using innovative ways to gather intelligence from community networks to strengthen their voice. This may require some additional and flexible resources.

Report
Background

East Riding of Yorkshire Council requested that the Yorkshire and Humber ADASS undertake an Adult Safeguarding Peer Challenge at the Council and with partners. The review used the LGA Adult Safeguarding Improvement Tool and a LGA Associate to manage the Challenge Process. The work was commissioned by Rosy Pope, Head of Adult Services (Director of Adult Social Care), who was the client for this work. She was seeking an external view on East Riding Council and partners' ability to safeguard people in the East Riding of Yorkshire.

The Council intends to use the findings of this peer challenge as a marker on its improvement journey. The specific scope of the work was:

- How effective is the Board in assuring itself that partners are working to deliver the SAB's strategy?
- How effective is the Council in engaging and hearing the voice of people at risk of harm and their carers?
- How robust are the safeguarding enquiries that are undertaken?
- How far is Making Safeguarding Personal (MSP) embedded in practice, culture and systems?

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

2. The benchmark for this peer challenge was the Adult Safeguarding Improvement Tool, March 2015. The Standards for Adult Safeguarding are at Appendix 1. These were used as headings in the feedback with an addition of the scoping questions outlined above. The headline themes were:

    - 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

3. The members of the peer challenge team were:

- **Ian Winter CBE,** Lead Peer, LGA Associate
- **Councillor Viv Kendrick,** Kirklees Council
- **Simon Richards,** Head of Adult Safeguarding and Practice Development, Sheffield City Council
- **Liz Walton,** Designated Nurse, Safeguarding, NHS Salford, CCG

- **Sam Newton**, Assistant Director Independent Living and Support, Rotherham Council
- **Michaela Pinchard,** Head of Integration, North Yorkshire County Council
- **Venita Kanwar,** Peer Challenge Manager, LGA Associate
- **Dave Roddis**, Yorkshire and Humber ADASS

4. The team was on-site from 27th February – 1st March 2017. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

    - interviews and discussions with councillors, officers and partners
    - focus groups with managers, practitioners, frontline staff and carers
    - reading documents provided by the Council, including a self-assessment of progress, strengths and areas for improvement
    - comprehensive audit of a select number of individual service records

5. The peer challenge team would like to thank staff, carers, partners, commissioned providers and councillors for their open and constructive responses during the challenge process. The team was made welcome and would in particular like to thank Rosy Pope Head of Adult Services (Director of Adult Social Care), Keith Jackson, Project and Practice Development Officer and Lorrissa Davies, Management Assistant, for their invaluable assistance in planning and undertaking this review.

6. Our feedback presentation to the Council on the last day of the challenge gave an overview of the key messages. This report builds on the headlines and gives a more detailed account of the challenge.

7. The Care Act (2014) provides the statutory framework and guidance for adult safeguarding. This defines an 'adult at risk' as 'a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'. The previous Government published a review of No Secrets with the following key messages for safeguarding:
    - safeguarding must be empowering (listening to the victim's voice)
    - everyone must help empower individuals so they can retain control and make their choices
    - safeguarding adults is not like child protection – vulnerable adults need to be able to make informed choices
    - participation / representation of people who lack capacity and the use of the Mental Capacity Act are important.

    The Care Act has put safeguarding adults on a statutory footing. Safeguarding remains a complex area of work and case law continues to test the basis on which it is undertaken.

Leadership, Strategy and Working Together

Strengths

- The Chief Executive, Elected Members, The Head of Adult Services (Director of Adult Social Care), senior management team and partners demonstrate a high level of commitment to safeguarding.
- The Chair of the Safeguarding Board provides robust and positive challenge to the Council and partners.
- There is a well-represented Safeguarding Board with evidence of good relationships with partners, who actively engage.
- This is a well led, strategically driven and aware partnership for example by the lead GP, and named GPs in practices.
- Strong assurance and risk management supported by sub groups.
- Use of an outcomes dashboard.
- Understanding of, and commitment to developing next steps as part of the new strategy.
- Board events well attended and valued (e.g. exploring service user engagement).

Areas for consideration

- There are concerns that Board activity/ priorities are not clear for front line staff
- Advisory roles on the Board may benefit from clarification
- The new multi-agency procedure is an opportunity to ensure the alignment of SAB expectations and individual agency safeguarding ensuring consistency and good outcomes
- This is the right time:
    - to extend the outreach of the Board to ensure there is clarity about its priorities at all levels across the partnership.
    - to pursue greater involvement with service users, front line staff and other key stakeholders to further develop and embed good practice. There could for example be an action plan for the next steps to ensure:
        - Community engagement and resilience
        - The voice of service users and carers is heard
        - An effective conduit for providers

"East Riding are engaged and forward thinking"

8. East Riding of Yorkshire Council and partners can be justifiably proud of the strengths that have been identified with regard to the leadership of the

Safeguarding Adults Board (SAB) working across organisations and developing and renewing the Safeguarding Strategy. The peer team recognise that the achievements for safeguarding adults has been the culmination of years of work and engagement activity coupled with the utilisation of individual people's skills, expertise and knowledge, and demonstrates huge levels of commitment to all who are part of and delivering on behalf of the SAB This is a very strong foundation to build upon.

9. The peer team found that the passion for safeguarding people was articulated at all levels of the organisation and included a clear commitment from the Chief Executive, the Chair of the SAB and the Director of Adult Social Services, and that the passion for safeguarding filtered through the organisation and was evidenced by the people that the peer team met. There was appropriate challenge from the Chair of the SAB and by elected Members to members of the SAB. The commitment from partners was evident by their engagement.

10. The Chair of the SAB was widely respected by members, partners, officers and staff for his commitment and knowledge of safeguarding people and his leadership of the Board. The Chair is effective and is committed to delivering improvement based on the evidence presented to the Board, for example by the lead GP and the work done to ensure that there were named GP leads within surgeries in East Riding.

11. The Head of Adult Services (Director of Adult Services) articulated a passion and commitment for driving services that demonstrated clear outcomes for people. The Director of Adult Services has a clear vision for safeguarding which is firmly rooted in Making Safeguarding Personal, the vision, and her obvious skill, knowledge and experience is supported and valued by her staff and partners.

12. The Safeguarding Board is well represented with a range of committed partners who provide support and meaningful input to the work of safeguarding. Terms of Reference for the Board are sound, setting out purpose, overarching objectives accountabilities, and a strong constitution outlining roles and responsibilities, and conduct of members and agencies.

13. Good use is being made of the outcomes dashboard which was put in place in the summer of 2016. The dashboard integrates Care Act priorities and graphically portrays outcomes achieved. The dashboard is well used by partners though it is recognised that there is more to do to develop, embed and extend the dashboard.

14. We heard from key health partners that the SAB was considered to be an exemplar of partnership working and was, for example, even more developed than the Children's Safeguarding Board, which is perhaps unusual and is commendable.

15. The safeguarding strategy has been refreshed and will deliver its 9 strategic objectives over the next 3 years. The SAB is committed to delivering its strategic priorities through the vehicle of Business Implementation Groups (BIG) and task and finish groups. Many of the people the peer team interviewed were involved in either one or the other of the delivery groups, demonstrating a commitment to achieving the shared safeguarding strategic objectives.

16. Board events are well attended by partners and are valued by them, for example the event held to explore ways to improve engagement with people who use services was referred to as a useful event. There is recognition though that the outcomes from this event need to be consolidated and progressed.

17. The engagement extends to the Board evaluation meetings led by the independent chair and well supported by partners The workshops held by the Board are interactive and enable partners to discuss issues and seek resolutions to problems and identify improvements

18. As in most organisations there are occasions where messages and information exchanges are not as fluid as they could be, this is particularly the case for large organisations where strategic messages may become diluted and potentially lose their impact and challenge as they progress through communication channels. The peer team heard that the activities and priorities of the SAB were not always clear to some social care officers, to health partners or to members of communities. The peer team would suggest that the SAB considers clarifying the communication of the priorities where there is confusion, working with partners and communities to develop processes that deliver the strategic objectives.

19. One way to assist with pushing progress is to develop, deliver and embed good practice. This could be done by setting out a clear and simple action plan that sets out the next steps to ensure:

    i. Improved community engagement and resilience

    ii. The voice of service users and carers is heard more consistently

    iii. Ensure an effective conduit for providers to get up to date messages, performance and learning from the Board and feedback practice examples and areas for development

20. This may be an appropriate time to review the role of advisory members of the Board and to consider their status. Some interviewees suggested that these roles lacked some clarity. Partners would appreciate the focus that this would bring to the responsibilities held by representatives of the SAB. It is important for ERYC to hear that partners are willing to listen, react, respond and understand what the SAB can provide to them and their agency and how they can reciprocate. The new multiagency procedures for safeguarding will provide a platform to align what the SAB requires to bring a consistent approach and outcomes across partners.

Outcomes for and the experiences of people who use services.

Strengths

- The need to embed Making Safeguarding Personal (MSP) is recognised
- SAR learning at Board level is consistent
- Carers Groups are recognised and ready for more engagement
- Healthwatch is a key asset
- Risk for individuals is generally well understood across agencies
- Training is well used and respected
- Community asset approach is a positive move forward
- Use of technology for social workers and domiciliary care has potential to improve responsiveness

Areas for Consideration

- Some front line staff are concerned that there is some over emphasis on process rather than outcomes
- Carers could be used for co-production - a conduit for information and challenge practice
- MSP could be further embedded in all front line settings
- Insufficient evidence of the user voice

"Prevention is what it's all about"

21. Individuals using care services are the best placed people to articulate their own preferred outcomes. There is recognition that this is a complex area of work. The Council recognises and understands that Making Safeguarding Personal (MSP) is critical and central across every agency and in every activity. We acknowledge that there is a good deal of work in progress and the Council and partners are working towards the Making Safeguarding Personal, and an outcomes based performance dashboard is in development.

22. The peer team found that the SAB uses learning from Safeguarding Adults Reviews (SARs), and the Council is turning learning into practice for example there are patient stories told at the Board, which is a powerful activity and makes the work of the SAB "real". The "Do not attempt cardio pulmonary resuscitation" (DNACPR) frequently asked questions document and guidance for care homes staff is another excellent example of the work arising from the learning from reviews, and has been well received and cited as a welcome and valuable piece of work by officers, providers and partners . The Council should perhaps consider how they could further share the learning from SARs with those partners who are more removed from the work on the SAB.

23. It was excellent to hear that carers were ready willing and up for strengthening links with the SAB. They are passionate about safeguarding and spoke of their willingness to work much more closely with the Council and partners. They recognise the valuable relationship that already exists with the Council and have told the peer team about the Carers Service Review that enabled the Carers Support Service to be retained. Carers have their own priorities and agendas to

bring to the table and their input in terms of co-production, providing a challenge and as a conduit for information will enrich the work of the SAB. We found carers to be well informed, well connected and very engaging.

24. They are a valuable asset and in their capacity as volunteers on groups, provide a great deal of their spare time to help each other and more importantly to help agencies understand their needs. They spoke of the recognition of the vast numbers of hidden carers in the locality (40,000 hidden compared with 3600 who are registered). They are willing to be used as a bridge to support and to seek out carers who are isolated, and by doing so, strengthen prevention opportunities.

25. HealthWatch is a key asset and brings real strength to the Board. They can and should be engaged to promulgate information for the SAB, and consideration be given to commissioning HealthWatch to use innovative methods seek the views of service users.

26. The key issue of risk is generally understood by individuals working at the frontline including those working in domiciliary care and residential care provision. The concept of mental capacity was also well understood by frontline individuals and this demonstrated to the peer team that this was a good foundation stone for embedding the risk matrix.

27. The peer team heard on several occasions that safeguarding and related training provided by the Council was valued by partners and that there was a great deal of respect for the Council officers that delivered it. Some partner agencies informed the peer team that some training had been fully adapted to suit their staff working patterns and rotas. Full engagement from the care sector is dependent on this flexibility.

28. There is a network of Carer's Groups across East Riding which could be used more to seek views and provide feedback. There is a magazine "We Care" which goes to carers and libraries. There is a 'Safe Places' scheme in East Riding but there were several comments that this has not been publicised enough and that there is insufficient public awareness of the scheme.

29. There are opportunities to enable consistency and response times in delivering services across partners with the use of improved technology. Technology is being effectively deployed to support transformation and improve quality, consistency and response times. For example a key driver for introducing a new Domiciliary Care system is to support quality and good monitoring of individual care improvements rather than simply being a mechanism for paying providers.

30. Front line staff referred to an emphasis on process rather than outcomes, which is to be expected as MSP is yet to be fully implemented, East Riding of Yorkshire Council appear to be in line with the national trajectory for Making Safeguarding Personal. The peer team recognise that the SAB is putting effort in to develop and embed processes that put the individual at the heart of safeguarding across the partnership. The use of the Risk Matrix is leading to more appropriate referrals, the change in paperwork to be more person centred and we found a general culture of individuals working well together. Front line staff have recognised the strengthened processes and are using them. Rather

than this being an area of consideration it is an area of strength and recognition that the work of the SAB is having an impact at the front line.

31. There may be further work to do to ensure that in the processes that the SAB have developed, that there is now a need to clarity for staff how outcomes are set out, captured and monitored. This was reflected in the workshops with staff and front line managers who found it more difficult than Board Members to articulate what difference safeguarding was making to people. This was also reflected in the Service Record Analysis details of which are given at page 19.

32. Feedback from frontline staff suggested that teams worked in different ways with varying levels of support across different teams. Staff wanted more face to face training and opportunities for peer support and learning opportunities between teams. The peer team heard of some disconnect between care management and the safeguarding team. The peer team found that front line staff viewed MSP as separate from the personalisation agenda. Specifically the following was noted:

    - Safeguarding champions in the teams to provide feedback. "We don't hear from Safeguarding unless there are ongoing cases."
    - Staff felt well informed about appointeeships within the community. However they reported receiving little feedback about deputyships and would benefit from being more informed in this area.
    - It would be helpful to have on-going training on safeguarding. "The induction training is good but over time one can feel out of touch."
    - Although shadowing opportunities have been offered to Care Management Teams with the Safeguarding Team this offer should be promoted further as a good way to gain a greater insight.
    - "We would welcome an annual conference which included safeguarding as a key item." There used to be annual conferences for social workers which would be welcomed in the future

33. Managers felt that getting feedback from service users could be improved. A Care Co-ordinator whose role involved asking users and checking the outcomes goes some way to address this. This information is to be brought back to Managers and team meetings and feedback provided to the Board. This suggest to the peer team that the Council is making efforts to ensure outcomes are achieved and that user voice is heard.

34. The peer team understand that the personalisation agenda means different things to different agencies, a nursing homes interpretation may be different from domiciliary care. The SAB could consider the possible next steps on MSP to be to emphasise the practical application of it across services, for example in the GP surgery or for the police services.

35. The peer team were not invited to meet with people who use services. The challenge to the Council is its progress in the engagement of people who use services and co-production. Specifically does the Safeguarding Board feel confident in the engagement with individuals and in the engagement networks, and is it being done alongside service users?

36. The infrastructure for user engagement is evident and carers were familiar with the networks in place. Carers recognised that improvement was needed in the LD Partnership Board attendance and its membership. There is a need to review and strengthen some of the approaches for flexible user engagement.

37. It is important that East Riding Council obtains feedback from individuals that demonstrate that people understand what safeguarding is and how it is assessed. When individuals have been through the safeguarding process they should be invited to feedback on what the process was like for them – with support if necessary. In this way it might be possible to pick up any issues that remain for the individual. Although the user voice was evident in the service record analysis the review team were not able to get a consistent sense that defined outcomes and systematic feedback were fully integrated into practice. This was in the main due to the majority of records analysed not having a recorded outcomes meeting. There may be good reason why an outcomes meeting has not been held. It would be good practice to record the reasons. However comments about the lack of outcomes meetings was also supported in conversations with providers.

38. Carers felt that when a member of the public rang the Safeguarding Team about an issue that there was insufficient feedback provided to referrers that the case had been recorded. They suggested that a caller could be given a number (similar to a police crime number) so that they knew a concern was logged and if a further incident occurred the number could be quoted when ringing again. They described situations where this had been a problem for them and that they often ended up speaking to a different person, describing details given previously and were not confident that the separate incidents were linked together in Safeguarding.

Commissioning, service delivery and effective practice

Strengths

- Strong evidence of the planning, procurement and quality cycle
- Residential providers are clear about the safeguarding process and the relationship with commissioning
- Recognition of the need to build community resilience eg dementia friendly businesses
- Planning and Procurement have good links with the SAB
- Commissioning has a good focus on low level intelligence gathering, evaluating and risk management through QDMOs and Adult Social Care (ASC) managers
- Strong thread of multiagency partnership working at the front line, evidence of mutual trust and respect across services
- The Safeguarding Adults Team (SAT) demonstrate strong team ethos and are enthusiastic, committed and supportive
- SAT have a strong proactive relationship with providers

Areas for Consideration

- SAT interfaces with other functions (Domestic Violence Care Management/QDMOs) needs more clarity on roles and responsibilities

- Feedback of safeguarding outcomes are not consistently provided to the source of the concern

"I couldn't have been more supported in my role"

40. The peer team heard good evidence of clarity, certainty and priority setting in terms of the commissioning cycle. Council officers have a good understanding of the services commissioned by them and providers have a good understanding of how commissioning and contracting work together. The words "respect" and "excellent" were used by providers in relation to Quality Development and Monitoring Officers (QDMOs) and in particular with regard to their training and workshop delivery on subject such as nutrition and fluids, and manual handling. Of note is the work delivered on "Do Not Attempt Cardio Pulmonary Resuscitation" (DNA CPR) which QDMOs contributed to, and the frequently asked questions document. The work of the QDMOs, who are represented and well linked into the work of the SAB, is to be commended, they achieve a great deal given the very small numbers of officers involved (the peer team were told there were only three people in the team)

41. Quality of care is assured at the front line using a range of processes, including quality assurance, performance reporting and mechanisms (such as file and practice audits, customer feedback, practice forums and mystery shopping). The reporting of safeguarding incidents is tracked and risk is identified and investigated by QDMOs for incidents arising in care homes. Low level incidents are logged on a RAG rated matrix, analysed and shared with safeguarding through team concerns on the Council's Adult Information System (AIS) workflow, and CQC colleagues are notified.

42. Providers and their representatives are clear about the relationship between commissioning and planning officers and refer to a culture of support and mutual respect "*you can pick up the phone and call safeguarding , they are very helpful, very supportive very willing to listen*" The SAB provides direct information, including safeguarding and MSP information to the Provider Association which represents 63 out of 148 providers (42%) used by the Council, and to all of its providers through workshops and fora.

43. Providers were positive about the support they receive from the Council including the training available, citing the Council as being "very innovative". Providers found Council officers to be accessible, they could speak to the right officer when they called, and found the Council to be very open and transparent about fee setting. A concern was heard about some lack of clarity and consistency about what was and was not investigated and feedback about reasons why. This was feedback provided by a single provider but echoes what the peer team heard from other interviews.

44. Positive messages about the work between the Council and local businesses to raise awareness about safeguarding and create community resilience by making the East Riding of Yorkshire locality a safer place for older and disabled people were stated. For example the Council has worked to nurture dementia friendly businesses and has provided "safe places" for disabled people. This preventative approach to build reliance is noteworthy.

45. The Safeguarding Team are enthusiastic, committed and supportive. While it was acknowledged that the team were relatively new, including the Team Manager, it was evident that they were very supportive of each other. They were passionate about the work they did and clearly demonstrated the right skills and knowledge in The Care Act, particularly section 42 and Making Safeguarding Personal. This was confirmed to the peer team by a range of partners and providers who talked very positively about open relationships with the team and their availability to offer advice and guidance when required. There was clearly open and timely dialogue which partners and providers appreciated

46. The peer team were told of some blurring of roles and responsibilities between safeguarding staff and QDMOs and officers working in domestic violence. The peer team recognise that there have been a number of personnel changes recently in the safeguarding team, and that there may a need to build new relationships and redefine responsibilities between teams. Officers said they were keen for this to happen. This would support the experience and value that safeguarding colleagues can bring to working relationships and strengthening the service provided to individuals.

47. The peer team heard that people who raised safeguarding concerns were not always told about the outcome. The peer team recognise that it is not always possible to inform people who feed into the safeguarding process. This is an area for consideration for the Council and could be better addressed through more consistent use of outcomes meetings, where those involved in the section 42 enquiry could be invited to be involved in agreeing the outcomes and action planning or formally notified of the outcomes via the minutes of these meetings.

Performance & Resource Management

Strengths

- SAB is mature and well functioning drawing on national requirements and local priorities
- SAB members contribute beyond their individual priorities and responsibilities
- SAB business management is good and the emphasis on process provides a solid foundation
- Board reporting, challenge and accountability are well established and well used
- Good alignment with the HWB
- Self assessment was insightful and demonstrated good self awareness, key priorities were recognised

Areas for consideration

- The medium term resourcing of the safeguarding partnership is uncertain, while understandable this is concerning given the priority of safety and freedom from harm for people and communities – 3-5 year funding needs resolving
- Learning from SARs could be disseminated more widely e.g. a regular broadsheet to partners with facts and figures
- There is a risk of "overwhelming" the SAT. There may be some over expectation of what is manageable within available resources. The multi agency procedure launch should provide an opportunity to address this
- Look for innovative ways of capturing and using intelligence from community networks

"Things are certainly moving in the right direction"

48. The SAB is a mature partnership in which a wide reach and involvement was evident. This informed the work of all the partners and of the front line staff. There was appropriate and robust challenge provided at Board level, for example to embed MSP across organisations that has been adopted.

49. There is a demonstrable willingness for SAB members to commit beyond their own remit and to make a difference in conjunction with partners. One leading example of this was from the Probation Service. There is a wide ranging membership on Business Improvement Groups and Task and Finish groups, and of partners actively working to connect those who are not members of the SAB to the work of safeguarding. For example the good practice being disseminated by the SAB that has led to the Provider Association developing a specific website to inform it's members and to provide good examples of policies and procedures rather than to rely on emails to do this. Health partners reported that safeguarding for adults is also being considered within the remit of the new Sustainability and Transformation Plans (STP). The footprint of the STP is much wider than East Riding and there may be an opportunity through this work to look for consistency between the respective SABs within the STP

considerations, This was seen as a positive given the high regard for the East Riding SAB. The engagement of primary services in the SAB was impressive and the valued resource of a named GP leads in surgeries is a fine example of leading practice.

50. The Board has put in place a solid foundation through robust processes and continues to do so. The work in progress to further develop the performance dashboard and capture performance data from partners will provide East Riding wide intelligence that can drive improvement across agencies, and make the best use of reducing resources in the partnership.

51. There is a very effective scrutiny process from partners providing challenge, and there is good alignment with the Health and Wellbeing Board (HWB) The strength of partnership was as evident in the Health and Wellbeing Board as it was elsewhere and there was confidence that HWB members had both a good awareness of and championed safeguarding. The SAB annual report is presented to and debated by HWB and key members of the board are part of 'state of the nation' discussions about safeguarding with the SAB chair.

52. The Council's self-assessment document demonstrated good self awareness and priorities are well understood, with plans and infrastructure in place to deliver against them. The peer team's work on site found that partners and officers all understood areas that required further consideration and this was not inconsistent with the scope or self-assessment documentation for this peer challenge. For example the need to establish closer working links with domestic abuse, and to develop improved mechanisms for monitoring domiciliary care services. This is recognised as an area of concern and risk by a range of staff and partners, as is the wider adoption and consistent use of the risk matrix and Vulnerable Adults Risk Management Model (VARMM.)

53. The Review team identified that there was some inconsistency in the understanding and application of VARMM. There is a need to focus on providing clear and consistent communication to all the staff who should use the VARMM. Promoting a more consistent level of understanding would help to improve practice across the partnership The launch of the new Safeguarding Adults Procedures would be an opportunity to do this.

54. Safeguarding is of such importance for vulnerable groups in the community that resourcing needs to be sustainable in the longer term. The need to ensure there is adequate resource to support the safeguarding partnership is a joint responsibility for statutory agencies. A sustainable financial plan that provides the necessary stability to implement the safeguarding adults strategy and deliver improved outcomes for people is essential. A three to five year funding plan would provide a sound financial foundation for safeguarding adults in East Riding of Yorkshire.

55. The Safeguarding Adult Team (SAT) is a valuable and finite resource. It is evident there is a strong team ethos. However they are a service that could be overwhelmed with the demand related to their work. The peer team would suggest East Riding of Yorkshire Council consider how the adoption and roll out of the procedures can be used to support prioritisation of work and resource allocation that ensures the SAT is used to best effect. One specific aspect that

could be considered is the direct public access to the SAT and whether alternative options for dealing with initial public enquiries would assist in optimising the contribution of SAT.

56. The peer team have heard that there is a good amount of soft intelligence gathering from QDMOs and that information sharing between CQC, SAT and Commissioning is working very well. However, there are further opportunities to gather soft intelligence from other areas. We recognise how difficult the task is, and would ask the SAB to consider how to use the partnership for more innovative ways to gather intelligence from community networks to strengthen the safeguarding of people who may otherwise remain unseen.

Service Record Analysis

57. The service record analysis process completed in this adult social care peer challenge follows the methodology outlined in the LGA Guidance Manual for Adult Safeguarding Peer Challenges. The records considered represented a mix of ages and include adults with mental health problems, people with learning and physical disabilities.

58. A total of twenty-eight case records were made available to the peer challenge team, of which fourteen were randomly selected, two from each category. In terms of context, this selection equates to a sample of circa 0.8% of the referrals received by the team each year. The feedback given here is based on the files that the peer challenge team have read and seen, which contributed to the overall conclusion that the service demonstrated very high standards and was protecting vulnerable people and keeping them safe.

Strengths

- Practice in many cases demonstrated MSP with good outcomes for people. There is evidence that the person was included in the safeguarding process and their safety was central
- Good evidence of managers taking a strong lead on decision making.
- Evidence that action was taken to immediately protect individuals
- Strong evidence of family and carer involvement
- There was evidence of good partnership working and clear communication between partners, and that the right people were involved

Areas for Consideration

- Strengthen recording on casefiles to ensure that outcomes are explicitly evidenced, a distinct narrative is apparent, and that dates of reviews of protection plans are clear
- Ensure that recording shows that mental capacity has always been considered
- Ensure that procedures are understood and that there is a consistent approach to following them
- Decision making (strategy meetings) and outcomes meetings should be held consistently

59. The service record analysis was carried out prior to the onsite visit by the peer team. The analysis was carried out by two of the members of the peer team who were provided with fourteen case files which had been randomly selected using the criteria set out in the peer review safeguarding peer challenge guidance manual.

60. The reviewers found that in the vast majority files demonstrated MSP with good outcomes for people. There was evidence that the person was included in the safeguarding process and that their safety was central. It was evident that East

Riding of Yorkshire is keeping people safe. The reviewers found that in the majority of records (11 out of 14) outcomes were clearly stated for people.

61. There was evidence in all cases, of management oversight and good evidence of managers taking a strong lead on decision making, demonstrating good practice and leadership.

62. There was strong evidence for auditors to conclude that action was taken immediately to safeguard and protect individuals. There was strong evidence that responses are timely and met local requirements with only 1 case not providing evidence of this. The auditors found evidence that initial decisions and responses to concerns raised were prompt and that appropriate safeguards were put in place to manage any immediate risk identified. Initial decisions were timely. Staff in the Safeguarding Team are working to keep vulnerable adults in East Riding safe and managing risk effectively.

63. In the majority of service records (11 records) there was strong evidence for auditors to conclude that people were involved in decision making affecting them which auditors found to be very positive. All the records audited showed evidence that the person at risk and their opinions and views of services had been sought. Where appropriate this included the opinions of family, carers or advocate. In 12 of the 14 cases this was fully recorded indicating a high standard of personal engagement in this aspect of safeguarding.

64. The vast majority of records (12 records) evidenced that people were supported or offered support, and this was very evident throughout the criminal justice system, and was fully evidenced in 8 cases. The auditors found this to be very positive and demonstrated good working relationships between practitioners and police colleagues.

65. There was very strong evidence that information was appropriately shared with relevant partner agencies signifying a highly developed level of collaborative working between front line practitioners across the safeguarding partnership.

66. With regard to areas of consideration from the service record analysis the findings should be read in the context that the auditors were unfamiliar with the various forms and recording procedures used by the service in 2015 and 2016. This being so the narrative within some of the safeguarding forms was not easy to navigate and resulted in the auditors concluding that there was some lack of clarity in the records. It is also acknowledged that new forms and processes were revised at the beginning of 2017, addressing some of the areas for improvement identified.

67. However, while this was taken into account, auditors found that some of the stated outcomes for people were subsumed in the narrative of safeguarding forms and as a result appeared less well defined and had in some instances to be inferred.

68. Auditors found in some records explicit evidence that people had been directly involved in setting their outcomes (3 records), however in some records there was less explicit evidence of outcome set by people using services. In these

situations this meant that the auditors had to search for evidence of outcome setting within the narrative of safeguarding forms or case recordings.

69. To assist with this, the council could consider inserting a clearly identified section within all safeguarding forms that required outcomes to be clearly defined at the outset and how outcomes had been reached allowing outcomes to be tracked to conclusion at whichever point the enquiry ends.

70. Auditors found that 7 records fully evidenced positive outcomes as having been achieved, a further 5 records referenced positive outcomes although these had to be inferred to some degree by auditors. Only 2 records did not reference positive outcomes, as in some instances it is not possible for there to be a positive outcome, and auditors thought these were probably attributable to the nature of the case rather than failings in recording.

71. Although auditors found strong evidence of people being involved in decision making which was very positive, it was less clear to auditors what advice, and information about the options available to people was given. Auditors thought it possible that all the advice and information conveyed to the individual was not always recorded. The council could consider whether it would be useful to check against ASC quality assurance processes to determine the extent to which this could be something that requires further consideration. Auditors found there to be some correlation between cases where outcomes were set as goals that there was subsequent recording of progress against them. Auditors thought that developing a focus on goal setting would be a useful way of prompting recording against progress

72. Auditors found that there were some care and protection plans that did not have a review date clearly recorded, there were 5 records in which review dates were clearly identified. Auditors found without the dates for reviews being clearly stated they could not identify whether reviews had taken place. Auditors found that improvements could be made in the records that they saw that a complete picture could not be identified around care planning for people in services because there was a sense from the auditors that the files they saw contained extracts from overall case files, which gave a partial picture. Auditors thought that a fuller picture would be evident on the electronic adult social care records. Auditors found that in some records, entries on files were not always dated or signed.

73. Auditors found that where lack of capacity was identified or recorded that this could have been cross referenced to a Mental Capacity Assessment and Best Interest Decision and to Deprivation of Liberty Safeguards that were in place. These could not be found within the safeguarding file and may have been recorded on the wider adult social care file.

74. The service record analysis did not reach a conclusion on the extent to which local policy and procedures were followed. This in the main was due to a perceived lack of consistency in the forms used i.e. form 1, 2 and 3 appeared to the auditors to be presented in an ad hoc manner within files. There was also inconsistencies in how recording was evidenced e.g. in some files there were extensive case recording notes while in others there were no notes present. Auditors have noted that their lack of knowledge on local procedures could have

compounded this and there was a sense from the auditors that as stated above, the files were extracts from an overall case file and therefore a fuller picture was probably evident on the electronic adult social care records.

75. Given that the auditors were not familiar with the safeguarding forms used by East Riding of Yorkshire Council, it was difficult for them to see where a Decision Making Meeting (actual or virtual) had been held, this is where outcomes could have been clearly stated as opposed to being inferred. It was not easy to identify evidence of formal outcomes meetings (case conferences) being held following a section 42 Enquiry (investigation), which is where positive outcomes from safeguarding interventions could have been recorded as achieved. Auditors have cautioned that the files audited may not have involved in a section 42 enquiry and all records, except three **did** record outcomes in some way.

76. Whilst there were inconsistencies identified by the auditors in some records it was clear that the service record analysis evidenced areas of considerable knowledge and expertise in adult safeguarding in East Riding of Yorkshire Council. Auditors found good practice, front line staff actively engaging with the person at risk and their family or carers and working alongside them to reduce risk. It was clear that the safety of the adult at risk was central.

Your scope and key messages

- How effective is the Board in assuring itself that partners are working to deliver the SAB's strategy?
- How effective is the Council in engaging and hearing the voice of people at risk of harm and their carers?
- How robust are the safeguarding enquiries that are undertaken?
- How far is Making Safeguarding Personal (MSP) embedded in practice, culture and systems?

"Safeguarding is always a learning journey"

77. Safeguarding Adults Board has developed a risk matrix, for all partners to report performance and to share intelligence. The Council, police, probation and health partners are working well together and this is as a result of long standing performance approaches across the sector. Inevitably, and from time to time, there are leadership changes that need to be accommodated. There is a recognition by members of the SAB, that not all partners around the Board table have the same level of resource, knowledge or experience to be able to provide similar levels of data. The peer team understand that the SAB has the process and mechanisms in place, and there is work to be done to enable all partners to contribute effectively to the performance management approach.

78. The SAB is a longstanding and mature forum and with support there will be assurance on a performance level from partners of the delivery of the SAB strategy. The peer team heard evidence from partners of their willingness to deliver the nine strategic priorities of the Board, but of those nine priorities we heard more specifically that partners were committed to delivering embedding MSP in their organisations, to increase service user and carer involvement, to work more closely with communities and to deliver outcomes for people. To this effect the SAB can be assured that partners are working together to deliver the SAB strategy. More could be done to gather partnership intelligence as a next step for evidence of outcomes and to enable partnership wide priority setting based on shared data.

79. The peer team believe that there is a good infrastructure in place to engage people who use services and their carers. We understand with some of the structures, for example the Learning Disability Partnership Board, that there is further work to be done to strengthen the Board and to reinvigorate the membership, this is work in progress. There are specific carers groups across the locality, with an articulate and passionate carer population, willing and able to work alongside the Council and who have recognition that Adult Social care is using the limited finances it has to engage them.

80. Furthermore the Council has used audit's on service records to determine whether the voice of the person using services is heard, it has used mystery shopping, it has used surveys, it is embedding MSP, Healthwatch are at the

SAB, and the use of peer challenge to focus on this area – to name a few. There is no doubt that there is a great deal of work that East Riding of Yorkshire is involved in to hear the voice of people at risk of harm and their carers, and this is an area that front line staff are clear that they do in their practice.

81. There is always room for improvement when it comes to engaging people who use services and their carers. The addition of a carer or expert by experience at SAB level would be a valuable addition, but must be done with great care and support. We have been informed that this is an addition that the SAB is looking at, and that this is an area of work that needs to be approached with care. It was evident in the Service Record analysis that we completed that efforts were made to hear the voice of people at risk and to act on this to personalise the Safeguarding response.

82. The service record analysis conclusions were based on a very small snapshot of files provided by the Council many of which were not section 42 enquiries. Given this random selection our final analysis as set out above is that ultimately that the safety of people in East Riding is paramount for adult social care, and that safeguarding adults is seen as a priority by Council officers and partners.

83. Making Safeguarding Personal is an important priority for the SAB and for partners. MSP is beginning to be embedded in Council procedures and this is evidenced by the Council joining the MSP initiative. Further work is required to build MSP into mainstream practices and processes and in making it relevant to partners. Suggestions have been made by frontline staff for further training and opportunities for peer support and learning. The Council could consider how the enthusiasm for improving support and connections across teams could be harnessed to improve and develop practice in this area.

Adult Safeguarding resources

1. **LGA Adult Safeguarding resources web page**
2. http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/3877757/ARTICLE

3. **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

4. **LGA Adult Safeguarding Knowledge Hub Community of Practice** – contains relevant documents and discussion threads
https://knowledgehub.local.gov.uk/home

5. **LGA Report on Learning from Adult Safeguarding Peer Challenge**
http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/4036117/ARTICLE

6. **Making links between adult safeguarding and domestic abuse**
http://www.local.gov.uk/web/guest/search/-/journal_content/56/10180/3973526/ARTICLE

7. **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

8. **Social Care Institute for Excellence (SCIE)** website pages on safeguarding.
http://www.scie.org.uk/adults/safeguarding/index.asp

9. **Adult Safeguarding Improvement Tool**
http://www.local.gov.uk/documents/10180/6869714/Adult+safeguarding+improvement+tool.pdf/dd2f25ff-8532-41c1-85ed-b0bcbb2c9cfa

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

Appendix 1 – Standards for Adult Safeguarding Improvement Tool, March 2015

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