directors of adass
adult social services
Yorkshire & Humberside

Kirklees Safeguarding Adults Board

Adults Safeguarding **Peer Challenge Report**

December 2018

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Introduction

Kirklees Safeguarding Adults Board (SAB) requested that the Yorkshire and Humber ADASS undertake an Adult Safeguarding Peer Challenge of the SAB. The work was commissioned by Mike Evans, Chair of Kirklees Adult Safeguarding Board who was the client for this work. He was seeking an external view on the work of the SAB and their ability to safeguard people in Kirklees.

The SAB intends to use the findings of this peer challenge as a marker on its improvement journey. The SAB asked us:

1. To evaluate performance against strategic priorities
2. How are we doing on the alignment of strategy and delivery action (golden thread)?
3. To consider and evaluate current SAR improvement plans.
4. To consider the potential for further refinement /development of the dashboard
5. To consider the effectiveness of integrated working and partnership collaboration
6. To consider whether intelligence from file audit and any case follow up show:
    a. Evidence of risk assessment and capacity assessment
    b. Timeliness
    c. Making Safeguarding Personal (MSP)
7. A peer challenge is designed to help 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 and its partners identify current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.
8. 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:
    - Leadership, Strategy and Commissioning
    - Outcomes for, and the experiences of, people who use services
    - Service Delivery, Effective Practice and Performance Management
    - Working Together

9. The members of the peer challenge team were:

- **Bev Maybury,** Lead Peer, DASS, Bradford Council
- **Shona McFarlane,** Deputy Director Leeds City Council
- **Wendy Barker.** Deputy Director of Nursing, NHS England – North Region
- **Kyra Ayre**, Head of Service, Adult Safeguarding, City of York Council
- **Jackie Scantlebury**, Safeguarding Adults Board Manager, Rotherham
- **Venita Kanwar,** Peer Challenge Manager, LGA Associate
- **Dave Roddis**, Programme Director, Yorkshire and Humber ADASS

10. The team was on-site from 5th December – 7th December 2018. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of SAB Board Members, partners and external stakeholders. These activities included:

    - interviews and discussions with councillors, officers, experts by experience and partners
    - focus groups with managers, partners, providers and frontline staff
    - reading documents provided by the SAB, including a self-assessment of progress, strengths and areas for improvement
    - comprehensive audit of 14 individual service records

11. 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.

12. Our feedback presentation to the SAB 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.

13. The Care Act (2014) provides the statutory framework and guidance for adult safeguarding, which replaces the 'No Secrets' guidance.

    The safeguarding duties apply to an adult who:

    - has needs for care and support (whether or not the local authority is meeting any of those needs)
    - is experiencing, or at risk of, abuse or neglect
    - as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

    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 Commissioning

Strengths

- The Council's Chief Executive has confidence in the Safeguarding Adults Board.
- The Chair of the Safeguarding Board provides robust and positive challenge, and is well regarded by Board members
- The Chair holds people to account and is hands-on
- Board members have expressed that partners have an equal voice and that the work of the Board feels relevant to their respective organisations.
- This is a well led, strategically driven Board
- The Board Manager is widely recognised as pivotal to the Board and sub-groups
- Partners feel involved and engaged in the Board, inclusive
- Legal update is seen as a real positive
- The work of the Board is cascaded into partner organisations
- The golden thread is clear from strategic priority to action on the ground
- Open, transparent and challenging!

Areas for consideration

- While there is a golden thread, there are still some issues for operational staff who have stated that they may not have been supported to understand the implications of the policy or action
- Representation at the Board – consider the involvement of councillors, social care and third sector providers, community groups and workforce development staff. Get more from the partners who attend
- Strengthen the links between the Children's Safeguarding Board and consider the interactions with other Boards
- Self awareness of user/carer voice at the board – capitalise using HealthWatch and potential collaboration with Lay Member, also what can partners bring to the table. Elected Members can bring an important dimension to promote the work of safeguarding voice and act as a conduit to communication with local communities.
- Significant change in ASC safeguarding operation over last 12 months – KSAB assurance? How do you know it is working beyond the statistics?

"Other departments have savings, Adults have transformation"

14. Kirklees Safeguarding Adults Board 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 reviewing the Safeguarding Policies and Procedures, and the Performance Dashboard. 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.

15. The peer team found that the passion for safeguarding people was articulated at all levels of the Council and included a clear commitment from the Council's Chief Executive who is able to get her assurance from the Board, the Chair of the SAB, the Portfolio Holder for Adult Services and the Director of Adult Social Services. The passion for safeguarding is filtered through the partner organisations and was evidenced by the people that the peer team met.

16. The chair of the SAB is highly thought of and well regarded by all Board members. There was a real sense of people belonging to the Board and understanding their roles and responsibilities, all partners felt involved. There was appropriate and positive challenge from the Chair of the SAB, who holds people to account while remaining hands on. The commitment from partners was evident by their engagement.

17. Partners feel that they have a very equal voice on the Board. The Board is fortunate in having a good mix of individuals as members, there are some people who are very new in their role, and some who have been on the Board for much longer. All feel welcomed, and all have a sense of responsibility to ensure safeguarding procedures are protecting people.

18. It was evident to the peer team that the Board was well led and strategically driven. This was demonstrated by the many comments we heard about the role of the chair, and the importance placed on the five strategic priorities for safeguarding adults which were:

    a. To provide Strategic leadership and effective collaboration including working productively across Kirklees in safeguarding adults

    b. Gain assurance that adults are safeguarded through timely and proportionate responses to concerns of abuse or neglect, with support for adults to have informed choices.

    c. Support the development of and oversight of preventative strategies that aim to reduce instances of abuse and neglect

    d. Promote multi agency workforce development and consideration of specialist training it may be required

    e. Gain assurance of effectiveness of partners safeguarding arrangements and improvement plans

19. The newly appointed Board Manager is widely recognised as pivotal to the whole process and is a key person in the Board and the sub groups. Partners clearly recognised that significant progress had been made since the Board Manager has been in post. He is seen as being a significant player in the coordination of the board's functions, processes and programmes.

20. The Board should take care to ensure that there are other linking mechanisms in place, and that these are firmly embedded within Board governance processes to ensure that this effective work is sustainable.

    The Board needs to build upon its collaborative working to ensure that it is inclusive and can demonstrate joint coordinated leadership across all its partners. This will ensure that safeguarding is embedded in all corporate and service wide strategies across the council and all key partners.

21. Partners have said time and again that the Board is inclusive, and they feel that they have an equal voice and are heard. This is a real achievement given the numbers and range of partners around the table.

22. The Board are fortunate in having a rare resource as part of the Board business a regular presentation from a legal representative who provides up to date case law information to Board members. The peer team heard from many partners how much they valued the legal update provided. The legal update is an incredible strength for the Board and the region would benefit from the suggestion and offer that was made by the Director of Adult Social Services that Kirklees could provide the legal update at regional forums. This would be a welcome and valuable contribution.

23. The work of the Board is cascaded by partners into their own organisations, and made relevant for their own settings. The practice of safeguarding is shared across organisations and partners in Kirklees, and commitment is evident.

24. The 'golden thread' is evident from strategic priorities developed at Board level, through to actions on the ground. For example the peer team heard of the new policies and procedures developed at Board level, being used at the frontline, and recommendations from Safeguarding Adult Reviews (SARS) being implemented on the ground.

25. While the golden thread was evident at a strategic level, there may be more work that needs to be done to understand the way in which strategic priorities impact and are embedded at an operational level. Operational staff that we spoke to were not clear of the rationale of the new procedures, and why they were being asked to change. It might benefit them to understand more fully the reasons why things had changed so that they could be more effective in their practice. Staff have received presentations on the new forms and processes, it is possible that some more time spent working through how the changes will impact on their practice and how they complete the forms would be of benefit. Operational staff are aware of the Safeguarding Adults Board but would benefit from an overview of how the Board is set up and how it works, therefore providing valuable insights into how the processes could be improved and ensure buy in.

26. The voice of people using services being heard at Board level, requires further strengthening. The Board has a real opportunity to utilise the full potential of its current assets to make real its vision. The peer team have heard that experts by experience have had opportunities to attend the Board. The Board needs to build upon this and consider how they can strengthen the voice of its people by making this routine business of the Board. There are opportunities to better utilise the Board's Lay Member and Healthwatch to bring people's experiences

to the Board. Opportunities also to involve in the Board, elected Members who can provide the eyes and ears of Kirklees Communities. Consider also the role that Providers could bring to the Board with their unique access to people using care services, and the involvement of voluntary groups that could enhance the SAB's reach into diverse communities. Given the KSAB vision "*The citizens of Kirklees, irrespective of age, gender, culture, religion, disability or sexual orientation are able to live with their rights protected, in safety free from abuse and fear of abuse*" , the question posed might be, do you have the reach into communities that the vision aspires to? How could you use your members and their reach into the communities that they are part of to answer this question. The Board needs to take stock and reflect on how effective it is in reaching the communities its vision aspires to reach. It may be worth exploring, with other key partners such as Health and Housing, bringing a wider user and community voice to the table. It could help bridge the gap between the strategic approach and reaching into communities.

27. There was evidence that partners were fully committed and passionate about safeguarding adults for example the Fire Service provided a unique role in which fire officers had time to spend with vulnerable people in their own homes and therefore able to assess whether people were in need of safeguarding. We also heard of council 'bin operators' who through their wide and regular reach into communities, were able to provide information about possible changes in people's circumstances.

28. There could be stronger and improved links between the Adults and Children's safeguarding Boards and also with the Health and Wellbeing Board, There clearly are cross overs. The peer team understand that this is work in progress. The importance for improving the connections, particularly with the Children's Safeguarding Board are to work in a preventative way, particularly with those children who may have been subjected to abuse or sexual exploitation as children and who as adults will require support.

29. The peer team would pose a question to the Kirklees Safeguarding Adults Board as to how they are assured that the recent revised safeguarding procedures are working in practice? Are the procedures working in the way that the SAB had intended? While it is clear that safeguarding staff are implementing the process well, and there is clear evidence of ensuring that people's outcomes are addressed, and the practice is consistent with Making Safeguarding Personal, it would be useful to check with staff and potentially with people who are being safeguarded or their families that this is making a difference to people's experience and resulting in people feeling safer. Kirklees make effective use of audits. An audit of the outcomes, both intended and unintended would be useful especially in respect of the increase in S42 enquiries to identify the impact on front line staff, response times and effectiveness of the service. It might also be helpful and timely, to undertake a consultation/review of the new procedures, perhaps with focus groups of staff involved, to elicit their views on how the procedures are working in practice. The team heard from some frontline staff, that they have some suggestions as to how the process and the paperwork might be improved.

30. Given that there is now a clearer line around whether people have given permission for the concern to be raised, and there is less scope for advice to be

sought by referrers, there is a risk that referrers may experience repeat concerns that don't initially trigger for a safeguarding response resulting in some people being left unsafe for longer. The peer team think that feedback from referrers, especially from community staff to KSAB could be useful in determining how this risk could be minimised. Referrers may experience being asked to check if the person has capacity and have given permission as a negative interaction with the council so more may have to be done to explore why this is happening and what the role for providers in managing risk (as opposed to reporting safeguarding concerns) is. The new Principal Social Worker could play a significant role here, both in ensuring that safeguarding practice is safe and is incorporated into wider social work practice

31. During the peer review it was evident that partners who we spoke to were implementing the Boards revised safeguarding procedures in practice with a degree of confidence. They recognised the importance of safe, consistent and effective outcomes for individuals. They were well versed in the principles of making safeguarding personal. However, the Board must not be complacent, further assurance is required to test and ensure that these are embedded into practice and to make sure that it is making a difference to people's experiences. It would be beneficial for the Board to fully understand the impact on outcomes, especially in respect of the increase of the number of S42 enquires. This would help the Board to understand the impact on people's experience and demand on resources at all levels.

32. Frontline staff felt that at times when trying to make a referral they were left feeling vulnerable and placed in situations that they did not feel comfortable with. An example was when a nurse tried to raise a concern they felt totally unsupported. They were asked to go back and gather further information which they felt put them in a potential volatile situation which could have been avoided.

Outcomes for and the experiences of people who use services.

Strengths

- The need to embed Making Safeguarding Personal is recognised particularly by operational staff
- Kirklees Involvement Network – great work with people with LD
- Feels like good partnership working at ground level
- Advocacy is of high quality and is well-used at an operational level, use more strategically
- Case file audits are evident across teams and the front door
- User Survey – contacted everyone who indicated they were not safe
- Some organisations start with stories from a service user perspective.

Areas for Consideration

- Insufficient evidence of the user voice at Board. Stories about people could become part of the Boards agenda
- It was difficult to evaluate the outcome and impact of your work with people who use services
- MSP language translating to front line and service users – having a meaningful conversation
- Recognising your diverse communities – you are self aware. You need to set the strategic plan and work with established networks to meet the challenge to engage with all communities
- Do all service user groups and all professionals feel confident and safe to make a safeguarding referral?

The Board Chair makes us feel uncomfortable and that's a good thing"

33. The Kirklees SAB (KSAB) recognises that Making Safeguarding Personal (MSP) is critical and central across every agency and in every activity. Operational staff understood and articulated the language of MSP. We acknowledge that there is a good deal of work in progress and the Council and partners are working to Making Safeguarding Personal, and an outcomes based performance dashboard has been developed and is providing improved performance information.

34. The Kirklees Involvement Network is a fantastic vehicle for adults with a learning disability and autism to be involved in the development of services and provide

their unique experience in the improvement process. The Involvement Network spoke of their attendance at KSAB and of their pride in being involved. The KSAB should harness their enthusiasm further, to improve safeguarding adults!

35. With regard to partnership working at ground level, we heard of the way in which staff in the hospital and social work staff work well together in relation to safeguarding activity, they hold regular meetings in order to identify drift in cases and address them, and feel that there is effective joint working. There was also seen to be effective working with the police. Health staff felt that there was alignment between their commitment to personalised ways of working and Making Safeguarding Personal, and operational staff have demonstrated a commitment to learning from incidents such as around discharge planning, and have implemented lesson learned processes as a result.

36. The focus on Making Safeguarding Personal is well received by partners, and the conversation with the person is undertaken by whoever is best placed to do it, which enables the best outcome for the person. In some areas, this may be less well embedded so further work to ensure that all partners understand the process and why they may be being asked specific questions (and their responsibility in the process) may be of benefit to ensure embedding of policy and process. Partnership working at ground level was considered effective, where individual agencies understood their role and responsibility in safeguarding the local population. For those agencies represented at Board there was clear evidence of ownership and collaborative working. Both the case file audit and the interviews, demonstrated some great partnership working to safeguard adults.

37. The Advocacy Service operates at a very high quality, they understand their roles and responsibilities and they are very clear that they put the person at the centre of everything they do. Timescales are kept and joint working between social work teams and advocates is described as good. The Advocacy Service would benefit from providing their customer with informative literature that explains their role in the safeguarding procedure, this is something the board could assist with. They are a valuable asset!

38. Case file audits are used regularly across teams and at the front door. Officers are quality assuring regularly and the paperwork associated with the case file audits is very thorough. Peer support across teams ensures objectivity and consistency of approach, and helps to share learning.

39. Efforts have been made to understand people's experience of safeguarding. Using the Adult User Survey is a good example, we heard that people who had identified as not feeling safe were contacted further to provide help and support. While this may be limited in numbers in people responding to this, it will provide the SAB with a flavour of what user experience has been. Keep up your perseverance, you have made a great start on this.

40. The peer team heard that some of KSAB partners start their organisations safeguarding board meetings with case stories that express people’s experiences of safeguarding. KSAB should consider adopting a similar approach to bring alive the work of the Board, and to evaluate your outcomes and impact. This would feel like the next step in the SAB’s development.

41. HealthWatch is a recent addition to the SAB and their future attendance will bring a 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.

42. There could be a disconnect between the work of the Board and the language that people use in particular translating the language of Making Safeguarding Personal for people working at the front line. The Board could help operational staff understand exactly what MSP means so that staff can use it and explain it to people who use services so that they understand what operational staff mean. The language of safeguarding is not familiar to many communities so working with people to develop a shared language about 'keeping people safe' would be of benefit to all.

43. KSAB recognises the diversity of the communities in Kirklees. Whilst we recognise this self-awareness there could be more in the Strategic Plan about how you connect and deal with some of the issues that diversity in Kirklees presents. This will need all partners to be signed up, engaged and involved in addressing. The strategic consideration will help the Board work with the longer-term inequalities that currently exist.

44. There were concerns expressed from some operational staff across the partnership and people who use services about the difficulties they have in referring people to safeguarding services. People did not feel confident in reporting their concerns. For some people using services there was a question they had about the repercussions for them in making a report. This may be something that the Board should consider further to embed safeguarding as everyone's business. For example, one worker had referred a safeguarding concern into the front door but was instructed to go back to gather more information. The worker felt that this placed them in a very vulnerable situation as they had no reason to return to the client and this could of but them or/and the client in a dangerous situation. Skilling the workforce of all board partners would give workers the confidence to ask the necessary questions when a safeguarding concern was identified, possibly a prompt card or telephone app could remind staff of what to do.

45. Some operational staff we spoke to felt unprepared when asked to go back and gather further information by Gateway to Care staff. Another concern raised related to the amount of additional information they were asked to gather, which they felt should have been undertaken by the frontline staff dealing with section 42 enquiries. An example was where a community nurse was asked to go back and gather further information when the potential perpetrator was still present.

Service delivery, effective practice and performance management

Strengths

- A golden thread is evident from SAR's from implementation/ action plan through to delivery.
- New operational model in place, it's still early days, there is a need to evaluate the impact with operational staff, and partners
- Safeguarding Consultants seen as positive to support practice in some hubs
- CHESP – really positive replication of the model is under consideration for home care
- Policy and procedures reflects MSP and simplifies the process across multiple areas. Providers feel that relationships have improved as a result of new policy and procedures – better conversation.
- Delivery Group – empowered to make decisions and have oversight of what is happening.

Areas for Consideration

- Timeliness - strategic view, system view – the view of people who use services?
- Operational staff are concerned that the front door screening process may impact upon the timeliness of response – out of time before it hits the community hubs and three levels of screening exist.
- Mixed views on the success of the implementation of the new safeguarding operating model. Is it time for a review? Operationally people have ideas of how things can improve.
- Learning from SARs could be disseminated more effectively – mixed picture of next steps/improvement across partners.
- Training
- Stream lining the process
- Enhancing the presence on the Board structure
- Evaluation
- What happens next – Care Home/Families when they report through concerns. Consider your communication and feedback mechanisms

"People do want to be challenged"

46. The ‘golden thread’ is evident in the delivery of recommendations arising from SARS and this was triangulated by the peer team while they were on site. Operational staff could clearly identify how recommendations were informing practice, For example providers were aware of a couple of the initiatives that had come from the Oxford Grange SAR, they were aware of the Review and Quality Team and also the Early Support and Prevention Group and had positive views on both.

47. There are always unintended consequences when any new process is implemented. One area of consideration the Board might want to seek assurances from adult social care in regards to the referral to S42 pathway is working in line with the procedures and if changes are required to practice or procedures. This would help inform and assure the Board of effectiveness of Adult Social care service delivery and practice and help result in better outcomes for people. Concerns were raised by frontline staff about the screening process. Staff need to understand what is expected of them while working to the new procedures in order to minimise any duplication or delay of work. We heard “ c*ases are already out of date by the time they get to us, they sit on the clipboard and it affects performance*”

48. The Safeguarding Consultants were seen as a very positive development in those Hubs that they were based, they were seen as a good source of knowledge, expertise and support. As the Consultants are rolled out across all of the Hubs, ensure there is a consistency of approach in what they provide to the operational teams. Not all staff had clarity about their role and function.

49. The Care Homes Early Support and Prevention Group (CHESP) was very well received by all who are involved. The model is highly thought of in terms of provider improvement. The Board would benefit from having someone from the CHESP group sitting at one of the sub groups, this would provide a strong link to the Board.

50. The policy and procedures for safeguarding reflect Making Safeguarding Personal principles; it simplifies the process across multiple areas. Providers feel that relationships have improved as a result of new policy and procedures and that they are able to have improved conversations. They reflected on the way in which the previous process had felt quite ‘clinical’ and ‘process led’ and that the new policy felt like there was a better quality of conversation, with less focus on finding out what had gone wrong and more focus on enduring that lessons were learned. The Board should not be complacent following implementation of any new process or procedure, a time of reflection, evaluation and learning can only further enhance people’s experience.

51. The Boards Delivery Group has only been in place for the last 18 months. The group has delegated powers from the Board to make decision. The Delivery Group use the Board action plan as their work programme and see their role as having oversight of the delivery of the actions through the sub-groups. In governance terms this is recorded in the minutes and links through to the sub-group action plans. There are some initiatives which are dealt with at Delivery Group level which are not reported to Board. There is a risk that the Board does not have full oversight. It may be useful for the Board to review the work of the delivery group in preparation for the Annual Report to ensure that all of the work

undertaken is comprehensively captured to give a full picture of the work undertaken in the Boards name.

52. There is a strategic view of the system that timeliness of safeguarding is an issue and the peer team found that timeliness was indeed an issue in some cases. The issue was around duplication of effort. In some cases, operational staff had to visit people to re-establish information that was not fully gathered at the point of contact. This resulted in duplication, and delay. This may because of uncertainty of what information was needed on first contact and it might be worth considering if staff (both social care and health staff) are sure about what is expected of them. If the process was fully streamlined, only one visit would be necessary and may avoid any situations that prolong harm and may free staff time to make the timeliness deadlines.

53. The significant improvements that have been made to the front door access arrangements and the staffing reorganisation that have taken place over the last twelve months have been seen by the majority as a positive move however there was a feeling amongst staff and management that some processes were not working or in some cases causing duplication. The Boards safeguarding policy and procedures have been operational for a year. It would be timely for the Board to consider undertaking a review to understand how they are working at operational level. This would be fortuitous at this stage in order to assure the Board that they are fit for purpose, well understood and that their impact in keeping people safe and equipping frontline staff with the skills and tools to safeguarding vulnerable individuals. Given that the changes that have been made affect how safeguarding operates in Kirklees the SAB may want to play a more pivotal role in the review.

54. Some of the learning from SARs could be communicated more widely to disseminate good practice across organisations. Some operational staff were aware of SARS, but not completely aware of the learning arising from them. Consider how you communicate the messages from SARS and from the Board to a wider audience that provides the required impact to staff. There was some concern that the actions from SAR's could at times be less precise than was helpful – taking a more SMART approach to action setting and ensuring that those responsible for the implementation of the action are involved in the design of the action plan would result in a more effective plan that could be more easily monitored and implemented. The training sub group would benefit from being involved when SAR action plans are developed to ensure the learning is captured in training at all levels.

55. Training could be more streamlined. Learning is critical in all organisations and the attendance of training colleagues at Board could be further considered along with the quality of commissioned training provided, so that KSAB is confident that it is attaining the very high standards expected for the partnership, and strengthening the service provided to individuals. There was some concern that the recent training that had been provided to partners had lacked clarity, and had not provided them with the clarity they needed into key areas. The Learning Networks are very well received. The Training sub-group use case studies as a routine within their training and relate the training offer to the Board s objectives; this is planned in a multi-agency group and ensures relevance. The training on Making Safeguarding Personal has been well received and should be rolled out to all staff who require it. The training group

would benefit from being involved in the development of the SAR action plans to ensure they capture the specifics of what is required in a timely way.

56. 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 SAB and could be discussed further about how 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 if this is appropriate. This would reassure people that concerns have been dealt with, and give them more confidence in the system.

Service delivery, effective practice and performance management – Performance Dashboard

Strengths

- This was not an easy task – we recognise the work you are doing.
- Significant improvement recognised by all partners
- People who are working on this are passionate and are committed to get this right for the Board.
- Its work in progress – everyone recognises this and is willing to play a part in getting this right.
- Self-assessment was insightful and demonstrated good self awareness, key priorities were recognised

Areas for consideration

- What is its purpose? Is the dashboard providing assurance or do you use it to facilitate further work?
- Are you reporting what matters to the board?
- Rounded picture
- Performance Management / So What?
- Who owns it, who reports it, who is accountable?
- Understandable to all and can people use it to challenge?
- 'Can-openers' – do you have the necessary information for assurance

57. The KSAB performance dashboard has been reviewed and improved over the last year and many partners commented on the improvements made, particularly on the presentation of information. It is widely recognised that developing the ideal performance dashboard is a "hard nut to crack" and lots of SAB's across the country have struggled with this. The peer team have recognised the considerable effort that the KSAB have demonstrated and the Board is to be commended for this.

58. There is a demonstrable improvement on the presentation of performance information and a willingness from the KSAB partners to try to get and put performance to the forefront of the Board's agenda, in order to achieve and improve outcomes for people. The partners and individuals involved in trying to manage performance for the Board and they are willing and passionate about getting it right.

59. The dashboard is widely recognised by partners as "work in progress" and it was clear to the peer team that there were an abundance of partners who did express a view on the dashboard and these views should be harnessed to further improve and develop the dashboard. We feel that it is up to the Board to continually review its effectiveness and to contribute to its further development. The Board must continually ask if the information that is contained is easy to understand and can be used to challenge. As an example, during the peer challenge we had conversations with some Board members regarding the

conversion rate of Section 42's as the figures presented in the dashboard translated to a 98% conversion rate from concerns to Section 42 and this appeared to differ from the narrative of around 25%. We clarified this in the peer challenge, but clearer reporting could have made this much easier to understand and provide assurances.

60. There appeared to be confusion around 'the purpose' of the dashboard. This is perhaps a conversation that the Board should facilitate. There were some questions around 'the purpose' of the dashboard. This is a conversation that the Board should facilitate. The questions were around whether information provided enough assurance? Were people kept safe? Or was the dashboard a vehicle for facilitating further work and identifying what the issues for safeguarding were? Some further clarity to Board members should be provided, so that all partners are aware of what the dashboard should provide to give the assurance that partners want.

61. The question therefore that the peer team must pose to the Board is "are you reporting what matters, and do you have clarity about what matters to you as a Board?" Now is perhaps the moment to take a sense check on performance and ask if all what matters to the Board is provided in the data? Could performance information be further refined? Do you need extra information to give you the assurance you want? This is a process of continuous evaluation and will take several iterations to arrive at the point where you are satisfied with your dashboard.

62. It felt to the peer team that the dashboard had a heavy focus on social care and some focus on health data. The information could be more rounded, with an eye on ensuring that there is not an overload of information. Therefore, it is important as stated in the previous paragraph to make sure that you report what matters. There are key partners that could contribute significantly from an "eyes and ears" point of view, and who may provide you with further assurances. For example there is some very good work that CHESP is delivering which provides a picture of commissioning. CHESP have done much work which could be utilised by the dashboard and provide an insight into your providers and what is happening in communities. There is much to consider, particularly around those harder to reach communities.

63. There is information that is provided at regional level to which Kirklees contribute to about safeguarding that could be useful and can be used to sense check activity against others in the region. It was acknowledged that there is data quality issues around data that is collected regionally however it is recognised that this can be used as "can openers" to evaluate an area's performance and begin to ask questions and to benchmark. The dashboard would be enhanced by regional benchmarking data.

64. The conversation that a dashboard facilitates is important as are the actions that fall from that. The peer team were unable to uncover what happens as a result of the discussions of the performance dashboard, following the presentation of information and therefore were unable to understand how the data is used for performance management purposes. Perhaps KSAB could consider a future revised dashboard that reflects the discussions held about the data and the actions arising from it. As an example, some of the current narrative on the data

describes that there may be an issue in some care homes around abuse and neglect which appears to be high. The peer team could not determine whether this was a critical issue for the Board and what further was being done about this, and what were the next steps (the 'so what').

65. KSAB could further clarify, who owns the performance dashboard, who produces it, and who reports it and who is held to account and held responsible? The development of the dashboard has been done at a pace and it is perhaps time to take stock and re-evaluate.

Working Together

Strengths

- Lots of excellent partnership working
- The Board is inclusive and open
- Equal voice across all partners
- Annual Challenge Event is seen as positive

Areas for Consideration

- Consider how you can strengthen working across health and wellbeing board and children's safeguarding Board.
- Consider practical ways to address the issues of timeliness and quality by partners in the Board setting.
- Consider the interdependencies between the sub-groups
- Consider how you communicate the work of your sub- groups up and down the system.

"The board is open and welcoming, it's inclusive and it feels like we are in it together"

66. There is an evidence of excellent partnership working, the Board is open and inclusive and all partners, including the newest partners, have indicated that they are able to participate with an equal voice and contribute to the work of the Board.

67. The annual board development session is well regarded and viewed by all as a positive session. There is an opportunity to reflect upon what has happened over the last year together with a discussion of a forward view about where the Board's next steps are taking them.

68. There is an opportunity consider how KSAB can have a broader impact in other arenas, particularly with the Children's Board and the Health and Wellbeing Board. Identifying areas that cross over and would benefit from a joint approach in training and awareness would pool resources and send one clear message to all staff across agencies. Sharing annual reports will inform all Board members of issues across services.

69. Consideration should be given to bringing together the practical operational issues with the strategic direction to assist with addressing timeliness and improve the quality of the safeguarding response.

70. It might be helpful to think about the interdependencies between the sub groups. The way that the Board and Sub Groups are structured means that there is always a dependency on another group to get work moving along. It is important to manage those interdependencies so that communication flows effectively. There may be more to consider around how communication flows from the Board through the system via the Sub Groups and to operational staff and people using services, and back from operational staff and those with experience of services, to the Board. A key issue is how can the Board use it's influence to make an impact on people. The Board would benefit from having

the Training Sub Group chair attending Board meetings to ensure all messages are captured and fed back down as well as up, the reliance on the Delivery Group to do this may result in issues being missed.

Case File Audit

71. 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.

72. 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

- The forms used are very comprehensive and clear - they tell the story
- Decision making is clearly well recorded and evidenced
- A good level of detail in the reports
- The recording is clear, accessible, largely non-jargon based
- The recording is very factual and informative
- There is a clear focus on partnership working
- Making safeguarding personal is evident throughout the recording
- Paperwork and process is outcomes focused
- The paperwork has a section focused on learning and the way in which it is going to be embedded in practice
- Focus on capacity is consistent
- The section on ‘Contacts made during the decision making’ gives clarity as to the joint working and the outcome of decision making

Areas for Consideration

- Small number of cases lack of rigour in scrutinising provider investigations
- One case was closed despite a provider still undertaking actions in relation to the concerns, how do you assure yourself that all plans are effectively implemented?

73. The case file audit 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. These included a good mix of different client groups and scenarios (ie people living at home, with children, in care homes etc

74. The reviewers found that paperwork and forms used by staff were very comprehensive, factual and clear. Decision making and thinking was clearly outlined and captured. 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.

75. It was evident that there was good partnership working across cases.

76. The questions asked by staff of people being safeguarded demonstrated that MSP was in use. Responses did evidence a focus on people and what they wanted.

77. There was a section in the paperwork that is focused on the learning that came from a case and what officers were going to do next to ensure that learning was shared. The auditors were impressed with this. The only question that auditors would ask the Board would be how would you know that the learning was actually shared?

78. Capacity assessment were considered consistently in all the cases audited

79. In terms of the section on 'contacts' there was a lot of clarity about how the process was working, how the information was being used, who had been contacted and progress made.

80. Auditors felt in a small number of cases it was not always clear what scrutiny had taken place around when a provider had undertaken investigations and if concerns had been picked up. There was one example in the 14 cases where a home care provider had been left to undertake a provider investigation, but this had not been seen or quality assured by the manager who signed off the case, this would have been best practice. In another example, it looked like a provider investigation had not focused on the concerns that had been identified by the consultant at initial review, we were assured that the investigation had taken place but was recorded on the providers system.

81. The auditors found in one case had been closed while a provider was still undertaking actions. Auditors wanted to know why the case had been closed and this was taken up with the Board Manager during the peer challenge process.

82. There is no doubt that KSAB really is a well run, well resourced Board. The question is how can the shift be made from being a Board where change and innovation is driven so that it ultimately means that people are happier and safer in their homes. You have made an excellent start and have the building blocks in place, it's a matter now of enhancing the work that you do

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

Contact details

For more information about the Adult Safeguarding Peer Challenge please contact:

Venita Kanwar
LGA Associate
Email: venita.kanwar@yahoo.co.uk
Tel: 07865999508

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