Nottinghamshire County Council

Social Care and Health Standing Committee

Local Peer Review - Adult Safeguarding

Agenda Item 6

Purpose

1. This report seeks to:

    - advise Committee of the purpose and process of the local internal peer review
    - inform Committee of the main findings of the local review
    - advise Committee of the plans for implementing the recommendations arising from the review.

Information

2. Nottinghamshire Adults Safeguarding Board (NSAB) is a multi-agency partnership which oversees the implementation and development of policy, procedure and practice to ensure that vulnerable people within Nottinghamshire are safeguarded. Nottinghamshire County Council is the lead agency in ensuring implementation of the work of NSAB.

3. In recent years there have been high levels of safeguarding referrals relating to vulnerable adults from various places including from professionals such as GPs, District Nurses and other health professionals, from East Midlands Ambulance Service, from the Fire and Rescue service, from care home managers or their care workers, from family members and informal carers or from concerned members of the public.

4. Once a safeguarding referral is received, via the Customer Service Centre, it is passed immediately to the relevant social work team in the locality offices. The number of referrals continues to be high as a result of increased public awareness, media interest and due to high levels of training of care staff and other professionals. In recent years the number of referrals, and the number of safeguarding investigations have been as follows:

    - 2009/10 - a total of 2,416 referrals received, of which, 1,436 resulted in a safeguarding investigation/assessment
    - 2010/11 – a total of 2,357 referrals received, of which, 947 resulted in a safeguarding investigation/assessment
    - 2011/12 – for the first 3 Quarters of the year, a total of 2,034 referrals have been received, of which, 823 resulted in a safeguarding investigation/assessment.

5. The Local Government Group (LGG) advocates the use of peer review (also known as peer challenge) as a way of helping local authorities and their partners to identify good practice and, more importantly, areas of service that require further development or improvement.

6. The peer review framework identifies specific standards in relation to safeguarding, identifying opportunities for improvement and learning in 8 main areas as follows:

    - Outcomes
    - People's experience of Safeguarding
    - Leadership
    - Strategy
    - Commissioning
    - Service Delivery and Effective Practice
    - Performance and Resource Management
    - Local Safeguarding Adults Board.

7. The methodology applied in the review includes collecting evidence in a variety of ways, including completing case audits, data analysis and interviews with Members and officers, with staff in partner agencies and discussions with service users and carers.

8. Through the Nottinghamshire Safeguarding Adults Board (NSAB), the County Council recently commissioned a 'local' internal review of adult safeguarding arrangements in Nottinghamshire using the Local Government Group peer review framework and methodology. NSAB is committed to ensuring that local safeguarding arrangements are effective and efficient and the Board promotes the use of quality assurance measures to enable the service to develop and improve. The peer review process is a means of undertaking a comprehensive examination and evaluation of current safeguarding arrangements and practice.

9. In order to maximise expertise and ensure objectivity throughout the process, the peer review team was led by an independent person, Mr Mike Evans, who is currently the Chair of the Cumbria Safeguarding Adults Board and has previously been a Director of Adult Social Services and a Director of a Primary Care Trust. The other members of the peer review team consisted of staff from the County Council and from other NSAB partner agencies. The team members were:

    - Gregg Dunning, Team Manager, Adult Social Care Health and Public Protection, Nottinghamshire County Council
    - Amanda Peto, Team Manager, Adult Social Care Health and Public Protection, Nottinghamshire County Council
    - Dave Walton, Detective Inspector, Nottinghamshire Police
    - Karen Morgan, Clinical Governance Manager, NHS Nottinghamshire County

10. The review team was on-site at County Hall between 11th and 18th November 2011. During this time the team undertook:

    - An audit of a random selection of case records
    - Interviews with the Leader, Deputy Leader, Cabinet Member and Deputy Cabinet Member for Adult Social Care and Health
    - Interviews with the Independent Chair of NSAB, Chief Executive of the Council, the Corporate Director of Adult Social Care, Health and Public Protection and the Service Director with lead responsibility for safeguarding adults
    - Interviews and focus groups with members of the NSAB

- Focus groups with senior managers within the Council and within partner agencies including Health, Police and the Fire and Rescue Service
- Interviews and focus groups with service users
- Interviews and focus groups with carers
- Focus groups with operational staff from the Council and other agencies.

11. Prior to the on-site work a comprehensive self-assessment and evidence file was completed and provided for the team. This enabled them to assess if Nottinghamshire perceived its strengths and weaknesses objectively and if this could be triangulated by their findings.

12. In their report, the peer review team concluded that safeguarding in Nottinghamshire is 'basically sound'. They noted some areas of very good practice across the Council and the wider safeguarding partnership. The focus of their report however was the identification of aspects of practice and procedure which could be improved or developed further. The full report was presented to Nottinghamshire Safeguarding Adults Board on 19th January 2012 and is listed as a background paper to this report.

Findings and Recommendations

13. **Electronic Recording**

The review team commented on the strengths and merits of the electronic recording system (Frameworki) noting that it provides an effective way of recording activities in relation to safeguarding cases. However, the team stated that not all staff entered their records in a systematic way which could then delay or prevent people accessing the necessary information swiftly. Additionally, they commented that there is a 'lessons learned' field within the section relating to an individual's safeguarding plan in the electronic records which could be used more extensively as this could potentially help reduce the risk of similar safeguarding issues arising.

14. **Management of Safeguarding**

Through interviews and case audits, the peer review team noted that in some cases safeguarding procedures are not followed robustly in that some team managers delegate some of the management tasks within safeguarding to social workers. Whilst this may be appropriate in specific cases where the case is straight forward and where the senior worker is highly experienced, it should not be become regular practice.

15. **Transition Planning**

At a strategic level, the peer review team found that the links between the Children's Safeguarding Board and the Adults' Safeguarding Board could be strengthened. Additionally, the team felt that information should more effectively be passed from one service to another where a young person is due to move from children's services to adult services.

16. **Procedure and Guidance**

The team noted that there is clear and well established multi-agency policy, procedure and guidance in relation to adult safeguarding and the website is accessible to all

groups of people. However, they stated that the multi-agency procedure and internal guidance needs to be refreshed as a result of the constantly changing guidance.

17. **Learning Lessons from safeguarding cases**

Serious Case Reviews (SCRs) are sometimes undertaken following the death of a vulnerable adult, particularly where there has been multi-agency care and support. These SCRs are a useful way of identifying how practice can be improved to prevent similar situations from arising. In Nottinghamshire, there have been three SCRs since 2008. The review team noted the action plans that had been put in place following each of the SCRs undertaken in Nottinghamshire but they stated that the learning from these serious case reviews could be used more extensively such as in one-to-one supervision sessions, team meetings and through personal learning and development processes.

18. **Public Engagement and Involvement of Service Users and Carers**

The Council undertakes an annual survey of people who access services and the findings were that on the whole most people feel safe. This view was supported by the review team through their file audit. They found that in most cases people who are subject of a safeguarding assessment were involved throughout the process. The team observed that there is good understanding and work around tackling hate crime, and other community safety initiatives. The peer review team noted that the County Council has a user involvement strategy, 'Working with Carers and Users' but they said that it is in need of review. They commented that a system of rewards and payment should be developed for people who help the Council by giving their views.

19. **Leadership**

The review team found evidence of strong leadership and commitment from Members, and through the independent chair of NSAB. They also noted that NSAB operated as a statutory body even though there is no statutory requirement to have a Board, and they said that the strategic leads in all of the partner agencies worked together effectively to ensure good safeguarding practice across Nottinghamshire. To strengthen this even further, it was recommended that with the new Health and Wellbeing Board now established, it is timely to consider how it will oversee the work of NSAB.

20. **Commissioning**

The Council places requirements on independent sector providers to ensure that their health and social care services comply with safeguarding procedures and extensive safeguarding training is available to their care staff. The peer review team commented that with the move to personalised care services, there is an increase in small unregulated care providers and, therefore, it is important that the quality of these services is routinely and effectively monitored.

21. **Use of Language**

There is some considerable change in relation to adult health and social care services and in relation to safeguarding. There is national debate about the use of language when referring to safeguarding of adults. A report in 2011 from the Law Commission proposed that the term 'vulnerable adults' is replaced with 'adults at risk of harm or significant harm' and that the term 'abuse' should be replaced with the term 'harm'. The

peer review lead proposed that partner agencies within Nottinghamshire should now adopt the new language and terminology to help wider public understanding.

22. **Board Development**

Bournemouth University has recently developed a competency framework for staff to use to check that they have the required knowledge in relation to safeguarding adults. NSAB has already approved its use within Nottinghamshire but it needs to be used extensively by all the partner agencies.

Learning from the Findings

23. The findings and recommendations will now be incorporated in to an action plan with a timeframe for implementation. A team of staff have been identified to develop the action plan, identify key tasks and relevant leads, and to ensure comprehensive implementation of the recommendations. The Independent Chair of NSAB is leading this work and it is anticipated that the key actions and recommendations will be completed by late autumn.

Recommendations

24. It is recommended that:

- the Committee considers and comments on the report and supports the work of the Council and its partners in implementing the recommendations in order to further develop and improve their safeguarding practice and processes

- a report is presented to the appropriate Committee following implementation of the action plan in relation to the findings and recommendations of the peer review.

CAROLINE BARIA
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Background Papers:
Adult Safeguarding Peer Challenge – Nottinghamshire – November 2011.