Adult Safeguarding Peer Challenge

Nottinghamshire

November 2011

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1. Introduction

1.1 Nottinghamshire Safeguarding Adults Board commissioned this peer challenge into all aspects of Safeguarding Adults in the County. The review/challenge has followed the Local Government Group (LGG) peer review/challenge methodology. (appendix 1)

1.2 It is important to stress that this was not an inspection. A team of peers used their experience to reflect on the evidence presented on safeguarding adults at risk. The self-assessment prepared in advance of the on-site work was thorough and showed evidence of a desire for continuous self-improvement. We saw nothing to contradict that view and therefore our findings and the focus of this feedback report is to assist with the drive to adapt to the external changing environment and continuous improvement.

1.3 Whilst the LGG methodology was closely followed there was one significant variation. The Peer Review Team was led by an ex Director of Adult Social Services but the team was drawn from managers working within Nottinghamshire. The team was comprised of managers from the Local Authority, the NHS and the Police.

1.4 Whilst there may have been an initial concern that this involvement of local managers might impact on the objectivity of the review and inhibit challenge, this did not transpire. Indeed all team members saw challenge as a helpful and productive process and their local knowledge proved to be invaluable to the team. It should also be noted the auditing, service reviewing and peer challenge skills gained by the team members will have left a valuable legacy for the County.

1.5 Organisation in advance of the peer review on–site week was first class. The team was provided with suitable office and interviewing accommodation. The self-assessment was comprehensive, well referenced and provided in good time.

1.6 It was clear from the outset that there was effective leadership from the Board, the Council and its partners. This ensured access to key individuals and focus groups had the appropriate membership. We concluded the work feeling confident that the Safeguarding Adults Board holds its partners to account and safeguarding adults work in Nottinghamshire should be able to sustain a shared strategic direction and build on the learning gained from the Peer Challenge.

2. Nottinghamshire Context

2.1 Nottinghamshire is a large County with three tiers of local government:

- Nottinghamshire County Council (1st Tier)
- 7 District Councils (2nd Tier)
- Town and Parish Councils (3rd Tier)

2.2 The Police and NHS work to wider areas including Nottingham City. Hospitals cross boundaries also. All of this is relevant to effective partnership working. These organisations inevitably have to support several Safeguarding Boards.

2.3 Nottinghamshire has a population of just under **766,400 people** and a workforce of 360,000. The largest concentration of people is found in the Greater Nottingham conurbation, the suburbs of which lie mostly in the county. In total (including Nottingham city, 283,200 with a workforce of 125,000) this area has a population in excess of 500,000 (with a further 130,000 in parts extending into Derbyshire).

3. Executive Summary

3.1 The Safeguarding Peer Challenge is a thorough process. Whilst we have identified areas for improvement and made specific recommendations, it is important to stress that we found some very good practice and mostly we found that individuals were safeguarded.

3.2 We have made recommendations that relate to individual agencies, the Board and partnerships. These recommendations are detailed in section 7 of this report and formulated to support the development of an action plan.

3.3 The main areas for improvement and recommendations are:

3.3.1 There are issues relating to the application of the safeguarding process. This includes some poor record keeping and inconsistent management support. Also some updating of procedures would now be appropriate.

3.3.2 File audit illustrated the importance of effective transition planning and this area is worthy of closer attention. 'Think Family', alongside transition issues, raises the potential for closer working with the Children's Safeguarding Board.

3.3.3 The National Competency Framework has been introduced in Nottinghamshire but there is the need to ensure that this is rolled out across all agencies and at all levels in the organisation. The Competency Framework is an effective tool for achieving consistency across agencies, embedding an understanding of adult safeguarding into all practice and ensuring that safeguarding is "*Everbody's Business".*

3.3.4 There are several recommendations relating to involvement of service users and carers. There is in existence a strategy and this recommends that there should be an agreed approach across the partnership. We have recommended that the Nottinghamshire 2009-12 'Working with Carers and Users Strategy' should be reviewed to ensure actions outlined have milestones and are on target. (This includes the development of a Payment, Reward & Recognition policy across Adult Social Care and Health).

3.3.5 Over recent years there have been significant developments in the way in which social care and primary health care services are commissioned and provided. 'Putting People First' is now entering its next stage to 'Think Local, Act Personal' and the NHS is radically changing the way in which its services are being commissioned. There is a developing evidence base and learning from Serious Case Reviews. It is important that

Nottinghamshire ensures that practice is based on best evidence.

3.3.6 We looked at Governance for Safeguarding and have made a specific recommendation that consideration is given to the relationship between the Board and the Shadow Health and Wellbeing Board.

3.3.7 The publication of the Law Commission report this year and subsequent guidance from the Directors of Adult Social Services has raised issues about the scope of safeguarding adults and terminology and use of language. We have recommended that the Board consider the issues raised in these documents.

3.3.8 It is clear that there is an increasing recognition that effective commissioning is the route to securing and delivering safe services. We have made a number of recommendations relating to commissioning and have recognised the potential of the proposed multi-agency safeguarding hub as an effective conduit for intelligence to support the commissioning process.

3.3.9 The Board is developing its strategic and leadership role and intends to continue to develop the role of its Members as champions. Recommendations in respect of the Board are related to the continued strengthening and influence of the Board and its Members.

4. Background to Peer Challenge

4.1 The Peer Challenge was conducted in accordance with the Local Government Group Safeguarding Adults Peer Challenge Group methodology as refined through the experience gained from the initial peer review programme.

4.2 The methodology was originally developed by the Improvement and Development Agency (IDeA). The Association of Directors of Adult Social Services (ADASS), the Social Care Institute for Excellence (SCIE) and the NHS confederation have endorsed the standards used.

4.3 These standards focus on identifying opportunities for improvement and learning in 8 main areas:

1. Outcomes
2. People's Experience of Safeguarding
3. Leadership
4. Strategy
5. Commissioning
6. Service Delivery and Effective Practice
7. Performance and Resource Management.
8. Local Safeguarding Adults Board

4.4 The Challenge is based on mature reflection, constructive and challenging self-assessment and has been tailored to meet the needs of Nottinghamshire. The Peer Challenge Team worked objectively and as critical friends.

4.5 The review was conducted over a 6 week period (see detailed schedule appendix 2).

4.6 The Peer Challenge Team were:

Gregg Dunning:

Team Manager / Safeguarding Manager for Nottinghamshire County Council (Adult Social Care, Health & Public Protection Department).

Gregg has worked for Nottinghamshire County Council for 18 years and has worked in an acute hospital setting for 16 years across the Queens Medical Centre and King's Mill Hospital sites.
Gregg qualified as a Social Worker in 2000 and has been a Team Manager since 2008. Gregg has extensive experience of Safeguarding Adults both as an Investigating Officer and Safeguarding Manager.

Karen Morgan

Strategy and Development Manager, Nottingham West CCG

Karen has considerable experience in the NHS, having qualified as a Therapy Radiographer in 1982.
Karen has led clinical audit projects and developed clinical governance structures within Primary Care Groups and Primary Care Trusts.
She was the PCT lead for the Quality and Outcomes Framework and developed quality standards across all independent contractor groups.
In 2008, she was seconded to NHS Primary Care Commissioning as adviser for the East Midlands region and lead for QOF, including management of the national QOF helpdesk.
Karen managed the planned care QIPP programme, before taking up her current role where she is keen to ensure that commissioning is quality outcome focused, patient centred, and where patient safety is key, leading to effective care pathways across health and social care.

Amanda Peto

Amanda qualified as a social worker in 1986 and became a team manager in 1991. She has been the Social Care Manager of the Gedling Community Mental Health team. for the past 10years and prior to this was the Integrated Manager covering both health and social care. Since the advent of the new social care agenda she has had responsibility for Safeguarding across the County for mental health. Her previous experience has been in mental health working in the Recovery Service in Nottinghamshire Healthcare Trust and within Department of Psychological Medicine. She is committed and passionate about mental health and is also an AMHP.

David Walton

Detective Inspector - Nottinghamshire Police Service.

David has served 26 years within the Nottinghamshire Police service. David has worked within the public protection unit since October 2008, has been the safeguarding single point of contact for the county division, Divisional lead for domestic violence, Chair of the county north and south multiagency risk assessment conferences, Divisional lead for the dangerous person management unit, Mappa lead for the division and the senior investigating officer on numerous serious sexual offence enquires over recent years. David has also been responsible for individual management reviews within public protection.
David has championed collaborative working between the police service and social services resulting in social care having direct access to police data to promote the safeguarding of both adults and children.

Mike Evans:

Independent Leader for the Peer Challenge.

Mike is the Independent Chair of Cumbria Safeguarding Adults Board He has had an extensive career in Social Services working both in England and Scotland. He has had 14 years experience as a Chief Officer in Leeds, and two years in a joint role with the NHS as the Director of Health and Social Policy Modernisation, responsible for NHS commissioning and leading partnership work on whole system service redesign.
For the past three years Mike has worked independently and this has included work with DH on the Early Intervention and Prevention Programme, with Local Authorities on the transformation of Adult Social Care and as an Interim Director Adult Social Services.

5. Challenge Programme

5.1 The Group Manager Safeguarding Adults with support from her team prepared the comprehensive self-assessment and this was provided to members of the Challenge Team prior to the on-site work.

5.2 A detailed programme was agreed with the Challenge Team Leader. (see appendix 3)

5.3 The Challenge Team had 6 days on-site. The first day was to undertake the file audit. 5 days were devoted to conducting individual interviews and meeting with focus groups.

5.4 There was a full programme of interviews and focus groups throughout the week and this enabled triangulation of information. The programme included:

Interviews with:

- Julie Gardner – Associate Director Social Care, Nottinghamshire Health Care Trust
- Nicola Ryan – Head of Governance, Bassetlaw PCT
- Amanda Sullivan – Chief Operating Officer for Newark & Sherwood Clinical Commissioning Group
- Judy Thornley – Regional Lead for Learning Disability, Health & Adult Safeguarding NHS East Midlands
- Caroline Baria - Service Director Joint Commissioning, Quality and Business Change, ASCH&PP, Nottinghamshire County Council
- David Pearson – Corporate Director, Adult Social Care, Health and Public Protection, Nottinghamshire County Council
- Mick Burrows – Chief Executive, Nottinghamshire County Council
- Paul Broadbent – Assistant Chief Constable (Crime) Nottinghamshire Police
- Cllrs Rostance and Wallace, Nottinghamshire County Council
- Cllrs Cutts and Suthers, Nottinghamshire County Council
- Mrs P - service user.

Focus Groups with:

- NHS and LA Commissioners
- NHS Safeguarding leads
- District Councils and Supporting People Team
- Training Sub Group
- Disability Independent Advisory Group
- Communities and Trading Standards
- Local Authority Social Workers, Occupational Therapists and Senior Practitioners
- Safeguarding Team
- Safeguarding Board
- Police and Fire services
- Service User Group
- Team and Group Managers
- Carers

6. Findings

6.1 We found that Safeguarding Adults in Nottinghamshire is basically sound and there is much good practice. However through Peer Challenge Process we identified a number of areas for development. Following the themes outlined in the Peer Review Standards for Adult Safeguarding our findings are as follows:

Key Theme: Outcomes for and the experiences of people who use services

Element 1: Outcomes

Strengths

- We felt the framework electronic recording system was very good and has the potential to gather and record this information.

- We used Nottinghamshire's file audit tool and felt it worked well. Added an additional field:

  "In the event of a subsequent referral being made to the out-of-hours service, is the risk assessment plan and a contingency plan easily accessible?"

- The file audit showed some very good practice and involvement of service users at all stages of the safeguarding process.

- Deprivation of Liberty appears to be handled competently and used appropriately.

Potential for Improvement

- Through file audit we also identified some cases where it was not possible to locate evidence of good practice.

- We referred three cases for management consideration and received reports back on all three. We established that:

  - Case 1 Although the case was well managed and the individual appropriately safeguarded, the information was not easily available, risk assessment was only contained in case notes and not properly recorded on Framework.
  - Case 2 has transition elements. We feel this case would benefit from a multi agency discussion to identify learning and any action that may be appropriate relating to a previous allegation. This allegation was not picked up as part of the police investigation. The focus appears to have been on child protection elements, which were dealt with appropriately for a child in the family but not disclosures made by the young adult.

- Case 3 was similar to case 1. Information was recorded in the case notes, which covered our concerns about apparent lack of action into concern about standard of care in the care home.

- There were also examples of where some managers had delegated the entire cases including the management tasks to the worker.

- There is field on framework that allows the manager to record lessons learned and include Service User and Carer views. Unfortunately this is rarely used and this we believe is a valuable missed opportunity to gather information that would support the development of more evidence based practice.

- This would also be valuable information for the Board to go alongside the harder data it normally receives.

- In some cases we had a concern that safeguarding incidents were seen as one off even though there was a historical pattern that may have been relevant. Holding a strategy meeting may well have better information sharing and avoided this.

- There appears to be some confusion about involving Service Users in strategy meetings. The written multi-agency procedures are clear about this but conflict with framework where it is clear that they should be involved unless there is a clear reason to exclude. We saw little evidence that they were involved and indeed we felt there could have been greater use of strategy discussions or pre-strategy meetings to inform decision-making.

- Currently workers receive training on Safeguarding and this now includes how to use Framework but in the past this was not the case. There is clear evidence that it is not being used as intended and that this can make it difficult to locate information.

Element 2: People's Experience of Safeguarding

Strengths:

- The Councils annual survey found that on the whole most people feel safe.

- The file audit also suggested that in most cases individuals were involved throughout the investigation and satisfied with the outcome.

- The ***Smile Stop Hate Crime*** initiative started in 2011. This is an important multi-agency initiative (in partnership with MENCAP) for Nottinghamshire and closely links with tackling some of the risks associated with personalisation.

- The ***keeping people safe group*** works in conjunction with the ***Smile Stop Hate Crime*** initiative and is the workstream created as a direct result of the hate crime survey undertaken by the county council, which asked disabled people to share their experiences of hate crime. The group aims to raise awareness of disability hate crime and improve responses from organisations when disability hate crime is reported.

Potential for Improvement

- The field on Framework for the Safeguarding Manager to complete on lessons learned appears to be either not filled in or sparsely completed. This is an opportunity missed to record the service user and carer experience.

- It proved difficult to locate an agreed Council protocol for liaising with service users and carers. There is an action plan ***'Working with Service Users and Carers – A Strategy for Adult Social Care & Health 2009-12 - Actions from Service User Strategy'***. However, we found it difficult to locate this strategy during our time on site. The Action Plan lacks milestones.

Key Theme: Leadership, Strategy and Commissioning

Element 3: Leadership

Strengths

- It is clear to us that there is strong leadership. The Board has its 3-year strategic plan and your Independent Chair has clear vision and expects commitment and participation from Board members as Safeguarding Champions.

- Our meeting with Elected Members showed clear and ongoing commitment to the extent that they wanted to discuss the merits of an Elected Member joining the Board.

- Leaders in partner organisation showed a high level of commitment and gave the impression that they engage with the Board as if it already has a statutory function.

Potential for Improvement

- Whilst it was clear to us that there is strong Leadership for the Board and within the partner organisations, the role of Leaders as Safeguarding Champions is important. Leaders have not all had the opportunity for personal and professional development as outlined in the Competency Framework for Adult Safeguarding**.**

Element 4: Strategy

Strengths

- The Board has developed its three-year Strategy.

- A Shadow Health and Wellbeing Board has been established and it is developing its terms of reference and this includes the opportunity to provide governance for the Safeguarding Adults Board.

Potential for Improvement

- We are in a rapidly changing environment and your strategy and Adult Safeguarding arrangements pre-date the publication of the Law Commission Review and subsequent Guidance.

- The Pan London Authorities and many other Safeguarding Boards have already adopted the new language, terminology and definitions. ‘Adult at risk’ replaces ‘vulnerable adult’ and ‘abuse’ is replaced by ‘harm’ or ‘significant harm’.

- The Association of Directors of Adult Social Services' guidance also envisages a relationship between Safeguarding Adults Boards and Health and Wellbeing Boards.

- We have found there to be a strong desire from partners to have this debate about language definitions and threshholds.

- It may be that the outcome of this could be an even better understanding between agencies, fewer but more appropriate referral and a higher conversion rate of referrals into safeguarding enquiries.

Element 5: Commissioning

Strengths:

- In various ways commissioning and contracting is quality assured and there is recognition in the LA and the NHS that this is an area that needs to continue to improve.

- Contracts do have a safeguarding focus.

- It is hoped that the MASH will assist in intelligence gathering from Social Workers, clinicians etc.

Potential for Improvement

- Commissioners are concerned about growing plurality of small possibly unregulated providers. Examples ranged from Personal Assistants through to day services.

- Commissioners have not universally received training in line with the Competency Framework for Safeguarding Adults.

Key Theme: Service Delivery and Effective Practice, & Performance and Resource Management.

Element 6: Service Delivery and Effective Practice

Strengths:

- There are established good multi-agency policy and procedures and awareness of these is high. The website is easily accessible and contains relevant and up to date information.

- Whilst in this rapidly changing environment procedures inevitably need updating, they are thorough, easily available and supported by Framework.

- Nottinghamshire has a well-developed audit tool and this enables managers to assess performance on a regular basis.

- The file audit demonstrated knowledge, skill and effective partnership working.

- The Mental Capacity Act appears to be used appropriately.

Potential for Improvement

- The file audit showed how outcomes might be influenced by use of language. For example the description of theft as financial abuse does not easily engage the police in the investigation.

- Audits undertaken by Group Managers were inconsistent in both quality and numbers undertaken. Some were a very light touch and some were over zealous.

- There is some slippage in observing safeguarding timescales but we found strong evidence that on the whole the focus is on ensuring adults are safeguarded.

- The involvement of service users and carers was not always evident. The presumption that they be part of strategy meetings unless there is a clear reason why they should not was not always followed.

- There is inconsistency of practice and confusion in the procedures between strategy ‘discussions’ and strategy ‘meetings’.

- We found in focus groups with practitioners that they had a tendency to view their professional development as being the employer’s responsibility and related it to attendance at training courses.

Element 7: Performance and Resource Management

Strengths

- Self Assessment Survey demonstrates strong commitment to keeping people safe and demonstrates strong partnership working.

- NASB has a 3-year strategic plan and associated action plans for the Board and the sub groups.

- All agencies are saying that they either are or intend to implement the competency framework and it has now been formally received and adopted by the Board.

- Nottinghamshire has commissioned and completed four serious case reviews and three were in the past two years. The recommendations relating to three of those are contained in a multi-agency action plan thus enabling the Board to monitor progress.

- Utilising the File Audit Tool, Group Managers, on behalf of the Local Authority, undertake a small number of file audits and the results are collated in a quarterly report. This report identifies themes arising from the audits and makes recommendations for the Board to consider.

- The post of Quality Assurance Manager for Adult Safeguarding is a highly valued resource.

Potential for Improvement

- The Board receives quantitative data in the form of a quarterly report on activity. This is broken down into client group and locality. However, location is not shown – '*care home*' or '*at home*'. There is no information on NHS activity – serious untoward incidents reported, pressure sore incidents etc.

- There is a strong interest in finding better ways to get qualitative data, and it is an opportunity missed that the lessons learned field on Framework is not used properly by safeguarding managers and the results incorporated into performance reports.

- From information gained through the focus groups and from the file audit we were concerned that regular supervision is not always happening and personal and professional development needs may not be addressed sufficiently well.

- Also Safeguarding can still be seen as an extra add on to case loads rather than an integral part of the practitioner task.

Key Theme: Working Together

Element 8: Safeguarding Board

Strengths

- There is effective leadership for the Board and clear ambitions for the Board to make a difference.
- The Board clearly sees itself as having a scrutiny role.
- The Board carries out its work effectively and is supported by sub-groups, which develop their own work programmes.
- The Board has determined to develop the role of its members and development days are planned over the next few months.
- The Board has developed a strong culture of co-operation.
- Multi agency training takes place under the auspices of the Board

Potential for Improvement

- As a non-statutory Board, Governance needs careful thought. There is potential to strengthen governance for the Board through the developing Health and Wellbeing Board.
- In terms of its performance management role it receives information on activity and the outcome of SCRs but Serious Untoward Incidents and other relevant NHS data is not currently included in the quarterly report. The SHA informed us that they have determined that there will be a "zero tolerance" of pressure sores. This approach would suggest that they could be viewed as safeguarding referrals unless there is exceptionally a clear clinical reason. This would also ensure that such incidents are reported to CQC as they are with care homes.
- The File audit included 5 transition cases and this is an area, which does present challenges to both Safeguarding Boards. This is particularly the case where the 'Think Family' approach is gaining increasing credence. There may well be both child protection and adult safeguarding issues in the same family arising from a single alert.

7. Key Recommendations and Action Planning

This report has been structured in accordance to the Peer Challenge/Review guidance. We have made 31 recommendations (see appendix 4)

The development of the action plan will commence at the action-planning workshop with the Safeguarding Adults Board on 19th January 2011.To faciliate the action planning process these recommendations have been refined to 10 areas for action.

7.1 Recommendation One – Use of Framework

Linked to: Element One, Outcomes
Element Six, Service Delivery and Effective Practice

1a. Risk assessment and planning can be difficult to locate easily within records held on Framework (the council's electronic record keeping system). We felt that this is a good system and the safeguarding module is well put together. There is inconsistent use of Framework and there is a need to develop workers and managers to use the system consistently.

1b. We recommend refresher safeguarding briefings, including the use of Framework, for those whose initial training did not include the Safeguarding module.

1c Framework with the safeguarding module is a well-designed electronic record keeping system as long as information is put in appropriately. Far too often we found risk assessment hidden in case notes. This we feel is an urgent training need.

7.2 Recommendation Two - Management of Safeguarding

Linked to: Element One, Outcomes
Element Two, People's Experiences of Safeguarding
Element Six, Service Delivery and Effective Practice

2a. We found inconsistent and at times inappropriate delegation of the management task and at times the whole case was passed to the worker. This is potentially a practice that could leave the worker isolated when dealing with safeguarding issues. This should be addressed with managers.

2b. Safeguarding Managers should be advised of the importance of completing the Lessons Learned field on Framework and it should be analysed and included in performance and dashboard reports to the Board.

7.3 Recommendation Three – Transition Planning

Linked to: Element One, Outcomes
Element Eight, Safeguarding Board

3a. File audit illustrated the importance of effective transition planning and this area is worthy of closer attention. We would recommend some specific development time with children's services on this area would be of benefit.

3b Throughout the Peer Challenge we heard reference to 'Think Family' and this, alongside transition issues, raises the potential for closer working with the Children's Safeguarding Board.

7.4 Recommendation Four - Procedure and Guidance

Linked to: Element One – Outcomes
Element Six, Service Delivery and Effective Practice

4a We suggest reviewing the current written guidance and ensure alignment of the guidance manual to Framework.

4b The involvement of user and carers needs clarifying in the procedures with the assumption that they are fully involved in strategy meetings etc unless there is a clear reason to exclude.

4c Clarification is needed on the use of strategy discussions and strategy meetings. Strategy discussions to be clarified as information gathering forums to assist decision making on whether there is a safeguarding issue and need for a strategy meeting.

7.5 Recommendation Five - Competence and Evidence-based Practice

Linked to: Element 5 – Commissioning
Element 6 - Service Delivery and Effective Practice
Element 7 - Performance and Resource Management

5a The NHS and LA should ensure that Commissioners have competencies as outlined in the National Competency Framework for adult safeguarding.

5b The development of evidence based practice is essential. It is important to ensure that commissioners and indeed all workers take trouble to inform themselves on evidence emerging from SCRs etc.

5c Professional development is not only about attending appropriate training courses. A culture of development through one's own reading, effective use of supervision and effective use of team meetings is important. We recommend that this is addressed as a development issue with Group Managers and Team Managers.

7.6 Recommendation Six - Public engagement and involvement

Linked to: Element 2 - People's Experience of Safeguarding
Element 8 – Safeguarding Board

6a The 2009-12 'Working with Carers and Users Strategy' should be reviewed to ensure actions outlined have milestones and are on target. (This includes the development of a Payment, Reward & Recognition policy across Adult Social Care and Health).

6b Board recognises the need to strengthen public engagement **.**

7.7 Recommendation Seven - Governance

Linked to: Element 3 - Leadership

7a The Board is in many respects behaving as a statutory board but clearly it is not. Governance for the Board is not well defined and we would recommend that the emerging role for the Health and Well Being Partnership (the shadow Health and Well-Being Board) could be considered as the route to strengthen governance arrangements.

7.8 Recommendation Eight – Commissioning

Linked to: Element 5 - Commissioning

8a The Multi Agency Safeguarding Hub appears to have potential as long as front line workers recognise the need to use it and are equipped to do so. They can be the commissioners' eyes and ears.

8b Consider how Service Users can report poor practice. Is there a way in which their information will go through the Multi Agency Safeguarding Hub? (Though not an alternative to lodging a complaint)

8c The Council and its partners have recognised the strategic commissioning potential of the Health and Well-Being Board. There is now a need to agree the scope of joint commissioning and how this could contribute to the delivery of safer services and in particular contribute to early intervention and prevention.

8d Given the level of concern raised by commissioners in the focus group about the growing plurality of small possibly unregulated providers we recommend the Board request a report on this. Specifically this report could describe the issue, types of services being described, the quantity of such services and suggested ways forward for improving monitoring of those services.

7.9 Recommendation Nine – Scope

Links to: *Element 3 – Leadership*
Element 4 – Strategy
Element 8 – Safeguarding Board

9a Nottinghamshire did some good work on Dignity in Care but this has not been driven of late. Many Adult Safeguarding Boards have adopted this work viewing it as closely linked with the prevention agenda. There is an opportunity to revitalise this work and for the Board to provide the necessary leadership.

9b In 2010 The Board produced its 3-year Strategic Plan. This plan pre-dates the publication in 2011 of the Law Commission report and the subsequent Association of Directors of Adult Social Services guidance on Language, Terminology and Definitions. The time is now right for the Board to consider this guidance in detail.

9c It is timely for the Board to review the scope of its activity.

9d We identified differences in the use of language between partner agencies. It is recommended that where a crime is believed to have been committed the terminology used to describe the offence is recognised by all agencies.

7.10 Recommendation 10 - Quality Assurance and Performance Monitoring

Links to: *Element 6 - Service Delivery and Effective Practice*
Element 7 - Performance and Resource Management

10a Performance management and learning through practice would benefit from the incorporation of more soft data into reports and some of this could be derived from the lessons learned field in Framework.

10b Discussion should take place with partners on developing the data that could be usefully included in the quarterly performance reports.

7.11 Recommendation 11 - Board Development

Links to: *Element 3 – Leadership*
Element 8 – Safeguarding Board

11a Board to continue with its development of the Champion role for its members. Each Member to access the competency framework for their own development and ensure the competency framework is rolled out in their respective organisations.

11b There is the opportunity through implementation of the Peer Challenge findings to further strengthen this championing role to develop and implement an action plan related to the findings.

11c The Board has already determined to develop the role of its members and development days are planned over the next few months. It would help the Board to utilise this protected development time to be more specific about its priorities and expectation of what Board Champions deliver and feed back from their own organisations.