Local Government Association

Adult Social Care
Regional Peer Challenge Summary Letter

Plymouth City Council
December 2014

Report

Introduction

1. Plymouth City Council (PCC) asked the Local Government Association (LGA) to run a Regional Adult Social Care Peer Challenge as part of sector led improvement within the South West ADASS Region. The specific issue identified by PCC for the team to focus on was:

    - From November 2013, Plymouth Adult Social Care moved from an approach where all staff undertook safeguarding investigations to a dedicated adult protection pathway. How robust and effective is this model in protecting adults at risk, while ensuring that safeguarding remains everyone's business?

2. Regional Peer Challenge is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It is designed to help an authority and its partners assess current achievements and areas for development, within the agreed scope of the review. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement in a way that is proportionate to the remit of the challenge. All information was collected on the basis that no comment or view from any individual or group is attributed to any recommendation or finding. This encourages participants to be open and honest with the team. The LGA Peer Challenge Team would like to thank Councillors, staff, people who use services and their carers, voluntary sector and other partners for their open and constructive responses during the challenge process. The team was made very welcome.

3. The members of this Regional Adult Social Care Peer Challenge Team were:

    - Alison Elliott – Director of People, Southampton City Council
    - Zoë Johnstone – Chief Officer: Adults and Joint Commissioning, Bracknell Forest Council
    - Cllr Jonathan McShane – Cabinet Member for Health and Social Care, London Borough of Hackney
    - Paul Clarke – Senior Advisor, Local Government Association
    - Jonathan Trubshaw – Challenge Manager, Local Government Association.

4. The team was on-site from 1st – 4th December 2014. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

    - interviews and discussions with Councillors, officers and partners;
    - focus groups with managers, practitioners, front line staff and people using services and carers;
    - the reading of documents provided by the Council, including a self-assessment of progress, strengths and areas for improvement against key areas of business.

5. The recommendations in this summary letter are based on the presentation delivered to the Council on 4th December 2014 and is based on the triangulation of what the

team have read, heard and seen. This letter covers those areas most pertinent to the remit of the challenge only.

Summary

- Adult Protection Pathway provides greater assurance that safeguarding alerts are responded to consistently
- Good understanding that quality services help to prevent abuse
- There is an opportunity to build on recent improvements to drive the safeguarding agenda at a strategic and operational level through:
  - The Board
  - Performance management
  - Governance arrangements
  - Leadership, responsibility and accountability

6. The Team was well aware of the organisational context in which the Challenge was taking place. Included in the factors that the Team thought relevant to take into account was the recent Ofsted inspection and the impact that this had had on staff who had gone through this process. The Team emphasised to those participating in the Challenge that this was not an inspection and that the peers had been invited in by the Council as sector led support. The Team was also aware that the City has a challenged health and social care economy; whilst the Team was on site news was broadcast about conditions regarding treatment being placed on patients who were over-weight or who smoked. Plans are being implemented to integrate both provision and commissioning and whilst the Team was on-sight affected staff received TUPE notifications. Within this context the Team was aware that there was a high level of expectation being placed on the incoming independent chair of the Safeguarding Board to resolve key partnership issues.

7. In the Team's view the Adult Protection Pathway (APP) does provide greater assurance to the Council that safeguarding alerts are being responded to consistently.

8. There was a good understanding from across the partnership that having good quality services does help prevent abuse. There was also awareness that a high level of effort is required from all involved in safeguarding to ensure that quality standards are maintained right the way through an individual's safeguarding journey. Not only is safeguarding everybody's business, so is being aware of the processes involved and the standards that are to be attained.

9. There is an opportunity to build on the recent improvements in service delivery and to drive the safeguarding agenda at both the strategic (including the work of the Safeguarding Board) and at an operational level. This should be done through enhanced management oversight, by all members of the partnership, of their staff's work. Key areas were improvements could be driven forward include; the Board, performance management arrangements, governance structures and leadership responsibility and accountability. These areas interlink and the Team was aware that some steps were already being taken to address these.

Service Delivery and Effective Practice

Strengths

- Partners and staff are positive about the Pathway – they feel it is more timely and more responsive, they feel it is a better arrangement than was previously in place
- Committed, capable and enthusiastic staff
- Police have clarity on thresholds and process
- PCC staff feel processes are applied more consistently
- Training for elected members is good and well regarded
- Commitment to Making Safeguarding Personal

Areas for consideration

- Inconsistent feedback from across the system about the safeguarding process and thresholds
- Do you need to apply a risk assessment tool consistently across the agencies?
- Lack of rigorous and consistent approach to performance management
- People are unclear as to why time scales are not being met
- Partners report out-of-hours response is poor and high risk
- Whose responsibility is it to lead on safeguarding and are there risks if based on commissioning arrangements?
- Where is the multi-agency decision making?
- A sense that each organisation deals with safeguarding separately – not in a multi-agency way
- Alerters report a lack of feedback
- Service users want a dedicated safeguarding number

10. The staff and partners that the Team met with were committed, capable and enthusiastic. They were positive about the changes that had been made to put the Pathway in place and stated that it was an improvement on what was there before. They said that alerts were dealt with in a more timely and responsive manner.

11. The Police were clear on their understanding of the thresholds and how these were being applied and PCC staff felt that processes were being applied more consistently.

However, there was feedback from across the partnership on the inconsistent application of thresholds and it may be useful to build on the Police's clarity with other organisations so that there is greater understanding and consistency across the partnership as a whole.

12. There is a commitment at all levels to making safeguarding personal. One way that this is demonstrated at a senior level is through the training offered to elected members, which is of good quality and is well regarded.

13. The team found some inconsistencies in the way in which safeguarding alerts were being prioritised. It may therefore be useful to implement a multi-agency risk assessment tool that would direct organisations, right the way across the partnership, to operate in a more consistent way

14. There appeared to be a lack of a rigorous and consistent approach to performance management. Information was collected but there was little evidence that this was routinely and systematically interrogated so that issues, once identified, were monitored to establish trends and the impact of interventions to address these.

15. Some participants were unclear on timescales, even though it was acknowledged that these were written down. There was also a lack of clarity on when delays occurred as to why these had happened. It is important that reasons for delays are understood and can be explained, e.g. due to an on-going police investigation.

16. The out-of-hours service was criticised by some participants, with them saying they had been asked if they could wait until the morning to resolve their issues.

17. In the Team's view there appeared to be a focus on safeguarding those individuals receiving commissioned services (Domiciliary Care and those in Care Homes) but not those funding their own support or not receiving support at all. There also appeared to be a lack of clarity on who was leading on the safeguarding. This needs to be resolved at a multi-agency level so that all partners understand who is responsible. At present there is a sense that each agency deals with safeguarding separately, with clear reporting lines within their organisation.

18. Alerters feel they receive too little feedback once their concern has entered the system. A routine mechanism needs to be put in place to keep people informed of what is happening, including where no further action is required.

Commissioning

Strengths

- Clear shared vision of Making Safeguarding Personal
- Dignity in Care Forum reported as working well
- Good alignment between QAIT and the Adult Protection Pathway
- Increase in provider alerts as a result of increased uptake of training by providers
- QAIT aware of trends in registered care homes, have programme of work and are able to respond to concerns raised
- Weekly multi-agency 'Overview' meeting
- Plans are in place to take learning from the current Serious Case Review

Areas for consideration

- Lack of understanding of where the Safeguarding Unit and the Adult Protection Pathway integrate
- Are there risks of creating further hand-offs?
- Commissioning need to respond to quality concerns
- How do you ensure learning from complaints, SCRs and investigations improves commissioning, services and practices?
- Is alignment of Adult Protection Pathway and QAIT due to personalities or governance?

19. In the Team's view there was a clear and shared vision for Making Safeguarding Personal with a good alignment between the Quality Assurance and Improvement Team (QAIT) and the APP. However, there was some concern expressed that good working relationships might be reliant on the personalities involved and not sufficiently based on embedded practice and procedures. It was reported that the Dignity in Care Forum (led by the QAIT) works well, although this is a large meeting and it may be worth considering if this could be refreshed.

20. There has been an increase in alerts from providers following training. It was recognised that the previous Safeguarding Lead was from a Commissioning background and that there may therefore have been a focus on commissioned services. It may now be necessary to consider how to broaden where alerts are raised from and how people not in receipt of commissioned services receive an equitable response.

21. The Team considered that there was a lack of clarity as to where the Safeguarding Unit and the APP integrate, both now and in the future. It needs to be made clear whether the integration will be at a commissioning and/or provider level. However this is done care needs to be taken about additional 'hand-offs' being built into the system, creating the potential for duplications, delays or gaps in the process.

22. Commissioning needs to respond to quality concerns, particularly where issues are identified from service user feedback. Some service users that the Team spoke with reported inconsistency in their care, with a high number of care workers being used within a short period of time. Commissioning could take a more proactive role in researching and facilitating solutions with service users.

23. The Team acknowledged that there was a plan in place to take the learning from the current Serious Case Review. However, more could be done to link the learning from other feedback, including from; complaints, practice reviews, investigations, etc. This learning needs to be embedded in a systematic way so that it informs future commissioning.

Performance and Resource Management

Strengths

- Trend information provided to QAIT
- QAIT undertake quality reviews of care homes with a view to improvement
- Beginning to conduct consistent, structured practice audits
- Beginning to look at outcome focussed reporting
- Quantitative information captured on dashboard
- Weekly safeguarding overview meeting considers health and adult social care alerts

Areas for consideration

- How do you use the dashboard as a management tool to drive performance improvement?
- Implement a systematic approach to performance management and governance
- No evidence that performance information is systematically interrogated throughout the organisation
- In addition to the annual return what other performance information should the Board require e.g. practice audits?

24. The Team recognised that performance information was being collected by the QAIT, including that obtained from the quality reviews of care homes. It was also recognised that you are beginning to conduct structured practice audits and to look at outcome focussed reporting. The challenge is how the information that is captured and presented (including on the Dashboard) is used to inform practice improvements and how these improvements are then monitored.

25. There is a need for management information to be systematically interrogated throughout the organisation. You need to be clear as to why information is being collected and then what needs to be presented at different levels. What does the Board need to see and how do other levels within the organisation provide and interrogate their contributions so that this is made meaningful and relevant?

Working Together

Strengths

- People reported good relationships between partners, especially at operational level
- People reported that partners were able to challenge and there is an openness at the Board
- Multi-agency commitment to the Board
- Some multi-agency participation in training
- New Independent Chair is highly thought of – people are keen for him to start and have high expectations of the difference he can make
- Agencies have undertaken self-assessment – report on findings January 2015
- Developed an information sharing protocol – waiting for sign off

Areas for consideration

- People reported a lack of commitment, drive and leadership from PCC within the Board
- Board does not drive the multi-agency vision for safeguarding across the city
- There is a sense of limited challenge, pace and grip in driving forward improvements
- How does the Board assure itself that it is making a difference?
- Need to review sub-committee structure to ensure clarity of purpose
- Consider combining with LSCB on sub-committees
- Does the Board hold agencies sufficiently to account?
- Governance arrangements – clarify links with Health and Wellbeing Board, scrutiny and other partnership arrangements
- Lack of participation in multi-agency training
- Lack of regional working across the three Boards – meeting has been arranged for January 2015
- Lack of service user and carer voice into the Board

26. People that the Team spoke with reported good working relationships, both operationally and at the Board. Board members were able to challenge one another and there was a commitment to making the Board work. However, some of the participants that the Team spoke with expressed a desire for PCC to take a stronger lead within the Board. The Team acknowledges that the Care Act does not give clear guidance on this but recognises that other authorities have taken a clear lead and PCC could be clear about its leadership role.

27. There was some multi-agency training, although it was also reported that individual organisations, most notably Health and the Police, were still focussed on their own training. There are benefits in multi-agency training above raising skills and the Board has a role in ensuring that all organisations understand this and engage more fully.

28. There was a high level of expectation from all those that the Team spoke with about the new Independent Chair. He was seen as a credible choice and someone who could stimulate change and further challenge.

29. In the view of the Team it was positive that the partnership had undertaken a self-assessment of how they were working together and that this was being taken to the January 2015 Board. It will therefore be important how the findings from this self-assessment are used to influence the development of the partnership, so that it is viewed as a positive and useful undertaking by all the organisations.

30. It is the Team's opinion that the Board needs to drive the multi-agency vision for safeguarding across the City. There needs to be clear and simple guidance that sets out what the vision is so that it can be followed by all the agencies involved. The Board then needs to hold members to account in a transparent and accessible way. To do this effectively there needs to be greater challenge, pace and grip so that improvements are driven forwards.

31. There is an opportunity with the Board moving to a statutory basis and the commencement of a new Independent Chair for the Board to consider the culture in which it operates. Each Safeguarding Board is developing its own style and at its own pace. It is now time for the Plymouth Safeguarding Adults Board to become more challenging of its members and more responsive to the needs of its residents in the ways in which services are commissioned and provided.

32. The Board needs to put in place sufficient measures and information gathering systems so that it can demonstrate the difference it is making for the residents of Plymouth. The Board needs to become more outcome focussed.

33. There is an opportunity to review the Board's sub-group structure and consider where there are possibilities for combining with the Safeguarding Children's sub-groups, e.g. training. A significant number of organisations send the same people to represent them at both the Adults' and Children's Boards. The people attending the Board's current sub-groups value being there. However, you need to be assured that the right people attend the sub-groups and that the work of the groups drives forward the work of the Board. The Lead Officers' group is highly valued because it allows the participants to share operational experiences and issues. It may be practically beneficial for this group to continue but does this need to be a sub-group of the Board?

34. Greater clarity is needed on the relationship and governance arrangements between the Safeguarding Adults Board and the Health and Wellbeing Board, scrutiny and other partnership arrangements.

35. Regional agencies, including the Police and Ambulance services, would welcome greater linkages between the three sub-regional boards (Plymouth, Torbay and Devon). The Team understood that a meeting has been arranged for January 2015 and believe this will be helpful in aligning policies and practices.

36. Service users and carers reported to the Team that they felt they did not have a voice into the Board. They did not necessarily want to be represented on the Board but a mechanism needs to be found so that views are recognised and acknowledged.

What you might like to do

- Review the language used across the system to ensure everyone understands what is meant
- Be clear about your processes and tell staff, partners and the public what they are
- Clearly communicate what is meant by integration and confirm that people understand
- Consider whether the Adult Protection Pathway should respond to all alerts rather than to those receiving commissioned services
- Consider whether the Public Protection Unit should respond consistently with above
- Implement a performance management framework using the “dashboard”
- Review SAB sub-groups
- Review out-of-hours response to adult protection alerts
- Develop a feedback process for alerters
- Review integration arrangements so that hand-offs are not increased
- Put in governance arrangements for the SAB
- Consider strengthening the Board support and whether this could be shared with the LSCB
- Publish Board minutes earlier and make them easier to find on the website

37. The Team felt that some of the language used in describing services and processes could be confusing and interpreted in different ways within different organisations. .An example is the use of the term ‘APP’; which in practice is a team of people but could be viewed as a process by other partners. There is therefore a need to review the language used by all partners so that it is understood by staff in the different organisations and service users.

38. Be clear on which organisation leads on which process. In the Team’s view there is an argument to be made that it should be the Local Authority that leads on all Safeguarding. Whatever is decided staff, partners and the public need to understand and be clear on where the accountability lies.

39. It is important to continue to communicate what is meant by and what is happening with integration. The Team recognised that a considerable amount of information has already been made available to staff and partners but there still remains some uncertainty and this is having a negative impact on effective delivery.

40. Consider whether all alerts should be dealt with by the APP. At present some alerts are dealt with by Health and others managed by another Pathway. You will need to

assure yourselves that alerts are being dealt with consistently and in a way that minimises hand-offs and unilateral closures (this is of particular importance in regard to the integration arrangements), thereby making responsibility and accountability clear to all. You will need to be clear as to what the APP is required to deal with and that it is adequately resourced to meet these requirements. The remit of the APP needs to be clearly communicated to all staff so that any perceptions that it only deals with commissioned services are addressed. Any review of arrangements should include the Public Protection Unit so that risks are fully assessed and not on the basis of where people live or the services they receive.

41. Review the existing Dashboard measures to assure yourselves that you are able to track and respond to performance issues. This needs to form the basis of a robust performance management framework that draws in data from all levels of the organisation and is able to provided targeted feedback and requirements for change. You should also consider how the dashboard might aid scrutiny, both within PCC and through the Board.

42. A quick win would be to develop a system for feeding back actions taken (including where no further action is required) to alerters. This can be a useful demonstration that you have listened to people and have responded. This could subsequently be linked in to any review of the alerts process.

43. Review out-of-hours arrangements to ensure there is sufficient capacity to deal with alerters concerns so that there is a consistent response.

44. The commencement of a new Independent Chair provides you with the opportunity to review operating arrangements within the Board including; strengthening and clarifying the governance arrangements, reviewing and where necessary revising the sub-group structure, increasing Board support and consider sharing staff with the Children's Board so as to maximise resources and enable sufficient capacity to publish Board reports swiftly. There is also an opportunity to develop the culture within the Board so that partners are more confident to engage in even more robust challenge and meaningfully hold each other to account; particularly on issues on capacity and clarity of process. The Board's website should be refreshed so that it easier for staff, partners and residents to find information and be clear on what they need to do and when. This would also help meet the expectations of service users, who ask for information to be published, so that they are kept informed and feel that they are being responded to.

Next Steps

45. After due consideration of the issues and recommendations in this summary report the Peer Challenge Team assume you will take forward aspects of this report in your future plans. We suggest you disseminate the key messages to staff and partners and seek to publish the report.

46. In due course LGA and South West Regional ADASS will evaluate the progress of this work in line with the wider regional sector led improvement work.

Contact details

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For more information on peer challenge and the work of the Local Government Association please see our website: http://www.local.gov.uk/peer-challenges