directors of adass
adult social services
Yorkshire & Humberside

Salford Safeguarding Adults Board

Adults Safeguarding **Peer Challenge Report**

April 2019

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Introduction

Salford Safeguarding Adults Board (SSAB) requested that the Yorkshire and Humber ADASS undertake an Adult Safeguarding Peer Challenge of the SAB. The work was commissioned by Salford Safeguarding Adults Board. The Adult Safeguarding Board was seeking an external view on the work of the SAB around partnership working and governance in their integrated organisation.

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

- Performance and Quality,
- Effective Communication
- Multi-agency training
- The application of MSP and how the Board is assured of this
- Collaborative working – supporting, communicating and holding partners to account
- Leadership
- Integrated systems

1. 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.

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

    - Leadership, Strategy and Commissioning
    - Outcomes for, and the experiences of, people who use services
    - Service Delivery, Effective Practice and Performance Management
    - Working Together

3. The members of the peer challenge team were:

- **Bev Maybury,** Lead Peer, DASS, Bradford Council
- **Wendy Barker.** Deputy Director of Nursing, NHS England and NHS Improvement – North East and Yorkshire Region
- **Kyra Ayre**, Head of Service, Adult Safeguarding, City of York Council

- **Jackie Scantlebury**, Safeguarding Adults Board Manager, Rotherham
- **Shona McFarlane,** Deputy Director Leeds City Council (Case file audit)
- **Venita Kanwar,** Peer Challenge Manager, LGA Associate
- **Dave Roddis**, Programme Director, Yorkshire and Humber ADASS

4. The team was on-site from 4th – 5th April 2019. 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, people who use services and partners
    - reading documents provided by the SAB, including a self-assessment of progress, strengths and areas for improvement
    - comprehensive audit of 14 individual service records carried out by two Heads of Service and Safeguarding leads, who are multi-agency working.

5. The peer challenge team would like to thank staff, people using services, partners, commissioned providers, and councillors for their open and constructive responses during the challenge process.

6. 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.

Leadership, Strategy and Commissioning

Strengths

- The Board has a good culture of being open and receptive to challenge
- Chair of the Board is committed and regarded as inclusive, partners feel valued
- Well managed, well organised Board with great relationships
- Director of Adult Social Care at Board level
- Well briefed and engaged lead member
- Salford has good examples of improving services and quality
- Strengthened social care leadership in the integrated setting
- Everyone has bought into integration – this is a single functioning organisation

Areas for consideration

- Structure and length of the Board meeting can be an issue, as agenda items generate constructive discussion which results in over running meetings. However, members believe that it is always chaired well
- Need for improved working across Boards especially with Community Safety Partnership and Children's Board
- Reflect on the role of the sub-groups
    - Assurance processes
    - Connectivity horizontal and vertically
    - Frequency
    - Membership
- Consider formal induction for board members and sub group members.
- Lots of good stuff happening, how do you know it is having an impact on people?
- The Board should harness the energy of the voluntary sector and probably would benefit from a 3rd sector sub group
- A 360 Degree look may be beneficial to the Board

7. In 2016, organisations in Salford which included the Council, the Clinical Commissioning Group (CCG), Salford Primary Care Together, Salford Royal Foundation Trust, Greater Manchester Mental Health and Salford Community and Voluntary Sector entered into a partnership to form Salford Together. Salford Together is an Integrated Care Organisation (ICO). Staff from across the NHS organisations and the council were brought together into the ICO, which was one of the first ICOs in England. The ICO has enabled more than 2,000 health and social care staff (including district nurses, social workers, hospital staff, and mental health professionals) to work within one organisation, with the aim of creating a more streamlined service for people who use health

and social care services. The Salford Care Organisation has implemented an integrated governance and assurance framework and hold divisional assurance meetings on a monthly basis to consider (a) Quality and Experience (b) Finance and information (c) Operations and performance.

8. The peer team heard of pooled budgets since 2014 which currently stands at a budget that is pooled as much as it can be legally possible. The ambition for integration is evident at every level we spoke with and partners speak highly of the Integrated Care Organisation

9. Salford Safeguarding Adults Board SSAB) can be justifiably proud of the strengths that have been identified with regard to the leadership of the Safeguarding Adults Board working across organisations as an integrated system, this was seen as something very special.

10. 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. The Board has been cited by many people interviewed that it has a culture of being open and receptive to challenge and this is a very strong foundation to build upon within the Integrated Care Organisation (ICO).

11. 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 Director of People who gets her assurance from the Board, the Chair of the SAB, the Lead Member for Adult Services and the new Director, and Divisional Director of Adult Social Care. The passion for safeguarding is filtered through the partner organisations and was evidenced by the people that the peer team met.

12. The chair of the SAB is highly thought of and well regarded by the Board members, and senior officers that the peer team met. The passion for safeguarding adults is evident. There was a real sense of people belonging to the Board and, all partners felt involved, valued and engaged. There was appropriate and positive challenge from the Chair of the SAB, who holds people to account. The commitment from partners was evident by their engagement.

13. The Director of Adult Social Care has an equal voice and influence at Director level within the ICO, with parity on decision making on the Salford Royal Foundation Trust's Board. This was a valued position. The new roles of Director of Adult Social Care and Divisional Director of Adult Social Care have strengthened social care leadership in the integrated setting

14. It was evident to the peer team that the Lead Member for Adult Social Care, despite having a large portfolio was well engaged and knowledgeable. The Lead Member spoke of the journey Salford had undertaken in becoming an ICO but spoke of the benefits of joint working and the learning undertaken by local authority and health partners in achieving integrated services, some of this work was facilitated by the Kings Fund, which the CCG commissioned.

15. The support for SSAB is provided by one full time Business Manager and one full time Senior Business Administrator. Two additional fixed term posts to

support the work are a Performance and Quality Officers post (funded October 2017 to September 2019) and a Training and Development Officer post (funded April 2018 – April 2020). Since February 2019 the permanent Board Manager is acting into a different role for 2.5 days a week and subsequently the Training and Development Officer has been acting up as Board manager for 2.5 days, meaning that the board manager role is currently filled on a job-share basis. The peer team noted that the joint Board Managers were widely recognised as key to organising the work of the Board, which the team had been told had become more structured since the board manager came into post. They were seen as pivotal to delivering the work of the Board and the sub groups. Partners clearly recognised that significant progress had been made since the Board Manager had been in post they were seen as important in the coordination of the Board's functions, processes and programmes.

16. The SSAB has commissioned an independent consultant to review resource requirements across the strategic boards for areas of shared work that will inform further decisions about support roles in the SSAB.

17. There have been examples cited of where the Board has improved services and quality, and this was strongly evident of the work carried out following "Andy", where collaborative working has improved safety in provider organisations, and the work of the "Practitioners Forum" where front line staff are directly linked into the work of the Board, raising awareness for the front line around key safeguarding policy implementation, and an opportunity to feed into the work of the Board.

18. The peer team felt a strong sense that everyone we met had bought into the integrated system. It felt like people belonged to a single organisation and this is a commendable achievement.

19. While Board meetings were well chaired, the peer team felt that consideration should be given to the length of the meetings and the number of agenda items. There is a lot of work to get through, and the peer team heard that this could sometimes be an issue for Board members.

20. Boards are clearly working collaboratively, for example we have heard of a regular joint Board meetings with the Children's SAB, and have heard that Salford's Chief Executive, has been working with Board Chairs to facilitate closer links. However, further work could be done to work more closely with Community Safety Partnerships, particularly around safeguarding of people who may have been trafficked, around the Prevent agenda and radicalisation, and working with gangs. There are further opportunities for improving the connections, with the Children's Safeguarding Board 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.

21. SSAB could reflect further on the role of the sub groups, and strengthening the Board's overarching assurance of the work coming out of the sub groups. The peer team's perception was that the groups were working well, with strong relationships, but is there sufficient challenge from the Board and does the data provided, lead you to be assured that the groups are working well? The peer team would ask the SSAB to consider how it reviews the effectiveness of its sub groups and how it ensures they are sustainable. What might happen if key

people were to leave, and if performance of the groups started to diminish, how would the Board know? Reflect upon the process of assurance, and think about the connectivity across Boards and sub groups. This is in terms of the learning from others and the communication horizontally and vertically, and how that connects and provides assurance. SSAB may also want to look at the frequency of sub-groups to ensure they timely enough for all to be engaged and are not resource intensive.

22. That is not to say that there is not a great deal of excellent work in progress, the peer team would pose the question, how do you measure the impact of your good work on the people of Salford, and understand at your fingertips the direct correlation of the work you do, and how things are improved for people using services?

23. A formal induction for people new to the Board could improve people's understanding and contribution to the work of the Board and also highlight and clarify people's roles and responsibilities. Partners have very varied roles and work to different legislation requiring specific actions to that organisations. Understanding the explicit requirements of each partner, could prevent any misunderstandings and tensions, and improve the streamlining of service delivery and practice.

24. The peer team have heard very positive things about the "soft landing" which describes the effortless way in which Adult Social Care (ASC) and Health became the ICO. The "soft landing" the peer team believe might have resulted in not having the detailed structural debates that set out the absolute clarity of roles and responsibilities to the degree that they should. The peer team heard "*Soft landing, so soft we didn't notice it*".

25. Salford SAB should harness the energy and enthusiasm of the voluntary sector. Consider setting up a sub group specifically for the Third Sector, colleagues have stated that they would welcome this! A sub group would help the sector to be more fully involved, they have a great deal to offer.

26. The peer team felt that the Board was well established, had worked well within the ICO, with strong relationships. It was felt that the Board may benefit from a 360 degree look at roles, responsibilities and impact, to further establish if there were skills gaps that could be addressed. Though it may not currently be an issue currently, the SSAB may wish to consider succession planning for the future. There is a great deal of organisational knowledge and memory in Salford and this should be harnessed before it becomes too late, and the opportunity to do so is missed, as the organisation evolves and changes.

Outcomes for and the experiences of people who use services.

Strengths

- You have recognised that community engagement and hearing the voice of the person is important and you are doing something about it.
- Case studies presented at the start of every Board meeting
- Commissioned an in depth piece of work to look at service users and their views of the safeguarding process.
- Writing Communication and Engagement Strategy with a wide range of involvement.
- A strong feeling that integration has led to better communication and more person-centred approach for professionals

Areas for Consideration

- The use of the service user voice and experience needs strengthening at the Board level as part of the improvement cycle.
- Service User Stories – increase referrals, ensure there is a good representative sample, learning and action takes place.
- Wider engagement needs consideration particularly with diverse and hard to reach communities – consider linking better with ward members and community groups
- People who are still unsafe after safeguarding input – what are you doing to complete the loop? Are you asking the right questions?
- Further investment in the promotion and raising awareness of adult safeguarding to the people of Salford
- Service User we met could bring value to the Board – he is an Ambassador!

27. It was clearly evidenced to the peer challenge team that the Board have significantly worked on ensuring that that the service user voice is part of the SSAB business. This remains a priority for the Board and it continues to find ways of doing so without being tokenistic.

28. Real service user case studies are presented at the beginning of every Board meeting. This grounds the meeting from the very start with the user experience at the heart of the Board and sets the tone for the meeting. The Board might want to consider how it can evidence it has learnt, adapted or influenced a change in practice or policy following a service-user story. Service-user stories do not also have a positive outcome.

29. An in-depth piece of work has been commissioned to look at people who have been through the safeguarding process to better understand their views regarding their experience. This has helped to further improve the way you are continuing to engage with service users but the Board must be assured that all service users groups are represented and all feedback good and bad is reported and acted upon.

30. We recognise that you are writing a communication and engagement strategy which will have a wide range of involvement. So far we have heard that ten groups across Salford have been involved, as have the Practitioners Forum. However, officers and partners are aware that more needs to be done to reach the very hard to hear groups. Salford has improved publicity around safeguarding following consultation and a re-branding of leaflets is now in draft stage.

31. There is a really strong feeling that integration has led to better communication and more person-centred approach for professionals, this is demonstrated by the work carried out with Care Providers to improve CQC ratings and standards.

32. The peer review team heard time and again during our interviews with Board members, providers and front-line staff that Making Safeguarding Personal (MSP) is being embedded across the ICO. Operational staff understood and articulated the language of MSP and the importance of developing a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs who may have been abused. Evidence was available that all partners have self-assessed against the MSP framework and the Board can assure themselves that work continues to deliver Making Safeguarding Personal. The language and approach of MSP however, could be better reflected in the safeguarding paperwork for example there was use of terms such as strategy meeting and case conference rather than planning meeting.

33. Salford SAB recognises the voice of people using services being heard at Board level is a priority and whilst it has grappled with this, we feel that it is an area which requires further enhancement. For example, the peer team struggled to find how the service user/patient's stories read at Board had made a difference to the work of the Board, informed practice or identified action and work programmes of the sub groups or to the people who need safeguarding?

34. If SSAB strengthen the voice of people there is still an issue which is not unique to Salford, about how you get the message of safeguarding to your communities? Some thought could be giving to the wider public particularly hard to reach groups and difficult communities to communicate with. A possible route into communities could be by linking in with your elected members and community groups through established forums. Your elected members are your eyes and ears on the street and have a wealth of information which the Board could harness in getting the message out to localities. If SSAB could demonstrate that adult safeguarding is as important as children's safeguarding, then Salford will have succeeded in raising awareness.

35. From the dashboard performance data that was shared, we noted that there are still people who speak of feeling unsafe after they have been through safeguarding system. We were unclear what the safeguarding system was

providing for those people who continue to feel unsafe. Are practitioners asking the right question around safety and feeling safe, and can you confidently close the loop?

36. There are a lot of good initiatives and developments around service user engagement that are producing case studies and soft intelligence, but it was unclear to the peer team what learning and action was being undertaken from these valuable pieces of information.

37. During the service-user session the peer team met an amazing young man who is passionate about speaking up for vulnerable groups at risk of exploitation. He is a volunteer at Healthwatch, and chairs a learning disability forum to name but a few of his roles. He has recently become an ambassador for the North West and received an award for his work in speaking out for hard to be heard groups, he received over 12,000 votes. He was an engaged, enthusiastic, energetic and fascinating individual who would value the opportunity to come to Board and tell you about his experiences. The Board could consider inviting him once to give a service-user perspective instead of reading out a service user story at one of the Board meetings. The peer team would urge SSAB to invite him.

38. We heard from a number of people that the next step for Salford SAB is to further promote safeguarding adults and the work it does better to the people of Salford. Systems have been set up to take in referrals from the public however there is a low take up and more could be done in the form of promotional campaigns to raise awareness and increase vigilance. The peer team found that referrals were predominantly from professional staff and suggest the SAB consider engaging elected members as champions for the Board. In turn, this could help increase your current level of service user engagement. We heard that members of the public could complete an electronic referral form, but that there were limited referrals directly into the safeguarding portal.

Service delivery, effective practice and performance management

Strengths

- Really good multi disciplinary training, valued by partners.
- Some examples of intelligent use of data to identify issues and improve practice e.g. use of advocacy and MCA training
- Self-Neglect and Hoarding Multi-Agency Guidance and Procedures, this is an area of best practice
- Safeguarding Practitioners Forum is an asset
- Opportunities in the Multi-disciplinary groups in the 5 areas is valued and useful
- Performance Dashboard in place and recognise it's work in progress

Areas for Consideration

- Have you reflected the service user voice in your training programme
- SAR could be strengthened particularly in how you disseminate lessons learned and make use of lessons from national SARs
- Where is the oversight of serious incidents? Triangulation with other data sources
- Performance dashboard heavily weighted on ASC, needs to become a system dashboard
- Issues around Police investigation timescales emerging

39. There was evidence of multi-disciplinary training that was valued by partners and all partners would welcome more collaborative training sessions that included social care, health and GP's. The Board needs to be assured that Mental Health services are included and considered in all training aspects as the service feels isolated and disconnected.

40. There is a performance dashboard in place which supports the Board and the Performance and Quality sub-group. The peer team and SSAB recognise that this is work in progress and it is continually reviewed to ensure that the data captured is relevant and gets underneath any issues identified. The peer team heard some examples of intelligent use of dashboard data to identify issues and improve practice e.g. use of advocacy and MCA training. For example, we heard that there was a disconnect between the data on MCA and staff's understanding of the implementation of MCA in practice which required further training. Further interrogation identified that it was much more than training that was needed, and the issue has been resolved. Also, we heard how access to advocacy support had now improved as a result of intervention following an in depth look at what the data was showing.

41. The peer team thought that the Self-Neglect and Hoarding Multi-Agency Guidance and Procedures were an example of good practice. The procedures are embedded with human rights at the heart of practice, and the way that the procedures seek to manage the issues of not being neglectful by overriding people's rights and responsibilities but focused on how to minimise risk is the best that any practitioner can do. Several people interviewed during the course of the review mentioned how useful they found this guidance and in some cases had gone to great lengths to ensure it was disseminated in their organisations; the team were told for example that referrals about self-neglect from the Fire Service had increased by 40% as a result of awareness raising on the procedure.

42. The Safeguarding Practitioners Forum is an asset. Staff speak very highly of it and those who attend understood the work of the Board and helped to disseminate it's work. The forum also provides advice on how safeguarding can be improved with the benefit of the people who deliver services experience on the ground. Forum members were aware of the recommendations from SARs and took their role as representatives of the forum to ensure that these were implemented in the workplace. Members see a direct link to Board and see the change that is recommended and implemented following their reports.

43. There are opportunities in the five multidisciplinary groups (MDG) that are valued and useful. Several people described how useful the MDG meetings are in terms of sharing information and concerns and checking out practice issues with colleagues from other disciplines.

44. Team members welcome the opportunity to share a workspace with a multi-disciplinary team and find sharing knowledge and intelligence a huge benefit that works extremely well. Teams adapt their way of working to fit with their clientele so each area will differ and provide a more tailor-made service.

45. The peer challenge team identified that the performance dashboard is focused on ASC data, this was also fed back to the peer team in interviews. It would benefit from being a dashboard that collates partner information and intelligence to escalate it to a system-wide dashboard. We are unclear on what assurances the current dashboard gives the SSAB on the whole systems and its partners. We feel it could be enhanced if it included health and police data as well as soft intelligence from other agencies such as housing. The performance sub group has members from different partners and the information needed to improve the dashboard could be provided by these representatives.

46. Following discussions with several people about the current performance dashboard there appear to be some issues around police investigation timescales. This seems to be causing some concerns to partners. It may well be that this is appropriate, and delays are occurring because of investigations into criminal activity which do take time. However, this could an area that would benefit further scrutiny and potentially adding to the current dashboard for further performance management. The peer team have been made aware that police partners have engaged positively with the Board regarding this issue and will be attending future Board meetings to listen and respond to concerns.

47. Reflecting the experiences of people in your training would strengthen its impact enormously. The case studies that are provided to Board could be adapted and

used in training sessions, the use of real stories makes training far more valuable and memorable.

48. SARs could be strengthened particularly in how you disseminate lessons learned from both local and national SARs. The peer team felt that the consistent communication of lessons learned would add to the continual cycle of improvement. Involving training officers in this process would ensure that lessons learned are captured in training at all levels.

49. The peer team were curious about where the overview of serious incidents occurred for the SSAB? Was there triangulation of data, and were the systems of serious incidents and safeguarding being managed correctly?

Working Together

Strengths

- Evidence of system learning for all partners, e.g. fire
- Multi-disciplinary group meeting seems to provide good support for professionals
- CCG safeguarding team seen as invaluable
- Each GP practice has a safeguarding lead
- Strong partnership involvement at all sub-groups
- Supportive role for care homes/providers to improve standards and quality is excellent practice
- Inter-board protocol – ongoing developments

Areas for Consideration

- Are all Board members held to account? There is an opportunity through partners contribution to your annual report to challenge each other
- It feels like a single organisation, however the same language is used to describe different things. There is potential for lack of clarity.
- How well are the priorities of the Board known at all levels?
- More to be done on prevention
- There is a need to pay attention to ensuring that the place-based work keeps directly relevant to the people you support.
- Absence of evidence for the management of risk
- Are all partners as engaged as they should be?
- Different IT systems not talking to each other / unable to access them.

50. There is an evidence of system learning for all partners. The area has had two fatalities due to fire. It was very impressive that from that very sad occurrence that a lot more work has been done to identify similar people that might be at risk. The system has identified 160 people who fall into the four identified shared risk characteristics to be exact. The level of detail involved in identifying those people at risk with the level of insight and knowledge that SSAB possess is incredibly good.

51. The multi-disciplinary group meetings at locality level seems to provide good support for professional people who benefit greatly from sharing issues and/or concerns and gaining feedback from each other. They are well attended and appreciated.

52. The CCG Safeguarding Team were very highly thought of for their open-door approach, they were seen as easily accessible and their expertise and knowledge appreciated by practitioners.

53. In line with the Salford standard, each GP practice has a GP as the practice lead for safeguarding, this shows commitment at the highest level, these GP's meet bi-monthly and take the responsibility to disseminate any learning in their own practices.

54. The peer team had a real sense that there was partnership involvement in the majority of sub groups. Each sub-group appears well attended and each

partner is contributing to the delivery of its work programme. Many examples were given such as enhancing the service user voice, improving the language and branding used in safeguarding literature through the community and voluntary sector and strengthening the use of making safeguarding personal at front line. However, it was noted that membership of the Impact and Improvement Network could benefit from attendance from the Fire Service particularly given the recent learning from the recent fire incidents.

55. The level of support provided to care home providers to improve standards was impressive. The role has moved from "monitoring" providers to "supporting them by the full range of professionals who worked with them. The professionals ranged from safeguarding officers, pharmacy colleagues to CQC to contract officers. By establishing the wide range of professionals who were involved independently in working with care homes, a core group of professionals began to work collaboratively to share intelligence. The resulting network, the Quality Improvement Network (QIN) began to raise standards in homes and improve communication between professionals. The resulting performance improvement of care homes saw Salford rise from 150 out of 151 in the CQC rating rankings to 85 out of 150 since 2017. The trajectory is on the upward trend and the approach is worth sharing regionally and nationally. The peer challenge team found this to be a fantastic example of how once Salford identify a problem, they mobilise all partners to sort it out for the benefit of the people they serve.

56. The Inter Board protocol would make a great difference once fully operational in terms of cross Board working towards a safer Salford – the team heard how the Board managers are now meeting regularly to ensure a shared understanding of each Board's priorities and agendas and are working fairly closely together. One suggestion which could potentially improve inter-Board working was that the Children's and Adult's business units could be co-located.

57. Working together the Board managers and chairs will influence agenda setting across the three boards and ensure that key issues are shared and possibly join boards together for certain issues to avoid duplication. Many key partnership representatives will attend more than one board and will benefit from shared agendas. The Inter Board Protocol will also allow training agendas to be shared to ensure a more collaborative training package and possible save money and again avoid duplication.

58. Although partners feel valued and included, are all Board members held to account? There is an opportunity for each organisation to carry out an audit which is fed into the annual report. This could be used as a broader challenge session for each partner to identify what is happening in each organisation and ramp up the degree of challenge to ensure rigour in the system.

59. While SSAB is operating well in a single system, it was noticed that there were examples of the same language being used to describe different things. For example, "risk" for health professionals could relate to infection control, whereas to social care professionals it could mean that a person's behaviour potentially puts them "at risk" equally best interests also has very different meanings dependent on context. As a professional clinician etc it could be my opinion that it is in your best interest to follow the advice that I am giving, however under the

Mental Capacity Act there is clearly a legal decision to act in someone's best interest when they have been assessed as lacking capacity.

60. Clearly there is opportunity to understand and challenge these differences with a strong integrated setting further removing the different cultural understand and backgrounds that the partners each bring.

61. The Board have developed a strategic plan and this could be shared across the partnership and disseminated to all levels of staff including, this will increase awareness of the board and it priorities for the next 3 years.

62. Various partners spoke of the need to do more on prevention. There currently is no prevention strategy in Salford, therefore how is the Board assured that there is effective preventative safeguarding practices across all partnerships? This should include individuals, professionals and agencies working together to recognise the potential for, and to prevent, harm. The peer team would ask the SSAB, how are you managing to get prevention embedded into the work of the Board? How are you assuring yourselves? Are the referrals appropriate? How are you keeping people safe without that wider prevention strategy?

63. The peer team noted that Salford has the 2nd highest Prevent referrals in Greater Manchester (with most being for adults). Effective multi-agency partnership working is essential for the successful delivery of the Prevent Duty. The Board along with the Safeguarding Children's Partnership has held joint sessions on Prevent to ensure that board members have oversight of the local risks and are aware of their responsibilities. Health, along with the Police and the Local Authority are represented on the Channel Pannel. However the Board may wish to consider what further work could be done to provide assurance on the safety of its local population and organisations compliance to nationally reported training figures (figures reported quarterly)?

64. The ICO delivers care across a large footprint. The work of the Board should ensure that the balance is right and to pay attention that the place based work keeps directly relevant to the people the ICO supports. Organisations can fall into the trap of wanting to deliver a standardised approach to communities, but what is very important is to be mindful of the place based work you are delivering which is specific to Salford's five neighbourhoods and not losing that in a broader structure.

65. The peer team were concerned about the appetite and management for risk. It was not fully evident that that there was a process for colleagues to come together to consider risk in a managed way. As organisations we are beginning to work in different ways and asking people to avoid using traditional care services. Further consideration needs to be given for the appetite of risk. For example, acute hospitals may be considering risk for pressure ulcers or infections, but there are risks associated with people living independently at home, and how is Salford managing that process? In trying to do this, does the ICO have the right structures and protocols in place that could help that process? For example, if people are at risk at falling, organisations may admit them to a care home. However, people are seven times more likely to fall in a care home's unfamiliar setting than at home. Organisations doing this are shifting risk, rather than managing it. The ICO should be mindful of that given

the complexity and size of the organisation. Consideration should be given to how the ICO support staff and people to be empowered.

66. Are all partners as engaged as they could be? Mental health services work remotely and there was some evidence to suggest that messages, protocols etc. from the SSAB were not fully understood or known outside the ICO. Some frontline staff felt disengaged and isolated. The peer team understand that the SSAB and ICO colleagues are aware of this and are working towards integration of the whole system. The practitioner's forum would be an ideal place to include mental health colleagues and all efforts should be made to ensure representation is made available. The Board should be assured that all partners are invested in safeguarding and working together as well as feeling part of the Salford story.

67. An integrated system such as Salford's suffers from a range of IT systems that cannot be accessed by all colleagues. Improving the access to different systems for frontline staff would improve their work practices, make them feel they are trusted and diminish the frustration they currently feel.

Case File Audit

68. 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.

69. 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

- Comprehensive forms which provide the 'story' and key timescales
- Details of service users' views and outcomes being sought
- Some very good joint working particularly with the police and fire service
- Purposeful and persistent social work practice – ensuring rigour in the process
- Recording is factual
- People were being asked their views and these were being responded to sensitively and with impact
- Generally very good in respect of timescales

Areas for Consideration

- Purpose of, scrutiny over, and quality assurance of provider enquiries which have recently been piloted
- At times, perhaps a lack of clarity around interface between (hospital) Adult Safeguarding Team and adult social care, in respect of roles and responsibilities, which impacts on timescales in some cases seen.
- Inconsistent use of language – pre and post Care Act – is evident in recordings i.e. investigation/enquiry, use of 'strategy meetings' and 'case conferences' instead of 'planning meetings' and 'outcome meetings'
- Evidencing the application of MCA could be improved
- Consider making the impact of decision making more evident within the recording process

70. 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, in care homes etc

71. Although comprehensive, the paperwork at times is repetitive and staff interviewed subsequently during the review, often said they found it very

onerous. It would be helpful perhaps for the paperwork, including the terms used to be reviewed, particularly in the light of MSP.

72. People were asked about their outcomes however, and it was clear throughout, that they, or their representative were consulted and involved. However, greater clarity around mental capacity and evidence of adherence to the principles of the Mental Capacity Act would further improve the process.

73. There was some excellent evidence of multi-agency working, but in at least one case, some confusion evident between roles and responsibilities of nursing and social care staff.

74. It would be helpful to ensure that there is a robust process put in place in terms of quality assuring provider-led enquiries.

75. There is no doubt that SSAB 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

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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