Leeds CITY COUNCIL

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Report of the **Chief Officer Social Care Commissioning**

Board: **Adult Social Care Scrutiny Board**

Date: **11th March 2009**

Subject: **Adult Inspection Progress Report Against Key Recommendations**

Electoral Wards Affected:

☐ Ward Members consulted (referred to in report)

Specific Implications For:

Equality and Diversity ☐

Community Cohesion ☐

Narrowing the Gap ☐

Executive Summary

This report includes a summary of progress to date against specific recommendations following the Inspection of social care services and the resulting action plan. This follows from the request made by this Board in December 2008 and refined in the subsequent proposals working group. In accordance with those recommendations this report specifically addresses progress in relation to recommendations 2, 6 and 11.

The report shows that there has been progress in strengthening arrangements to ensure that vulnerable adults are effectively safeguarded across Leeds. A number of immediate measures have been put in place to strengthen frontline processes in particular management responsibilities to monitor and quality assure practice relating to safeguarding work.

Multi-agency partnership arrangements have also been strengthened and a number of sub-groups have been convened by the Safeguarding Adult Partnership Board with delegated responsibility for the specific areas of work including Performance, Audit and Quality Assurance. This group will oversee and report on arrangements across organisations to assure practice against agreed procedures and standards.

Initial work has started to ensure that reviews are undertaken on time and to an agreed quality. A team of operational experts will review existing procedures and standards. A baseline of current activity levels and an analysis of performance has been undertaken, This will provide a basis for generating an action plan with operational staff to improve levels of reviewing activity.

1.0 Purpose Of This Report

1.1) In December 2008 Scrutiny Board agreed that an update of progress against specific actions in the Adult Inspection Action Plan would be provided to this Board. This is the second report against specific recommendations agreed by the Proposals working group.

2.0 Background Information

2.1) The Adult Inspection Action Plan was agreed by the Commission for Social Care Inspection (CSCI) and by Executive Board in December 2008.

2.2) This is the second report to Scrutiny Board against specific recommendations. It includes an update on progress against the following recommendations relating to Safeguarding arrangements in Leeds:

> **Recommendation 2:** The Council should strengthen frontline quality assurance arrangements to ensure that minimum standards of practice and recording are implemented routinely in responding to adults safeguarding alerts.
>
> **Recommendation 6:** The Adult Safeguarding Board should prioritise the development of a quality assurance sub-group.
>
> **Recommendation 11:** The Council should ensure that Departmental standards in relation to the timeliness and quality of reviews are met.

3. Main Issues

3.1) Recommendation 2.

3.1.1) An independent expert in the field of adult safeguarding, Dr Margaret Flynn, was employed to undertake an analysis of a sample of case files where the case reason included safeguarding work, with the aim of establishing a snapshot of current practice. As part of her work with Adult Social Care, Dr Flynn was also asked to develop processes that will be used in the future to independently monitor and quality assure frontline practice in relation to all aspects of safeguarding activity.

3.1.2) Dr Margaret Flynn is a specialist in the field of Adult Safeguarding. She is the independent chair of Lancashire Safeguarding Adults Strategic Partnership Board and was an Advisory Group Member for the DH Consultation on the Review of 'No Secrets' Guidance. She is a Senior Lecturer and Principal Research Fellow at Sheffield Hallam University and has undertaken a wide range of research and consultancy work in the field of Adult Safeguarding. Dr Flynn chaired the serious case review undertaken in Cornwall following the death of Stephen Hoskin in 2007.

3.1.3) A review of a sample of files was undertaken during November and an interim report produced. Follow up work is currently being undertaken in order to produce the final report. Margaret has been asked to produce a final summary report based on the overall assessment of the file audit at the conclusion of her work in April.

3.1.4) The work to establish an independent quality assurance process for monitoring frontline practice in safeguarding has started. An overarching framework was taken to the Departmental Management Team and agreed on January 22nd.

3.1.5) Dr Flynn has now met with key personnel including the Chair of the Safeguarding Partnership Board and the Safeguarding Adult Enquiry Coordinators to establish the quality

assurance methodology. This includes the further development of practice standards which build upon the newly revised procedures and managerial requirements. This work is due to be completed by the end of March 2009.

3.1.6) To ensure the work undertaken by Dr Flynn is taken forward and embedded, a new post of Senior Quality Assurance Officer (Safeguarding and Risk), is currently being recruited to. Interviews were held on the 17th February and a recommendation to appoint was made. This person will be responsible for further developing and implementing the processes currently under construction. The methodology employed will focus upon ensuring that vulnerable adults are safeguarded and that any risk factors are identified and addressed. It will provide the basis for a comprehensive quality assurance system based upon independent file auditing and casework follow-up, this will be employed by the Senior Quality Assurance Officer as they take up their post in March or April.

3.1.7) The above work is being complemented by a strengthening of arrangements at the frontline. All fieldwork teams have been involved in a training session which clarifies roles and responsibilities in relation to safeguarding practice. A checklist for use by managers has been developed in consultation with staff and the Adult Safeguarding Unit. The checklist acts as an aide memoire, ensuring that key requirements of the safeguarding procedures and standards are met. The checklist is to be completed by managers for all safeguarding cases. This will provide information which will contribute towards file auditing activity and ongoing monitoring.

3.1.8) An important finding of the Adult Inspection was the need to ensure that supervision of Adult Safeguarding work was evidenced by managers who are required to record their oversight of work in case files. The above work has provided an immediate response to ensure that manager's responsibilities are being met. In addition a revised approach to supervision has been developed and consulted on widely. This will be rolled out to staff commencing in April.

3.1.9) A team of service delivery managers will work with the Adult Safeguarding Coordinator to establish a quality circle and a process for peer review of safeguarding cases files. An initial task will be to review current practice and scope out requirements.

3.1.10) Finally, the recruitment process continues to employ three independent chairs of safeguarding conferences, whilst these posts will operate to assure practice in safeguarding across the partnership, their work and feedback on the interventions of adult social care staff will provide an essential compliment to that described above.

3.1.11) Once in place a programme of assurance work will be put into place for the coming year alongside the timetabling of the production of reports for the Director of Adult Social Services.

3.2) Recommendation 6.

3.2.1) The structure of the Safeguarding Partnership board has been strengthened and a Memorandum of Understanding (MOU) has been agreed which specifies the roles and responsibilities of all member organisations, including Adult Social Care in relation to Adult Safeguarding activity and governance across Leeds. The work of the Corporate Governance and Audit Committee in respect of this work is covered at section 4.

3.2.2) The Audit and Quality Assurance Sub-group will report to the main Partnership Board. The group will be responsible for ensuring effective information and quality assurance systems are in place to enable effective monitoring and management of safeguarding work

across agencies. This includes having in place regular reporting of quality and performance to the Partnership Board

3.2.3) The Terms of Reference for the Performance and Quality Assurance subgroup has been agreed as part of the Memorandum of Understanding. The first task will be to undertake an audit of current monitoring and reporting within agencies. This will be used to produce an analysis of the current shortfalls leading on to a specification of the requirements needed to establish a comprehensive and coordinated approach to assuring safeguarding practice across the city.

3.2.4) Full members of the Safeguarding partnership board have been invited to nominate one of their agency leads to chair the Performance, Audit and Quality Assurance sub-group which will have met for the first time by the next partnership board meeting in April 2009.

3.3) Recommendation 11.

3.3.1) A team of service delivery managers has been identified to undertake work which will improve both the timeliness and quality of reviews. An initial task is to review the current documentation and standards in relation to reviews.

3.3.2) Initial baseline data has been produced which includes a gap analysis of reviewing activity. This was discussed by the Departmental Management Team on 18th February with a series of actions agreed aimed at making immediate improvements in performance with regard to improving overall timeliness of reviews in the current financial year. This include3s the targeted deployment of the Adult Reviewing Team on those areas of service identified in the gap analysis as being under-represented, this particularly includes people whose sole service is meals provision or day-care.

3.3.3) An independent survey of people who have recently had reviews will be undertaken in March 2009. This will include a random sample of service users from across service user groups and fieldwork teams across the city. Data will provide some baseline information regarding the experience for service users of the review process, practice and enable service user input into how the process can be improved.

4. Implications For Council Policy And Governance

4.1) On the 20th January 2009 a report was presented to the Audit and Governance Committee of the Council at their request. The report highlighted issues of governance raised in the Independence, Wellbeing and Choice Inspection specifically in relation to the operation of the Leeds Safeguarding Adults Partnership Board. Following discussion of the content of the report the committee determined that:

(a) That the contents of the report, the Independence Wellbeing and Choice Inspection Report and the associated Action Plan be noted;
(b) That further reports be submitted to the Committee regarding progress in addressing concerns expressed in the inspection report relating to the safeguarding arrangements and risk management; and
(c) That the Committee be advised of any amendments to the 'No Secrets' guidance which have governance implications.

4.2) On the 30th January 2009 two reports were requested by the Corporate Audit and Governance Committee of the Council, firstly in relation to the multi-agency arrangements that have been put into place to adequately safeguard adults in the City. Secondly, to

provide assurance with regard to risk management arrangements operating within adult social care with a particular emphasis on describing how strategic risks identified within adult social care are translated into operational controls. These two reports will be considered at the 18th March meeting of the Committee.

5. Legal And Resource Implications

5.1) Legal implications in relation to the governance of the partnership are considered above. There are believed to be no further resource implications, the work of Dr Flynn and the recruitment to new posts within adult social care and the wider partnership, are budgeted for in the current financial year.

6 Conclusions

6.1) This report provides an update to Scrutiny Board of progress which has been made against recommendations relating to Adult Safeguarding arrangements in Leeds as outlined in the Adult Inspection Action Plan.

7. Recommendations

7.1) Members are asked to note the contents of this report in relation to the specific recommendations 2, 6, & 11 drawn from the Adult Independence, Wellbeing and Choice action plan.

7.2) Members are asked to note the continuing overview of the Corporate Audit and Governance Committee in the overview of governance and risk management arrangements within adult social care.