Leeds CITY COUNCIL

Originator:	Dennis Holmes
Tel:	2474959

Report of the **Deputy Director (Strategic Commissioning)**

Board: **Adult Social Care Scrutiny Board**

Date: **6th April 2009**

Subject: **Adult Inspection Update Report (Recommendations 2,3,6,7,8,11,25**

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

Executive Summary

This short report provides 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 March 2009. In accordance with that request this report specifically addresses progress in relation to recommendations 2,3,6, 7, 8,11 & 25.

Appended to this report is the evidence submission prepared for the meeting held between the Lead Inspector, Tim Willis and the Adult social Services Directorate Management Team on the 19th March. In addition, the final report arising from the quality assurance audit conducted by Dr Margaret Flynn and reported to the Board in March is also appended. Finally, the supervision checklist used by Adult Social Care staff in safeguarding cases is also appended.

Taken together, the materials submitted to the Inspector and appended to this report, indicate good progress in all key areas of the plan. Further, the Inspector has indicated his willingness to consider proposals to amend some of the targets for achievement set out in the original plan in the light of progress. It is intended to incorporate those submissions and his specific views on them into a future report to the Board.

1.0 Purpose Of This Report

In February and March 2009 Scrutiny Board received reports setting out progress against recommendations made in the 2008 Independence, Wellbeing and Choice Inspection of Adult Social Services. This report provides a short update on the position in relation to those recommendations at mid-March.

2.0 Background Information

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

This is the third report to Scrutiny Board against specific recommendations. It includes a short update setting out the position at mid-March 2009 in relation to progress against the following recommendations relating to Safeguarding and other related arrangements:

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 3: The Council and its Partners should agree and implement improved procedures ensuring that these:

- Set out specific and monitorable expectations on staff from all agencies.
- Implement a system of compliance monitoring processes that ensure consistent practice.

Recommendation 6: The Adult Safeguarding Board should prioritise the development of a quality assurance sub-group.

Recommendation 7: The Adult Safeguarding Board should agree an adult safeguarding serious case review process and mechanisms for sharing performance issues and learning with partner agencies.

Recommendation 8: The Leadership Board should strengthen its leadership role and reporting practice issues to elected members.

Recommendation 11: The Council should ensure that Departmental standards in relation to the timeliness and quality of reviews are met.

Recommendation 25: The Council and its partners should strengthen governance arrangements so that elected members and relevant officers in partner organizations have a clear understanding of the performance of adult safeguarding.

Officers and the Lead Member (Adult Social Services) met with the Lead Inspector on the 19th March to provide evidence to him with regard to progress made to date and objectives for the next period, the evidence pack provided to him, covering elements of all the areas outlined above is appended to this report.

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 was undertaken in order to produce the final report which is appended to this report. (Appendix 2), A commentary on the main findings of the report is contained at pages 7,8 & 9 of Appendix 1. The commentary on page 8 also provides information on the numbers of staff trained so far and including the level of training received.

3.1.4) Dr Flynn will continue to work with officers until June this year to ensure that a robust quality assurance framework and work programme is in place. This work will be undertaken by an officer due to commence employment on the 6th April with the objective of providing regular reports in relation to the quality of intervention by Adult Social Care staff in the first instance. In the future it is intended that the scope of such audits will broaden to incorporate the wider safeguarding partnership.

3.1.5) Dr Flynn has accepted the invitation of the Board to attend the meeting of the 8th April to respond to any questions arising out of or relating to the content of her report.

3.2) Recommendation 3.

3.2.1) Significantly revised multi-agency procedures were produced by the Safeguarding Adults Partnership in July 2008, since that time, these revised procedures have been through a series of amendments and alterations to ensure that they fully capture the requirements highlighted by the inspection and the introduction of more recent national policy initiatives.

3.2.2) These have now been completed and are available in their current form to inform front line practitioners pending their full implementation which is scheduled to commence in April.

3.2.3) At the Board meeting held on the 18th February, partners agreed to receive a paper to the April Board from Children Safeguarding colleagues who have developed a protocol with regard to holding partners to account for poor performance. It is intended that this work be adapted to cover the work of agencies engaged in safeguarding vulnerable adults. The adoption of such a protocol will form a substantial step towards addressing this recommendation.

3.2.4) The intention to quality assure the work of the wider partnership is highlighted in paragraph 3.1.4) above. This will be complimented by the work of the three independent

chairs of adult safeguarding conferences who will be uniquely placed to comment on the practice they observe through the course of their work.

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3.3) Recommendation 6.

3.3.1) As has been previously reported, 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 content of the MOU has now been reported to the Corporate Audit and Governance committee (18th March).

3.3.2) Also, the Terms of Reference for the Performance and Quality Assurance subgroup have 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.

3.4) Recommendation 7.

3.4.1) The Terms of Reference for the serious case review sub-group of the Partnership Board have been adopted. This group will be responsible for overseeing the serious case review function and reporting this to the Board. It is anticipated that the group will itself review casework episodes and make recommendations to the Board with regard to actions that can be taken by the partners to improve how they work together. However, the group will also wish to make recommendations with regard to the need to undertake independent case reviews where they believe this is warranted. Two cases have been identified which will be used as a pilot for this process and that work is underway. A report will be submitted to the Partnership Board following the completion of these reviews and learning from the cases will be disseminated to partners. Following the conclusion and report of these two cases, the process will be reviewed in the light of the thresholds at which a review should be conducted independently and the procedure then finessed to be used to review all subsequent cases meeting that criteria.

3.5) Recommendation 8 and 25.

3.5.1) Progress against these recommendations is addressed through the adoption of the MOU highlighted above and which was presented to the March meeting of the Board.

3.5.2) To support and service the Board infrastructure a new senior appointment is in the process of being recruited. It has now been confirmed that the Head of Safeguarding will be in post on the 3rd June 2009 at the completion of her notice period with her current employer.

3.6) Recommendation 11.

3.6.1) 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 includes 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. The effects of this work will be formally reported to

the Care Quality Commission (formerly CSCI) after the end of the 2008/09 performance period (23rd May).

4. Implications For Council Policy And Governance

4.1) On the 18th March 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, the development of the Memorandum of Understanding and the agreement by partners that it's content to be subject to ongoing review and amendment. Following discussion of the content of that report the committee determined that:

> The content of the report were noted and consideration to be given to the submission of a future report setting out the development of the Leeds MOU and any changes to current national standards or guidance.:

5. Legal And Resource Implications

5.1) The Legal implications are dealt with in the preceding paragraph, there are believed to be no resource implications.

6. Conclusion

6.1) This report and its Appendices provide an update to Scrutiny Board of progress made against recommendations contained in the Adult Social Care Inspection as set out in the Action Plan response to the Inspection..

7. Recommendations

7.1) Members are asked to note the contents of this report and its Appendices in relation to the Adult Inspection Adult Plan .

7.2) Members are asked to note the continuing involvement of the Corporate Audit and Governance Committee in the overview of risk management arrangements and governance arrangements in relation to the Leeds Adult Safeguarding Partnership Board.

7.3) Members are asked to consider the information presented before them, comment and make recommendations as appropriate.

8. Appendices

Appendix 1 Independence, Wellbeing & Choice Inspection Progress Review 19/03/09

Appendix 2 Case Audit – CPEA Associates, March 2009

Appendix 3 Safeguarding Supervision Checklist for Team Managers – January 2009