

# Adult Safeguarding **Peer Review**

Wolverhampton City Council  
September 2013

**Final**

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### Appendix 1 – LGA Standards for Adult Safeguarding Peer Review

## Executive summary

Wolverhampton City Council Adults' Services asked for a Peer Review of its Adult Safeguarding work to be conducted by the Local Government Association. Through a process of internal and external stakeholder engagement Wolverhampton asked for the scope to focus upon:

1. How effective is information sharing across partners, what early warning systems are in place and how effective are these in identifying institutional safeguarding issues?
2. How well do we risk assess the need for reviews around safeguarding including quality and timeliness, particularly for younger adults? And do we prioritise the right reviews?
3. How do we ensure we have a holistic approach for adults and children when working with families with multiple and integrated needs; what works well and what are the barriers to joint working and how do we tackle them?
4. How effective is the Wolverhampton Safeguarding Board in terms of performance managing the knowledge and learning from SCRs and DHRs?

After due consideration across the variety and complexity of the adult safeguarding business of Wolverhampton City Council, the Peer Review Team made a number of recommendations covered in the detail of this report. Staff told us that the process of preparing for the review was helpful in itself as it focused on what needs to be done and actions were already being taken as a result.

The findings from this Peer Review of Adult Safeguarding at Wolverhampton City Council are that it is generally a positive picture with a key aspect being the strong partnership working arrangements in place based on good personal relationships. Where there are gaps these are identified and there is a genuine desire to improve.

The Safeguarding Adults Board is well led. The right partners are around the table and represented at the most appropriate level of seniority. This exhibits collective responsibility for the safeguarding agenda. The Safeguarding Adults Board has a good understanding of its strengths and weaknesses and a well worked up action plan with clear priorities to address improvement areas.

Our judgement from the Case File Audit we completed is that overall frontline practice seems to be good and is improving. It is understood by all those we spoke to that this is the key part of the work of the directorate that seeks to keep adults safe in Wolverhampton.

You asked the Peer Review Team to consider people's experience of adult safeguarding as you recognise you can improve in this area. As a result you are beginning to put in place the methodology to learn about people's experiences. The next steps will be to roll this out, collect data, analyse it and consider how to feed this back into the system to further improve practice.

A simple headline from this Peer Review Team is that Wolverhampton Adults and Communities Directorate is well placed through its foundation on strong partnership working to make significant progress in the next twelve months.

Other recommendations and comment are detailed in the report.

# Report

## Background

1. As part of its programme of quality assurance and improvement Wolverhampton City Council requested the Local Government Association undertake an Adult Safeguarding Peer Review. Sarah Norman, the Strategic Director Community, at Wolverhampton City Council was seeking an external view on the quality, processes and procedures of Adult Safeguarding. The Council intends to use the findings of this Peer Review as a marker on its improvement journey.
2. A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit ‘critical friends’. 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.
3. The basis for this review is the LGA Standards for Adult Safeguarding (Appendix 1). A range of guidance, tools and other materials has been produced by national and local government, the NHS, police and justice system in recent years. The LGA Standards reflect this. The headline themes are:
  - Outcomes for and experiences of people who use services
  - Leadership
  - Strategy and commissioning
  - Service delivery and effective practice
  - Performance and resource management
  - Working together – the Safeguarding Adults Board
4. The members of the Peer Review Team were:
  - **Cath Roff**, Strategic Director, Adults Health and Housing, Derby City Council
  - **Councillor Keith Cunliffe**, Cabinet Member, Health and Adult Services, Wigan Metropolitan Borough Council
  - **Sue Cart**, Assistant Director, Safeguarding, West Sussex County Council
  - **Donna Telfer**, Associate Health Peer & Lay Member North East Essex CCG
  - **Gavin Roy**, T/Detective Chief Inspector, Kent Police Public Protection
  - **Kam Padda**, Safeguarding Adults Specialist, Bucks County Council
  - **Cathie Williams**, Adult Safeguarding Lead, LGA (Monday & Tuesday)
  - **Chris Rowland**, Associate Peer (Shadowing) (Monday & Tuesday)
  - **Dr Adi Cooper**, Strategic Director, Adult Services and Housing, London Borough of Sutton (Wednesday)
  - **Marcus Coulson**, Programme Manager, Local Government Association
5. The team was on-site from 16<sup>th</sup> – 20<sup>th</sup> September 2013. 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, frontline staff and people using services / carers
  - reading documents provided by the council, including a self-assessment of progress, strengths and areas for improvement against the LGA Standards for Adult Safeguarding
  - A comprehensive review of a select number of case files
6. The Peer Review Team would like to thank staff, people using services, carers and councillors for their open and constructive responses during the review process. The team was made welcome and would in particular like to thank the DASS Sarah Norman and her team, which includes both Amrita Sharma and Carole Owens for their invaluable assistance in planning and undertaking the review.
7. Our feedback to the Council and Safeguarding Adults Board (SAB) members on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review. The report is structured around the main areas of the Standards for Adult Safeguarding listed above.
8. 'No Secrets' (DoH 2000) provides the statutory framework and guidance for adult safeguarding. This defines 'a vulnerable adult' as 'a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'. The previous Government published a review of No Secrets with the following key messages for safeguarding:
- safeguarding must be empowering (listening to the victim's voice)
  - everyone must help empower individuals so they can retain control and make their choices
  - safeguarding adults is not like child protection – vulnerable adults need to be able to make informed choices
  - participation / representation of people who lack capacity and the use of the Mental Capacity Act are important.

The draft Care Bill currently going through Parliament proposes to put safeguarding adults on a statutory footing. Safeguarding remains a complex area of work and case law continues to test the basis on which it is undertaken.

## Outcomes

### Strengths (from the case files we have seen)

- Majority of people are involved in decisions about themselves
- Appropriate support is offered
- A large majority of people identify what they want to happen and are given information and choice
- Policies and procedures are followed and responses are timely
- The evidence demonstrates good partnership working with appropriate people
- There are referrals to professional bodies including Disclosure and Barring Service (DBS) when needed
- Historically records suggest a process driven approach however there appears to be a transition towards an outcome focussed approach in relation to client engagement

### Areas for consideration

- Review and evaluate the steps you have taken to include and respond to the voice of the user and carer in adult safeguarding
  - Continue to move towards a change in focus from being process driven to being outcomes focused
  - We suggest you explore the service user experience of hospital discharge especially to Care Homes
  - The flowchart in the Policies & Procedures for the West Midlands should be amended to include service users participation much earlier in the safeguarding process (refer to the flow diagram)
  - More work needs to be done on holistic risk assessment particularly in the area of Mental Health. Embrace the Social Model of Disability
  - Some excellent work appears to be fettered by the rigidity of the IT system
9. As part of the Peer Review process the team conducted a Case File Audit of thirteen cases selected from across the work of the Directorate. The findings from this audit indicate a number of strengths and areas for consideration. It must be noted that observations are based entirely on the cases audited, which are a small sample of the total over the capture period.
10. From the cases we looked at the majority of people are involved in decisions about themselves. It is important that such views are recorded clearly. Any feedback in relation to the service outcome should be documented and if appropriate used to inform policy and practice and views about the service provided need to be sought and recorded.

11. In the main appropriate support is offered to the person using services, including access to specialist communications and advocates.
12. A large majority of people identify what they want to happen and are given information and a choice of options to enable them to select a preference although it is explained that the safety of others may preclude this being achieved.
13. Policies and procedures are followed and responses are timely in particular the signing off by a manager within the day.
14. The evidence demonstrates good partnership working with appropriate organisations including the Police, Health colleagues and providers
15. There are referrals to professional bodies including Disclosure and Barring Service (DBS) when needed.
16. Looking back at older records in the sample they suggest that social workers had a process driven approach, however there appears to be a transition in the more recent files towards an outcome focussed approach in relation to client engagement. This would suggest that aspects of frontline social worker activity are changing. The outcomes for the individuals do need to be more clearly identified from the electronic record as outcomes are not always clearly stated. An area for development for the service as a whole would be the mainstreaming of an outcome focused approach with the client at the centre of the process.
17. When considering the voice of the user and carer you recognise that this is an area for development and this was identified an aspect of the scope for this work. We agree with you that it needs to be more clearly evidenced in the written records. You have taken steps to address this and we suggest that you review and evaluate the steps you have taken to include and respond to the voice of the user and carer in adult safeguarding. More work needs to be done with staff to ensure this is obtained and clearly recorded.
18. The Case File Audit completed by the team indicates a change in behaviour towards hearing the voice of users and carers. We recommend that you continue to move towards a change in focus from being process driven to being outcomes focused. Engagement with Making Safeguarding Personal should help to kick start this and enable you to start to measure effectiveness.
19. Some of the information we had the opportunity to consider leads us to suggest that you explore the service user experience of hospital discharge especially to Care Homes. It was not possible for us to completely triangulate this information but we are sure it would bear further scrutiny from all stakeholders involved.
20. The flowchart in the Adult Safeguarding Policies and Procedures for the West Midlands should be amended to include service users' participation much earlier in the safeguarding process. This is particularly with reference to the flow diagram which is used to summarise the process for practitioners. This would help toward a consistent and more positive user and carer experience across the region.

21. More work needs to be done on holistic risk assessment particularly in the area of Mental Health (MH) and embrace the Social Model of Disability. Staff reported that they felt there was a disproportionate weighting of the view of risk by health professionals and that, with carefully worked-up support plans, a greater number of people with mental health needs could be supported in the community rather than in residential or nursing care. A social model of disability gives due regard to the barriers that society presents and that disables people with impairments. The system needs to challenge itself as to whether or not it is putting up barriers through the nature of its practice. It might be helpful to refer to the research done by imPower on the influencing role physicians have on people's choice of care and support, which has been sent separately.
22. The Case File Audit allowed us to see some excellent work by social workers and colleagues. Some of this appears to be fettered by the rigidity of the information technology system in that it does not contain prompts as to whether the customer is asked what outcomes they want and then prompts as to whether they are achieved. The system does not follow the sequencing of events as prescribed by the procedures.

# People's experience of safeguarding

## Strengths

- You asked the Peer Review Team to consider people's experience of safeguarding and you are beginning to put in place the methodology to learn about people's experiences
- CCG culture shifting to hear more patient stories for CCG Board
- HealthWatch capture user voices through a variety of community engagement events

## Areas for consideration

- Website should be made more user friendly with regard to adult safeguarding
- Review the accessibility of the information and advice for users and carers
- Consider co-production approaches to service improvements in safeguarding
- Improve the timeliness of feedback and information to users and carers involved in safeguarding processes
- Maximise the use of community assets to keep people safe

23. You asked the Peer Review Team to consider people's experience of adult safeguarding as you recognise you can improve in this area. As a result you are beginning to put in place the methodology to learn about people's experiences. The next steps will be to roll this out, collect data, analyse it and consider how to feed this back into the system to further improve practice.

24. The Clinical Commissioning Group (CCG) has an emerging culture which is changing to seek to hear more patient stories at the level of the CCG Board. The Team see this as a welcome development as it represents the user and carer voice at the table where strategic decisions are made, and would therefore influence them.

25. HealthWatch (HW) capture user voices through a variety of community engagement events. HW also has access to various groups of the community and can assist in targeting hard to reach groups helping to redress the balance of engagement with ethnic minorities and faith groups and have an extensive library of linked organisations. This includes stalls at community events in the city and attending a parent/partnership event with 150 people. They also undertake "enter and view" and refer directly to the safeguarding team, picking up re-occurring themes. It would be of benefit to involve HealthWatch when commissioning and re-commissioning services as they can assist with assessing the likely impact on customers.

26. When researching the prominence of adult safeguarding on the Wolverhampton Council website the team found it relatively hard to find the topic of adult safeguarding and it would seem a fairly straightforward action to make it more user friendly in this with regard. What was particularly difficult was finding “adult social care” at first click as it did not appear in the banner list of services on the Home page. Only by clicking on a small dialogue box which says “more” did adult social care services appear on a drop down menu of further services. Once this hurdle was overcome it was straight forward to find information about safeguarding adults. You should consider how to make it more accessible.
27. The Peer Review Team recommend that the adults department review the accessibility of the information and advice for users and carers. The Team were unable to find hard copies of leaflets in users and carers environments and were unable to obtain clarity on how much information was available and to what extent this information was available to specific target groups (e.g. carers, ethnic minorities, faith groups and people with learning disabilities or mental health issues). It may be available but is not being circulated to where it will have best effect.
28. It would appear that there is an opportunity to develop the service through consideration of approaches to co-production in the service improvements in adult safeguarding. Voluntary and community sector organisations in particular are keen to do this with you.
29. There is a need to improve the timeliness of feedback and information to users and carers involved in safeguarding processes as well as to staff in other organisations who make referrals on behalf of customers. They want to know the referral has been received, acted upon and to know the result of the interaction.
30. Maximise the use of community assets to keep people safe. The thirteen case files sampled did not demonstrate that the use of natural support in the community of family, neighbours and friends had been drawn upon as part of a protection plan. Local community groups and voluntary sector bodies have daily access to some of the most vulnerable people and with better information can be more vigilant and potentially more confident in raising safeguarding concerns or making referrals.

# Leadership

## Strengths

- Cabinet Member is seen as a credible leader and valued for his active direct engagement with service users and carers
- There is visible leadership from the DASS on Adult Safeguarding
- The Chair of SAB & LSCB has provided strong leadership for partnership working
- CCG are exemplary in getting GP engagement in adult safeguarding

## Areas for Consideration

- There is a need for development in members awareness, understanding and ownership of adult safeguarding
  - Review the political governance and scrutiny arrangements for adult safeguarding
  - Ensure adult safeguarding is owned corporately
  - Ensure all adult safeguarding leads in the health community are known to each other
31. The Wolverhampton Council Adult Social Care Cabinet Member is seen as a credible leader and valued for his active direct engagement with service users and carers as well as with staff in the Council and other agencies.
32. It is quite evident that there is visible leadership on adult safeguarding from Sarah Norman the Director of Community who holds the statutory DAS role. She sets a clear agenda and follows through on the plans and actions set in motion to ensure they are carried out.
33. The Independent Chair of both the Safeguarding Adults Board (SAB) and the Local Safeguarding Children's Board (LSCB) has provided strong leadership for partnership working and is recognised as effective.
34. The CCG's approach in getting General Practitioner (GP) engagement through their successful uptake of training in adult safeguarding is exemplary with a high level of attendance at focused training events and a named GP lead in every surgery.
35. It was clear, and understood by those who considered the feedback, that there is a need for development in the awareness, understanding and ownership of adult safeguarding for the majority of elected members at Wolverhampton. One potential outcome that could be used as a measure of greater awareness would be the number of referrals through Councillors' political surgeries across Wolverhampton.

36. The Council has taken on board the need for a review of the political governance and scrutiny arrangements for adult safeguarding. Clarity should be achieved in the reporting arrangements for the SAB, clarity in public documents of the roles and responsibility for adult safeguarding and understanding for all about which Scrutiny Board considers the work of adult safeguarding and how that agenda is driven by the political priorities of the Council. Furthermore regular meetings, similar to arrangements for Children Safeguarding, between the Cabinet Member, Leader and Chief Executive should take place.
37. Adult Safeguarding is everyone's business and therefore you should ensure that adult safeguarding is owned corporately.
38. Given all the changes in the Health landscape it would be beneficial if you could ensure all adult safeguarding leads in the health community are known to each other and are working together cohesively.

# Strategy

## Strengths

- West Midlands Policies and Procedures for safeguarding adults with a suite of forms rolled out
- Evidence of a good strategic approach to quality assurance of commissioned services
- There are good strategic links between MAPPA, MARAC and SAB
- Evidence of effective joint strategy development e.g. Dementia Strategy

## Areas for Consideration

- Ensure a strategic multi agency approach to workforce learning and development with particular attention to; legal literacy for Social Workers, Domestic abuse, Mental Capacity Act & Deprivation of Liberty Safeguards
- Ensure a strategic approach to improving practitioner confidence and competence in information sharing
- Further develop your strategies to increase referrals from under represented groups
- Use the next opportunity for JSNA refresh to include adult safeguarding
- Look at opportunities for a more Think Family approach
- Opportunity to use the DPH to have a stronger role in adult safeguarding
- There needs to be a more strategic approach to earlier intervention and prevention to adult safeguarding

39. The West Midlands Regional ADASS group has agreed, published and rolled out Policies and Procedures for safeguarding adults.

40. The Peer team saw evidence of a good strategic approach to quality assurance of commissioned services. This was evidenced by a written framework of explicit and comprehensive care standards. Evidence is collected on visits to care homes and other services against those standards. This evidence is evaluated and used as the basis for an opinion on the quality of care given and a template for an action plan for improvements. Furthermore this effective risk management system is partly assisted by the co-location of the commissioning, safeguarding team and the quality assurance team as they have complementary roles and are able to share information immediately and build up a comprehensive picture of a provider or service. Safeguarding is written into the tender process and included in service schedules, specifications and monitoring.

41. There are good strategic links between Multi Agency Public Protection Arrangements (MAPPA), the Multi Agency Risk Assessment Conferences (MARAC) and the Safeguarding Adults Board (SAB). This ensures that in cases

which straddle different forums a holistic risk assessment can take place allowing for robust intervention in relation to perpetrators, appropriate support for all parties and identification of the multi-agency forum best placed to lead, thereby avoiding unnecessary duplication.

42. There is evidence of effective joint strategy development, e.g. Dementia Strategy.
43. Ensure a strategic multi agency approach to workforce learning and development with particular attention to; legal literacy for Social Workers, Domestic Abuse, Mental Capacity Act & Deprivation of Liberty Safeguards. This will provide invaluable networking opportunities, increased understanding of partners roles and widen the collective workforce for each organisation. It was mentioned to the team on a number of occasions the benefits and potential value of future joint safeguarding training sessions (across the partner agencies and including the third sector). Train together, work together.
44. Ensure a strategic approach to improving practitioner confidence and competence in information sharing. Although an information sharing protocol is in existence this needs to be translated to how practitioners apply it in their specific role. This will then ensure timely and appropriate information sharing to better manage risk and a person's support. This is linked to the above comment on training as the workforce needs to be confident that they have the mandate to seek and share information with partners. In safeguarding scenarios one should reverse the justification in favour of sharing the information.
45. Further develop your strategies to increase referrals from under-represented groups.
46. Use the next opportunity for the Joint Strategic Needs Assessment (JSNA) refresh to include adult safeguarding as a specific chapter. This would give clear focus to the issues and set out the priorities for action.
47. Look at opportunities for a more Think Family approach. There was clear evidence of reflective practice taking place within the adult social care services. The involvement of children's social care practitioners in this from time to time would support a greater understanding of each other's roles and responsibilities and promote holistic social care practice. This will ensure practitioners focus on the wider picture (children, adult, carer) enhancing their awareness and utilising the wider workforce where appropriate and necessary. This would enable practitioners to identify opportunities for early interventions and prevention for all members of the family and other associated risks. Making better use of 'Making every Contact Count' across the partner agencies would help with this.
48. There is an opportunity to use the Director of Public Health (DPH), her team and their practices, to have a stronger role in adult safeguarding. Public Health has a clear role and expertise in Evidence Based Prevention and Early Intervention which could help the Board to develop a more pro-active approach to adult safeguarding. This would enable partner agencies to maximise their contact time with the community, particularly the most vulnerable and signpost them to other supportive and appropriate early interventions.
49. There needs to be a more strategic approach to earlier intervention and prevention to adult safeguarding. It is important to reduce risk and the need for

safeguarding activity so that that evidence based care, support and protection is delivered safely, appropriately and is focused on the individual needs and experiences of people. In addition there would be benefit in a strategic review of older people's commissioning to transfer to a re-ablement and convalescent service post hospital discharges. A strategic approach would maximise opportunities to keep people safe and reduce the need for interventions further upstream. Increased awareness across all agencies will not only widen the collective workforce but act as an early-warning system where first contact signposting or intervention can prevent a situation escalating.

# Commissioning

## Strengths

- There are effective relationships between commissioning, safeguarding, social workers and quality assurance with a risk matrix approach
- An integrated commissioning manager for Mental Health
- CCG have appointed Quality Nurse Advisers located within the Council QA team to ensure a coherent approach to quality in nursing care
- Joint commissioning of 14-25 year old Mental Health practice
- Excellent quality standards for care delivery

## Areas for Consideration

- Adopt an evidence based approach to early intervention and prevention in adult safeguarding
- Adopt as a guiding principle that no-one should go into long term care from a hospital bed
- Optimise rehabilitation and recovery for older people after hospital admission instead of the step-down bed model
- Greater emphasis on community based support to reduce over reliance on residential care
- Recommend you set up a Personal Assistant register
- Recommend adoption of a portfolio of learning approach for Personal Assistants

50. The commissioning function at Wolverhampton Council and specifically in relation to adult social care appears to be strong. This is due to the effective relationships between commissioning, safeguarding, social workers and quality assurance staff. Together they share information readily, identify need and are investing in community services and early intervention to reduce tertiary services. This also ensures both timely and appropriate information sharing regarding risks to individuals and ensures an effective and co-ordinated approach when incidents occur.

51. There is an integrated commissioning manager for Mental Health. This is positive as it provides a whole systems view of the customer pathway and the inter-relationship between models of acute mental health care and community-based services.

52. The CCG has appointed Quality Nurse Advisers located within the Council Quality Assurance Team to ensure a coherent approach to quality in nursing care. Opportunities exist for these teams to work more widely with other agencies involved in safeguarding, including the Third Sector and HealthWatch.

53. The Team were impressed with the approach to the joint commissioning of 14-25 year old Mental Health practice. It was felt this was an appropriate way to meet the needs of younger people in the mental health system and addresses the concerns people have about people on their eighteenth birthday entering the adult mental health system. This ensures that this vulnerable group are afforded the security of continuous and consistent organisational involvement and do not suffer a lesser service merely because they have become legally adult.
54. There were excellent quality standards for care delivery which provided a clear framework for quality assuring commissioned care. Wolverhampton has developed a set of quality standards for care and support services that they commission which includes safeguarding. They are excellent and comprehensive.
55. We recommend that you adopt an evidence based approach to early intervention and prevention in adult safeguarding using information from the JSNA and using the expertise of the DPH to inform Councillors, partners and commissioning priorities. The DPH and the Public Health team are well placed to assist with this. (Previously covered. see comment at 49)
56. Adopt as a guiding principle that no-one should go into long term care from a hospital bed. This should drive system reform to ensure health and social care services maximise opportunities for recovery. The first principle should be that people should return home wherever possible and where this is not possible immediately use intermediate care and intensive rehabilitation to maximise recovery and promote independence.
57. Optimise rehabilitation and recovery for older people after hospital admission instead of the step-down bed model. Step down beds are passive and there is sufficient evidence that proves people rapidly lose their functioning and confidence if pro-active programmes of recovery are not in place. This drives a higher cost to health and social care and leads to poorer outcomes for older people.
58. There should be a greater emphasis on community based support to reduce over reliance on residential care. The urgent care strategy and the reconfiguration of health and social care services should include investment in intermediate forms of facilitating the transition from hospital to home with temporary support and respite care. A programme of providing extra care housing may help to reduce reliance on residential care. Wolverhampton maintained that it is already trying to make best use of natural social support to sustain people in their community. This is to be encouraged and supported.
59. The Peer Review Team recommend you set up an accredited Personal Assistant register. This would try to ensure that quality and standards are maintained for those people on Direct Payments and improve accessibility to personal assistants. If these are quality assured they will give people greater confidence to employ personal assistants with their direct payment.
60. We recommend adoption of a portfolio of learning approach for Personal Assistants. It is important that Personal Assistants are supported as new members of the social care workforce and that the local authority has a statutory duty to educate and develop. Local authority commissioned training courses and

those of other accredited trainers could issue certificates of attendance that a Personal Assistant could put into a portfolio of learning. This is portable and can be used to demonstrate to potential employers their skills and training (for example on matters such as moving and handling). Their portfolio of learning could also be part of their profile on the Personal Assistant register.

# Service Delivery and Effective Practice

## Strengths

- New West Midlands Policy and Procedures rolled out with training implemented
- Strategic Safeguarding Team recognised as a resource of excellence
- Evidence of effective partnership working e.g. Police, FRS, CCG, Wolverhampton Homes, etc.
- Development of dedicated Police SVA Hub that has raised profile of ASG with Police and multi-agency partners
- GP engagement at operational and strategic level
- There is multi-agency sign up to information sharing protocols
- There is evidence that there is reflective practice taking place at all levels of practice
- Early planning with children's services for transition
- Wolverhampton Homes using a play to raise awareness of “mate” crime with its workers
- Fire Service training staff in “Making Every Contact Count”
- Appreciative Enquiry approach to exploring safeguarding issues in Asian communities
- Adult safeguarding awareness training for DWP staff
- Black Country Vulnerable Adults Hub
- Domestic Violence worker in A&E

## Areas for Consideration

- The SAB recognise training provision, delivery and evaluation is a priority for improvement
- Ensure effective information sharing across all areas, e.g. health records
- Engagement with most partners is effective but would be enhanced by better relationships with the Black Country Partnership Foundation Trust
- Developing legal literacy for legal advisers, frontline staff and managers on adult safeguarding
- A real need to integrate Domestic Abuse (DA) approaches and legislation to safeguarding

- Feedback could be improved to include; service users and carers, referrers, partner organisations, care homes etc; it also needs to be timely
61. The West Midlands Regional ADASS group has created new Policies and Procedures for Adult Social Care and these have been rolled out with appropriate training implemented. This seeks to create consistency of experience for those who use services across the region.
  62. When the Peer Review Team met members of the strategic Safeguarding Team we were impressed. Their knowledge, experience and understanding of safeguarding issues from the operational up through the system to the strategic was obvious and they had a clear passion for their work. They are recognised as a resource of excellence by colleagues with good engagement at every level.
  63. Throughout our conversations with partners we saw a range of evidence to indicate that there is much effective partnership working going on with, for example: the Police, West Midlands Fire Service (WMFS), the local co-terminus Clinical Commissioning Group (CCG) and Wolverhampton Homes (especially in regard to domestic abuse) amongst others.
  64. There has been the development of a dedicated Black Country Safeguarding Vulnerable Adults (SVA) Hub that has raised the profile of adult safeguarding with the Police and other multi-agency partners. This venture is unique to West Midlands Police. It brings expertise and consistency of Police response via an introduced threshold tool. It provides a single point of contact for partners. All referrals are collated to ensure any trends and patterns can be identified, analysed and acted upon. Officers in the hub are trained in domestic abuse and child safeguarding, leading to timely signposting or intervention where required. It could develop into a co-located multi agency safeguarding hub.
  65. The engagement of General Practitioners (GP) is positive and appears to be at the operational and strategic levels with a GP representative on the Safeguarding Adults Board and a high percentage of GPs attending, and trained, in basic adult safeguarding awareness. There is a named safeguarding GP lead in every surgery.
  66. There is multi-agency sign up to information sharing protocols.
  67. From the evidence that we saw there is reflective practice taking place at all levels of practice. This provides a good basis for shared practice learning with staff from Children's Services and other strategic partners. Though this is likely to be further enhanced by capturing and learning more from service user and carer experiences.
  68. There is a process for early planning with colleagues from Children's Services to manage the transition of individual's into the adult social care system through the 14-25 mental health service and in learning disability with relevant adults' staff attending 14-plus reviews.
  69. The Peer Review Team were impressed that Wolverhampton Homes are using a play to raise awareness of "mate" crime with its workers. This appeared to be taking the understanding of adult safeguarding to another level using an innovative approach.

70. An example of a strong commitment to adult safeguarding and good partnership working was evidenced in that the West Midlands Fire Service deliver training to staff in “Making Every Contact Count” to encourage firefighters to be able to identify and report adult safeguarding issues in the community. A good model for other services and partners.
71. The adult social care department has recently used an Appreciative Enquiry approach to exploring safeguarding issues in Asian communities having identified that they are underrepresented in referrals. This is a creative use of the model to elicit useful information and to facilitate better service delivery with a comprehensive action plan.
72. There has been adult safeguarding awareness training for all staff in the Council and for staff from the Department of Work and Pensions to help them identify and report issues in their work.
73. There is an Independent Domestic Violence Adviser based in the local Accident and Emergency Ward who takes domestic violence referrals from the hospital. This ensures a swift and appropriate response.
74. Whilst on-site in Wolverhampton the Peer Review Team heard a great deal about the many issues related to the training function and the need for improvement. It is commendable that the Safeguarding Adults Board recognises its training provision, delivery and evaluation as a priority for improvement. It would appear this is a ripe area for further development.
75. The team recommend that you seek to ensure there is effective information sharing across all partners and areas, for example with health records. Whilst this is a problem faced by many agencies involved in the care of others across the country it is still the case that if done well it can improve the holistic care of those who use services.
76. Engagement by Wolverhampton adults’ service with most partners is effective in the area of adult safeguarding but would be enhanced by closer relationships with the Black Country Partnership Foundation Trust. The creation of the Trust and its relocation was experienced by a number of stakeholders as creating a “distance” that was both real and metaphorical. This was not interpreted as being “unfriendly” rather just too internally focussed. There are a number of areas to be considered for review and possible development, including: how people with mental health (MH) issues in the community can access support when in crisis, (they reported being unable to self-refer or being able to access local MH services); how patients and their carers needs are addressed in the local hospital urgent care services; and how best the relationships can be re-established and developed as soon as possible with other partners.
77. With the introduction of the Care Bill, and also as an opportunity for move from ‘good to great’, we suggest that you seek to develop the legal literacy for legal advisers, frontline staff and managers on adult safeguarding. This should include ensuring that staff are aware of new case law and legal updates and are prepared for future legal changes and opportunities.
78. There would be a benefit to integrate Domestic Abuse (DA) approaches and legislation to safeguarding domestic abuse support services to ensure they are

well embedded locally and nationally. They provide avenues for advice, support and intervention in adult safeguarding scenarios that contain any element of domestic abuse. This ranges from welfare to legal issues. The key is to increase awareness amongst staff, which in turn leads to identification and intervention.

79. The service recognises that feedback from customers' needs to improve. This was clearly identified in the self-assessment received prior to the on-site phase of this work. We concur with this view and suggest that it could be improved to include: service users and carers, referrers, partner organisations and, care homes. We would also like to add that to be useful for all those in the system, not least users and carers; it also needs to be timely. This feedback then needs to be collated to inform policy and practice.
80. As elsewhere in the country, there is work to do to ensure that the Mental Capacity Act and Deprivation of Liberty Safeguards are fully implemented across all partners and in all circumstances.
81. We suggest that consideration of the development of a Practice Governance Framework that embeds practice development, quality assurance, a focus on outcomes and people's experience together with risk management could be helpful in linking and consolidating safeguarding work. We will send an example that may be helpful.

# Performance and resource management

## Strengths

- Performance management information supports and empowers operational staff
- Good supervision and support to learn, effective practitioners group, legal advice and support available
- File audit tool useful, still too early to see if it delivers consistency
- Standard of Social Worker skills in court good
- Multi-agency training work on forced marriages has taken place
- Mental Capacity Act training and follow up support is effective
- SAB Performance report clear and accessible

## Areas for consideration

- The present challenge in ASC is to sustain quality service whilst resources are reducing
- The Public Health function can be further utilised in the SAB approach to adult safeguarding
- Develop Care First to better support operational practice
- Progress the work on Triggers at pace
- Make better use of the skills and expertise of initial contact staff to appropriately signpost safeguarding alerts

82. The performance management information used by operational staff is seen as accurate and useful. It supports them in their work and empowers them to drive improvements with individuals and the service as a whole.

83. Staff believe they have good supervision and are supported to learn, this is evidenced through the effective practitioners group and that access to legal advice and support is readily available in particular for Court of Protection cases.

84. Wolverhampton Adults directorate staff are using a new file audit tool and initial feedback suggests it is useful. However it is still too early to see if it delivers consistency. There is also a need for multi-agency case file auditing to be formalised.

85. Social Workers compile comprehensive statements and are amenable to legal advice. The standard of skills social workers display in court settings is seen to be good.

86. The multi-agency training on forced marriages has taken place and some cases have been taken through the court system.
87. The Mental Capacity Act training and follow up support is seen to be effective.
88. The Safeguarding Adults Board performance report is clear and accessible. It could be strengthened by incorporating wider partner information. A description of the work undertaken by Southampton Safeguarding Adults Board which might be helpful is being sent separately.
89. The Peer Review team felt the need to make the point that like all other adults departments across the country the present challenge in adult social care is to sustain quality services whilst resources are reducing. This is a significant and lasting challenge.
90. The Public Health function can be further utilised in the SAB approach to adult safeguarding by, for instance, providing expertise and support in: health intelligence (evidence-based data and practice); a dedicated adult safeguarding JSNA chapter in the next refresh; contributions to community and service user engagement methodologies; joint commissioning and working on early interventions and prevention models; identifying and developing relevant monitoring and evaluation tools to measure impacts and outcomes.
91. The Care First social care case management system is used by Wolverhampton adult social care staff. It deals with most of the demands upon it. However it needs to be developed to better support operational practice. The outcomes for the individuals do need to be more clearly identified from the electronic record and there is a lot of repetition.
92. We recommend that you progress the work on Triggers at pace. The Triggers work aims to develop a multi-agency early warning system that identifies vulnerable adults at risk before they hit the safeguarding adults risk threshold. This will provide a preventative and co-ordinated approach across agencies to reduce the vulnerability of some adults who have not yet experienced abuse but could be at risk of doing so.
93. The Peer Review Team had the opportunity to meet Wolverhampton's adult care initial contact staff. They are well informed with a high level of skill and expertise. Because of this, they could be better used to appropriately signpost safeguarding alerts. They are aware of, and prepared to initiate, a number of changes for the better working of the contact system for example; referring alerts that are about self-neglect to the assessment and support planning function rather than the safeguarding adults' team to deal with.

# Working together – Safeguarding Adults Board

## Strengths

- Good breadth and seniority of representation
- Chair is well respected and been a catalyst of positive change
- Clear strategic priorities with lead responsibilities allocated
- Board well placed to learn from each other and share best practice
- Good strategic links between: SAB, Community Safeguarding Board, DV Forum
- Work stream of user engagement with HealthWatch Lead is a good way forward

## Areas for consideration

- Focus on prevention and early intervention could be strengthened
  - Give active leadership to the Think Family approach
  - Adopt a strategic approach for disseminating learning from SCR, DHRs, SUIs and Never Events to the frontline
  - Maximise the opportunity for multi-agency training
94. The Safeguarding Adults Board has a good breadth of representation from across the variety of stakeholders in safeguarding and the seniority of representation is appropriate to the importance of the issues involved. This enables the SAB to have influence through those organisations and deliver its priorities.
95. The Independent Chair performs the role for both the Children's and Adult's Boards and is well respected. He has been the catalyst of positive change in the SAB making sure that clear policies and procedures are in place, that representation is appropriate and that the priorities are a shared endeavour.
96. The SAB has clear strategic priorities with lead responsibilities allocated to partners. This allows for priorities to be tracked and owned. The formation of clearly defined subgroups working to the board retains and cascades multi-agency input at middle-management and operational levels. The mechanisms for monitoring progress and delivery against the priorities would benefit from being clearly identified and agreed by all members of the Board.
97. Board members demonstrated an open and supportive, challenging culture and are well placed to learn from each other and share best practice. Having the same Chair for both Children's and Adults safeguarding allows for an element of 'twinning' and learning from the other discipline, both good practice and bad.

98. There are good strategic links between Safeguarding Adults Board the Local Safeguarding Children's Board and the Domestic Violence Forum. This is helpful as it promotes a holistic, whole family approach with a continuum of intervention.
99. The work stream of user engagement with HealthWatch Lead is a good way forward as this provides a valuable resource to the SAB in ensuring service users and carers will, in future, become more directly involved in service improvements whilst also bringing independence to the task.
100. The SAB's focus on prevention and early intervention could be strengthened The DPH is leading on a piece of work that will enable all agencies to include early interventions as part of their 'day job'.
101. Give active leadership to the Think Family approach. This would benefit all family members and bring a holistic approach to prevention and intervention and joint working when adults and children are experiencing abuse.
102. Adopt a strategic approach for disseminating learning from Serious Case Reviews, Domestic Homicide Reviews, Serious Untoward Incidents and Never Events to the frontline. This would require closer joint working across relevant agencies and the issues of data sharing to be suitably resolved.
103. Maximise the opportunity for multi-agency training. This should be Board directed via the relevant subgroup that is attended by representatives from each agency. Opportunities outside the safeguarding adults arena should be exploited, particularly children's safeguarding and domestic abuse forums. Developments would include using the opportunity of this joint training to share good practice and ensure the training itself is well timed so that it does not conflict with other initiatives such as winter pressures. To be effective it will need good marketing and advertising.

## Summary

- Strong Partnership
  - Strong SAB that exhibits collective responsibility for the safeguarding agenda
  - Well worked up action plan with priorities
  - Overall Practice seems good and is improving
  - Well placed to make significant progress in the next twelve months
104. We would like to summarise our findings from this Peer Review of Adult Safeguarding at Wolverhampton city Council. It is generally a positive picture with a key aspect being the strong partnership working arrangements in place based on good personal relationships. Where there are gaps these are identified and there is a genuine desire to improve.
105. The Safeguarding Adults Board is well led. The right partners are around the table and represented at the most appropriate level of seniority. This exhibits collective responsibility for the safeguarding agenda.
106. The SAB has a good understanding of its strengths and weaknesses and a well worked up action plan with clear priorities that are set to address the areas where it can improve.
107. Our judgement from the Case File Audit we completed is that overall frontline practice seems to be good and is improving. It is understood by all those we spoke to that this is the key part of the work of the directorate that seeks to keep adults safe in Wolverhampton.
108. A simple headline from this Peer Review Team is that Wolverhampton Adults and Communities Directorate is well placed through a foundation on strong partnership working to make significant progress in the next twelve months.

## Contact details

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For more information on peer reviews and peer challenges or the work of the Local Government Association please see our website [www.local.gov.uk/peer-challenges](http://www.local.gov.uk/peer-challenges)

## Appendix 1 - LGA Standards for Adult Safeguarding Peer Review

The standards are derived from:

- CQC performance and board reports
- The No Secrets Review
- LGA engagement with safeguarding developments
- Broader local government and NHS developments

The standards are grouped into four main themes which are further divided into sub themes:

Themes	Outcomes for and the experiences of people who use services	Leadership, Strategy and Commissioning	Service Delivery, Effective Practice and Performance and Resource Management	Working together
Elements	<p><b>1 Outcomes</b></p> <p><b>2 People's experiences of safeguarding</b></p> <p>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</p>	<p><b>3 Leadership</b></p> <p><b>4.Strategy and</b></p> <p><b>5. Commissioning</b></p> <p>This theme looks at the overall vision for adult safeguarding, the strategy that is used to achieve that vision and how this is led and commissioned</p>	<p><b>6. Service Delivery and effective practice</b></p> <p><b>7. Performance and resource management</b></p> <p>This theme looks service delivery, the effectiveness of practice and how the performance and resources of the service, including its people, are managed</p>	<p><b>8. Local Safeguarding Board</b></p> <p>This theme looks at the role and performance of the Local Safeguarding Board and how all partners work together to ensure high quality services and outcomes</p>

For the complete, detailed version of the LGA Standards for Adult Safeguarding please go to:

[http://www.local.gov.uk/web/guest/peer-challenges/-/journal\\_content/56/10171/3510407/ARTICLE-TEMPLATE](http://www.local.gov.uk/web/guest/peer-challenges/-/journal_content/56/10171/3510407/ARTICLE-TEMPLATE)