Committee:	Date:
Safeguarding Sub Committee	5 February 2014
Subject: Safeguarding Adults Audit November 2013	**Public**
Report of: Director of Community and Children's Services	**For Information**

Summary

This report, which is for information, provides details of an independent quality assurance review of safeguarding adults arrangements conducted within the Adult Social Care team over a period of three days in November 2013. A draft report was published on 2 December 2013 and a feedback session for City of London staff was held on 9 January 2014. The final report was sent to the Directors in City of London and Hackney on 13 January 2014.

The review was jointly commissioned by both City and Hackney, although specific reviews took place in each authority.

The review was undertaken by an independent freelance consultant who specialises in the fields of safeguarding adults, personalisation, integrated models of service delivery and social care practice.

It was agreed at the outset of the review that both adult safeguarding services would be measured according to the 'outstanding' matrix as defined by the Care Quality Commission (CQC) and the Social Care Institute for Excellence (SCIE).

Three City of London cases were independently chosen by the reviewer and analysed against the reviewer's audit tool (see appendices) together with the guidelines as set out in the London Multi-agency Safeguarding Adult Policy and Procedures 2011.

The Adult Social Care Team Manager was asked to complete an evaluation of each case in advance, giving their view of the quality of the practice, their managerial overview and recording.

The overall headline findings were as follows:

- Of the three cases examined, one was found to be excellent, one good/very good and one satisfactory overall.
- Recording was very good in one case and satisfactory in two cases.
- There was knowledgeable and competent management of safeguarding work.
- There was general adherence to the London Policies and Procedures.
- Quality of protection planning is good.
- Follow-through on protection plans is evident.
- Personalisation/prevention is evident.
- Engagement of other agencies is evident.
- Outcome, closure and review stages are evident.
- There was positive development of the strategic joint City and Hackney Safeguarding Board.

Comment [AM1]: Is this the intended sense here?

- Development is required around publicity, and public awareness of safeguarding is needed through information systems via the website and information literature.

The reviewer made no specific recommendations for the City of London. An improvement plan will be drafted to support implementation of City and Hackney development areas which will be reviewed by the Safeguarding Adults Board Sub Committee and progress will be reported back to this Sub Committee.

Recommendation

Members are asked to note the report.

Main Report

1. Background

1.1 The City and Hackney Safeguarding Adults Board (CHSAB) jointly commissioned an independent safeguarding audit which sought to examine practice in both authorities in relation to these outcomes:

- Adhering to the London Safeguarding Adults process and timescales
- Multi-agency engagement
- Risk assessment and protective action
- Person-centred practice
- Equalities
- Use of the Mental Capacity Act
- Use of advocacy
- The people/agency alleged to have caused the harm
- Management ownership of casework
- Dealing with institutional abuse
- Duties towards children
- Prevention, user choice and control
- Review/closure/longer-term protection.

1.2 In addition to the primary benchmarking function for senior managers, it was envisaged that the review would also increase learning and develop practice.

1.3 Three City of London cases were independently chosen by the reviewer, who spent three days at the Guildhall. All available records on ~~Framework I~~Frameworki were accessed.

1.4 Cases chosen were analysed against the reviewer's audit tool (see appendices) together with the guidelines as set out in the London Multi-agency Safeguarding Adult Policy and Procedures 2011.

1.5 The Adult Social Care Team Manager was asked to complete an evaluation of each case in advance, giving their view of the quality of the practice, their managerial overview and recording.

1.6 After the cases had been audited, two follow-up meetings were held with front-line staff, qualified social workers and Safeguarding Adults Managers, which focused on the views of staff around practice and legislative knowledge and understanding, together with a safeguarding quiz.

1.7 Minutes of meetings and related documents pertaining to the City and Hackney Adult Safeguarding Board were read and public information on safeguarding awareness was examined via both authorities' websites and public literature.

2. Findings from the review

The following areas of strength were identified.

2.1 The review findings identified good practice and development areas across City and Hackney collectively; however, the reviewer noted that there were no recommendations specific to the City of London and that practice was good in the City of London.

2.2 The review found that there is good strategic governance provided by the Joint Safeguarding Board, which was developing well towards the new roles and responsibilities which will place it on a statutory footing via the Care Bill in 2015.

2.3 The City of London website and general safeguarding literature were judged to be adequate but require development to ensure that there is increased community awareness and public and self-referral.

2.4 City of London has sound, unified and fit-for-purpose recording systems with the implementation of ~~Framework i~~Frameworki.

2.5 City of London partners are 'well educated' in safeguarding adults matters.

2.6 Casework is timely and person centred.

2.7 There is sound consideration of mental capacity and best interests in relation to safeguarding.

2.8 The carer's needs should always be addressed and fully documented.

2.9 It was evident that operational staff have sound practice skills but are weaker in relation to theoretical knowledge.

2.10 Recording safeguarding processes was felt to range from good to satisfactory, with areas of improvement required in some circumstances.

2.11 The report highlighted knowledgeable and competent team management and supervision of safeguarding casework, together with good recorded management advice and overview.

2.12 The team adheres well to the London protocols on timescales and processes.

Areas for further development included the following:.

2.13 A system of ongoing case audit should be directed by the strategic board, to be reported back to the board, using a suggested line management 'swapping cases' peer system.

2.14 All case records should have clear risk assessments and analysis, and inform the protection plan directly.

2.15 Risk assessments and protection plans should be agreed with the adult at risk wherever possible.

2.16 Carers need to be fully assessed and documented during the safeguarding process, especially if they are alleged to have caused harm.

2.17 The adult at risk's views and desired outcomes should be ascertained and recorded wherever possible.

2.18 In relation to agencies or non-family members alleged to have caused harm, it should be clearly documented that all appropriate steps have been taken according to CQC and London Safeguarding Adults policy and procedures.

Comment [AM2]: Pl spell out - 'safeguarding adults'?

2.19 Advocates should be utilised whenever possible in relation to safeguarding.

2.20 The report highlighted that the CHSAB should consider how best to involve service users in strategic planning and service improvement.

3. Next steps

3.1 A City of London improvement plan will be formulated to ensure that the audit remains a dynamic tool with which to measure change at a local level in order to ensure that safeguarding casework, recording quality and systems, front-line staff and management knowledge can be measured and monitored.

3.2 The City of London Adult Safeguarding Sub Committee, which reports to the CHSAB, together with oversight from the Community and Children's Services Safeguarding Sub Committee, will ensure

that there is a clear accountability framework for evaluating the improvement plan.

3.3 A current piece of work is under way across Children's and Adult Services to specifically raise awareness of adult and child safeguarding through a joint poster and leaflet campaign across the City for residents and professionals.

3.4 Work will also need to be carried out to ensure that the Adult Social Care website complies with the recommendations set out within the review.

3.5 Adult Social Care would look forward to working with Hackney partners as part of an inter-borough safeguarding 'case swap' audit, akin to that which has been recommended by the audit, as a process to be mapped via the Joint Strategic Board as part of an ongoing case audit system.

Corporate and strategic implications

The work of Children's and Adult Services and our partners supports our communities and makes the City safer.

Comment [AM3]: Presumably (since this is about adult services)?

Building on inspection findings helps the City to continue to provide modern, efficient and high-quality local services.

Conclusion

This review has formed part of the ongoing professionalisation of adult social care in an arena of inspection and the need to strive for 'outstanding'. This audit has given the service a benchmark from which to build on its safeguarding practice to ensure that we are offering protection to adults at risk in a person-centred and timely manner.

Appendices

- Final report
- Audit tool.

Marion Willicome-Lang
Service Manager,
Adult Social Care

T:~~0207~~: 0207 332 1216

E: marion.willicomelang@cityoflondon.gov.uk

Comment [AM4]: Give external phone number?