Safeguarding adults
Learning from peer challenges

Contents

Introduction and context

About this report

This report sets out the key themes and issues arising from peer challenges in the field of safeguarding adults. The term 'peer challenges' is used throughout, although those in the earlier phase of work were known as 'peer reviews'.

All documents referred to in this report are available on the Adult Safeguarding Community of Practice on the Knowledge Hub: https://knowledgehub.local.gov.uk/ group/adultsafeguardingcommunityofpractice

The Local Government Association (LGA) has run a Safeguarding Adults Programme for three years now, in recognition of the importance of this field of work for councils and their partners.

The programme has been closely co-ordinated with the work of the Association of Directors of Adults Social Services (ADASS) and has engaged with a number of other key partners, including the NHS Confederation (NHSConfed), the Social Care Institute for Excellence (SCIE), The College of Social Work (TCSW), national government, Research in Practice for Adults (RiPfA) and others.

To date there have been twelve peer challenges specifically on Safeguarding Adults run through LGA. The first four of these were pilots to test the standards and methodology. These were evaluated and a report collating the key findings was written by Richard Humphries: 'Adult Safeguarding: Early Messages from Peer Reviews' and published in August 2010.

This report builds on that and summarises the principal conclusions from that and subsequent challenges. It sets out key learning points to assist the improvement of safeguarding policy and practice. Despite the difficulties of reaching generalised conclusions from just twelve challenges, there are some common as well as differing issues arising from them that may inform learning and development.

Safeguarding – everybody's business

The context and framework for what was originally described as adult protection has changed substantially since the publication of the statutory guidance, 'No Secrets', in 2000. Adult safeguarding is the responsibility of all agencies and cannot exist in isolation. It must be effectively linked to other initiatives, as part of a network of measures aimed at enabling all citizens to live lives that are free from violence, harassment, humiliation and degradation.

Safeguarding adults is a core function for councils, the NHS and the police, going to the heart of their responsibilities for public service, and cannot be viewed as a social care responsibility alone. It is also a key

function for a wide range of other agencies and groups.

Adult safeguarding is not just about reactive policies and procedures to protect people needing care and support who have experienced abuse or neglect but a core purpose of local strategies and operational practice. We drew up the following diagram at the very first safeguarding peer challenge and think it remains relevant.

Policy and practice are developing, as is the legislative framework. There have been a number of important judgements in case law and the draft Care and Support Bill includes both a framework that incorporates safety and wellbeing as well as statutory safeguarding boards and other dimensions.

Safeguarding is everybody's business

People look out for each other in our communities

Community safety and other services include 'vulnerable people

The council, with NHS boards and the Police, lead this

The safeguarding board develops and co-ordinates strategy and holds partners to account

Care and justice service standards safeguard people's dignity and rights and enable them to manage risks and benefits

Safeguarding is personalised. There are effective specialist services to safeguard 'vulnerable' people, work with abuse and support other staff

There is support and empowerment for people experiencing abuse

About the peer challenges

Peer challenges

Peer challenges in local government originated in the Improvement and Development Agency as peer reviews and, as external inspection has reduced, have become a key building block for sector led improvement. The LGA offers both adult safeguarding and adult social care peer challenges.

Safeguarding is one of the areas that councils and their partners have struggled with most, partly because it is a developing field. It has a key impact on people's lives as well as implications for organisational reputation and the potential for legal challenge if it is not done properly.

As well as providing feedback to the council concerned and its partners, safeguarding adults peer challenges have proved rich learning for those on the peer team. Each challenge has also sought to elicit areas of good practice, which, with the council's permission, have been posted on the Adult Safeguarding Community of Practice, now on the Knowledge Hub.

The peer challenges have also informed the improvement work of the Safeguarding Adults programme. These are highlighted in the respective sections of the report.

A peer challenge is designed to help an authority assess its current achievements and its capacity to change. The peer challenge is not an inspection. Peer challenges do not produce a rating at conclusion and there is no 'moderation' process. Workshops and reports are structured and phrased with the intent of being most helpful in enabling the council and its partners to improve and develop safeguarding strategy, practice and outcomes.

Peer challenge offers a supportive approach to an authority that voluntarily opens itself up to the scrutiny of 'critical friends'. It aims to help a council identify its current strengths, as much as what it needs to improve.

Peer challenges are not a substitute for the ongoing need for the council and its partners to satisfy themselves that their safeguarding arrangements are effective. They are intended as an opportunity for partnerships to open their practice to the challenge and supportive discussion from peers and experts in the field.

Final reports belong to the council concerned. Some choose to share, some not, though the LGA encourages councils to make the findings of the challenges public.

Safeguarding standards

Adult safeguarding peer challenges are based on the safeguarding standards. These were developed by LGA (in its former Improvement and Development Agency originally) and have been endorsed by ADASS, NHSConfed and SCIE. These standards have also been used in other contexts, such as self-assessment and local improvement work. The standards were piloted and evaluated and set out an ideal partnership for delivery:

everyone has said that they have taken examples of good practice back to their own organisation. Thus, peer challenges are processes of mutual learning.

Wherever the safeguarding programme has been involved early enough we have tried to put together not just a peer team, but experts in their fields. This is on the basis that safeguarding is a complex area of developing practice and as councils are paying for their challenge we should offer the most experienced and knowledgeable

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	1. Outcomes 2. People's experience of safeguarding	3. Leadership 4. Strategy 5. Commissioning	6. Service delivery and effective practice 7. Performance and resource management	8. Local Safeguarding Board

Peer teams

Peer teams have been mixed, but have always included a review leader – a Director of Adult Social Services – (in the early challenges this was on two occasions an associate), a senior manager specialising in safeguarding, and a partner peer, either from the NHS or police. Councillors have been involved in all bar two. All challenges have had a challenge manager from LGA; in two this was the Adult Safeguarding lead.

Every peer team has found the process to be exhausting but incredibly rewarding and

team we can. To that end, we have, for instance, engaged the ADASS co-lead for the Safeguarding Policy Network on three occasions. The LGA Safeguarding Programme Lead has been involved in each challenge for at least 24 hours, and has read and commented on each of the sets of preparatory reading and final reports. The purpose of this was to both provide some continuity and to seek examples of good practice that have been (with the council's permission) shared on the Adult Safeguarding Community of Practice on the Knowledge Hub. Where themes are

emerging from the peer challenges, these have also informed the development work of the Safeguarding Programme in LGA.

During 2012/13, the LGA worked with The College of Social Work, who have recruited and accredited 7 expert practitioner peers for safeguarding adults who will join and contribute to peer teams in the future.

The councils that have had peer challenges

- Northamptonshire
- Coventry
- Gateshead
- Derby
- Hartlepool

These councils were pilots

- Cheshire West and Chester
- Newcastle
- Central Bedfordshire
- London Borough of Kingston
- Wirral (this was a safeguarding peer challenge to complement the adult social care peer challenge)
- West Sussex
- London Borough of Barnet (this was part of a London pilot of 'light touch' peer challenges)

The challenges have been commissioned by either the Director of Adult Social Services (DASS) or by the safeguarding board.

Typical peer challenge process

The form and content of peer reviews has varied, depending on the areas that the council and their partners have requested that the review focus on. Typically, they have involved:

- an initial meeting between the LGA Challenge Manager and the DASS and/ or Safeguarding Board Chair to explore the focus, length of on-site time, discuss the preparation, take initial views as to the type of peer team that will be involved and whether any follow up will be required. This will impact on the cost.

- preparation by the council and/or safeguarding board of a self assessment and supporting documentation and setting up the on site timetable

- selection of the peer team by LGA for approval by the council

- pre- reading of the documentation by the peer team and the

- pre-meeting of the peer team to agree the formulation of hypotheses and key questions to follow up on-site and who will do what

- on site – interviews, focus groups and file audits. Feedback to the peered council/ safeguarding board

- either an action planning workshop on site, or a report after the on-site work

Peer challenges have lasted between 3 and 5 days on site. Additional activities have included workshops for practitioners on key issues and national developments, observation of practice forums and telephone discussions with people who have used services.

The more recent peer challenges have focussed to a much greater extent on front line practice, on the basis that the best strategies, policies and procedures can sit unused on the shelf, and that they are only as good as what front line staff do. This involves a mix of file audit, engagement with, particularly, social workers, observing training, assessment, team meetings, call centre activity and a range of other areas. Practice observation greatly enriches the process.

It has happened on a number of occasions that having had a peer challenge, staff go on to be peer reviewers themselves, or have engaged with the LGA programme in wider development work. This could be either because the area concerned was one in which they had strengths, or because it was an area they were struggling with and they agreed to, for instance, road test materials that were intended to improve practice.

General findings

It is obvious that policy and practice is developing in the field of safeguarding. Everyone that we have seen has some aspects of excellence in their safeguarding practice and some areas they are struggling with. Some of those areas differ from council to council area. Some have emerged as themes for general development and these appear throughout the rest of this report. These themes have also been picked up as key messages for the sector, by sector partners, both based on the earlier report on peer reviews and subsequent engagement. They are included in a range of guides and advice notes, including guides for councilors, directors, practitioners and managers produced by the LGA and ADASS.

The council areas are self-selecting. Three of the challenges were part of councils' seeking to evidence that they had improved to the extent that they had moved out of their final Care Quality Commission (CQC) rating of 'adequate' for adult social care, some of which were 'inadequate' for safeguarding. One council more recently has been identified as having particular challenges. But it is evident that as well as there being areas of excellence, safeguarding is a challenge for all of the partners involved, particularly for social care, health care and the police and criminal justice system.

There has been huge investment in developing boards, in structure and process since No Secrets was published.

In all of the peer challenges, the commitment of staff to safeguarding is impressive, possibly all the more so given the turbulence that has arisen from councils needing to make extensive savings in many areas and in the changes in the NHS and the new Police and Crime Commissioners. There are some very knowledgeable professionals in all of the council areas.

Outcomes for, and people's experiences of safeguarding

The extent to which councils engage with people who have experienced safeguarding varies. In some peer challenges the team has been able to speak with many people in such circumstances and there is documented evidence of their views. In others, the team has seen very little documentation and hasn't been able to meet with anyone who had been safeguarded. Involvement of people in safeguarding processes is patchy, though there are some good examples at an individual practice level. Most policies and procedures state that people should be involved, but few build in that they should be in control of the process. Some merely state that the person who is being safeguarded should be 'kept informed' of what professionals are doing.

Many people appreciate the support they have had, particularly from individual social workers. There are, however, strong messages that people feel driven (sometimes out of control) through a process.

Peer challenges highlight that people tend not to be asked the outcomes they want. Often they want more than one outcome, which are sometimes not easy to reconcile. People generally want to feel safe but also to maintain relationships. For some people the only human contact they have is with the person/people who is/are harming or abusing them.

People told us that they, in general, want access to justice or some form of resolution. Whilst there appears to be a big issue in ensuring that older and disabled people have access to criminal justice (prosecutions and convictions as a result of safeguarding activity remain relatively rare), justice could take many forms: criminal, civil, social, interpersonal or restorative. It could also take the form of knowing that some form of disciplinary action has been taken.

It is probably fair to say that the emphasis of safeguarding activity so far has been on investigation and conclusions rather than on improving outcomes. This has been strongly affected by the fact that national reporting has focused on this. Although 'outcomes' are recorded, they are in reality outputs rather than outcomes ('increased monitoring' or 'increased services' for example).

As a result of this, LGA therefore developed 'Making Safeguarding Personal' with ADASS, and some key academics and, during 2012/13, has been working with a small number of councils to test-bed this. A number have developed an outcomes focus, a number invested in ascertaining the experiences of people being safeguarded on a retrospective basis, and two have invested in social work development and the use of family group conferences, network meetings, restorative approaches and tools for working with people who are 'complex cases'. The Department of Health has provided some funding for the continuation of this in 2013/14. This will be important both in terms of outcomes for individuals and, on an aggregated basis, as one of the factors

by which Safeguarding Adults Boards can assess their effectiveness.

LGA and ADASS have also engaged with the NHS Information Centre to seek to review the data collection and they hope to pilot outcomes indicators during 2013/14.

Practice to consider

One of the peered councils had introduced asking people being safeguarded, their carers and the person who had allegedly caused the harm for feedback on their experience of safeguarding at the strategy meeting stage. This was shared on the community of practice. Another was undertaking retrospective review interviews to ascertain the quality of people' experiences.

We recommend that people are asked at the beginning, during the information gathering stage, what outcomes they want. This starts the dialogue about how the outcomes might be realised. We also recommend that a discussion is held at the end of the process about whether the outcomes were realised.

Leadership, strategy and commissioning

Leadership and strategy

Most councils were very committed to safeguarding adults and awareness is increasing, partly in response to high profile cases such as Steven Hoskin, Fiona Pilkington and Winterbourne View.

However, there is a mixed awareness amongst councillors as a whole. The Overview and Scrutiny Committees in about half of the peered councils had scrutinised safeguarding.

There is a very mixed picture in relation to the extent to which safeguarding adults is embedded in strategy, in relation to adult social care, the council as a whole and in the strategies of partners. In some councils the safeguarding of both children and adults is evident in their corporate strategy. Others do not mention safeguarding adults. Some Community Safety Partnerships highlight the needs of vulnerable people though few have embedded it. Of the more recent peer challenges, we saw one Local Account that highlighted safeguarding. We also saw one very clear Joint Strategic Needs Assessment that had explicitly looked at Safeguarding Adults.

It is rare for adult social care to have fully aligned safeguarding and personalisation. This appears challenging in both policy and practice terms. Whilst many have developed risk assessment as part of personalisation, and Making Safeguarding Personal is

mentioned above, few see both with one integral strand: supporting people to weigh up the risks and benefits of different choices.

Leadership from partners is very mixed. The NHS has increasingly engaged with safeguarding within its own organisations and with partners, particularly following safeguarding being a requirement of registration with the CQC, and part of the establishment of Clinical Commissioning Groups (CCGs). But concerns have been raised, particularly over the last year, about a leakage of leadership and expertise through the NHS re-organisation. Guidance from the Department of Health (DH) certainly helped, but there remains inconsistency in relation to how safeguarding is dealt with across the NHS and concerns to ensure that the new CCGs engage with their responsibilities. The new Accountability and Assurance Framework offers increased clarity to support this.

Police engagement is increasing. Fiona Pilkington and her daughter's deaths together with a much greater, more recent focus on hate crime were noticeably significant.

Commissioning

Much safeguarding work results from a failure to have sufficient quality standards in place in health, care and, to a certain extent, police responses that safeguard people's dignity and rights. Evolving practice

has created a stronger awareness of the powerful protective effects of commissioning. Of the councils and their partners we saw, all bar one had links between contracts management and safeguarding staff with clear processes for addressing service quality issues that had deteriorated to the extent that safeguarding had been invoked. About a third of them were strong.

Practice to consider

One council, with Primary Care Trust (PCT) input and support, has introduced a robust 'provider concerns' process where safeguarding and contracts management staff meet with the provider and together agree necessary actions to improve the situation. Another follows a similar process and quality premiums are dependent upon concerns being addressed.

The interfaces between commissioning, regulation and inspection are, generally, by no means clear. The engagement with and by the health and social care regulator, CQC (and its predecessor, CSCI), has varied over time and from place to place. Its policies on safeguarding, and practice, (in terms of the number of inspections completed and action taken, for example) have also changed over time. In some council areas that we saw the contracts management and safeguarding functions have moved into ground that the regulator previously occupied. Increasingly councils, sometimes with the NHS, are developing quasi inspection/ quality units. About a year ago a protocol was introduced by CQC which has helped to some extent,

but there remains more to be done in terms of how these functions work together strategically and operationally.

The inter-relationship between councils, providers, NHS commissioning and their providers and the regulator in the context of safeguarding has been equally variable. Some providers have reported that there are differing expectations of what to report. In some areas CQC require reporting of a high level of concerns, some of which relate to the need to address service quality rather than safeguarding per se. This can create large numbers of referrals to safeguarding. Other providers report that it is council safeguarding teams that are more exacting. Some providers report that the expectations of the council were clear and the support given to address issues was positive. Others felt that the council was 'heavy handed' or slow, and could have left them to address their own staffing and quality issues.

In another context, the joint Inspectorates of Constabulary, the Crown Prosecution Service and Probation have recently focused on the reporting of and response to disability hate crime, which again should give focus for the future.

Service delivery, including performance and resource management

Safeguarding activity

In all councils involved in peer challenges, safeguarding activity has been increasing year on year. All have engaged in awareness raising amongst professionals and the public and all include information on what to do if people are concerned.

Practice to consider

A number of councils have undertaken activities with a range of people, such as older people or people with learning disabilities, to support them to 'say no to abuse' and to keep themselves safe. One council has a forum of people who have experienced safeguarding who asked for video information in BSL which is now on their website. Others have had events such as safeguarding awareness weeks.

Referral patterns vary. These are indicators of the extent of awareness of abuse and neglect and responding to it as well as awareness of the threshold at which safeguarding activity operates in that area. Councils tend to either have much more safeguarding activity centred in institutions such as care homes and hospitals or much more activity in relation to people in domestic circumstances. When asked, the response is usually that this is historical, for example

in having key quality issues to address in relation to care homes. All had experienced some form of major safeguarding issue to address in relation to institutional abuse.

Two councils had experienced a very high level of referrals relating to pressure sores. In both they had had to instigate separate initiatives to address this, one in tandem with the PCT. In one council this was as a result of a death linked to neglect and subsequent heightened awareness. In another it related to a blanket requirement by the NHS to refer to safeguarding. This does raise issues as to both the extent of this as a care quality issue and how it is best responded to.

In two areas there were very few referrals from acute hospitals. In many there were few from primary care. This is surprising, as it might be expected that primary care and Accident and Emergency staff might be the first professionals having contact with a fair proportion of people who have experienced abuse or neglect. The extent of referrals from Mental Health Trusts and the Police varied – from many to very few.

Councils have taken very different approaches to addressing safeguarding: some have a specialist team, some work on the principle that all care management and social work staff should engage with safeguarding. If the former, then it is probably true to say that there is generally greater consistency in the quality of the response, but at the expense of introducing different

staff into people's lives. If the latter, then there appears to be greater engagement and ownership of safeguarding, but sometimes more challenges by way of consistency of quality. A couple of safeguarding teams included a nurse lead seconded from the PCT to address health care issues.
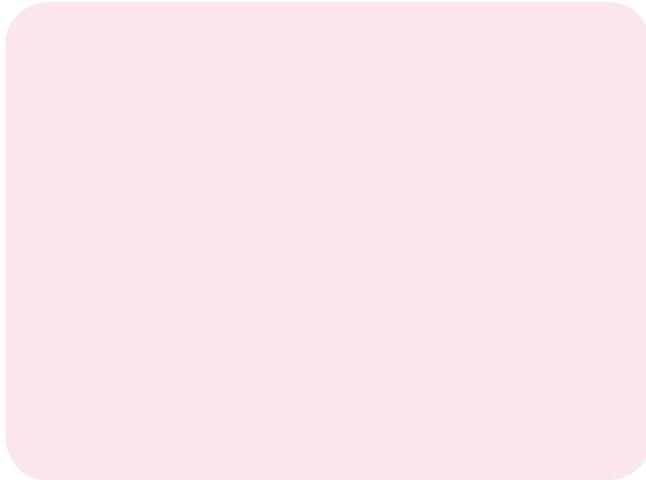
The safeguarding co-ordinator or manager is a critical post. These staff have been respected as experts in the field by both council and partner staff.

Safeguarding responses

All councils and their partners have developed processes and structures for responding to safeguarding concerns. Many councils and their partners have spent a great deal of time working through, for instance, what is an alert and what a referral, when safeguarding starts and what the 'thresholds' are for safeguarding.

The peer challenges have highlighted that safeguarding, whether done by a specialist team or social workers and others in other teams, can become the route for a wide range of concerns. This varies from council area to council area. In one council safeguarding was picking up many concerns

that might have been better dealt with by contracts management and regulation. In another, a proportion of safeguarding referrals at least were emerging where there was a backlog of care and health reviews. In a couple, there were few social workers in the community care teams and care and support processes were more administrative than interpersonal and at least some people with complex relationship issues were being referred for safeguarding. Many others were working with older and disabled people who were experiencing domestic violence and abuse, whilst their domestic violence services were preponderantly working with younger, able-bodied people (in response to this, LGA, with ADASS, produced 'Safeguarding adults and domestic abuse: a guide for practitioners and managers' during 2012/13).

Practice to consider

We saw some excellent examples of links between community safety, commissioning and wider services. It appears to be a common challenge for safeguarding boards to ensure that the 'right bits of the system' are doing the right things and that the interfaces are working well in order to both proactively safeguard people and to ensure that those doing safeguarding work are not overwhelmed.

There were few council partnerships that were confident enough to see safeguarding as intrinsic to wider social care, health care and police responses.

For many others, safeguarding is a very different approach to personalisation, which, once triggered, sets in train a process of a strategy meeting, investigation, and a case conference. A significant proportion of people told us that they feel that safeguarding is done to, rather than with, them and that they feel driven through a process. Safeguarding and personalisation are two sides of the same coin but to make both real, requires good judgement and social work with some people. There is therefore considerable development work necessary.

Working within a legal framework

The legal framework for safeguarding is complex and wider than the statutory guidance set out in 'No Secrets'. It is being tested in case law.

Essentially safeguarding involves balancing the different articles of the Human Rights Act. However, finding the right balance in relation to the right to life and to a life that is free from detention, cruelty or inhuman degrading treatment, the right to privacy, autonomy and a family life can be difficult and the perception of the right balance may vary from

person to person. What is a place of safety for one person may be detention for another, particularly if they are mentally, intellectually or physically disabled. Circumstances where a family member steals money may be unbearable for one person but better than never seeing that family member to another. Involving the person concerned is therefore essential.

Peer challenges indicate that staff rarely explicitly think in those terms but that when discussion is framed in that context they rapidly see that as the core of social work. Some, if not many, policies and procedures do not support that professional practice as fully as they might.

Adult safeguarding is a developing field and with new legislation going through parliament, and associated guidance anticipated, it may be that it moves away from linear processes that were originally based in and imitate those of child protection to more appropriate approaches.

terms 'rape' or 'sexual assault', not 'sexual abuse', and 'theft' or 'fraud' not 'financial abuse'. They felt that the use of such terminology contributed to a lack of equal access to justice.

Social work responses

Given the legal framework, the development of social work skills and practice is necessary to make safeguarding personal for people in complex personal relationships. Making safeguarding personal is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes that were realised at the end. It is about understanding the range of legal and social work interventions that may be used, depending on people's wishes and circumstances. There are some challenges about how many social workers have the skills, confidence (and feel they have the permission) to use a range of methods to work with and resolve those circumstances.

Practice to consider

Some of the peered councils (particularly more recently) are starting to look at a range of responses to assist people to better resolve their circumstances. These include peer support, circles of support, interventions to empower people with difficult decision making, family group conferences and network meetings.

They have also highlighted that there are few prosecutions and convictions as a result of safeguarding activity. Disabled people have told us clearly that where crimes have been (or are alleged to have been) committed, they should be described in the same terminology as would be used with anyone else – for instance, we should be using the

However, these are in very early stages and rare to find. More frequently, the outputs described are increased monitoring, or increased or different services.

Care management, good contracts management and quality assurance in safeguarding will go a long way to addressing safeguarding, but without social work skills there will remain people who have increased services or monitoring rather than improved circumstances and outcomes

Information sharing practice

Nearly all of the councils and their partners had some form of information sharing protocols in place. Information sharing practice varied, however, both within and between council areas. Different people, and different professional groups have different understandings of when the exchange of information is required or permitted. This is clearly a national issue of some long standing.

Performance management

As with other areas of safeguarding, performance management is a developing field. National data requirements have focused on process and outputs, not on outcomes. Generally, we know how much activity there is and where harm and abuse takes place but we don't know how effective individual practice is, or boards are, from current arrangements. A couple of council areas were struggling with getting meaningful data, particularly if they were switching their own systems. Within the specialist safeguarding response, all councils have some form of file audit process, some done internally, some by someone independent.

LGA and ADASS, in response to this, undertook work on Safeguarding Standards and Performance.

Training and development

All councils have invested heavily in training and development across the board – for council staff, provider staff and partners. This is, in the majority of instances, funded solely by the council. To date it has focused on two main areas: general awareness raising, and how to contact specialists if concerns are apparent and in the implementation of policies and procedures.

Practice to consider

A number of councils are using competency frameworks and report that they are helpful. It is apparent that councils now need to invest in the knowledge and skills development for specialist safeguarding social workers so that they are able to appropriately ask, in each safeguarding instance, "what are the appropriate legal and social work responses I should be considering as options to discuss with this person?"

It is also apparent that partners and providers have been happy for the council to train their staff: we see training offered to a wide range of people, from care staff to hospital consultants. There is certainly a need for partners to address their own staff training issues, or to at least resource this training.

Practice governance

Practice to consider

In the council that we think is probably the most advanced of those we engaged with, they have put in place a practice governance framework. This links training, supervision, file audit and feedback, practice forums and a risk forum. We hope that they will share this shortly.

Working together

Safeguarding adults boards

All twelve areas have well-established Boards in place, with a significant proportion having an independent chair. All of the peer challenges had been agreed with the Safeguarding Board, and in all areas we were able to meet with Board members and most often observed at least a part of a Board meeting. Whilst, clearly, the twelve council areas were self - selecting, they had all, through the peer challenge process, opened themselves up to external challenge.

Practice to consider

All have policies and procedures in place. Given what we have learnt that is set out in the sections on outcomes for people and on service delivery earlier in this report, all would benefit from review to more explicitly set out outcomes, engagement, requisite legal considerations and a range of responses.

Membership and ownership

There is mixed ownership by partners, both on Boards and actually in the safeguarding practice in the respective partner organisations. The strength of partnerships also varies bilaterally – for instance in some areas the partnership between the council and the PCT has been strongest, in others between the council and the police and so on.

NHS engagement and expertise grew exponentially over the first two years of the challenges. Concerns in the last year have been about potential loss of that expertise through re-organisation and to engage with, and build up expertise, in CCGs.

Equally, the engagement of police has grown, though the impact that new Police and Crime Commissioners will have is yet to be ascertained.

CQC were seen as Board members in the early challenges and their presence then diminished. In the most recent challenges, we heard that they comply with their protocol to attend annually. The picture in relation to regular meetings to discuss quality and safeguarding concerns was mixed.

Practice to consider

We saw two Boards with very effective LINKS members who both raised concerns with the Board and responded with Enter and View visits. This is something that Boards may wish to take forward with HealthWatch.

Those Boards that had engaged a wider partnership have undertaken some very interesting and useful pieces of work, for instance delivering 'Adult Abuse Awareness' weeks, working with Trading Standards on rogue traders and/or financial abuse, work with the fire service through the home safety route and work with local shops to provide 'Safe Places' for people with learning disabilities to go if they don't feel safe. Wider engagement and awareness has also delivered benefits, through, for instance, the Ambulance Service becoming aware of and referring a nursing home where every resident had a 'Do Not Attempt to Resuscitate' note.

Boards varied in whether the lead councillor was a member. Some take the view that membership demonstrates ownership. Others argue that they cannot hold officers to account if they are party to the decisions of the Board. We didn't see that councillor membership of Trusts or other organisations had particularly influenced the safeguarding practice of that organisation.

Practice to consider

Some Boards have very strong governance arrangements – for instance Board members sign up to the Board and to the engagement of their respective organisation.

In general, the people we met who attend Boards were knowledgeable, committed, enthusiastic and work really hard in the safeguarding field. What is often more questionable is the extent to which they are really able to pull levers within their own organisation to ensure that the whole of that

organisation fully exercises its safeguarding responsibilities. It is rare for the annual reports/ business plans of the Board to be considered in detail by the respective Boards/ Authorities of all the partners.

It is also rare for partners to resource the activity of the Board other than through the attendance of their representative – and it is not unusual, therefore, for the council to be perceived to carry the partners through the Safeguarding Manager/Co-ordinator and the activity that ensues.

Hearing the voice of people needing safeguarding

All of the Boards were, to some degree, challenged to hear the voice of people who had experienced the safeguarding process. One Board had someone who had experienced safeguarding as a Board member. Many had advocacy, carers' organisations representatives or disabled or older people's organisations on the Board.

Practice to consider

Two of the most recent peered councils were systematically interviewing people who had experienced safeguarding when the process had finished in order to ascertain the quality of their experience. One was also interviewing carers and people who were alleged to have caused the abuse or neglect. These views were considered by the Boards.

Measuring effectiveness

Two Boards were struggling to get meaningful data and one had data but wasn't sufficiently analysing what it had and acting on it. Although the Abuse of Vulnerable Adults Return has its limitations, it does enable Boards to look at where referrals are coming from, and act if there is over, or under representation. However, it is probably fair to say that in the absence of outcomes data, all boards were struggling to demonstrate the difference that they are making for their populations. LGA and ADASS have produced a report on Safeguarding Standards and Performance, which may help. The LGA Safeguarding Adults Programme has also provided some support to the Independent Chairs Network and they have been working on producing a quality assurance document, which will be available shortly.

It is not an easy process for safeguarding partners to both work together and to challenge their own and each others' practice.

Practice for consideration

What we thought was probably the most effective Board was where partners did say that they had had to produce reports from their organisation and that they felt challenged and held to account. That Board had gone through some very detailed work with each organisation and had a very knowledgeable and experienced chair.

Practice to consider

There is scope for all of the Boards that we saw, and the respective partner organisations in other contexts, to be much more systematic about ensuring that the respective parts of the system do what is needed in order to be effective. In doing that, Board members' really do have to be able to influence how their organisation works in order to proactively safeguard people as well as to respond to safeguarding concerns.

Providers, for instance, are responsible for providing care of sufficient quality to safeguard people's dignity and rights. Commissioners and regulators support and safeguard that. The police respond to people experiencing hate and other crimes and need to ensure that people needing care and support get access to that response.

Sharing information at a Board level

Whilst all the Boards we saw had some form of Information Sharing Protocol in place, information sharing practice remains variable and in some instances problematical, within and between organisations. Pooling data and intelligence in such a way as to establish what are serious concerns is also a challenge. There is much information that board members collectively have (through regulation, whistleblowing, safeguarding alerts and referrals, complaints, reviews, HealthWatch, vulnerable people in crime hotspot mapping, contract monitoring

amongst others). Most look at some aspects of this, but none we saw had found a way of fully integrating it. LGA commissioned a piece of work to develop this, which will be shortly available.

Learning from individual cases

A number of the Boards had instigated Serious Case Reviews and considered reviews from elsewhere to some extent. Most had developed strong mechanisms to decide to undertake such a review, given the expense involved. One had piloted a review based on the Social Care Institute for Excellence methodology, though that had equally been resource intensive. All identified the need to find ways to learn more effectively.

Making the links with other partnerships

Links to Health and Social Care Boards (and more recently to Health and Wellbeing Boards), Local Children's Safeguarding Boards and Community Safety Partnerships, varies in policy and practice. All are necessary, but we didn't see any particular model that appeared to be either stronger or weaker than others. It's possible that where the links were closer with Health related Boards there did seem to be more of an emphasis on health and social care in the SAB. Where the links were stronger with Community Safety there was, equally, possibly more emphasis on domestic abuse, hate crime and anti-social behaviour.

Key messages

There are some key messages from these twelve peer challenges that will be relevant both for future challenges and for wider sector led improvement and development. These can be summarised as:

In every peer challenge we have found some excellent practice as well as some areas in which partners are struggling.

There have been considerable developments and learning over the period of implementation of the No Secrets guidance. There has been much investment in structure, policies and procedures, training and development. From having no guidance, there is now much. All councils and their partners now have safeguarding adults boards and mechanisms to respond to concerns about abuse.

The combination of complex organisational change in the NHS, the election of Police and Crime Commissioners, budget reductions in local government and the impact of welfare reform will make effective safeguarding even more essential yet all of these pressures could threaten the progress that has been made. It is therefore vital for councils and partners to stay focused on safeguarding as a core role.

There is a challenge to engage now with new bodies such as HealthWatch, CCGs and with Police and Crime Commissioners.

The circumstances at Winterbourne View and Mid-Staffordshire Hospitals, and Ash Court Home for Older People have highlighted growing concerns about the quality of care and the importance of police responses (as do individual cases such as Fiona Pilkington). They all raise fundamental issues about culture and values in promoting a safe environment.

There is work to do for all partners to ensure that services are of sufficient quality to safeguard people's dignity and rights, that people needing care and support are included in the wider safeguarding activity of partners and that providers, commissioners and regulators play their appropriate parts. There is also work to be done to clarify the relationships and functions of commissioning and contracts management, regulation and safeguarding.

There is much to do, to ensure that safeguarding focuses on outcomes and engages with people (or their advocates or best interest assessors if they lack capacity) to define the outcomes they want such that they are more in control of the process.

There also remains much to do to more closely align personalisation and safeguarding. It is to be hoped that final legislation makes safeguarding fully integral: in draft, it is intermittently so.

There is development needed to fully embed practice within the context of the

legal mechanisms that are available, to fully implement the Mental Capacity Act across partners, to ensure that practice more explicitly takes account the complex balance of people's different human rights and to implement new legislation when it is enacted.

There will continue to be a need for training that focuses on awareness raising and the implementation of policies and procedures, and partners need to take responsibility for training staff. There is scope now for councils to focus on professional development so that social workers can use their skills to empower people needing safeguarding and work through with them and their families the legal and social work responses that might best realise the outcomes they want.

Collectively we need to work to develop the means of ensuring that people have access to justice as a result of safeguarding activity. This might be criminal, civil, restorative, social or interpersonal justice.

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