# Rotherham Safeguarding Adults Board

# **Peer Challenge Report**

11-13 July 2023

# Contents

# Report

## Background

The Rotherham Safeguarding Adults Board (the RSAB) requested that a peer challenge be undertaken by the Local Government Association (LGA). The work was commissioned by Moira Wilson, Independent Chair on behalf of the RSAB who was the client. The Board was seeking an external view on the effectiveness of the RSAB which included the relationships with the three statutory partners. The RSAB intends to use the findings of this peer challenge as a marker on its journey of improvement.

Scope:
The RSAB requested a greater focus on 2 of the 4 benchmark themes**:**

- Outcomes for, and the experiences of, people who use services.
- Leadership, Strategy and Working Together.

In addition, the RSAB highlighted areas where the Board believe improvement is most needed. The Board sought the views of the peer challenge team on the following areas:

- Customer Voice.
- Co-production.
- Embedding Learning from Safeguarding Adults Reviews and Lessons Learnt.

A peer challenge is designed to help an organisation and its partners assess current achievements, areas for development and capacity to change. The peer challenge 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 well as what it needs to improve but it should also provide it with a basis for further improvement.
The benchmark for this peer challenge was the Safeguarding Adults Board Improvement Tool (2017) (Appendix 1) which provided a template of headings for the feedback with an addition of the scoping questions outlined above. The headline themes were:

- Outcomes for, and the experiences of, people who use services.
- Leadership, Strategy and Working Together.
- Commissioning, Service Delivery and Effective Practice.
- Performance.

The members of the peer challenge team were:

- **Kathy Clark**, Independent Chair, Safeguarding Adults Board, North Lincolnshire.

- **Angela Connor**, Assistant Director and Principal Social Worker, Stockton-on-Tees Borough Council
- **DS Sam Hammond**, Force Tactical Lead for Adult Safeguarding, West Mercia Police
- **Steve Turner**, Strategic Safeguarding Partnerships Manager, Oxfordshire Safeguarding Adults Boards
- **Michelle Turner**, Clinical Nurse Director, Eight Ninths Ltd
- **Ernest Opuni**, Peer Challenge Manager Local Government Association

The team were on-site for three days from Tuesday 11 July to Thursday 13 July 2023. 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, especially those who were members of the RSAB.
- Reading documents provided by the RSAB and Council, including a self-assessment from the RSAB.

The peer challenge team would like to thank the RSAB, staff, people using services, carers, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made very welcome and would like in particular, to thank Jackie Scantlebury (Rotherham Safeguarding Adults Board Manager), Danielle Radford (Adult Safeguarding Coordinator, Rotherham Metropolitan Borough Council) and other colleagues for their support whilst the team was on-site in Rotherham.

Our feedback to the RSAB on the last day of the challenge provided an overview of the key messages. This report builds on the initial findings and gives a detailed account of the challenge.

The Care Act 2014 has placed all Safeguarding Adults Boards on a statutory footing. The Care and Support Statutory Guidance defines adult safeguarding as “protecting a person’s right to live in safety, free from abuse and neglect”. The Care Act requires that each local authority must:

‘Make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to other appropriate adult to help them.
Cooperate with each of its relevant partners (as set out in section 6 of the Care Act) in order to protect adults experiencing or at risk of abuse or neglect’

The aims of adult safeguarding are:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives.

- To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible.
- To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

There are six key principles that underpin all adult safeguarding work:

- **Empowerment** – Personalisation and the presumption of person-led decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”
- **Prevention** – It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented. “I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed.”
- **Protection** – Support and representation for those in greatest need. “I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me.”
- **Accountability** – Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life.”

# Key Messages and Recommendations

### Key Messages

- Pride and commitment in Rotherham.
- Voices are listened to in Rotherham, but not yet heard at the RSAB.
- You can go much further on collaboration and constructive challenge.
- To be an outstanding SAB you need sufficient resources to support it and robust processes to plan and deliver on your strategy.
- Mainstream the pockets of excellent practice.
- Celebrate your good work!

### Recommendations

To support RSAB on its improvement journey the peer team make the following recommendations:

- Use the groups and mechanisms which already exist in your partner organisations to start the work to increase voice in the work of the Board. Take time to think what questions you would want to ask these groups.
- Set aside some time for a development session to better understand the relevance of the various meetings, who attends them and why. We recommend reconsideration of the best way to include representation of the independent care provider market.
- Review how the SAB sets its agendas to encourage oversight of broader safeguarding related matters arising from partnership working.
- Ensure you have robust SMART plans which you can track and monitor. Look to other Boards for good practice and templates in this area.
- Explore how best you can use the data and information to identify areas for improvement, celebrate successes and answer the ‘so what’ questions.
- Consider whether partners’ understanding regarding the safeguarding pathways and expectations around these is sufficiently clear and shared and whether there are strategic or operational changes which can ensure better alignment.

# Outcomes for and the Experiences of People who Use Services

**Strengths**

- Our overriding impression is that Making Safeguarding Personal (MSP) underpins the work of the RSAB and Partners and shapes the approach to outcomes.
- The operational safeguarding pathway paperwork is supporting practitioners to think about improving outcomes for the person.
- MSP exit questionnaires enable the voice of the people who use services to be heard.
- We have seen discrete examples of work where the voice of the person is actively sought and used to shape responses.
- We have heard of a number of ways in which you are supporting people to stay safe before and outside of formal safeguarding processes.
- The continuing support offered to CSE survivors who have been affected by Operation Stovewood is particularly impressive.
- Data suggests good performance around use of advocacy and Deprivation of Liberty Safeguards (DoLS) authorisations.

**Areas to Consider**

- The voice of the person is not evident in the SAB strategy development.
- We did not see evidence that the RSABs work is shaped by the person's experience of safeguarding.
- The RSAB is not fully sighted on the good engagement work with people undertaken by a number of partners.
- We heard some views that the agencies in Rotherham may be more protective and less comfortable with a positive risk-taking approach than other Places. The Board may wish to consider if this is so and whether there is a shared model to support people to take informed risks where they have capacity to choose.
- We heard positive reports about new safeguarding processes which help keep a focus on Making Safeguarding Personal (MSP). The new exit questionnaire is also contributing positively to embedding MSP by capturing the outcomes and experience of people who have undergone safeguarding, at whichever point they exit the process.

The South Yorkshire principles which underpin the work of the RSAB work are based on MSP and your Strategy priority around Back to Basics is aiming to embed these further in all organisations and strengthen the voice of adults in the Board's work.

There are good examples of the RSAB partners seeking to listen to the voice of those using services. One particular example relates to the work of the Complex Lives Team. This work evidences good multi-disciplinary working underpinned by a

commitment from many partners to design services through co-production and engagement whilst having regard to the voice of users. It is a strong example of good integrated prevention work where social workers, housing staff and the Police are collaborating effectively.

Other examples of listening to people's voices, which is happening outside of the Board's work, include multi-agency co-production in your mental health services and with the development of new homes which involve both carers of, and clients with, autism and Learning Disabilities (LD). This is likely to lead to improved outcomes and reduced waiting lists for assessments.

There is some evidence that training and development to enhance professional curiosity is contributing positively to delivery of improved outcomes. Joint working across and between agencies is also assisting in this regard as exemplified by the collaboration through the joint visits undertaken by the Council's Housing department and the Fire and Rescue Service to tackle hoarding.

There was clear evidence of a strong partnership approach across the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to enable users of hospital health services, who have been in crisis, to be discharged home in a safe, timely and responsive manner.

The work on co-production appears to be happening outside the auspices of the RSAB. There is a clear ambition within the RSAB to strengthen user engagement and voice. However, the development of a communications strategy had limited input from service users and although it provides a foundation for increasing the RSAB engagement with people with Lived Experience, we felt that there have been opportunities missed to build on the work already happening in partner agencies. There is awareness and commitment of the need to do more and develop this further.

We heard about some good preventive work including proactive work to engage rough sleepers through most appropriate workers including utilising non-statutory capacity such as from the Third Sector. There is evidence of positive engagement with community catalysts.

Partnership working has remained strong through Covid with a greater focus on timely decision making. This is a good example of work continuing to improve outcomes (e.g., in crisis management).

The work of the Complex Lives Team and the support provided by multiagency partners to CSE survivors as a result of Operation Stovewood is impressive, as it is clear you are working together and are responding to both the legacy for individuals and the continuing impact of further court actions. Many of these individuals are now a key part of the generation of users who have transitioned into adults requiring

support which has been strongly shaped by what they encountered as children. Your focus on trauma informed approaches is one we think could be extended to broader safeguarding responses. It is good to see that the Complex Lives team are also working with self-neglect concerns and other vulnerable behaviours and lifestyles.

We did hear a number professionals in different groups that we spoke to suggest that there may be another, different legacy from the experiences around CSE, which they have described as being a system that is less confident and comfortable with a positive risk taking model. We did not see concrete examples of this, but as we heard it from several sources, it may be worth some consideration of your Board's approach and support for partners around Positive Risk-Taking models which can support people who have capacity to take informed risks where this is their choice.

The peer challenge team was left wondering whether there is more work to do for SAB partners to be assured that outcomes are consistent regardless of which agency pays for services provided. We heard that there are still debates about funding between health and care partners which can affect the timely access to support needed. We also heard concerns expressed in some meetings about the impact of delays in discharge from hospital and a suggestion that the RSAB could do more to understand any safeguarding risks that result from this. This would be in line with recent national discussions about how and whether Boards are sighted on the impact of hospital delays on safeguarding activity.

We also heard of further opportunities to seek advice from experts, much earlier during the users stay in hospital, to enable timely discharge to home or to an appropriate provider of care for people with mental health difficulties, learning difficulties or autism.

The absence of an agreed delivery plan for the new Strategy of the RSAB suggests that the RSAB does not yet seem clear on how it will translate a stated intent to have a greater voice of the user in service delivery into common and embedded practice. The plans we heard about seemed to rely on the voluntary sector and Healthwatch to support the development of co-production. We did not hear any reference to harnessing the co-production that is already being undertaken to help the SAB shape and develop the Board's strategy or deliver its strategic plans around Voice and co-production. We also noted that both Healthwatch and the voluntary sector have struggled to attend meetings and fully engage with the SAB due to insufficient capacity, so you may need to assure yourselves they are able to support the work you are expecting from them. We heard some examples from partners as to how staff use the experience of users to continually improve the development of their services however this is not reflective of the work of the Board.

The 'Front door' responsibility for response is not always clear. The way in which some concerns about adults deemed vulnerable or at risk are being generated by some partners is resulting in high referral levels juxtaposed with a low conversion

rate. Responses to concerns do not always seem to be as coordinated as they might be and there have been examples of police, council and domestic abuse teams responding separately to the same concern and not communicating their responses between each agency. Additionally, there appears to be a difference between partner agencies in their understanding of thresholds and vulnerability meaning this does not always provide a consistent picture.

Services could do more to learn from the person-centred approach adopted by the complex lives team, which was explained to the Peer Challenge team as holistic multi-agency work that had the person at the centre throughout. In essence the peer challenge team would encourage an approach to service delivery better designed to fit the needs of the person rather than expecting individuals with complex needs to adapt to the way in which services are delivered.

# Leadership Strategy and Working Together

**Strengths**

- We heard views suggesting that the SAB is starting to shift toward more collaborative leadership.
- We have been informed that there is a real willingness to have difficult conversations.
- Strategic cross-partnership working is coordinated (SAB, HWBB, RSP, etc).
- Senior political and officer ‘buy-in’ to a whole council approach, evident for example through Council Safeguarding Champions
- The recent RSAB Strategy was developed by all partners with external facilitation.
- There is confidence in the level of attendance from statutory partners at the RSAB meetings.
- The RSAB Board produces a strategy, Annual Report and SARs, in line with the terms of reference, as required.

**Areas to Consider**

- We heard that attendance at meetings was good as evidence of good partnership working but think you should look beyond attendance at formal meetings to assure yourselves of good partnership working.
- Missing or absent partners (e.g., independent providers, voluntary and community sector partners, Healthwatch).

- There is evidence that difficult conversations take place, but we saw limited evidence of constructive challenge and the ‘so what?’ question being addressed consistently in the RSAB meetings, with regards to reports, information and intelligence received.
- Sharper focus on the way the RSAB does its business including how the agenda identifies the purpose of the items.
- Capacity of the RSAB Manager to meet all partners’ expectations.
- Low visibility of the RSAB and its activity.
- Structure of the RSAB, Exec and its subgroups are unclear to many we have spoken to.
- Lack of clear action plans and tracking progress.

The leadership role of the council on the SAB is clearly providing value. While we heard that there is some positive shift to a more collective leadership, we also heard that there still a perceived lack of separation of the RSAB from the Local Authority. The council is still seen as driving safeguarding and the RSAB with the Board Manager seen as a Local Authority employee as opposed to a resource for all partners. We recognise this may in part be due to capacity, and that the Board is recruiting to an additional post, but we also think a refresh of the expectations of these posts would be helpful. We think this is an area which could be addressed by strengthening the joint communication and delivery of strategies with underpinning plans, targets and measures being jointly constructed by all partner agencies. We think there is an appetite among SAB Members to collaborate on pulling together the Board’s agenda and forward planner.

There are positive interactions and relationships at a senior management level among partners. We heard from several of our conversations that difficult issues are being addressed and difficult conversations are not avoided. One example we heard about was the initial consideration of the ‘Right Care Right Person’ policy initiative. The agreement for ongoing further consultation as this goes into further phases of development is an indication that potentially challenging conversations will not be avoided.

Relationships between the work of the RSAB and other boards are positive and provide a conduit for further and ongoing cross agency collaboration and joint delivery. Council Members and the Chief Executive of the Local Authority are all actively engaged on Adult Safeguarding as well as Chief Executives from partners in ‘place’ and across the Integrated Care System (ICS) in South Yorkshire regarding Adult Safeguarding.

Additionally, the approach of the whole council to safeguarding within RMBC is providing further impetus for MSP being yet further embedded, with Safeguarding Champions supporting colleagues to understand their roles in making safeguarding everybody's business. For example there is good active engagement from the council's housing department within the subgroups of the SAB. The council is encouraging sign up by partners to areas for improvement through positive and proactive engagement with agencies.

There is a strong ambition for collective work at a strategic level. There is evidence that the cross-agency Development Day provided a valuable space for positive collaborative engagement which was successful in getting effective involvement from the RSAB members, partners and sub- groups.

There is evidence that some of the SAB's subgroups and sub-structures are providing forums for better joint leadership. For example, the Policy and Procedure Subgroup is engendering some improved collaboration whilst the meeting of the Executive is providing a useful space in which partners can join up their thinking. However, the co-ordination between Subgroups, the Executive and the Board appears to rely on assumptions about shared membership and the role of the SAB Manager to ensure work plans are coordinated and linked. Your new SAB Strategy and plan is very light on actions deliverables, timescales or a monitoring plan and we were not shown plans which allocated responsibilities for the delivery of the strategy.

There is an ambition to use existing voluntary and community sector deliverers more effectively as a bridge to better understanding residents' needs. This would also be a means of getting the right messages about the work of the SAB out beyond the Board itself.

There is evidence of improving attendances from strategic partners at the SAB alongside greater involvement in Subgroups from statutory partners which includes senior managers. These are all examples of stronger foundations for effective joint leadership however there is a shared recognition that there remains still more to do.

Cross-partnership working seems well coordinated and is delivering good outcomes which is contributing positively to support for survivors of CSE. There are six-monthly updates on the Stovewood investigation, which supports oversight.

There is evidence of increased effective cross working between the SAB and the Health and Wellbeing Board (HWBB). The SAB's annual report, strategy and developing delivery plan is programmed to go to the HWBB. Additionally, there are wider conversations timetabled at both HWBB and SAB on early help with a strong focus on prevention including on those at risk of suicide.

The peer challenge team would encourage the SAB to explore further how it might secure and sustain permanent board membership from the independent sector. The

improved relationships built during the Covid-19 pandemic demonstrate that this can be achieved in the face of challenges around engagement from some partners. Whilst it is not always clear why some partners are not attending, there may be an underlying capacity issue and challenge which will require collective support in order that this can be addressed.

Furthermore, there is learning available to the SAB from the work of the Children's Safeguarding Board as well as lessons learned on the back of the CSE to improve systems and approaches to partnership and collaboration.

There may be some duplication in the RSAB structure. The role of the Executive subgroup could be clearer and made more distinct from other structures as part of addressing this. More widely there may be some value in considering ways of maximising the effectiveness of all SAB subgroups in encouraging greater learning from SARs. The SAB is not fully sighted on the extensive positive work done to protect and support people experiencing homelessness for example.

The RSAB members were not always clear on why items were on the agenda of the Board or its subgroups or what actions were expected of them in response to the items presented. The RSAB may want to consider a more structured approach to how the agenda and the forward planner is set for the year and to invite all partners to own this approach.

Consideration could also be made to review how reports come to the RSAB and its subgroups as well as the tracking of actions from these reports and recommendations. For example, SABs in other areas have a standard front sheet for reports that summarise the report, the decisions required and recommendations to be addressed.

With regards to the tracking of actions, SABs in other areas will use a standard action tracker table that states the date the action was agreed, who will complete the action and by when. The description of the action should be made very clear so the original minutes are not necessary to understand the action.

The SAB may also want to consider a more formal Member Role Description so that those attending the Board and its subgroups are clear on what their role is at the Board beyond attending.

Finally other SABs are increasingly being much clearer on what needs to go to their respective SABs, and what can be processed via an executive Subgroup. In some areas this subgroup is also seen as an executive "delivery" subgroup to manage the day-to-day day business and to oversee the Subgroups on behalf of the RSAB. This enables the RSAB to concentrate on key strategic business in line with their Terms of Reference.

# Commissioning, Service Delivery and Effective Practice

### Strengths

- Clear commitment to working together and good operational links between organisations.
- Community Multi Agency Risk Assessment Conference (CMARAC) and Vulnerable Adults Risk Management Model (VARMM) processes are seen as effective in coordinating support for people who may be at risk but might not meet Safeguarding Adults thresholds.
- Use of the Provider Assessment and Market Management Solution (PAMMS) Quality Assurance System work to support Local Authority Commissioned services is providing a shared understanding with providers of the commissioned market quality.
- Strong contract monitoring arrangements.
- Role of the Integrated Care Board (ICB) place-based safeguarding team.
- Good Voluntary and Community Sector services.
- Eyes and Ears is a good initiative for LA-commissioned services.
- Safeguarding Champions model within the LA.
- Trauma-informed work as a response to experiences of CSE in Rotherham is very strong.

### Areas to consider

- Review of the safeguarding pathway was done by a single agency initially, so there are missed collaboration opportunities.
- Repeat themes in SAR learning and minimal feedback to frontline staff across agencies on the learning.
- Opportunity for further joint recruitment and posts across agencies.
- Consider building on your current multi-agency training to extend some of the single agency training offers to become a multi-agency training offer, including evaluation approaches and materials.
- Assure yourselves that you have a positive risk management model that is developed together and between partners and ensure it is embedded into practice.

- Review arrangements for delegating an enquiry to other agencies to ensure confidence and competence.
- Local Authority contract and quality arrangements focus on the commissioned services rather than the whole of the market.
- Trauma-informed work in response to the Stovewood Investigation to help others become more trauma-informed.

The commitment from all partners to work together and improve life for adults/people in Rotherham is clear and evidenced by attendance at the RSAB, agreements, directives and change. A good example of this is the planned closure and repurposing of two homes to provide support for adults with learning disabilities (LD) and/or Autism. This will benefit from the input of 12 new providers thus offering more choice and this is a good example of co-production. Multi-agency RSAB Training is making a positive contribution, this includes the training to develop and enhance professional curiosity, and promotion of a more shared and common understanding of terminology. We believe you can use the skills already being deployed by partners to develop a shared approach that works to get the learning from SARs embedded.

We have already commented on the strong practice through the Complex Lives team, and we believe there is real potential to develop your trauma informed practice to embed it in all safeguarding practice.

We heard from health colleagues that there is an opportunity for the SAB to better utilise and benefit from the role of the ICB safeguarding team which is uniquely placed to advise on the role of health care providers, General Practices and Primary Care Networks in dealing with safeguarding enquiries.

Provider Assessment and Market Management Solution (PAMMS) is a commissioning toolkit and is viewed positively for its effectiveness in helping to identify quality issues. It also ensures providers are supported because it gives them the ability to see issues for themselves. Whilst the peer challenge team noted and commended good practice in the commissioning and contracting teams with regards to quality assurance and improvement, it was also noted that more could be done by the team to strengthen market management. In particular the focus is still predominantly on working with providers with whom the Council does business, rather than the whole market, which would be better aligned with both Care Act responsibilities and with safeguarding responsibilities to all, regardless of who pays.

It is positive that there are emergency pathways in place to address the need of homelessness, whilst integrated discharge utilising all partners is viewed as being excellent.

VARM (Vulnerable Adult Risk Management) and early help and prevention provision is viewed positively, although the links between CMARAC and VARM need review,

as you have identified. We heard from some people who seemed to be less clear about the VARM process or how this might fit with a new hoarding panel which we were told was being considered.  We were not confident that thinking has been joined up on this. As part of any review of structures and approach there may be some value in exploring either whether a separate a hoarding panel would be useful and/or how to ensure that any discussion to develop new initiatives are not undertaken without reference to the other processes.

There is also a clear process for proactive work by Housing partners, such as making contact with all residents who have not requested a repair, within their own homes, in 2 years which can ensure possible vulnerable adults are reached at an earlier stage than might otherwise be the case. A similar approach to this is also being considered with the focus on residents with particularly low levels of energy usage. Overall, the Peer Challenge Team believes that Rotherham should take time to celebrate its success and share some of the stories shared with us more widely.

Improvement of communication between the SAB, the HWBB and the wider public would be beneficial. It would be a valuable means of raising the profile of safeguarding work and provision outside of the arena in which the SAB's role is known and understood. Increasing awareness of staff about the role of the RSAB would be of value and there would benefits in a review of the current website as it is not sufficiently user-friendly. The SAB may also wish to reflect on whether key messages from the HWBB are being disseminated through organisations and other partnerships which could be of benefit to the work of the SAB.

The process of delegation relating to Section 42 enquiries to ensure the right outcomes for those referred would benefit from further consideration by all partners working together. There is scope for agreeing more of a partnership approach to the review of safeguarding pathways, the role of partners and how S42 enquiries are made and acted upon in line with the Care Act (2014) with a focusing on improving outcomes for local people. This extra work could streamline processes for staff from all partners.

The challenges of funding levels and the difficulty in recruiting staff is a national problem and therefore is not unique to Rotherham. There might be value in consideration of joint posts across partner agencies to achieve economies of scale whilst improving capacity. Another potential action to improve capacity could be opening up the comprehensive Local Authority training such as Mental Health First Aid and other Safeguarding modules to potential Third Sector providers.

It was not always clear to the team as to where adult safeguarding is placed within the individual organisational policies of the various SAB partners. Providers appear to have clear processes for the management and oversight of incidents, but it seems that some  partners did not always understand others' systems and the difference

between quality oversight and safeguarding arrangements within individual organisations. The RSAB may want to request clarification from all partners.

The SAB is aware that it has more to do to embed learning fully and effectively from the themes from SARs and there is a recognition that this is contributing to a higher than optimal level of repeat issues. Your new approach, to undertake a themed review seems sensible, but we think there may also be value in a focused evaluation of learning to ensure sustainability of positive outcomes. Better use of case studies could improve learning and better highlight the richness of information to improve outcomes. It is important that time is taken to establish whether the learning has been embedded in a sustainable and replicable way.

The views from the independent care sector are not directly heard at the RSAB. Their voice currently comes indirectly via commissioners. While commissioners are confident that this is arrangement is adequate, they are nonetheless not looking at non-commissioned providers and the team's view is that there remains scope for keeping overall arrangements under review. Part of this work could explore how best to embed principles of safeguarding in the private sector. This is particularly relevant because significant numbers of concerns and enquiries concern care and support providers.

The peer challenge team would encourage the SAB to explore how best to ensure that 'who pays' does not get in the way of safeguarding adults delivery and achieving the best possible outcomes for persons.

The voice of local users/people at the RSAB and its subgroups could be strengthened to enable a more effective method of assessing and evaluating the quality of service provided and the impact on outcomes and experience.

There appears on occasion to be some partnership drift where partners struggle to or cannot engage a person. This is leaving some services, such as housing, to hold risks and deal with issues outside of their expected skills, roles and responsibility.

# Performance

**Strengths**

- Safeguarding Awareness Week is a huge achievement and very well spoken of.
- Appreciation of the multi-agency the RSAB training.
- Good regular data report to the RSAB that includes partner information.
- Evidence of case file auditing across a range of partners.
- Early signs of outcomes being achieved being reportable.

- Learning from SARs is shared at the RSAB and subgroup level.

**Areas to consider**

- We did not see evidence that data reporting includes narrative or ask ‘so what?’, which would limit effective challenge.
- SAR learning could be more effective, as identified by SAB.
- We have seen some evidence of shared case file audits being done but limited evidence that these are coming to Board.
- Similarly, are multi-agency case studies are coming to the RSAB.
- More could be done to promote and share positive stories across the RSAB, agencies and the public.

Safeguarding Week as a means of sharing learning has been very well-received. Overall, this work has resulted in safeguarding concerns being brought to light which might have otherwise not been picked up or could have been delayed. One example of the impact we heard about was that all maintenance staff in the council’s Housing department are trained in safeguarding. and over one hundred thousand maintenance home visits have been undertaken, resulting in a number of safeguarding concerns being raised and enabled an early, preventive and proportionate response.

We also heard that the multi-agency training provided by the RSAB is highly valued by partners and is seen as very positive. We heard from some partners that they think more can be done to increase multi agency collaboration on further opportunities for specific training led by providers, and in the sharing of good practice. The next stage of ongoing improvement would be in sharing much of the learning that happens within partner individual organisations across the partners more widely.

The SAB is reviewing data and making changes to how it is collected in order to better understand and quantify these additional concerns being picked up. This would provide a clearer picture on conversion to Section 42 referrals. Overall, the team’s view is that the SAB is utilising good data with regular reports going to the Board. That said those the subgroup team met with are also very aware of the importance of continually improving data sets in a timely fashion to enable sharing of learning and intelligence not only within the SAB but also between the Board and other bodies such as the HWBB.

In terms of areas for consideration in to continuing to improve, there is more to do in by the SAB in supplementing its rich supply of good quality data with a greater degree of qualitative narrative – supplementing ‘what’ with insights into the ‘so what’, and turning your data into intelligence.

There would appear to be further opportunities for all to conduct shared case audits and develop case studies together rather than these happening only within each single agency. There is evidence of good internal Local Authority auditing work around safeguarding which is not yet being shared across the SAB more widely. A focus on doing this could serve to promote and share positive stories across agencies and the wider public.

This would be one means of creating a deeper understanding of lessons being learned in order to provide a wider context and secure richer learning. It would provide the RSAB with a better ability to sustain and replicate learning whilst also challenging itself as a collective as well as between its individual component parts. This may go some way towards answering the question as to how lessons learnt from SARs might have an impact on practice because following the thread of performance data is difficult without a narrative.

Finally, we heard many positive stories of the work that is happening in your partner agencies, but a number of people said they are not aware of work of the RSAB or of its partners. You have some very good things happening in Rotherham. We think you could bring these together more and raise the profile of the RSAB and of adult safeguarding.

# Safeguarding Adults Board resources

1. **LGA Safeguarding Adults resources web page**

http://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/safeguarding-resources

2. **Safeguarding Adults Board resources** including the Independent Chairs Network, Governance arrangements of SABs and a framework to support improving effectiveness of SABs

http://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/resources-safeguarding-adults-boards

3. **LGA Adult Safeguarding Knowledge Hub Community of Practice** – contains relevant documents and discussion threads

https://khub.net/web/adultsafeguardingcommunityofpractice

4. **Adult Safeguarding Peer Challenge**

http://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care

5. **Making links between adult safeguarding and domestic abuse**

http://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/safeguarding-and-domestic-abuse

6. **Making Safeguarding Personal**

http://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

7. **Social Care Institute for Excellence (SCIE) pages on safeguarding.**

http://www.scie.org.uk/adults/safeguarding/index.asp

# Contact details

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Read the Adults Peer Challenge Reports here: http://www.local.gov.uk/peer-challenges-adult-peer-reviews-reports

# Appendix 1 – Safeguarding Adults Board Improvement Tool

**Overview**
There are four key themes for the standards, with a number of sub-headings as follows:

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

Safeguarding Adults Board Improvement Tool here: http://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-improv-ddd.pdf