Appendix 1

directors of adass
adult social services
South East Region

Medway
SE ADASS Peer Review
Medway 31st January to 2nd February

1.0 Introduction

1.1 This review was part of the Regional Programme for Directors of Adult Social Services (ADASS) in the South East. Directors support peer reviews as a basis for improving services by acting as a critical friend.

1.2 Medway Council, Adult Social Care requested that the peer review focus on Safeguarding:

- 'Our care pathway
- Our quality of practice
- Review of our safeguarding procedures relating to concerns of potential abuse about a person who died (Local Government and Social Care Ombudsman complaint response)
- Our resources - are they appropriate?
- Our structure - is the hub structure the right approach?
- Is the Medway Safeguarding Adults Executive Group needed? '

1.3 The review team spent 3 virtual days in Medway and met staff, managers, and partners. The team were provided with a range of information including reports, policies, procedures, and performance data.

1.4 All information collected from interviews and in the focus groups was recorded on a non-attributable basis. The team was made very welcome, and we would like to thank everyone we met for their open, constructive responses and commitment to look at how services could be improved.

1.5 The Peer Review took place against a background of extreme challenge, change and opportunities for Adult Social Care in Medway:

- Continued impact of Covid
- Change of personnel - new DASS, new AD for ASC, new SAB Chair, new appointment to PSW role.
- Newly formed People's Directorate
- Vacancies in key posts, number of locums, competition with London Boro's and Kent
- CQC Assurance from April 2023
- Changes to legislation/policy - Care Cap; Mental Health Act; LPS and MCA; Health & Social Care White Paper; Integration White Paper and possible consultation and legislation regarding LPS
- Funding - resources and emphasis on C&YP; ceasing Covid Grants; Cost of Care Exercise
- ICS developments

2. 0 Feedback

For ease, this report is broken the following areas:

- Leadership
- Quality of Practice
- Structure and Resources
- Performance
- Partnerships

3.0 Leadership

Medway has a clearly articulated identity with strategic objectives which include 'supporting people to realise their potential' and investing in the future with an emphasis on supporting children and young people.

The DASS and AD understand and own the challenges facing the council and are committed to finding solutions and opening up an honest dialogue with staff and partners.

Governance:

- Governance arrangements for the SAB were clear, Medway Council are now well represented in all the sub-groups, chairing a number, and there are clear lines of accountability and communications with Medway management systems.
- The review team understood that the NHS are reviewing all meetings associated with the SAB which will help inform the council when making any changes to its structure.
- The review team were specifically asked to look at the Medway Safeguarding Executive Board and although several people valued this group, felt that it duplicated SAB meetings and had outlived its usefulness. There were comments that this group could more usefully look at Quality Assurance issues and assurance.
- There were comments about the number of meetings and governance arrangements. These have apparently grown organically leading to a lack of clarity, work arounds and duplication. Internal and external partners would welcome a clear structure with organizational and individual roles and professional accountabilities, decision making processes, clear interoperability's with internal and external partners structures.
- There are a range of people in leadership roles with the Safeguarding Lead, PSW, operations and AD. All appear to be responsible for safeguarding within the council, but it was unclear who would have professional accountability for safeguarding.
- Clarity about professional Social Work supervision at a senior level would also be helpful, especially given the appointment of a new PSW
- A lot of emphasis is placed on relationships, many of which are long term and have been sustained through organisational and senior management changes. The stress placed on this has meant that there a handful of people who are 'go to' – for quicker access and decision making.

Communications

- The weekly newsletter was welcomed by staff who valued hearing about ASC news. The review team thought that splitting the 'chattier' news could be separate from formal messages.
- There was a view that messages about Medway Council emphasised Children and Young People's services to the detriment of ASC. All understood that this was a result of recent Ofsted reports, but with changes to legislation and the CQC Assurance process there was a concern that the council will be vulnerable to criticism if this messaging remains.
- Although there were now more discussions about ASC priorities there was a feeling from some people that ASC were 'trying to do everything' and there were several things that could be dealt with which would enable a more effective service. This included agreeing on an end-to-end process; a forum where all the ASC changes

were discussed and agreed (rather than an improvement board that the review team were told was dominated by discussions about C&YP services).

Relationships

- There was a strong emphasis on relationships and named individuals - the 'go to' people. This small group of individuals were able to respond and unlock to issues. If this continues, the challenge for Medway is the impact if someone leaves or changes role, the overall governance framework and lines of accountability which doesn't enable people to grow and develop and crucially acts as a single point of possible failure.

Workforce

- The review team were struck by the numbers of agency staff, some of whom had been working in Medway for several months.
- Medway clearly is fully committed to 'growing their own' and there were several good examples of this happening.
- Whilst this is a good strategy to enable career development it is also helpful to attract managers and staff externally as this brings with it different talent and a richness of different experiences to help balance the organisation and add potential challenge to established methods as ASC needs to grow and develop over time to remain a healthy and learning organisation.

Leadership - suggested actions
1 Consideration needs to be given to the Safeguarding Leads mandate to influence and ensure compliance across adult safeguarding
2 Governance structure. Review meeting structures; focus, individual accountabilities; attendance; hierarchy of decision making and develop a clear communication structure with interoperability's
3 Medway Safeguarding Executive Group – ensure that its functions can be dealt with under the K&MSAB arrangements and consider re-shaping this group to focus on Quality and Governance across internal and commissioned services.
4 Consider splitting weekly communications. To focus on the business of ASC – new initiatives; changes to legislation etc and separately staff changes etc
5 Consider undertaking a workforce audit to review agency staff, pay rates for PAYE and agency staff and comparisons with neighbouring councils, working with NHSTs on the development of joint roles and recruitment and retention of staff; looking to have a workforce that reflects the population.
6 Medway may benefit from linking with a local FEE (Teaching Partnership) which could help encourage students, provide practice placements and attract permanent staff.
7 Given the number of new appointments and changes to the structure some leadership support and training could be considered.

4. Quality of Practice

Case file audit – peer review team

- Due to issues accessing the Mosaic case file system only one member of the review team was able to look at case files, others had limited access to information via Sharepoint. Despite the small sample, recording appeared to be good, there was evidence of feedback to people making a referral, action plans, and timetables for future reviews with practitioners using the three-conversation model. The team found no multi agency risk plans.

- The safeguarding referral process appears to be convoluted with people being seemingly drawn into the safeguarding system and the team did question to what extent the council were Care Act compliant

LGSO

- The Peer Review Team was asked to look at a review of a complaint investigated by the LGSO.
- The LGSO identified that Medway did not need to open a Retrospective Enquiry, however, the decision was taken and recorded to investigate and proceed to a non-statutory enquiry, to consider Acts of Omission which may have consequences for the wider public. Following this, the agency has taken remedial action.
- Medway could have considered a number of other approaches:
    - Multi-agency working earlier on in the process under the safeguarding framework
    - A non-statutory enquiry before then considering whether a SAR is the next course of action (the 'non-statutory' enquiry can be a useful starting point)
    - Internal critical incident review that sits outside the statutory framework.
- Medway considered a SAR referral.
- Although not part of the peer review the file audit showed that:
    - the rationale for this was not evidenced in the case file
    - SAR referral - internal process states SAR referral to be sent to Op manager, which was not recorded
    - ILRs case discussed approx. 5 times but may have drifted?

Medway case file audits

- One case audit had been undertaken in late 2021 by the Safeguarding Lead and Managers. There had been an agreement that a further series of audits would be carried out. a further series of audit. Practitioners would welcome feedback on this audit and when/whether this process would be carried out again.
- The review team looked at the case file audit tool and suggest that the tool could be shortened and be less mechanistic
- Concerns were expressed about the use of a ‘virtual worker’ and the potential risks that significant safeguarding issues might be missed; deteriorate

Supervision

- The team talked to practitioners and understood that case supervision is recorded on Mosaic. It was difficult to assess the consistency or quality of case supervision but on the case files seen, there did appear to be mixed practice. This is something that could be looked at if Medway agreed to the above offer from Reading and Portsmouth.
- From the structure charts and document explaining how this was managed it appeared that some had over 12 people to supervise, the recommended number is 6 to 8 staff.
- The teams have daily huddles to discuss work for the day which is good practice
- The team didn’t see any personal development supervision and there was a suggestion and concerns that agency staff may not be having this type of supervision.
- Many practitioners benefit reflective practice groups, but the review team were not aware of these occurring on a regular basis.

Training

- The team were told that training is not offered to locums including people have been in post for 3 months plus. This is a significant risk to the organisation and it is

suggested that there is a review of this policy and an review about what training has been provided to locums.

- Operational teams move between duty, safeguarding and generic 'hubs'. Mainly within the three locality hubs, but on occasion between hubs. Although this ensured that all practitioners got to know the different practice areas, and the localities, skills built up could be lost and for some areas of practice could lead to poor outcomes for individuals. It was also highlighted that for Mental Health and Learning Disability services this was leading to increased costs where practitioners did not have the necessary skills or knowledge a=bout services.
- 'Grow your own' is a key policy workforce issues across Medway. There were limited examples of staff members taking part in SW Apprenticeship programmes, succession planning and developing leadership skills was not part of the Medway
- Mental Capacity Act – there was little evidence that the council was promoting MCA with partners and internally. This is a risk to the council which will grow in significance when LPS is implemented.
- Staff reported that although there were numerous incidents where coercion and control was a factor in safeguarding, they believed there was not enough emphasis on training or development
- Working with internal and external partners is key to safeguarding. By not acknowledging and valuing the skills and knowledge of safeguarding teams might be losing a considerable resource and could lead to poor outcomes for people involved.

Quality of practice - suggested actions
1 As part of SE ADASS planning for assurance offer, Medway, Reading and Portsmouth will be 'buddies' and working together. Reading and Portsmouth have offered to undertake a case file audit as part of this process.
2. Internal case file audits: • feedback findings from the first case file audit • agree future programme of audits - frequency; number, process and communicate any agreements with with practitioners
3. Supervision. In order to provide some assurance to senior managers a Supervision Audit (supervision arrangements; supervision of cases, reflective practice and personal development) could be carried out.
4. Training – review the training offer for locums
5. Consider how to retain skills if staff continue to move between locality hubs.
6. Agree and update the Safeguarding Policy to include a note about how complaints or safeguarding referrals should be dealt with when the individual has died.

5. Structure and Resources

Three Safeguarding Hubs

The review team were specifically asked to look at the aspect of the organizational architecture.

- SWrs and TMs liked and valued working with the small teams which they found supportive with increased opportunities to understand what the issues are about their localities and able to access local resources
- The review team were told that having 3 Team Managers and 3 separate teams has led to:
- a lack of co-ordination between hubs and the development of different practices and processes in each hub e.g if the concern is related to a provider, then the Quality Assurance team may/may not be included and/or attend the meeting

- no agreed roles for staff working in the Safeguarding Hub and no standardised training or joint reflective practice sessions. A suggestion that people continued practice 'as they were' before moving into a new role.
- cover arrangements were often difficult to arrange
- Partners (internal and external) reported:
    - poor experiences with confusing reporting arrangements and opaque professional accountability
    - concerns of a post code lottery as hubs approaches not always the same
    - inconsistent links and approaches to commissioning, (provider) quality, safeguarding and contract reviews and Quality Assurance for commissioned services,
    - comments that the overall structure was 'messy' and difficult to navigate hence talking to people they know

Front door

- The Digital Safeguarding forms – part of the digital process means that all referrals to the three safeguarding hubs are directed towards making a safeguarding enquiry and it is not easy for people to ask for Care Act Assessments. There is no option for partner organisations to request a call back to discuss the issue before making a referral.
- Although there is a good triage system, practitioners are making a number of possibly unnecessary enquiries and what appeared to be a number of 'hand offs'.
- Partners and practitioners believed that the whole system was a 'tick box' and process driven system with electronic workflow leading to people being 'pulled' into safeguarding unnecessarily
- The front door on in each hub apparently work differently e.g., pressure ulcers; no opportunity to discuss first; overlapping processes that could be addressed by engagement with CCG Practice Nurses.
- Safeguarding concerns are not automatically routed to practitioners working with individuals leading to duplication of effort and a question about whether this approach led to delays in progressing work whilst further information was sought. It is also not in line with Making Safeguarding Personal.
- Concerns were expressed about a lack oversight on some retrospective work and open enquiries.

Allocation

- Whilst each safeguarding hub has a triage system getting further information delayed progressing straightforward referrals. This has led to some retrospective work, open enquiries, the use of a 'virtual worker' caseload with over 900 cases awaiting action with the associated risks and requirement for further assessments.

Although not part of the review, there were also comments that the wider generic structure impacted negatively on practice, decisions and budgets. This included a question about the location and function of the Quality Assurance Provider Team and its relationship to the commissioning function, safeguarding hubs and the Commissioning Team. Under the Care Act Local authorities must facilitate markets that offer a diverse range of high-quality and appropriate services. Commissioning and quality are separate in Adults, with commissioning sitting under Public Health (in Children's they are within the same team), It seems that Commissioners are not always informed of quality issues across providers, also some partners shared they no longer have this information shared, in the local market, with informal sharing and conversations appearing to be the main conduit for sharing intelligence.

Structure - suggested actions

1 Consider reducing the number of safeguarding hubs from 3 to 1
2 Review the and replace digital forms to ensure that asking for a Care Act assessment or a general enquiry is more obvious and accessible, so people do not automatically make a safeguarding referral. This would reduce workloads and ensure better use of limited resources
3 Understand the demand at the front door
4 Consider allocating all safeguarding enquiries of people known to ASC to their allocated workers, including practitioners within in-house services
5 Review the whole pathway including other part of the locality hub structure.
6. Linked to safeguarding is quality, suggest considering where the 'quality' function sits in relation to the Commissioning Function, taking account of why this would be different in Adults to Children's Services.
7. Suggest a more formal way of capturing quality concerns and sharing both within the council and with partners should be considered.

6. Performance

- Medway has developed a Dashboard and has set up Performance Clinics these were welcomed, with managers reportedly keen to learn about/run and use reports for current activity and trend data. Monthly meetings look at retrospective data and the narrative is provided by Operational and Team Managers.
- No specific analysis is done regarding Safeguarding, but there is access to 'live' safeguarding issues. Comments were made about the different localities, case numbers and demand and a suggestion that further work should be done to identify routes for enquiries and mitigating actions if these are from a small number of places e.g. Ambulance Trust, specific care providers.
- More analysis with a clear action plan to address the issues will improve practice and the safeguarding and the there could be consideration to the Medway Executive Safeguarding Group reviewing this (and other) data on a regular basis. It was unclear how data was reviewed and the frequency of review with the Directorate management team. Consequently, how this was then picked up with operational managers and reflected in practice, supervision, and any annual appraisal process.
- The volume of data and the work the performance team have down, faced with staffing challenges, was good, however there seemed to be missing a focus on key data indicators that could highlight potential areas 'risk' to the business

Performance - suggested actions
1.Develop a set of benchmarking data across the CIPFA family including staff numbers; pay and locum/agency rates (see above)
2 Look at opportunities for Demand Modelling
3 Develop a set of qualitative data that can be collected regularly which could lead looking at trends and improvements.
4.Introduce governance to set a framework to regularly review high level data by Directorate Management Team, ownership of data by the service areas (including providing the narrative) and understanding and using the data to drive performance at team and individual level (including comparative performance across teams, underpinned by vacancy/FTE data).
5.Develop a set of core quantitative ('safe') indicators, no more than 5, that can be reported regularly and show areas of risk e.g.on time to start/close safeguarding, assessments, reviews in/out of time etc.
It has been suggested that all SE councils take part in a process to prepare for CQC Assurance. This includes use of the TEASC Risk Awareness Tool and use of the PSW Quality Tool. Medway is buddied with Reading and Portsmouth and has the opportunity to use this review as a basis for further discussions

7. Ensure a forum is identified to considers/monitor the data and actions that result from the analysis.

7. Partners

Working relationships

- Partners reported very positively about their working relationships with Medway. As above, they did highlight there were a handful of 'go to' people. These links were valued but recognised that changes to personnel have had a negative impact with processes not always clear and understood.
- It was recognised that relationships had been compromised due to Covid, the emphasis on Hospital Discharge and Care Homes, and agreed that some time an effort would need to be devoted to working on this. Opportunities with the development of ICSs and ICBs were highlighted.
- The review team heard about some good examples of joint working relationships (housing and the Police) on cases, although these were said to be limited, and siloed. \The review team also heard that opportunities for SWrs to develop closer relationships with adult mental health services would be beneficial.
- Clarity about roles and legal responsibilities - when to ask partners to lead e.g. Pressure Ulcer tool is owned by, and the responsibility of, community health teams. ASC need an awareness to raise concerns but should not take ownership.
- Partners acknowledged the pandemic has created new challenges but suggested that sometimes practice was process and paper based rather than fact finding through meaningful conversations.

SAB

- Everyone the review team talked to about the K&MSAB talked about the improvements that had been made since the last Peer Review visit and all agreed that Medway is well represented on the SAB, chairing a few key sub-groups.
- Several individuals were highlighted as making key contributions to the SAB and there was clearly high regard for the Safeguarding Lead who was considered to have significant expertise in this area.
- Self-neglect, coercive control, team around the person/use of outreach teams were areas highlighted as needing focus.
- The Medway Executive Group was discussed. For some having a focus on Medway was of value, although a focus on wider Medway quality issues would be welcomed. Some partners would like a Medway SAB.
- Safeguarding awareness week was highlight as a good example of joint working

Training:

- Joint training is not offered to all partners (e.g., care providers) and opportunities to undertake more learning together on key issues would be valued.
- Available training is not always accessible for all partners - a few partners are not able to use Zoom which is the preferred platform for the SAB.

Governance arrangements and links to partners processes

- Concerns about the lack of clarity and written processes e.g. Terms of Reference for all groups, reporting structures (including escalation points and how meetings feed into one another); decision making trees etc is needed
- Links to ILRs, MARAC and Vulnerability Panels lacked clarity.
- The QA process was seen as 'light' in comparison to C&YP e.g. quality and concerns process and concerns about the impact on the CQC Assurance

Working with Safeguarding Hubs

- Feedback and progressing work – a few partners reported delays in progressing work - and sometimes don't hear back (particularly the outcome of a S42) unless via a personal contact.
- Some partners were aware of the case file audit, but were not party to any feedback and action planning.
- Partners highlighted the potential risks and tasks outstanding of having Virtual Workers.
- Some partners shared there are some very good Social Workers, but felt they were few in number, with a sense that s42 was moved to ahead of any real exploration or conversations.

Partners- suggested actions
1 Review governance structures and links to partner structures – ensuring groups have ToR, clear roles and reporting arrangements
2 Learn from C&YP services and review QA processes
3 SAB review access to training for all providers – the platform used and access for care providers
4 Feedback any issues highlighted in the Case File Audit. and ensure mechanisms to monitor improvements.
5 Deliver mandatory refresher safeguarding training with a focus on best practice ahead of s42 i.e. fact finding and professional curiosity.

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March 2022