Safeguarding Adults in Stockport

Stockport Safeguarding Adult Board

Quality Assurance Framework

2017–20

The Quality Assurance Sub Group of the Stockport Safeguarding Adult Board have developed this Quality Assurance Framework to give assurance that the Board and its constituent partner agencies have effective systems, structures, processes and practice in place to improve outcomes and experience in the context of safeguarding adults at risk.

This Quality Assurance Framework is also a key mechanism by which the SAB holds local agencies to account for their safeguarding work, including prevention and risk management.

Introduction

Stockport Safeguarding Adults Board (SSAB) has a duty to ensure the effectiveness of what organisations and agencies do in order to safeguard and promote the safety and wellbeing of adults at risk. Effective work in this area will contribute towards achieving better outcomes for adults at risk and protection them from significant harm.

This framework has been developed taking account of the Care Act 2014 and Care and Support Statutory Guidance, March 2015.

National context

The Government's policy on safeguarding adults was set out in May 2011 and re-issued in 2013, when 6 principles were identified for local authorities, housing, health, the police and other agencies to follow and use for monitoring safeguarding arrangements.

Care Act 2014

The Care Act 2014 has provided a statutory framework for adult safeguarding, setting out the responsibilities of local authorities and their partners and those with whom they work, to protect adults with care and support needs from abuse and neglect.

Association of Adult Social Services (ADASS) and the Local Government Association (LGA)

This framework reflects the ***Standards for Adult Safeguarding*** (ADASS; LGA, Dec 2012) and also reflects messages in relation to Safeguarding Adults Boards set out in the ADASS paper ***Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services*** (ADASS; LGA, March 2013).

In June 2013 ADASS published ***Making effective use of data and information to improve safety and quality in adult safeguarding*** which provides 10 tips in relation to Safeguarding Adults Boards effectively using data and information to improve safety and quality in safeguarding adults:

1. Spend time on making sure data and information supplied is useful
2. Interrogate the data and information presented
3. Beware of overwhelming people with data and information
4. Use and develop the mechanisms you have
5. Have sound protocols in place to share data and information
6. Establish a method to share concerns about regulated health and social care services
7. Use community safety data and information
8. Route concerns to the right place
9. Find ways to support staff that may need it
10. Make data and information, like safeguarding, everybody's business

NHS

In March 2013 the NHS Commissioning Board produced a document ***Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework,*** which states NHS organisations – whether as commissioners or providers of NHS funded care – must demonstrate strong local leadership, work as committed partners and invest in effective co-ordination and robust quality assurance of safeguarding arrangements.

Social Care Institute for Excellence (SCIE)

Post Care Act 2014 SCIE offered guidance to SAB's to support them to seek assurance of the effectiveness of safeguarding activity and ensure safeguarding practice is continuously improving and enhancing the quality of life for adults with care and support needs and carers, in line with 'Making safeguarding personal'.

The guidance identified the following mechanisms for QA:

- data recording, analysis and reporting, case audits & SAB and agencies' self-audits & peer review
- safeguarding adults reviews
- practitioners' forums to share lessons from case audits and local good practice, from research and from safeguarding adults reviews
- holding member and partner agencies to account
- the management of large-scale investigations, serious incidents, complaints, grievances, disciplinary proceedings, whistleblowing and allegations of professional malpractice or unfitness to practice
- the implementation of 'Making safeguarding personal' at a local level and its impact on engagement and outcomes.

SCIE advised SABs need a range of approaches to quality assurance to monitor the effectiveness both of their own work and that of their partner agencies. These should include:

- use of data collection analysis for a quantitative perspective
- self-audit tools
- qualitative reviews and audits.

Local Context

The Stockport Safeguarding Adult Board (SSAB) is a group of statutory, private, voluntary, and independent organisations across Stockport who work together to empower and protect some of the most vulnerable members of our community

The SAB provides the strategic leadership for safeguarding work and is committed to partnership working. The Board needs to assure itself that;

- local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance,
- safeguarding practice is person-centred and outcome-focused,
- agencies are working collaboratively to prevent abuse and neglect,
- agencies and individuals are providing a timely and proportionate response when abuse or neglect have occurred, and
- safeguarding practice is continuously improving & enhancing the quality of life of adults in the area.

The remit of the Board is not operational but one of co-ordination, planning and commissioning and contributes to the wider goals of improving the well-being of adults.

All partner organisations in Stockport prioritise safeguarding with an approach based on promoting dignity, rights, respect, helping all people to feel safe and making sure safeguarding is everyone's business.

What is Quality Assurance?

Quality assurance is about assessing the quality of the work we undertake to safeguard adults at risk and understanding the impact of this work in terms of its effectiveness in helping to keep adults at risk safe. Effective quality assurance will contribute to a culture of continuous learning and improvement.

The primary challenge of quality assurance is to improve the quality of practice and safeguarding outcomes for adults at risk.

What is the QA Framework?

The framework is for strategic partnerships and individual organisations with safeguarding adults responsibilities in Stockport.

The framework is based on an 'Outcomes Based Accountability' (OBA) approach which will help those with leadership, senior management or scrutiny responsibility for safeguarding adults to gain a better understanding of how safe adults at risk are in their services and communities by considering:

- What we do
- How well we do it – are partners working well to respond to safeguarding concerns?
- What difference we have made/is anyone better off? - do safeguarding arrangements improve outcome for adults at risk

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Types of data:

There are three types of performance information/measures as follows;

Quantitative information
This will help to inform *What we do.* It answers the questions: 'How much/how many?'

Qualitative information
This will tell us more about *How well we do it*. It is concerned with the functioning of the organisation, the quality of what was done

Outcome information
This tells us *What difference, or impact we have made* (through our services, strategies and interventions) to the lives of adults at risk.

Traditionally, quality assurance information in safeguarding has focused largely on quantitative information, with some qualitative information and very little outcome information. The challenge is, over time, to increase the proportion and importance of outcome information as this constitutes what really matters, supported by qualitative information and then quantitative information.

Principals Underpinning the Framework

Empowerment
People being supported & encouraged to make their own decisions and give informed consent

Prevention
It is better to take action before harm occurs

Proportionality
The least intrusive response appropriate to the risk presented

Protection
Support and representation for those in greatest need

Partnership
All partners, Communities and Stockport citizens have a part to play in preventing, detecting and reporting neglect and abuse

Accountability
Accountability and transparency in delivering safeguarding

The Quality Assurance Framework is also underpinned by the following principles:

- **Openness and transparency:** each agency within the SAB is likely to know where good practice, areas for development and risk lies in its own organisation. The SAB needs to be assured agencies have identified and acted upon risk and areas of development, or to be enabled to do so as a multi-agency Board. All partners must bring good practice, areas for development and risks to the table so that the Board can agree how they can be mitigated. Some will be single agency actions and some will require multi-agency action.

- **Outcomes:** good quality safeguarding arrangements should be person-centred, defined by the individual, outcomes-based and making a difference, in line with ***Making Safeguarding Personal*** – i.e. to what degree do our safeguarding arrangements deliver what is important to adults at risk and the outcomes they want to achieve.

- **Triangulation:** that different qualitative and quantitative information sources need to be compared and contrasted to cross-verify the data and validate any conclusions being drawn. This will enable the Board more confidently to understand whether arrangements are effective and making a positive difference.

- **Learning & Improvement:** What we do with the information collated is as important as the quality of information we collect. Therefore, the learning from quality assurance will be shared with partners and used meaningfully to change practice and improve outcomes for clients and carers.

Sources of information

Information will come from the following sources

- Organisational performance / activity data
- Case Records
- Experiences of Frontline Staff and Managers
- Experiences of clients /carers

By and large, organisational performance / activity data and case records have been the two main sources of information used in safeguarding quality assurance. Whilst it is recognised that these are important and valuable sources, to get a full picture of what is really happening, it is important to capture the experience of client /carer/s, and the experience of frontline staff and managers.

All partner organisations will need to consider how they collate quantitative, qualitative and outcome-based information from the four sources to inform improvement activity in respect of their safeguarding practice.

Organisational performance / activity data

Clear, comprehensive range of performance information supports an understanding of effective safeguarding practice. It is at the heart of the drive to secure continuous improvement and delivery of high quality services.

Case records

The case records held by an organisation, in whatever format, will be a rich source of information.

Case record 'auditing' involves the systematic analysis of records by staff with relevant professional expertise, in order to glean the required information from a sufficient sample of cases to provide a picture of what is going on through gathering the case findings.

The experience of clients/ Carer/s

Obtaining the views of clients/ carers in safeguarding work is underdeveloped because it is hard to do, especially in what can be of a sensitive nature of safeguarding work.

It's important to know how clients/ and carer/s feel they are treated by the professionals and agencies they interact with. If their experience of such interactions is negative, this is likely to have an adverse impact on outcomes. Understanding what matters in terms of engagement and interaction, and whether this is something they experience in reality (and therefore identifying what professionals and agencies need to get right) is something only clients and carer/s can tell us.

The experience of front-line staff / managers

Staff and frontline managers will often know about the quality and impact of their own services, and those of partner agencies they work with. Safeguarding Adult Reviews have highlighted the false assurance between what is meant to happen in terms of policy and procedure, and what actually happens. It is important to have a constant feedback loop from the frontline to keep senior management and those with governance responsibilities 'reality-based'; not just in terms of what is or is not working, but to assist with ideas for improvement so that changes can be made systematically.

The Quality Assurance Framework

Elements of the Framework

1. **SAB Self - Assessment** of strategic and organisational arrangements to safeguard and promote the wellbeing of Adults at Risk. This tool has been developed to provide all organisations in Stockport with an annual framework to assess monitor and improve their Safeguarding Adults arrangements.

2. **Data/Performance** – a range of data will be required from partner agencies/organisations to inform Board Quality Indicators/Data/Performance Report. The aim is to use this information to enable the SSAB to understand the prevalence of abuse/ neglect, highlight themes and trends in safeguarding activity, and identify issues that need addressing in safeguarding arrangements. The information should cover trends in reported abuse, partnership working to respond to safeguarding concerns, and outcomes. As far as possible data from across the safeguarding partnership that is already collected and used by individual agency management teams to monitor the effectiveness of their individual safeguarding arrangements, will be utilised.

3. **Memorandum of Understanding / Duty of Candour** – the Board Quality Assurance Framework places a duty of candour on all partner agency/organisation – this in practice will mean there is an expectation that all partner agencies and organisation will notify the Board of any issues of concern – such as poor regulatory inspection outcome, safeguarding adult reviews, issues that might attract media attention, and any other pertinent information.

4. **User experience** – understanding their journey. All partner agencies should have processes in place to understand the service user experience of their service. SSAB is interested in adults experiences of the safeguarding adults process – therefore this framework places a duty on agencies/ organisations to ascertain people's safeguarding experience and report them to the Board, via the QA Sub Group, so that their experiences can inform the work of the Board.

5. **Training/Competency** –ensuring training is sufficient, positively impacts on practice and in turn improves outcomes for adults with care and support needs in Stockport, and staff working with adults with care and support needs are skilled and competent across all sectors. The Learning & Development Sub Group will lead on this area of work.

6. **Single Agency Audits** – Each partner agency must have in place auditing arrangements to assess the quality of their day to day safeguarding adults work. The QA Sub Group will ask, annually, to review such arrangements or ask partners to share findings.

7. **Multi-Agency Audits** - Each year the QA Sub Group will review and update a Quality Assurance work plan for approval by the SSAB. Three times a year the QA Sub Group will undertake themed audits, as proposed in the work plan. Where ever possible the experience of adults at risk will be a key factor.

8. **Complaints** - Each partner agency must have in place arrangements for monitoring complaints to ensure safeguarding issues are identified and responded to early and quickly. The SSAB reserves the right to ask partners to share complaints data.

9. **Safeguarding Adults Reviews** - SAR's will also review the effectiveness of procedures and identify lessons for improvement. The QA sub group will monitor progress against action plans and assurances will be provided to the SSAB on completion.

10. **Annual Report** – SSAB will publish, each financial year, an annual report to highlight achievements, objectives, strategies and priorities throughout the year. It will also include the findings of any Safeguarding Adults Reviews concluded in that year.

Learning & Improvement

Learning will be linked to the following areas:

- Training
- Team Meetings
- Workforce planning and development
- SAB Communication Strategy/Plan
- Policy & procedure
- Commissioning
- Supervision
- Partner Agency Improvement Plans
- SAB Business Plan
- Workshops/Briefing Sessions
- Learning and Development Sub Group

Briefings to share learning from multi-agency activity will be distributed across the partnership on conclusion of action planning.

Roles and Responsibilities

Individual agencies and organisations includes all statutory members of the board are responsible for:

- Their own quality assurance activity in relation to safeguarding
- Supplying information and data as required by this framework
- Ensuring appropriate representation on the QA Sub Group
- Participating the three times per year multi-agency audits as defined by the QA Sub Group
- Notifying the SAB on any areas of concern – poor regulatory inspection outcome with regards safeguarding
- Request a Safeguarding Adult Review, as appropriate

Quality Assurance Sub Group

On the SSAB's behalf, this Sub Group will be responsible for the co-ordination and management of the quality assurance framework.

The Quality Assurance Sub Group will provide a quarterly Sub Chair Report to members of the SAB.

Other SSAB Sub Groups

Each of the Sub Groups has a different remit with the consistent theme of understanding and achieving better outcomes for adults at risk.

Each Sub Group is expected to work within this Quality Assurance Framework and:

- Provide the Quality Assurance Sub Group with data, information and reports as required by this framework.
- Respond to and receive requests from the Quality Assurance Sub Group
- Participate in audits as directed by the Quality Assurance Sub Group

Stockport Safeguarding Adults Board

SSAB oversees the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard adults from abuse and is responsible for challenging all relevant organisations on their performance in ensuring that adults at risk are kept safe in Stockport.

The SSAB will:

- Receive reports from Quality Assurance Sub Group
- Receive and scrutinise agreed performance information.
- Participate in SAB Development events with a focus on quality assurance.
- Work effectively with Stockport Health and Wellbeing Board and other Partnerships to ensure adults at risk are safeguarded from abuse and harm and their wellbeing is promoted.
- In accordance with the provisions of the Care Act, the SSAB annual report will provide a detailed analysis of the effectiveness of safeguarding within Stockport. The report, through scrutiny of the evidence gained through the quality assurance programme, will highlight good practice and identify where (and how) improvements are to be made.
- Ensure the SSAB Quality Framework informs the Business Plan.

Appendix A: Quality Assurance Work Plan

Stockport Safeguarding Adults Board

Sub Group: QUALITY ASSURANCE SUB GROUP

April 2017 to March 2019

Relevant shared strategic objective for the SSCB and SSAB:
SCRUTINY CHALLENGE AND QUALITY ASSURANCE: from a safeguarding perspective for the quality, transformation of services including the development of Stockport Family , Stockport Together and all age Multi Agency support and Safeguarding Hub . Develop a standardised approach to assessing and evaluating the work of the boards in relation to partners engaged in safeguarding children, young people and vulnerable adults.

1. Transitions
2. Neglect
3. Domestic Violence and Abuse
4. Complex Safeguarding

Mental Health is an underpinning feature of these areas

RAG	
Red	Actions not started or completed
Amber	Actions underway or nearing completion
Green	Actions completed
Blue	Actions not yet due

Date Reviewed	Designated Officer
21st November 2018	SM/LW

	Aim	Actions	Lead	Measure /Outcome	Timescale	Progress	RAG
	Priority 1 Transitions						
	Statement of commitment is refreshed to include commitment of transitions work.	To refresh and update terms of reference for each sub group. Updates and refresh SAB membership Circulate to SAB for endorsement	LW	Refreshed Statement of Commitment available on SSAB Website.	February 2019	Statement of Commitment completed and to be published on both board websites	
	Priority 2 Neglect						
	Develop a multi-agency audit tool re self-neglect for single and multi-agency use	Agencies submit 1 audit in relation to neglect	QA Sub Group	Agencies to contribute to neglect audit to improve outcomes for children, families and adults at risk.	April 2019	Self-neglect audit day scheduled for Q4. Template completed and agreed at QA sub group	
	Development of data set on self-neglect and safeguarding arrangements	Develop a performance dashboard covering elements of safeguarding, harm levels, Dols and SAR's	LW/SM	We will have data that the board can scrutinise and challenge	June 2019	Dashboard is developed and will be shared at each QA meeting	
	Development of a 2 page practitioners guide on self neglect and hoarding to support the multi-agency self neglect and hoarding strategy	Develop a practitioners guide with up to date relevant contact details for practitioners to use when seeking advice	LW/SM	Increase awareness of self neglect strategy Adults at risk will receive evidence based , up to date support Increase professional knowledge Promote multi-agency working in cases of self neglect and hoarding	November 2018	2 page guide complete and embedded within the multi-agency self neglect strategy Shared with the training and development sub group	
	Priority 3 Domestic Violence and Abuse						
	Ensure the picture of data is evident and appropriate analysis of information is provided to board via the	DV data to be included into data performance dashboard. Business analysis send monthly updates on DV along with other data set which is	GMP/domestic abuse steering group	GMP data set provides a robust picture of Domestic Abuse within Stockport	June 2018	DV is incorporated into the Adult Social Care Safeguarding performance dashboard.	

	domestic abuse sub chair report	scrutinised at the domestic abuse steering group				The Dashboard is shared with Adult Social Care on a quarterly basis.	
	Support the Domestic Violence audit across agencies	GMP will identify the 50 cases and Prevention Alliance will highlight a further 10 cases. The QA Sub group will support and participate in the moderating of findings.	GMP/QA Sub group	Learning is achieved to inform good practice	July 2018	Action plan has been populated. Moderation panel confirmed for Partners to share and tell on progress against the action plan January 2019	
	Conduct a multi-agency domestic abuse audit.	Domestic Abuse Task & Finish Group meet quarterly. A template is to be populated and dates are to be confirmed for moderation of findings.	GMP/QA Sub Group	Learning is achieved to inform good practice.	July 2018	Completed	
	Priority 4 Complex Safeguarding						
	Establish data requirements in regard to complex safeguarding	To understand the definitions of adults complex safeguarding to determine the measures.	QA Sub Group	SSAB have a robust picture of complex safeguarding	June 2019	Currently underway with the complex safeguarding sub group	
	Invite the adult sub chair of the complex safeguarding group to the QA sub group for an update on data pertaining to complex safeguarding and adults	To understand the themes, patterns and trends alongside local and National complex safeguarding issues pertaining to adults	QA sub group	The group to have a better understanding of the issues and data in regards to complex safeguarding	January 2019	Invite sub chair to the QA sub group to discuss complex safeguarding Sub chair to attend and present to the group	
	Business as usual						
	Review the Multi-agency Policy for Safeguarding Adults at Risk and Operational Procedures for Responding and		QA Sub Group	Increase awareness and promote a consistent approach for all partners across the economy	March 2019	Peer review complete. Recommendations have been made and waiting actions from improvement plan.	

	Investigating abuse for 17/18					Task and finish group to be arranged in January to review and update the multi-agency safeguarding adult's policy and procedure.	
	Develop an overarching QA performance framework for monitoring safeguarding and local targets, and to escalate areas of concern to the SSAB	Develop a QA Framework	QA Sub Group	The SSAB will have the evidence to scrutinise and challenge areas of concern.	September 2018	QA sub tested a QA framework on two audit days. QA group agreed a framework that is suitable.	
	Establish a multi-agency audit programme on a thematic basis.	Develop templates that partners can use to share internal safeguarding auditing. Arrange share and tells to enable agencies to present to a wider group for additional scrutiny and challenge. Conduct three audits annually based relative themes: • Domestic abuse • Discharge Planning from hospital • Self Neglect	QA Sub Group	Multi agency audits to be completed each term. Identify key themes, good practice and learning points. Enable recommendations for improvement where areas have been identified.	September 2018	2 audits conducted, one on DV, and the other relating to discharge planning from hospital. Self neglect audit rolled out for January 2019. Methodology agreed and ratified.	
	To support the facilitation of the safeguarding adults conference in October 2018	To work closely with Training & Workforce development to ensure the content of the day is correct and to agree on target audience.	LW	A greater awareness across the economy	October 2018	Completed	
	Dip sample cases relating to care plans and good record keeping, in line with outcomes identified from SAR1 (BM) action plan	Care plans and daily records to be selected for scrutiny. 5 from nursing, and 5 from residential homes and to be moderated at QA sub group for assurance. Include the above indicators to the dignity audit for QA to measure.	QA Sub Group	• Promotes good practice • Leads to improvements in effective care planning • Service users receive person centred care • Improves team working and communication	Sept 2018	Completed	
	Partners to do a dip sample table top audit of 10 cases per agency of any adults	Develop a checklist for partners to follow	QA sub group	Prepare for a deep analysis of DNA's Identify learning in order to improve practice	March 2019	Task and finish group to be set up and agree checklist	

	who do not attend appointments						