KEY MESSAGES FROM THE LSAB MARCH 2013

Once again we had a packed agenda as well as working with a Home Office peer review team who were looking at local safeguarding boards across the country

The sub-groups reported back on their work, which as always has been pretty intense:

Training and Development Sub Group
Attendance at the Training and Development group meeting in January 13 was poor with only representatives from LA team managers, Sirona Care and Health and Way Ahead. Despite this they worked on the safeguarding adults training audit, training availability for MCA/DOLs, level three workshops and a possible joining up with the children's training sub-group. They also identified possible further areas for joint training development such as:

- Trigger thresholds for safeguarding and neglect in particular
- Training on supervision standards (supervisor and supervisee)
- Joint training on serious case review (SCR) recommendations

Awareness, Engagement and Communications sub group
The group have been working on a number of areas:

- A workshop took place on 29th January 2013 to develop a calendar of opportunities providing information for citizens, providers and publications. Also a large number of events, print and web opportunities were identified
- Service user and carer involvement in the LSAB is under active consideration. It was decided a wider discussion needed to take place with the whole LSAB to decide the purpose and what the LSAB needs to achieve.

Policy and Procedure sub group
The group is continuing to progress its work in line with the new Business Plan and has / is in the process of:

- Continued its work on the triggers
- Reviewing the Multi-Agency Information Sharing Principles
- Looking at lessons learned from Winterbourne View
- Working on an induction pack for new LSAB members

Quality Assurance, Audit and Performance Management sub group
The group met in March 13 and discussed or completed the following areas of work:

- Multi-agency audit
- Referral Audit Review undertaken by Sirona Care and Health
- Review of the safeguarding adults referral data
- Drafted a risk register for the LSAB to consider
- Reviewed the Children Services Ofsted Report in relation to impact on Adults
- Analysed the LSAB feedback questionnaire Survey Monkey (61% response)

Mental Capacity Act and Deprivation of Liberty Safeguards Quality and Practice Group
The group has focussed on the following areas of work:

- DoLS monitoring - 59 applications to date; all completed within required timescale

- Commenced work with SWAN the new IMCA Service provider
- Commenced work on new indicators for MCA/DOLS
- Continued to seek assurance on the application of the MCA

The rest of the LSAB looked at the following areas:

1. Risk register. This is to be adopted and used to understand the critical areas of risk. This is especially important as referrals continue to rise and resources remain very tight.
2. LSAB feedback survey. All LSAB and sub-group members were asked to complete an on-line survey about the Board's effectiveness and impact. There were a lot of positive comments but it is clear that we also need to make sure that all members communicate better what the Board is doing and how people can engage with its work. We also need to be clear that we focus on things that really make a difference to adults at risk. (Copies of the summary of this work can be obtained from Clare Tozer at B&NES Council).
3. Service user involvement. The Board needs to improve in this area and is looking for ways to do this. We are keen that we want to be able to reach all groups, that it should not be tokenistic. Healthwatch may be one way of moving this forward.
4. Commissioning. The Board looked at a paper about the fit with commissioning and agreed that a half-day workshop was needed to take this forward. This is also about risk and how this is shared between commissioners and providers.
5. The Board was presented with a community safety case study, which was also attended by the Home Office review team. This was a powerful study and demonstrated how it was possible for someone at risk to be missed by agencies. In fact, Fire and Rescue recognised what was happening and this led to this person being supported and helped. This case highlighted the need for good multi-agency working and for good communications and for people with concerns to 'just tell someone'. Board members agreed that this was very useful presentation.
6. Winterbourne View. The Board was updated on the actions taking place in the wake of this enquiry.
7. The key recommendations from the Francis Report (Mid-Staffs) were presented and the Board is starting to look at how they will affect practice and what local providers are doing in response.

For future Board meetings it was agreed that case-studies and asking people to present examples of practice would be helpful and would be a useful response to some of the points in the survey. It was also agreed that the Board needed to be aware of the impact of the current welfare reforms and their possible effect on safeguarding.

Please contact me direct if any of these points need clarifying or if you want to work with Board.

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