



**Bracknell Forest and
Windsor & Maidenhead**
Safeguarding Adults Board

**Bracknell Forest and Windsor & Maidenhead
Safeguarding Adults Board
Annual Report 2018-19**

“Safeguarding is Everyone’s Business”

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1 Preface

- 1.1 This report covers the period 1st April 2018 to 31st March 2019 in accordance with the Care Act 2014. It will be submitted to the Royal Borough of Windsor and Maidenhead (RBWM) Managing Director, Bracknell Forest Council (BFC) Chief Executive, Leaders of each local authority, the Local Police and Crime Commissioner and the Chairs of the Health and Well Being Boards. It should also be presented to the Boards of the CCG and all partner agencies.

2 Introduction

- 2.1 The Care Act 2014 put safeguarding adults on a legal footing for the first time and required Safeguarding Adults Boards to be set up across local authority areas to encourage partner organisations to work together and ensure local arrangements effectively help and protect adults in the local area so that everyone can live safely, free from abuse and neglect.
- 2.2 The Care Act 2014 also required all agencies to promote individual wellbeing with a multi-agency approach to achieving positive outcomes for people who use services. The accompanying statutory guidance - Making Safeguarding Personal – required a change in day to day practice and organisational culture to allow the person who may be at risk to be put in charge of their own life. This requires agencies to listen to the person’s voice about what they want and the outcomes that they are seeking from any safeguarding intervention.
- 2.3 The Care Act 2014 required each local authority to establish a Safeguarding Adults Board with core membership from the local authority, the police and the local Clinical Commissioning Group. In July 2017 The Bracknell Forest Safeguarding Adult Board and the Windsor & Maidenhead Safeguarding Adult Board merged to form the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board.
- 2.4 This is the second annual report of the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board. It describes the implementation of the Board’s 2017 / 18 strategic plan as well as future challenges. In line with the requirements set out in the Care Act the Board has continued to develop its strategic plan during the year.

3 Independent Chair's Report – Terry Rich

3.1 Independent Chair's Report – Terry Rich

Last year's report was to have been my last, but events have meant that I continued to chair the Board during 2018-19 and stand down at the end of March 2019.

During the year the Board has continued to develop well and has been rigorously pursuing the objectives set out in the Business Plan. Later sections will review progress in more detail. The engagement of partners in the work of the Board and its sub groups has been strong for which I am extremely grateful. The Board has also been ably and enthusiastically supported by Board Manager Dave Phillips, supported by Julie Sheppard. Deborah Maynard – joint Business Manager has brought her experience and expertise to bear in supporting the SAR group and managing active Safeguarding Adult Reviews.

The benefits envisaged from a joint Board have continued to be evident:

- A greater sense of Board independence - no longer seen as owned by a single local authority
- Increased range of partners involved and active in the Board and its work
- More opportunities for shared learning – wider area covered and more partners at the table
- Local benchmarking of activity and performance across the two local authority areas
- Less duplication of effort – statutory partners attend less Boards covering same business



Some of the notable areas to highlight from the past year have been associated with reviews of key cases.

Our conference: **“Ageing well with learning disabilities”** attracted an audience which came from across the region and nationally renowned speakers including from NHS England and active participation and contribution from people with lived experience. As a result of the conference we have identified a need for training in conditions of ageing including dementia and end of life amongst staff across all disciplines working with people with learning disabilities. The Board or its successor(s) will need to return to check progress in achieving this over the next year.

We also published a SAR related to a death in a house fire and partners from **Berkshire Fire & Rescue** have led the way in raising awareness amongst all agencies around fire risks and how to identify and mitigate them. Their presentation to the conference was well received and received many follow-up contacts.

A third SAR concerned a death in a care home which had been subject to the Windsor & Maidenhead **Care Governance framework**. The review made recommendations to strengthen this in a number of respects but also called for work to align the framework across the two local authority areas. The Board has recently heard that a single care governance framework – based on the Windsor & Maidenhead model - is to be applied across the whole of East Berkshire. This will be a very positive move.

The Board has also been working to develop the **Multi Agency Risk Framework** and this is being rolled out across both Bracknell Forest and Windsor & Maidenhead. This allows any agency to identify and escalate a case of concern to a multi-agency meeting where risks can be explored and an action plan agreed.

The **Quality Assurance Group** has been established and has further explored the differences in activity levels between the two local authority areas. The Board has maintained a view that further examination is necessary to be assured that a) safeguarding cases are not being under reported in one area, or b) an over cautious approach in another area is leading to unnecessary issues being raised and scarce resources being inappropriately deployed. A programme of case audits and peer audit activity has helped to elucidate further.

Themed Board meetings

During the year the Board has held a series of themed Board meetings examining key safeguarding risks in some depth. These have included: Mental Health and safeguarding of vulnerable young through transition. In each session we heard from a broad range of agencies and identified areas where further inter-agency work could be pursued to provide greater assurance. The Board and / or its successors may wish to consider further areas where this approach might be used. Some ideas that have emerged include: young adults at risk of exploitation, safeguarding at end of life, and how to ensure that people with lived experience are involved in a quality assured service.

As I end my work with the Board, I am aware that changes are planned, and disappointingly the Local Authorities have indicated that they see greater alignment between adult and children safeguarding structures as being their preferred way forward – and not a joint Safeguarding Adults Board. Clearly there are merits in this approach and our own work around exploring the gaps for vulnerable young people through transition to adulthood highlights the valuable work that could result from closer alignment.

However, in reforming the arrangements I truly hope that the joint working and shared learning that has been generated in the 2 years of this joint Board's existence will not be lost. I wish partners well in the future and trust that Safeguarding Adults will remain high on all agencies' agenda.

Terry Rich
Independent Chair 2017-19

4 Safeguarding Adults Boards Governance and Accountability

4.1 The main objective of the Board is to assure itself that local safeguarding arrangements, and partners, act to help and protect adults in the area who meet the criteria set out in the Act. That is, they:

- have needs for care and support and
- are experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs are unable to protect themselves from risk of, or experience of, abuse

4.2 The SAB has a role in overseeing and leading adult safeguarding across the locality. It has a role too as a source of advice and assistance. This includes a focus on:

- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- seeking assurance that agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area

4.3 The SAB has a strategic role and this is comprised of three core duties:

- publishing a strategic plan for each financial year setting out how it will meet its main objective
- publishing an annual report detailing the activities of the SAB
- deciding when a safeguarding adult review (SAR) is necessary, arranging for its conduct and if it so decides, implementing the findings

4.4 The Board has responsibility for safeguarding partnership working across other key agencies; this oversight ensures it applies effective processes and procedures to protect those adults most at risk and offers appropriate support. It also ensures that those agencies practise to a high standard and can evidence their performance.

5 Local Context

5.1 Demographics

5.1.2 Demographics provide a focus for the Board; nationally between 500,000 and 800,000 older people are subject to abuse and /or neglect in the UK each year and this number is set to rise by 1.6 million by 2050. The number of people aged 18 and over in Windsor and Maidenhead is 114,639 compared to 91,273 in Bracknell Forest. The number of people aged 65 and over in Windsor and Maidenhead and in Bracknell Forest is projected to rise from the current populations of 27,293 and 16,669 respectively (ONS Mid-Year 2011 estimates). This, together with increasing numbers of people with disabilities reaching adulthood, places additional demands on adult services.

5.1.3 There are a significantly larger number of care homes in Windsor and Maidenhead compared to Bracknell Forest. There are 1339 care home places available in the 38 care homes in Windsor and Maidenhead compared to 439 in the 15 Bracknell Forest Care Homes.

5.2 Local Arrangements

5.2.1 The Board has continued to grow following the merger which was effective from 1 July 2017. The Board comprises senior leads from statutory and non-statutory partners and is supported by both local, East-Berkshire-wide and pan-Berkshire-wide sub groups. Details of member attendance at the Board are given in Appendix 1.

5.2.2 All partner organisations in Bracknell Forest and Windsor & Maidenhead are expected to 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. The Board leads adult safeguarding arrangements across its locality.

5.2.3 The Board develops and actively promotes a culture with its members, partners and the local community that recognises the values and principles contained in, 'Making Safeguarding Personal'. The Board has an independent chair and meets on a quarterly basis. The Board's member organisations are currently:

Royal Borough of Windsor and Maidenhead	Berkshire Care Association
Bracknell Forest Council	Frimley Health NHS Foundation Trust
Optalis	Royal Berkshire Fire and Rescue Service
Thames Valley Police Local Policing Areas	Involve
Thames Valley Police Protecting Vulnerable People	Alzheimer's Dementia Support
Public Health	Healthwatch
East Berkshire Clinical Commissioning Group	Care Quality Commission
Berkshire Healthcare NHS Foundation Trust	Radian Housing
West London Mental Health Trust	Silva Homes
National Probation Service	Housing Solutions
Achieving for Children	Police and Crime Commissioners Office

5.2.4 The SAB met four times in the year providing oversight and direction to strategic and operational safeguarding activity across Bracknell Forest and Windsor & Maidenhead. A business planning session was held in June 2018 which was an important opportunity to review the strategic business plan and confirm and adapt the priorities for the year to come.

5.3 Finance & Resources

5.3.1 As there is no national formula for SAB funding, levels of contribution are agreed locally. RBWM and Bracknell Forest Council, as the local authorities, currently contribute just under 66% of the Board's direct funding. In addition, Bracknell Forest Council hosts the Safeguarding Board's business unit. The CCG and Thames Valley Police are the only other partners who currently contribute to the Board. Income and expenditure for 2017/18 are shown in Appendix 2.

- 5.3.2 Whilst it is possible for SABs to budget for planned activities, Safeguarding Adults Reviews (SARs) or other learning reviews present unpredictable financial pressures. The SAB currently has no contingency to cover these unplanned eventualities.

6 Progress on Priority Areas in Strategic Business Plan

6.1. The progress of actions in the strategic business plan, updated at the Board development day and ratified at the Board's June meeting, have been monitored throughout the remainder of 2018/19.

6.2 Over the past year the Safeguarding Adult Board has:

- implemented a Communications and Engagement strategy
- developed ways of capturing the voice of adult who use services
- implemented a Prevention strategy
- implemented the risk framework
- delivered a conference effectively disseminating learning from safeguarding adult reviews
- developed safeguarding forums
- carried out a training needs analysis and implemented multi-agency training
- held themed Board meetings on the subjects of mental health, risks associated with those who organise their own care and arrangements for young people transitioning from children services, to ensure challenge and gaining assurance
- implemented two new safeguarding reviews and concluded a third

6.3 The strategic business plan, demonstrating progress of all actions, is included in Appendix 3

7 Work of Sub Groups

7.1 Quality Assurance Sub Group

7.1.1 The Quality Assurance Sub Group has met on a quarterly basis utilising its quality assurance framework to drive its work. This work has included:

- implementing a partners' training questionnaire to gain assurance of safeguarding training in place throughout the partnership, and to identify areas for improvement
- implementing a service user involvement questionnaire to gain assurance that partners are building in processes to capture the voice of people who use services, and to identify areas for improvement
- implementing local audits – evaluating the quality of concerns and enquiries recorded
- receiving case studies from other partnership panels such as the problem-solving group, the chaotic lifestyle group, multi-agency risk assessment conferences and multi-agency public protection arrangements meetings, all to provide assurance that people are being kept safe within the wider partnership system

- Developing partnership data to include quarterly data for analysis from Thames Valley Police, Royal Berkshire Fire and Rescue Service, CQC, Community Safety and Public Health

The group has also maintained its work in relation to:

- monitoring performance data - bringing together quantitative multi-agency data on: trends in the nature and reporting of abuse; multi- agency responses; and outcomes for adults at risk
- monitoring qualitative information - collating views / feedback from customers, carers, families and staff to establish that safeguarding arrangements are working, delivering the outcomes people want and making a difference
- carrying out a desk top review of the Board's work - looking at how well the Board fulfils its statutory duties to understand if partners are working effectively together to keep people safe
- implementing a partners' self-assessment audit - evaluating the quality of individual agency safeguarding arrangements and developing action plans to improve how agencies keep people safe

In particular, the Sub Group has ensured that regular peer audits have taken place ensuring that concerns are being raised and enquiries taking place appropriately in each local authority area. This auditing takes account of local processes and also references a national report which highlights that local authorities are free to determine the way in which concerns are recorded and enquiries are implemented.

- 7.1.2 The Sub Group identifies areas for further analysis and improvement and makes recommendations as to how these improvements can be achieved. The Quality Assurance Sub Group has reported its work to the Board on a quarterly basis.

7.2 The East Berkshire Learning and Development Sub Group

- 7.2.1 The Learning and Development Sub Group's membership is drawn from members of the Slough and the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Boards. The group has focussed on carrying out a multi-agency training needs analysis during 2017/18 and implementing a delivery plan which for 2018/19 and 2019/20 will focus on embedding the multi-agency risk framework approach in all partner organisations through a series of training workshops.

- 7.2.2 The East Berkshire Learning and Development group will continue to focus on developing the training evaluation system to measure the impact of training provided during 2018/19. It will also review the East Berkshire Safeguarding Adult Board's Workforce development strategy including the workforce standards for safeguarding.

7.3 The Pan Berkshire Safeguarding Adult Boards Policy and Procedures Sub Group

- 7.3.1 The Pan Berkshire Safeguarding Adult Boards' Policy and Procedures Sub Group's membership is drawn from members of the three safeguarding adult boards in

Berkshire. During 2018/19 the work of the Pan Berkshire Policy and Procedures Sub Group has included:

- reviewing and updating its terms of reference and updating the membership to include representation from Thames Valley Police and Royal Berkshire Fire and Rescue Service
- holding a workshop to audit the content, quality and usage of the pan Berkshire policy and procedures website
- implemented training for business managers to manage and update the content of the website
- implementing an allegations management framework
- agreeing a multi-agency information sharing protocol taking account of GDPR legislation
- adopting changes to the pressure ulcer pathway, amending domestic abuse content and updating the modern slavery guidance to include a new reporting flowchart

7.3.2 During 2018/19 the Pan Berkshire Policy and Procedures Sub Group will:

- carry out a full review of policy and procedures
- explore opportunities to implement an easy read version of the policy and procedures
- promote the policy and procedures website

7.4 The Safeguarding Adult Review (SAR) Sub Group

7.4.1 The SAR Sub Group has continued to monitor the implementation of multi-agency action plans for completed Safeguarding Adult Reviews and co-ordinated the completion of one review during 2018/19. More detail about how the learning from completed reviews has been embedded into the work of the Board is given in section 14 of this report.

7.4.2 The SAR Sub Group initiated a further Safeguarding Adult Review during 2018/19. The outcomes of this review will be reported in a future annual report.

7.5 Communication, Engagement and Prevention Group

7.5.1 The new Group has met on three occasions during 2018/19. The group has:

- developed the new communication and engagement strategy and the new prevention strategy and monitored each strategy's action plan
- co-ordinated the capturing of the voice of the service user
- overseen the development of the new safeguarding forums
- developed a new website
- developed the use of social media
- developed the use of a newsletter to aid communication with partners and local communities

7.6 Performance Working Party

7.6.1 A performance working party continued to support the Quality Assurance Sub Group during 2018/19. The working party has:

- developed the partnership performance information to ensure that data analysis takes account of data collected from across the partnership
- continued to co-ordinate case file audits and audits of concerns recorded and enquiries taking place
- developed audits of partners' records including those of TVP, BHFT and Fire and Rescue Service

7.6.2 The sub group has made recommendations for the continuation of peer audits and the further development of multi-agency audits to be considered in the new safeguarding board arrangements in each local authority area from 1 July 2019.

7.6 Risk Framework Task and Finish Group

7.6.1 The Group has co-ordinated the implementation of the multi-agency risk framework training workshops, which were held across Bracknell Forest and Windsor & Maidenhead local authority areas. Details of the multi-agency risk framework training, developed to support those who do not engage with safeguarding process and also those who do not meet safeguarding thresholds, is contained within Section 10 - Training.

7.6.2 The Group's work included developing a multi-agency risk management recording tool to support the risk framework and the development of case studies to support effective learning. The multi-agency risk framework training has now ceased to allow for the cascading of information within partner organisations. The group has recommended that further training be delivered from September 2019 and an evaluation of the use of the multi-agency risk framework by Group members is due to take place in November 2019.

7.7 Conference Working Group

7.7.1 The conference working party met on several occasions to plan and deliver the conference entitled, 'Ageing Well with Learning Disability' on 18 October 2018.

7.8 Specific Risks

7.8.1 A task and finish group has met to address potential risks for those who organise their own care which were identified during a themed discussion at a Safeguarding Adult Board meeting. The group has recommended information to be shared on-line and in hard copy to address potential risk.

8 Contribution of Partners

8.1 Partner organisations have continued to work together as a Board implementing the Board's strategic plan. Partner contributions have included the following:

Taking part in task and finish and working groups to develop the Board's work

- 8.2 Partner organisation representatives have contributed to the work of all sub groups, working groups and task and finish groups. Representatives have also contributed to the organisation of the Board conference and multi-agency training.

Taking part in Board development

- 8.3 Partners provided valuable feedback to a number of questions aimed to determine development areas for the Board as a whole. Common areas for improvement identified which were considered in the end of year development review session included:

- improving the use of data to identify risks / trends
- strengthening links with other Strategic Partnerships

Taking part in a self-assessment to provide assurance that safeguarding arrangements are in place in partner organisations and to facilitate improvement planning in each organisation

- 8.4 During 2018/19 the self-assessment was carried out by partner organisations which provided assurance regarding safeguarding arrangements being in place and identifying areas for improvement. The Board noted that improvements and further developments in safeguarding had taken place when compared with the results from the previous year. Common areas for development highlighted in the self-assessments which were considered in the end of year review included:

- further improvement in community engagement and specifically making information available to the public in an easy read format
- aspects of auditing the impact of work
- aspects of PREVENT

Taking part in a self-assessment to provide assurance that safeguarding training arrangements are in place in partner organisations and facilitate improvement planning.

- 8.5 All partners completed the training questionnaire providing assurance that training was either in place or under review. Areas for safeguarding training development highlighted in the self-assessment included:

- evaluating the impact of training
- regular safeguarding training needs analysis
- disseminating learning from safeguarding adult reviews, coroner's inquests and learning events

Taking part in a questionnaire to provide information on partners' processes for capturing the voice of people who use their services, and approaches to community engagement to inform the Board's work.

8.6 All partners completed the questionnaire providing assurance that community engagement processes were in place or in development. Analysis of the completed questionnaires revealed the following areas for improvement:

- ensure that there are clear and accessible systems in place for the views of adults at risk to be heard and influence change in relation to adult safeguarding
- confirming the main themes identified through individual organisations' engagement with adults at risk in relation to adult safeguarding

The information provided by partners also enabled the Board to develop a new communication and engagement strategy and a new prevention strategy. Action plans were developed to address areas for development highlighted in the returned questionnaires.

Contribution to themed debate and challenge at Board meetings

8.7 Each Board meeting included a "theme" for partners to discuss and provide challenge to one another. The themes that were featured in the 2018/19 Board meetings included mental health, transition, care governance and risk associated with those who arrange their own care. The contribution of partners in this way, including the implementation of corresponding actions, has ensured a role for the Board in co-ordinating partners' work to help and protect adults with care and support needs. This approach has also contributed to the implementation of strategic plan actions.

9 Community Involvement and Capturing the "Voice" of Adults

9.1 The Board has ensured that the lived experience of adults with care and support needs has been captured to inform the on-going development of the Board's work. The voice of the adults who use services has been captured and fed back to the Board in the following ways:

Board conference

9.2 The Board conference featured a drama production by actors who have learning disabilities and also a presentation from a person with mild learning disabilities. The production and presentation provided insights into how people with learning disabilities experience the services they receive. A video featuring these insights was played to the Board and made available to partners via the Board website (see Section 11).

Training

9.3 The experiences of adults with care and support needs has featured in multi-agency training sessions organised by the Board.

Safeguarding forum

9.4 A new safeguarding forum was developed during 2018/19 with the aim of sharing information amongst the community whilst providing opportunity to capture feedback from people who use and provide services.

10 Training and Development

10.1 The table below sets out the breadth of training and development opportunities made available to local stakeholders during 2018/2019.

Training provided in Bracknell Forest & Windsor and Maidenhead Local Authorities

Name of course	Total attendees
Best Interest Assessors Report Writing	3
Children's basic safeguarding and child protection	1
DOLS Refresher/Legal Update for NON BIA 2018/2019	10
DOLS Refresher/Legal Update for BIA's 2018/2019	7
DOLS Awareness (Full Day) 2018/2019	11
DOLS - E-Learning	5
Best Interest Assessor	2
Hording Behaviours	22
MCA Legal Update	12
MCA Level One	47
MCA Level Two	26
MCA Level Three	13
Safeguarding Adults E-Learning	7
Safeguarding Adults Level One	87
Safeguarding Adults Level One Refresher	29
Safeguarding Adults Level Two	46
Safeguarding Adults Level Three	52
Universal Safeguarding	20

Multi Agency Training and Development provided by the Safeguarding Adult Board

Name of Training	Attendees
Multi Agency Risk Framework training	170
Learning from Safeguarding Adult Reviews - Ageing with Learning Disability	130
Learning from Safeguarding Adult Reviews – Fire Risk	130

10.2 The impact of training has been evaluated through seeking feedback at the end of development sessions and then again after 6 months. The following feedback demonstrates impact of the development opportunities offered:

“Since this training I have had contact with the fire service to help me talk with the individuals regarding the risks they are taking within their home. I have also used their service to implement additional smoke detectors within a property, including visual sensors for a gentleman that has a hearing impairment, a shake sensor (that operates under a pillow at night), fire retardant bedding and night wear. There was a fire in one person's home and all the fire retardant things and measures put in place ensured that nothing serious came of it – possibly preventing a death.”

“I have used the knowledge gained from this course whilst chairing several safeguarding meetings to ensure we are considering whether the person's health deterioration is caused by or at least impacted upon by their ageing process”

11 Feature: Board Conference 18 October 2019

The Board's conference took place on 18 October 2018, and was well attended by 125 delegates and staff. The conference focussed on the medical and social perspectives of ageing with disability, providing learning from a recent Safeguarding Adult Review, together with other reviews involving fire deaths. The programme included a drama presentation by Friendly Bombs, a local group of people who have learning disabilities, and a series of presentations that included the voice of people with learning disabilities.



(It was good) "to hear from the perspective of someone living in the community with a learning disability and the difficulties faced."



The quality of speakers was both high and varied and this was appreciated by the audience, as reflected in the feedback forms.

"What really resonated with me was their (people with a LD) perspective of support workers and how they don't always feel listened to."



"Very good and informative. I learnt new things such as the Fire service actively working with agencies to support vulnerable elderly patients at home which I felt was really encouraging to hear."

"Excellent—good mix of presentations and really excellent to see two sections involving people with a LD and particularly people with complex LD in the case of Friendly Bombs"

"I thought it was a good mixed programme with good speakers. There was a mix of health and social topics. The involvement in the day with people with LD was well thought through and went well with the day with the need for everybody to have support and care as an individual"

The speakers' presentations, video clips and photographs from the day can all be viewed on the SAB website - [here](#)

12 Case Studies - Examples of how partners are working together to implement the Board's strategy and keeping people safe through a personalised approach

The overall approach to safeguarding adults within Bracknell Forest and Windsor & Maidenhead aims to promote independence, wellbeing, social inclusion and maximise choice in service provision and safeguarding support. The following case studies demonstrate Board members' approaches to keeping people safe and the commitment to "making safeguarding personal" and demonstrate partners' contributions to the Board's strategic direction through application of the multi-agency safeguarding policy and procedures and the Board's new multi-agency risk framework.

Case Study 1

One evening in 2018 an elderly woman physically attacked her partner. Although he did not sustain serious physical injuries at that time, the abuse continued the following morning and he eventually suffered minor injuries after his partner attempted to stab him with a kitchen knife. She had also committed arson in the family home.

Police and the Fire Service attended and took details about the incident. The person at risk was very shaken by his experience and had left the house for his own safety. He explained how there had been an escalation in his partner's violent behaviours over the previous months. He said he had been verbally and physically abused on and off for over a year. The person at risk told the police his partner was threatening to kill herself on a daily basis and that he feared for her safety as well as his own. His partner had a history of depression and psychosis. Police arrested the woman and took her to the police station. She was seen by a police surgeon who asked for the woman to be assessed under the Mental Health Act and was later admitted to an establishment under section.

An IDVA from the local domestic abuse organisation was allocated to the person at risk and a referral was made to a local carer's support organisation. The man's GP also referred him for emotional support. The person at risk was concerned about his partner's possible discharge from hospital and risk to his future safety. Whilst an inpatient his partner had been diagnosed and treated for dementia and there had been several multi-agency meetings to discuss her future needs.

The hospital planned to send the woman home for a few days to assess her response; however, on a visit home supported by a health worker, the woman became extremely agitated and was returned to hospital. Her family and partner were concerned about her behaviours on this occasion and it was decided that alternative arrangements needed to be made for her eventual discharge. A few weeks later the person at risk decided he did not want his partner to return home as he felt he could no longer cope with her behaviours. Social workers continued to support the person at risk to make the difficult decision to find her placement within a care home that specialised in dementia care.

Case Study 2

The local authority was made aware of a gentleman, Mr M, who was becoming known to a number of health and support agencies due to his chaotic lifestyle. This included living in a car and placing himself in dangerous situations in order fund his lifestyle. Although he had previously worked and held down a tenancy, alcohol related issues had stopped him from fulfilling his responsibilities in these areas and he needed increasing levels of input from the police, social services and health. With winter approaching, there were serious concerns that Mr M would die from the combined impact of living in a car and the dangerous situations he was putting himself into. As a result the Multi-Agency Risk Framework was suggested as a way of engaging with Mr M.

Mr M stated he was happy for the meeting to take place but asked if his father could attend in his place as he did not want to be at the meeting himself. The meeting took place and was attended by representatives from several local authority departments / teams as well as the police and Mr M's father. An honest discussion took place where the concerns and potential risks to Mr M were outlined to Mr M's father who was also able to raise his own concerns and issues. Mr M's father said he was "amazed" by the range of protection and support options available to him and his son. He was given contact details for each agency and informed that a copy of the plan would be given to Mr M.

A week after the Risk Framework meeting Mr M was found injured in a town centre. Due to the Framework's information-sharing approach and the easy read nature of the tool itself, the ambulance crew were able to speak to a named person in the local authority. This enabled Mr M to speak directly to someone who was familiar with his case and could offer immediate support. Mr M said he did not need to attend hospital and agreed to meet with the member of one of the local authority's teams the following day to make an application for a Night Shelter scheme. Mr M attended the meeting and was accepted on to the scheme. Having the support he needed to understand and communicate with relevant agencies in a timely manner resulted in Mr M securing a permanent tenancy and he also started seeking full-time employment. All agencies reported significantly reduced levels of concern about Mr M and his overall appearance and well-being has significantly improved since the initial plan was compiled and implemented.

Although Mr M did not want to participate in the process himself initially, it is evident that having this action plan in place enabled the correct support to be implemented when Mr M was finally ready to accept it. Signposting to agencies for underlying health and well-being concerns was also a positive factor in this approach. Mr M has expressed that all he required was some directed support and "how kind everybody has been helping me get back on my feet."

13 Performance Information

13.1 The performance data reflects the key data monitored by the Board and its Quality Assurance Sub Group and to which all partners contribute. The safeguarding process including the definition of Concerns and Enquiries is defined in the [pan Berkshire safeguarding adult policy and procedures](#).

- An adult safeguarding concern is any worry about an adult who has or appears to have care and support needs, which they may be subject to, or may be at risk of, abuse and neglect and may be unable to protect themselves against this.
- When the Local Authority becomes aware of a situation that meets the criteria¹, it must make or arrange an enquiry under Section 42 of the Care Act 2014.

Number of Safeguarding Concerns and Enquiries Recorded

	Bracknell Forest	Windsor & Maidenhead	South East*	England*
Concerns	567	965	54,280	394,655
Concerns per 100,000 population	614	833	765	908
Concerns progressing to enquiry	137	298	21, 010	150,070
% of concerns progressing to enquiry	24%	31%	39%	38%
Number of enquiries ended	93	302	19,665	125495
Number of enquiries ended per 100,000 population	101	261	277	289

* 2017/18 figures

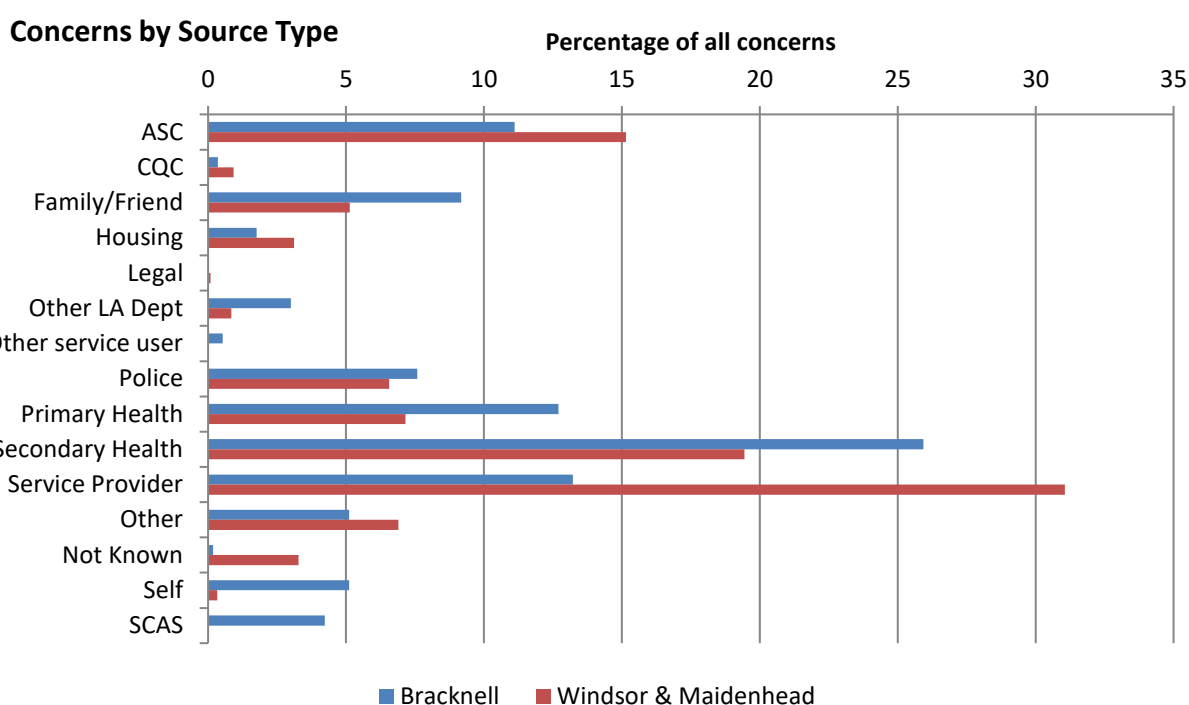
13.2 There is an increase in the number of concerns recorded in Bracknell Forest compared to the previous year (Bracknell Forest 17/18 – 369), while the figures for Windsor & Maidenhead are broadly similar (Windsor & Maidenhead 2017/18 - 922). The number of concerns recorded in Windsor & Maidenhead is similar to those recorded for England as a whole, whereas the number of concerns recorded in Bracknell Forest continues to be lower. Regular audits have taken place during 2017/18 and 2018/19 to gain assurance of local processes. The findings continue to reveal that the difference in the number of concerns recorded is primarily due to the method of recording in the two local authority areas and that all concerns are analysed on receipt before being recorded, with a higher proportion being dealt with separately through case management or signposting to other services in Bracknell Forest.

13.3 There has, however, been a change in the way concerns are processed In Windsor & Maidenhead with a filtering system introduced which is similar to that already deployed

¹ adult who has or appears to have care and support needs, that they may be subject to, or may be at risk of, abuse and neglect and may be unable to protect themselves against this

in Bracknell Forest. Audits have confirmed that all concerns are addressed but not so many are passing to a section 42 safeguarding enquiry in Windsor & Maidenhead but are being dealt with in other person centred ways, similar to Bracknell Forest. The percentage of concerns passing to enquiry is now more aligned in Bracknell Forest and Windsor & Maidenhead compared to the previous year. This again supports audit findings that all those that require help are receiving appropriate support either through the section 42 process or through person centred care where the section 42 threshold is not met.

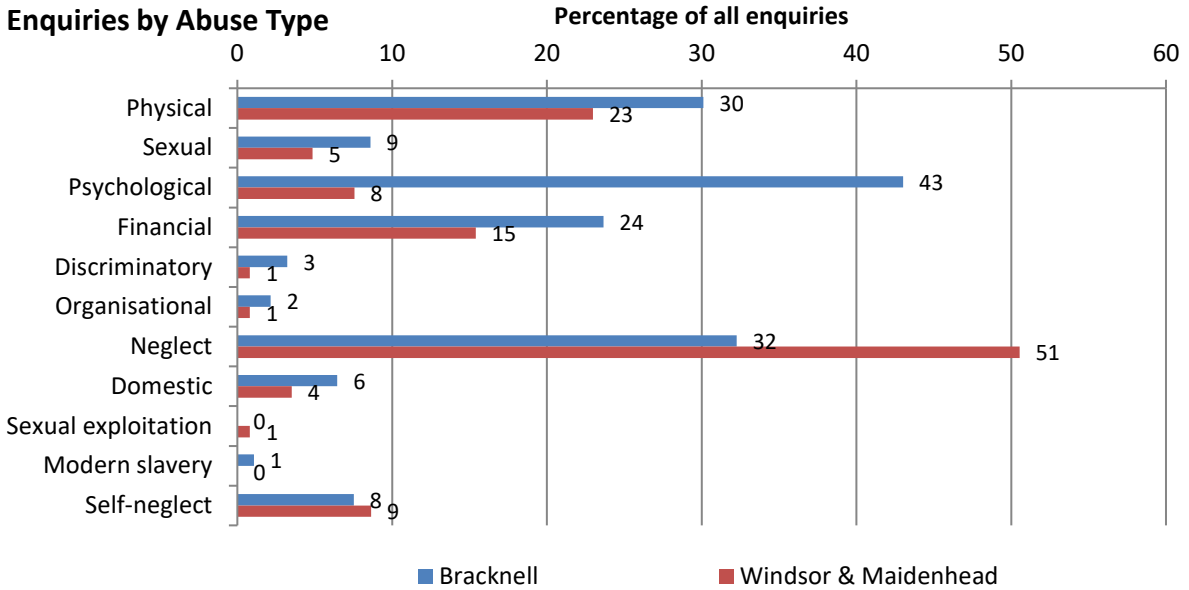
- 13.4 The Board has given consideration to the publication [“Patchwork of Practice”²](#) which highlights the different approaches to recording concerns and carrying out enquiries across England, which is similar to the difference in recorded concerns and enquiries locally and reported in this annual report. National workshops are being organised to explore the different approaches to recording nationally and representatives of the Board will contribute to discussions.



- 13.5 The analysis of the source of concerns received in Bracknell Forest and Windsor and Maidenhead reveals that a higher percentage of concerns are received from service providers in Windsor & Maidenhead which reflects the higher number of care home places in the Royal Borough compared to Bracknell Forest. This supports audit findings that the larger number of concerns and enquiries recorded in Windsor & Maidenhead can be due to multiple concerns being received as a result of single issues within the care home.

² A Patchwork of Practice 2017, Action on Elder Abuse

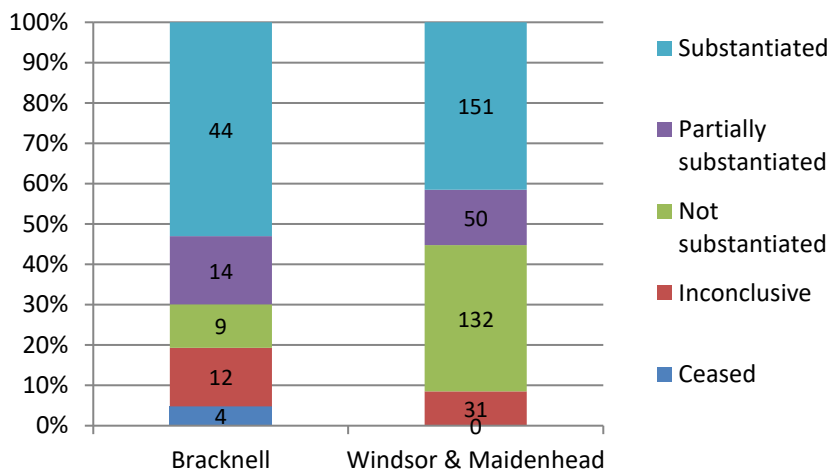
Enquiries by Abuse Type



13.6 As in the previous year the greatest percentage of enquiries in Windsor & Maidenhead are due to neglect. These figures again support audit findings that the number of enquiries recorded in Windsor & Maidenhead are greater than in Bracknell Forest as the definition of neglect includes acts of omission, and greater numbers of acts of omission are associated with such incidents in care homes. This combined with the larger number of care homes in Windsor & Maidenhead has contributed to the larger number of enquiries taking place. Typically an act of omission includes forgetting to give medication on time or being late for a home visit. The high number of neglect cases caused by acts of omission has been audited and assurance has been provided that remedial actions have taken place.

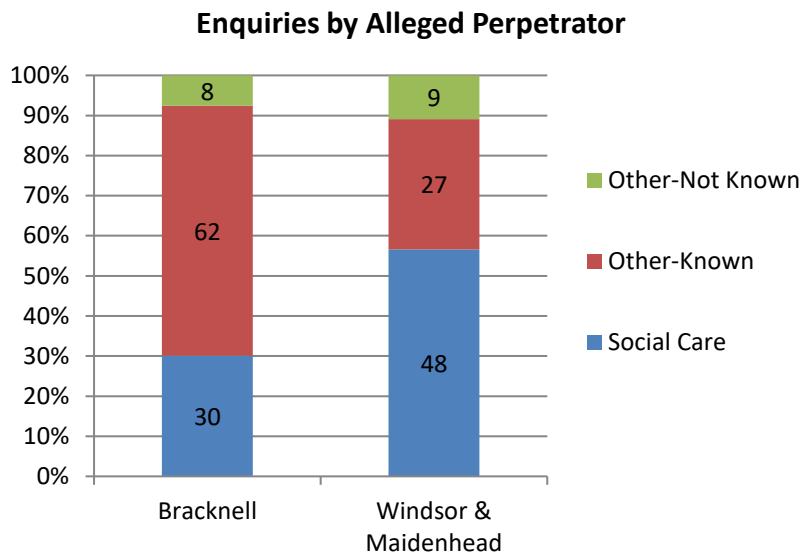
The higher number of psychological abuse in Bracknell Forest have been audited and findings have confirmed that the psychological abuse in many cases has been one of a number of abuse types recorded for individual cases, but in many cases it is not the main type of abuse taking place. Further training has been taking place to confirm the importance of recording the main type of abuse.

Enquiries by Conclusion

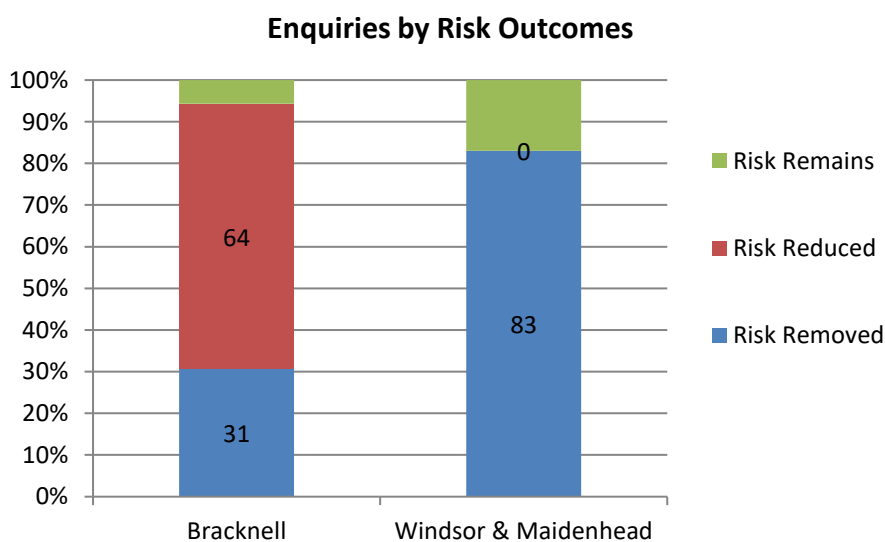


13.7 Analysis of the enquiries by conclusion reveals that a high number of enquiries are not substantiated in Windsor & Maidenhead and this may be related to the higher number of enquiries taking place in Windsor & Maidenhead whereas in Bracknell Forest more concerns would have been assessed as being able to be dealt with by other means through its established filtering process.

13.8 The data supports the audit findings that unsubstantiated enquiries recorded in Windsor & Maidenhead may have been filtered out at an earlier stage in Bracknell Forest. This provides some explanation for the lower number of concerns and enquiries recorded in Bracknell Forest compared to Windsor & Maidenhead.

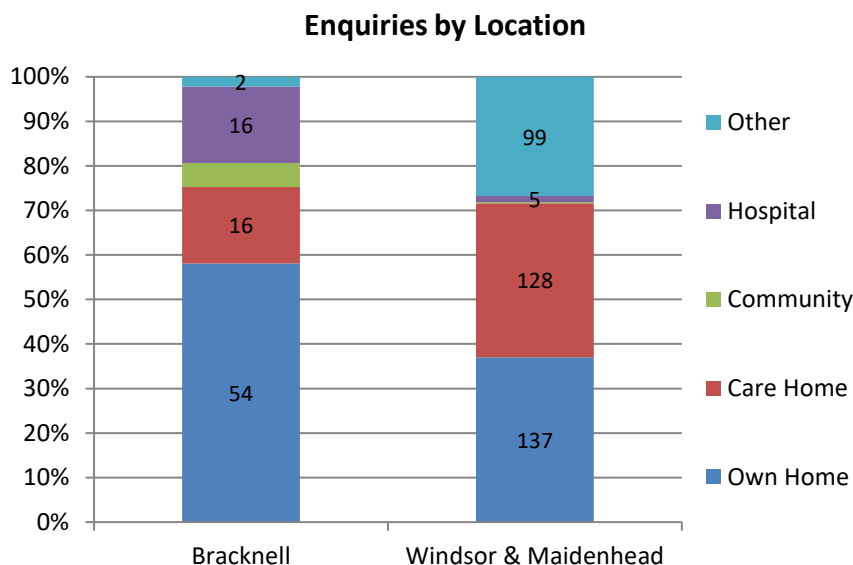


13.9 The higher percentage of enquiries where the alleged perpetrator was from the social care sector is consistent with the fact that there are a larger number of care homes in Windsor & Maidenhead and a larger number of concerns received from providers. The trends are similar to those reported for each area in 2018/9.

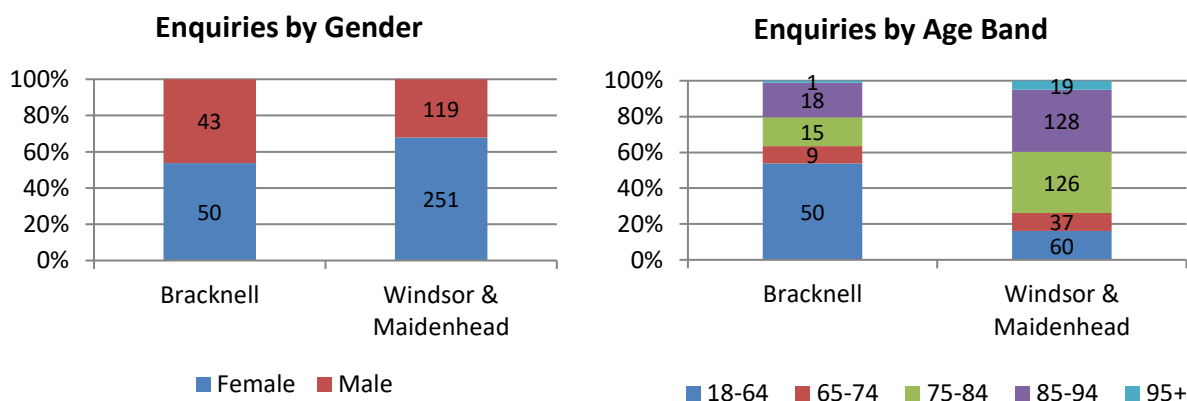


13.10 In most cases the risk to an adult at risk is either reduced or removed. In the very small number of cases where risk remains this is due to the decision of the adult at risk to

accept the risk, although these cases would be monitored on an on-going basis. The trends are similar to those reported for each area in 2017/8.



13.11 A higher percentage, and number, of enquiries related to incidents in care homes in Windsor & Maidenhead which coincides with the higher number of care home beds available. The trends are similar to those reported for each area in 2016/7.



13.12 The percentage of enquiries by gender and age band are similar in both Windsor & Maidenhead and Bracknell Forest with slightly higher percentages of over 65 in Windsor & Maidenhead which reflects the general demographics of the local areas.

Outcome	Bracknell Forest	Windsor & Maidenhead
I was listened to during the safeguarding enquiry	95%	95%
I feel safer as a result of the safeguarding enquiry	100%	85%

13.3 Information collected following completion of safeguarding enquiries reveals that a very high percentage of people confirm that they were listened to during the process, demonstrating the person centred nature of safeguarding practice and that making

safeguarding personal is embedded within organisations. A very high percentage of people also confirm that they feel safer after the support they have received.

14 Safeguarding Adult Reviews

14.1 Safeguarding Adults Boards are required under Section 44 of the Care Act 2014 to arrange a Safeguarding Adults Review (SAR) when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have worked more effectively to protect them. A SAR is also intended to ensure that lessons are learned and the Board is required to publish the outcomes in its Annual Report.

14.2 The Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board completed one Safeguarding Adult Review during 2018/19 (see details below) and commissioned another one which is still underway and will be reported in due course. As previously reported there is another completed, but unpublished, SAR for which an action plan is being implemented. No further information is available at this stage due to an ongoing criminal nature.

14.3 The Board, therefore, has benefitted from the learning from a number of recent Safeguarding Adult Reviews which are influencing Board priorities and how it conducts business. The following key themes have been identified:

- multi-agency involvement in the care governance framework – communication about the framework has improved awareness and partner organisations now regularly attend framework meetings. In addition, information sharing about providers (particularly where there are concerns) and understanding of the roles and responsibilities of different organisations has improved
- identifying and managing risk – the Board has developed and implemented a risk management framework through a series of multi-agency workshop training events held in both Bracknell and the Royal Borough. The framework is being used and awareness growing amongst partners
- Mental Capacity and Consent – embedding understanding of the Mental Capacity Act and issues around information sharing both with and without consent have been highlighted
- engaging positively with families and carers particularly during the commissioning process and/or when views maybe different
- recognising and responding to deteriorating health particularly in people with disabilities
- the duty of care to adults with care and support needs whatever their care funding arrangements - the Board has developed a communication and engagement strategy and is working on identifying what good looks like to help families navigate the care system

14.4 As a direct result of the EF Review completed and reported in the 2017/18 Annual Report, the Board hosted a conference in December 2018 around a theme of ageing with learning disabilities – see Section 11 of this report.

CD Safeguarding Adult Review

- 14.5 CD was a resident in a care home in Windsor where she died in May 2017. She was receiving visits from district nursing staff that were treating her leg ulcers. Towards the end of the review period, district nurses raised safeguarding concerns relating to the appropriateness of care provided by the care home staff. During the period under review, the care home had already been in the local care governance framework for commissioned services for some time and her family had raised concerns about the standard of care in the home, seeking to move her to a home closer to them.
- 14.5 The Board received the final report in September 2018 following which a multi-agency action plan was developed and implemented addressing issues such as multi agency involvement in the care governance framework, the impact on service users and their families during the commissioning process. These themes have been fed into the work of the Board as evidenced above. In response to the report, the Board requested that the two local authorities work together to review their care governance frameworks with a view to adopting one framework across the two areas – this work has been undertaken and while it did not prove possible to produce one common framework, partner involvement and understanding of the framework has improved as a result of this review. A common Care Governance framework is now being developed across East Berkshire as part of the Integrated Care System (ICS) implementation.

15 Challenges and Priorities Going Forward

- 15.1 A decision has been taken that the joint Board will end on 30 June 2019 and new safeguarding board arrangements will put in place in each area from 1 July 2019. The implementation of the new safeguarding arrangements in each local authority area will provide new challenges and opportunities to work more closely locally with children's safeguarding partnerships.
- 15.2 The Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board received a paper at its March 2019 meeting reporting the progress of actions within its strategic business plan and highlighting suggested areas for continuing work based on assessments by sub groups. These areas included:
- **Communication and Community & User Involvement**
Action - work closely with the voluntary sector in recognition of its growing role in safeguarding, early intervention and prevention and community resilience
 - **Risk Management**
Action - review of the risk framework
 - **Learning and Development**
Action - the Board is sighted on the impact that single / multi agency adult safeguarding training is having on frontline practice

- **Prevention**

Action - partner agencies demonstrate that safeguarding arrangements for vulnerable young people during transition are appropriate. Establish clear understanding of definition of transition

Action - ensure awareness of indicators of risk and ensure safe responses through awareness of referral routes and sources of support. To include fire and new abuse types

- **Quality Assurance**

Action - develop a programme of multi-agency audits to test effectiveness of safeguarding arrangements

Action - ensure a robust system is in place to join up intelligence to enable quality concerns in provider services to be identified early on and to put into place support to address concerns before they become significant safeguarding issues

In addition the Board received a recommendation for the outcomes of the annual partner self assessments, the partner training self-assessment and the user involvement questionnaire, all outlined on pages 12-13, to be considered in the development of new plans.

Appendix 1

Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board Record of Attendance at Board Meetings 2018/19

Alzheimer's Dementia Support	100%
Berkshire Care Association Berkshire	75%
Silva Homes	75%
Bracknell Forest Council – Adult Social Care	100%
CCG	100%
Children's Services (Achieving for Children – Windsor and Maidenhead)	25%
Frimley Park Hospital	100%
Berkshire Healthcare NHS Foundation Trust	100%
Healthwatch	75%
Housing Solutions	25%
Involve	100%
National Probation	75%
Optalis	100%
Radian	25%
Royal Berkshire Fire & Rescue Service	25%
Royal Borough of Windsor & Maidenhead	100%
South Central Ambulance Service	50%
Thames Valley Police	100%
W. London Mental Health Trust (Broadmoor Hospital)	50%
Office of the Police and Crime Commissioner	100%

Safeguarding Adult Board Budget – 2018/19

Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board

Income/contribution 2018/19

	2018/19
Bracknell Forest Council	-30,000
RBWM	-32,000
Thames Valley Police	-10,000
CCG	-20,000
	-92,000
Plus	
Unspent funds carried forward from 17/18	-13,623
Total	-105,623

Projected Expenditure 18/19		Comment
Staff (including support costs)	65,112	
Cost of Chair to 30/09/18	8,153	
Cost of Chair 01/10/18-31/03/18 - Fee	6,000	estimated
Cost of Chair 01/10/18-31/03/18 - expenses	1,000	estimated
Supplies and Services	1,305	
Conference costs	8,431	
Conference income/funding	-9,236	
SARS review March 19 10 days @ £600 per day	6,000	estimated
Total	86,766	
Projected underspend as at 31/08/18	-18,858	

**BRACKNELL FOREST AND WINDSOR & MAIDENHEAD SAFEGUARDING ADULTS BOARD Appendix 3
STRATEGIC BUSINESS PLAN 2017 – 2019 (as reported to the Board March 2019)**

Theme 1: Providing Quality Assurance & Challenge

1.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
1.1.1	Develop and promote the use of a single agency self-assessment tool audit tool across partners including implement of a bespoke CVS self-assessment audit	Quality Assurance Sub Group	Dec 19	Results of self-assessments Evidence from minutes	Single agency self-assessment tool developed and implemented. CVS audit has been developed and implemented although very low returns received	B	Consideration for extending the CVS self-assessment and / amalgamating with further or on-going action to develop work with the voluntary sector
1.1.2	Programme of multi-agency audits to test effectiveness of safeguarding arrangements, to include a focus from data analysis and recognising constraints within organisations	Quality Assurance Sub Group	2019	Programme of multi-agency audits Audit reports; minutes	Peer audits established. Multi-agency audits being implemented with partners auditing cases with the LA's	B	Develop multi – agency audits through a framework (in conjunction with Slough SAB) post Mar 2019
1.1.3	Develop an appropriate multi agency dataset that collates relevant information via agreed outcome statements to support the Board in their understanding of local provision and issues; this to include a review of concerns by each organisation.	Quality Assurance Sub Group / working group	Mar 19	Dataset Evidence in minutes	Dataset containing indicators from statutory returns developed. Multi-agency data set finalised with TVP, RBFRS, Community Safety, public health and CQC data secured	B	Develop a graphic representation of the data set Consideration for extending this action as on-going work or absorb into day to day or sub group work plan
1.1.4	Ensure a robust system is in place to join up intelligence to enable quality concerns in provider services to be identified early on and to put into place support to address concerns before they become significant safeguarding issues.	Quality Assurance Sub Group	2019	Evidence of effective intelligence sharing mechanisms in place.	Care governance reports being reviewed by quality assurance sub group and the Board at 6 monthly intervals	G	Care governance frameworks and reports being reviewed taking account of recommendations from safeguarding adult review Consideration for absorbing into with Policy & Procedures sub group work promoting policy and procedures on-going work of a QA Sub Group to monitor data and care governance as part of QA framework

1.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
1.1.5	Seek assurance that that the five principles of the MCA and best interest decision making are a feature of practice across the partnership	QA Sub Group / working group	On - Going	evidence of improved working within MCA principles through multiagency case file audit	Case file audits reports being received by QA sub group providing assurance regarding MCA and Best Interest decision making. Multi-agency auditing taking place	G	Recommend this action becomes part of on-going monitoring of audits by Quality Assurance Sub Group and the roll out of training and monitoring of impact of training by the Learning and Development Sub Group
1.1.6	Develop a charter of Good Care including development of charter. training, communication, review and feedback – Action altered to establishing and promoting what good looks like and improving communication with providers	QA Sub Group/task and finish	2019	Definition of what good looks like	Working group has produced information of what good looks like. Working group has also developed an approach to establish good communication between all partners and providers by attendance at BCA Board meetings	G	Consideration for on-going promotion of policy and procedures by the sub group to support what good looks like for providers

Theme 2: Managing Risk

2.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
2.1.1	Refine and implement a local risk framework to encourage consistent practice across organisations and to develop multi-agency response in a crisis, this to include a pilot implementation across all agencies	Task and finish	Sept 2018	Case audits demonstrate effective practice, robust risk assessment and protection planning	Risk framework finalised, piloted and being implemented. Multi-Agency training is being rolled out to support implementation.	B	Recommend continue roll out programme throughout E Berks from March onwards as part of east Berkshire training programme following TNA
2.1.2	Review the risk Framework	Task and finish	Nov 19	Feedback demonstrates effective systems in place	Review has been on-going during implementation and pilot work	G	Further review to be undertaken following roll out of implementation workshops over a period of time

2.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
2.1.3	Promote a good understanding of the forums available locally to address specific needs of adults at risk and promote awareness of the need to implement bespoke multi agency meetings for those cases for which there is no relevant forum.	Task and finish	Mar 2019	Minutes demonstrate good understanding of relevant forums. Evidence of bespoke multi-agency meetings taking place.	Multi-agency meetings being implemented through the roll out of the risk framework. Understanding of forums is promoted via roll out of risk framework QA sub group has received assurance of the work of forums	G	Recommend maintain training to support implementation of multi-agency risk framework as on-going work
2.1.4	Determine and monitor emerging significant areas of risk and ensure communication with other partnership boards.	QA Sub Group	2019	Emerging risks integrated into Board work plans/ strategic plan	Areas of risk being identified and communication with other partnership boards taking place Work has taken place to share QA Sub group work with other sub groups such as prevention and learning and development. Training plan developed and prevention campaigns being devised; promotion taking place via website	G	Agreed that this action needs to continue Communication with other partnership Boards to develop through implementation of a partnership protocol and regular liaison between partnership board leads / business managers – on going Recommend extending action or absorbing as on going, day to day work and part of QA Sub group work
2.1.5	Review impact of risk panels / chaotic lifestyles panels	QA Sub Group	TBC	Is it making a difference / are we identifying the appropriate people	QA sub group reviewed impact of work of panels and gained assurance	G	Continue to Implement risk framework highlighting links to existing risk panels Recommend incorporating work into implementation and review of risk framework

Theme 3: Developing the Workforce and Spreading Learning

3.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
3.1.1	Promote engagement of the whole partnership in MSP through a focus on and improvement in working within the MCA principles and through establishing confidence in taking person centred approaches to working with risk.	Chair / Alzheimer's Dementia support	2019	Evidence of effective partnership approach to MSP through multiagency case file audit	MSP formed a focus within the Board development session. MSP being promoted through implementation of risk framework and through the annual partner self-assessment. MSP promoted via newsletter and website Peer audits / case audits have provided assurance on application of MSP and working within MCA principles. MSP has been included in Training Needs Analysis and the on-going training programme post Mar 2019	G	Recommend this action forms a basis and underpins redeveloped strategic plans
3.1.2	Examine training needs analysis and training evaluations to ensure multi-agency safeguarding training provision is evidence based and fit for purpose; this to include evidence of feedback from those trained and the use of e-learning.	Chair of East Berks SAB L & D Sub Group	Mar 2019	evaluations evidence training feedback evidence	Multi-agency workforce development strategy approved by Board. L/D group has completed a TNA taking using range of evidence including evaluations. Training plan developed with a priority of implementing the multi-agency risk framework	B	Recommend continuing action to capture feedback from those trained in the multi-agency risk framework during review in October 2019 Recommend linking to action 3.1.4
3.1.3	Continue to ensure Berkshire Multi Agency Adult Safeguarding Policies and Procedures are up to date and fit for purpose	Chair of Pan Berkshire Policy & procedures Sub Group	Mar 19	minutes of meetings feedback from staff / partners	Policy and procedures updated as part of the launch of the new website in November 2017. Review of policy and procedures taking place every 6 months. Audit of website took place in Feb 2019 review and maintenance process has been formalised	G	Policy and procedures to be reviewed again in 2019 to take account of review taken by pan London policy and procedures group Recommend this becomes business as usual as part of policy and procedures sub group work

3.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
3.1.4	<p>The Board is sighted on the impact that single / multi-agency adult safeguarding training is having on frontline practice.</p> <p>Implement a survey to evaluate training at the end of training sessions and again at three months to measure learning and improvement in confidence and practice.</p>	Chair of East Berkshire SAB Learning & Development Sub Group	On-Going	<p>SAB training reports</p> <p>Training evaluations</p> <p>Case studies and audits</p> <p>Positive as a result of training e.g. appropriate referrals.</p>	<p>Learning and Development sub group re-established</p> <p>TNA session took place November 2018 / January 2019 – training programme developed with evaluation to be built in</p> <p>Initial evaluation of conference learning carried with further 6 month evaluation of partner actions</p>	G	<p>Recommend continue this action and absorbing into a redeveloped strategic plan – alternatively to form part of the l and d sub group action plan</p> <p>L and d group to focus on process for determining impact of training during 19 / 20</p>
3.1.5	Implement common / tiered set of workforce standards to support safeguarding across the partnership.	Chair <i>(East Berkshire SAB Learning & Development Sub Group)</i>	On-Going / TBC	evidence that common standards framework has been implemented and evidence of a positive outcome / change	Multi agency workforce development strategy approved by Board in October 2017 and reviewed in January 2019	G	recommend continuing as Sub Group action
3.1.6	Board Members ensure they undertake appropriate training as required to deliver their role and are active participants in Board and Sub group meetings and associated work – Action suspended by Independent chair	Chair	2019	Chair evaluation of Board Members	<p>Evaluation to be confirmed.</p> <p>Meetings taking place between chair and Board members</p>		Evaluation to be confirmed and to take place as part of meetings between chair and Board members when new chairs in place

Theme 4: Prevention & Raising Awareness

4.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
4.1.1	Partner agencies demonstrate that safeguarding arrangements for vulnerable young people during transition are appropriate. Establish clear understanding of definition of Transition	Chair	On-Going / TBC	Multi-agency action plans developed to address any weaknesses or to implement improvements.	Self-assessment audit takes place annually – reviewed January 2019 Meetings with LSCB reps taking place. Transition workshop took place at March 2019 Board meeting to gain assurance of transition arrangements	G	Implement review / audits of transition cases Recommend extending this action in redeveloped strategic plans
4.1.2	Ensure awareness of indicators of risk and ensure safe responses through awareness of referral routes and sources of support. To include fire and new abuse types	Task and finish / Prevention	2019	Data reflects level of engagement and understanding	Areas of risk / referral route being communicated via development of website. Fire risk and referral routes promoted by partners and numbers of referral being monitored via data monitoring New types of abuse and Fire risks being promoted in training and in particular during multi agency risk framework workshops	G	New types of abuse and fire part of multi-agency training needs analysis priority themes for implementation post March 2019 (this is partly being implemented at the moment via the risk framework training sessions) Recommend that this action continues in redeveloped strategic plan or sub group action potential need to extend action to confirm that data reflects engagement and understanding – recommend carrying out review during review of the risk framework in October and as part of the annual partner self-assessment
4.1.3	Promote and support identification, from the data and other intelligence, areas where safeguarding issues are commonly occurring; the Board will target these areas, seeking assurance that preventive measures are put in place; Standardise data and recording	QA Sub group	2019	Evidence that safeguarding issues identified are being targeted for action	Performance Working group has standardised data for reports to the Board and QA Sub Group. Quality assurance sub group monitoring performance and identifying trends and risks	G	Initial prevention / promotion campaigns developed including hidden carers and self-funders campaign Recommend this action to be extended – potentially as part of sub group action plan

4.1	Action	Lead	Time-scale	Success Criteria / Measure	Progress	RAG	Next Steps
	processes e.g. populations, thresholds				Prevention and Communication and Engagement strategy produced		
4.1.4	Produce guidance to ensure that cases of abuse and neglect that do not meet the section 42 criteria are reported and recorded in adult safeguarding; this is particularly important for new abuse types of domestic abuse, modern slavery, exploitation and self-neglect	QA Sub Group	Mar 19	Effective guidance produced which is followed	Guidance developed by performance working group following review of concerns data	B	Guidance finalised
4.1.5	Monitor data and carry out case file audits of safeguarding reports that do not meet the section 42 enquiry criteria	QA Sub Group	Mar 19	Evidence from pre S42 cases in case file audit	Peer audits have taken place to provide assurance and are on going	B	peer audits being maintained partners being involved in audits Recommend peer audits extended and absorbed into work Quality Assurance sub group work
4.1.6	Map / review preventative services across the partnership including sharing of partner campaigns calendars / information	TBC / New Group	TBC / Mar 19	TBC	Addressed via partner questionnaire. Prevention group had reviewed information, produced a prevention strategy and has initiated campaigns	B	Review of self-assessment returns taken place – prevention / promotion / engagement campaigns being devised Recommend annual review of preventative services with updated questionnaire devised

Theme 5 - User Involvement / Communication and engagement

5.1	Action	Lead	Time scale	Success Criteria / Measure	Progress	RAG	Next Steps
5.1.1	Map user involvement processes in place across the partnership and gather information of user involvement already captured by partners	New Group	TBC	Evidence of user involvement captured	Addressed via partner questionnaire. Engagement group has reviewed information, produced a communication and engagement strategy and has initiated forums to further capture the voice of the service user	B	Review of self-assessment returns taken place. Information used to develop training needs and prevention campaign Consideration for annual review with updated questionnaire devised

5.1	Action	Lead	Time scale	Success Criteria / Measure	Progress	RAG	Next Steps
5.1.2	Develop group to establish methods of community engagement / user involvement that includes awareness raising; Establish an effective and meaningful process for people who may be in need of safeguarding services to engage with the Board	Business unit / new group	TBC	Group developed and range of methods for capturing user involvement developed	Communication and engagement strategy developed Safeguarding forum developed and implemented Discussions with service users captured on video for replaying at the Board meeting	G	Recommend continue in redeveloped strategic plan or as part of sub group action plan
5.1.3	Ensure that any relevant community profiling activities undertaken by partner organisations are shared with the SAB for information and action;	Chair	On-Going / TBC	Self-assessment Board meeting reports repository of profiling outcomes and of feedback from people who engage with partners	Self- assessment evaluated Community profiling on going by performance working group Website developed in line with communication strategy to support engagement	G	Strengthen work with other strategic partnerships and share information
5.1.4	Work closely with the voluntary sector in recognition of its growing role in safeguarding, early intervention and prevention and community resilience; establish comprehensive representation from voluntary sector across the Board area along with effective mechanisms for information sharing across the sector	Chair (to be confirmed)	2019	evidence that local community intelligence is used to promote and target safeguarding work	CVS audit tool trialled to develop understanding of safeguarding and information sharing needs Work has developed with the CVS to establish a safeguarding forum and forums for capturing the voice of service users as well as promoting awareness of risks and how to keep safe	G	Recommend continuing this action within an updated strategic plan

Status legend		Where the action is not yet completed, but is on schedule	GREEN (G)
Where the action is behind schedule	RED (R)	Where the action is completed	BLUE (B)
Where there may be delay in achieving the action	AMBER (A)	Where the action is no longer applicable for whatever reason	GREY (Gr)