| MINUTES | | | | |
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| **Meeting Title** | West of Berkshire Safeguarding Adults Partnership Board | | | |
| **Date** | Weds 16-03-22 | | | |
| **Time** | 10:00-13:00 | | | |
| **Location** | Microsoft Teams | | | |
| **Chaired By** | Teresa Bell (Seona Douglas, acting Chair) | | | |
| **Confirmed Attendees:** | | | | |
| Teresa Bell, Independent Chair, SAB (did not attend) | Andy Sharp, Executive Director - People, West Berkshire District Council (did not attend) | Jane Barnett, Business Support Officer, SAB | Simon Broad, Assistant Director - Adult Social Care, Wokingham Borough Council, SB | Lynne Mason, Business Manager, SAB |
| Sue Brain, Service Manager – Safeguarding Adults, West Berkshire District Council, SBr | Rachel Spencer, CEO, Reading Voluntary Action (did not attend) | Abigail Mangarayi, Interim Head of Safeguarding Adults, NHS Berkshire West Clinical Commissioning Group (CCG) | Seona Douglas, Director of Adult Care and Health Services, Reading Borough Council (acting Chair), SD | Philip Bell, Involve (attended for 1st hour, only) |
| Jo Lappin, Assistant Director for Safeguarding, Reading Borough Council | Jennie Henstridge, Senior Probation Officer, National Probation Service | Linda Andrew, Acting Head of Service, Emergency Duty Service | Elizabeth Porter, Lead Nurse Adult Safeguarding, Royal Berkshire NHS Foundation Trust (attended on behalf of AD) | Anthony Hesleton, Head of Safeguarding & Prevent, South Central Ambulance Service (did not attend) |
| Lorna Pearce, Head of Adult Safeguarding, Care, Governance and ASC Covid-19 Taskforce, Wokingham Borough Council | Professor Keith Brown, Independent Chair, SAB (from 1st April 2022) | Alice Kunjappy-Clifton, Healthwatch West Berkshire (did not attend) | Truly Pinkarchevski, Reablement Service, West Berkshire District Council (for item 2, only) | Gemma Nunn, Assistant Head of Safeguarding, Berkshire Healthcare Foundation Trust (attended on behalf of HI) |
| Garry Poulson, Director, Volunteer Centre West Berkshire | Supt Steve Raffield, LPA Commander Reading, Thames Valley Police | | | |
| **Apologies/did not attend** | | | | |
| Simon Price, Head of Housing, Wokingham Borough Council | Heidi Ilsley, Deputy Director of Nursing, Berkshire Healthcare Foundation Trust | Simon Leslie, Solicitor, Joint Legal Service (virtual member) | Paul Coe, Service Director, Adult Social Care, West Berkshire District Council | Cath Marriott, Partnerships and Performance, Office of the PCC - Virtual member |

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| Deborah Fulton, Director of Nursing & Governance, Berkshire Healthcare Foundation Trust | Debbie Simmons, Nurse Director, NHS Berkshire West Clinical Commissioning Group (CCG) | Alison Drew, Interim Head of Safeguarding, Royal Berkshire NHS Foundation Trust | Cllr Joanne Stewart, Executive Member for Adult Social Care, West Berkshire District Council | Liz Warren, Risk Reduction Manager, Royal Berkshire Fire and Rescue Service |
| Matt Pope, Director of Adult Service, Wokingham Borough Council | Cllr John Ennis, Cllr, Reading Borough Council | Dorcas Nyabunze, Head of Service, Emergency Duty Service | Zelda Wolfle, Acting Head of Housing and Neighbourhood Services, Reading Borough Council | Susan Powell, Building Communities Together Team Manager, West Berkshire District Council |
| Jennifer Daly, Safeguarding Programme Lead, NHS England South (South East) - virtual member | Andrew Sharp, Healthwatch West Berkshire | Nicholas Durman, HealthWatch Wokingham | Cllr Charles Margetts, Executive Member for Adult Social Care, Wokingham Borough Council | Mandeep Kaur Sira, CEO, Healthwatch Reading |

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| 1 | **Welcome and Introductions**<br><br>SD: opened the meeting (she was acting Chair, as TB was unwell). No declaration or conflicts of interests were voiced, and the meeting was deemed quorate.<br>SD: passed on her debt of gratitude to TB for being Chair for the last 5 years.<br><br>The following people were welcomed to the meeting: Professor Keith Brown, the new Independent Chair of the SAB, from 1st April and Abigail Mangarayi, Interim Head of Safeguarding Adults, NHS Berkshire West Clinical Commissioning Group, covering for Kathy Kelly, who was due back from her secondment to Health England in August.<br><br>Additional apologies were received from Andy Sharp, Executive Director - People, West Berkshire District Council, as SBr explained that they had an OFSTED inspection that day. |
| 2 | **Case Study – Complex case involving pressure care management, with a positive outcome –** *Truly Pinkarchevski, Reablement Service, West Berkshire District Council*<br><br> <br>Complex Pressure Care Management.pp<br><br>TP: gave a short presentation on a complex case involving pressure care management. The case study had achieved amazing outcomes for the service user and hopefully for others through the learning from it.<br><br>SD: raised the issue of how this information could be disseminated across the whole of the West of Berkshire to ensure that the good practice principles learnt are heard by health and social care practitioners.<br>GP: thought a short video with simplified graphics would be really helpful based on the case study for dissemination across the voluntary sector.<br>SBr: previous SAR's involving pressure care management often involved poor compliance from the service user on the package of care and issues around capacity.<br>SB: suggested a 7 minute learning briefing.<br>LP: suggested combining a visual (short video) with a 7-minute learning brief that could then focus on how to |

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| | achieve good outcomes both for a person who had capacity but also for one who lacked capacity (i.e. a resource to be able to track back on).<br>SD: recognition of the issue and a multi-disciplinary approach are both vital to engage family/carers; how can this message can get through to front-line staff? Agreed that the presentation should be put on the website.<br><br>TP: would be happy to turn the 5 areas identified as pressure ulcer triggers into a graphic and to produce a short video.<br>LP: offered to produce a 7-minute learning brief with input from SBr and JL, which would then come back to the Board.<br>SD/GP: the combined approach would give suitable messaging for the public domain and the front-line.<br>LM: offered to support TP and LD; the Board had already discussed the link between self-neglect and pressure-care; promotion of case studies around non-compliance (although do not like that phrase) combined with bite-sized learning had been previously agreed.<br><br>SD: should be picked up by the Learning & Development (L &D) sub-group to cover all angles.<br>LA: as a generic service the Emergency Duty Service provide everything; pressure care and sepsis (often happen at the weekend due to carer breakdown); condensed learning to help identify the urgency would be really appreciated.<br><br>SD: summarised the **actions** as; TP to produce a graphic and a short video, LP plus SBr/JL to produce a 7-minute learning brief, the L and D sub-group to ensure dissemination across the partnership and the presentation, graphic and 7-minute learning brief to be added to the website. She thanked TP for her time, presentation, and valuable contribution. |
| **3** | **Louise SAR - Paper 1**<br><br> <br>1. Louise Seven Minute Briefing Note<br><br>SD: explained that full report (a WoBC case) had gone to the SAB Executive, due to allegations currently under investigation. The Executive had endorsed the report and agreed the 7-minute briefing note, paper 1. If the SAB agreed, then the practice note could be published on 20th June. The author is working on a podcast which will support the publication. The decision whether or not to publish the full report will be reviewed once the investigation had been concluded; the recommendation of the SAR Panel is not to publish the report in full as it may cause distress to the family.<br><br>LP: clarified that the concern of the SAR Panel was about the risk of distress to a child, not the family per se. The child also featured in the SAR materially and the risk of on-going trauma to the child if this were in the public domain felt disproportionate. The Children's Service had not gone to a serious case review as the criteria were not met but there was an on on-going Child Protection case with the Police. The significance of the date of 20th June was due to the management of legacy issues as WoBC had 3 SAR's which were all going to be published in succession and their Board directive had come up with the order and dates (as clarified by SB).<br><br>The Board **endorsed** the 7-minute briefing note and as the publication date had been agreed by the WoBC Board any change to this date would be discussed, as necessary. |
| **4** | **Self-Neglect Appreciative Enquiry – Paper 2**<br> <br>2. Self-Neglect Appreciatice Inquiry V |

LM: had written this paper on behalf of the Performance and Quality (P&Q) sub-group and gave an overview of its content; the Board had asked for assurance on self-neglect, as one of its priorities. The aim of the appreciative enquiry had been to understand what more we need to do to ensure that our ways of working with people who are self-neglecting are consistent and effective in mitigating and preventing risks. Delays were encountered and it was problematic to undertake but the sub-group were happy with what was produced, some good learning points were identified and some good reflective time was spent with practitioners on cases, who were very positive about the experience.

As a tri-board with high levels of SG concerns the sample size had to be reduced to 5%. A random selection of cases did not work as there were marked differences by area in terms of how cases were labelled and the Safeguarding Leads (SL's) for WoBC and WBC provided evidence to suggest that the cases selected would not provide assurance to the inquiry in regards professional practice around self-neglect. Therefore, it was agreed that the SL's would select the cases. Each 3 LA's were initially asked to pick 4 cases each; RBC had delays because of staff changes/capacity issues. The day was held virtually, with all Statutory Partners in attendance. The Voluntary care sector did not have the capacity to attend but TB did with others dipping in and out during the day.

In practice the only 3 cases presented were by WoBC; WBC practitioners did not have the capacity to take part on the day and written cases did not work as the practitioner needed to be there for reflective practice to happen. RBC provided some examples of referrals that had come through for self-neglect at the time but without the referrer or practitioner the level of detail required to provide context was missing. WoBC brought three cases to the inquiry where practitioners directly involved in the cases presented the cases to the panel by presenting the following:

- Provide a brief overview of the case
- What went well?
- What are the barriers and challenges you encountered and how did you overcome them?
- On reflection of this case what would you do differently?
- What would you change in practice to improve the outcomes for individuals that self-neglect.

The main findings (based on a very small sample were) categorised by:

- identifying and responding to risk;
- Making Safeguarding Personal (MSP); it was evident the individual was at the heart of all decisions made during the safeguarding intervention;
- Partnership Working; there was evidence of good partnership working, for a successful intervention all relevant agencies need to be represented at meetings where risk management plans are discussed and agreed. Actions need to be reviewed and where actions are not met need to be challenged and escalated through the appropriate channels;
- accountability; the professionals involved took responsibility for the cases, chased up and challenged actions. The presentation evidenced that speaking to other professionals directly in person or over the phone improved the outcomes for individuals. *"Don't underestimate the power of phone numbers";*
- building a relationship with the individual; in successful outcomes, there was consistency of professionals working with individuals, short term intervention for individuals that self-neglect is not suitable.
- Mental Capacity; as professionals are we too quick to assume capacity?; and
- Legal Literacy; the panel agreed that the partnership need to empower professionals to use appropriate legal frameworks when working with individual who are at risk of self-neglecting, the audit provided evidence of knowledge of legal frameworks however it was felt that knowledge could be expanded to build confidence when working with individuals. In the cases discussed there were assumptions of capacity made that could have been challenged.

Whilst it is the view of the appreciative inquiry panel that the day was a success and assurance was obtained regarding the practice of self-neglect from WoBC are the SAB assured?

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| | SD: thanked LM for the paper and WoBC for their valuable input; are there lessons to be learnt for how this could be repeated in the future?<br>JL: had presented on 2 RBC cases that day; examples of what practitioners are faced with everyday even if they did not meet the sample criteria.<br>SBr: would not have been able to get the practitioners there due to WBC capacity issues; she had therefore prepared most of their material but was not able to be present due to a bereavement. She had identified issues with the way they recorded in WBC, which did not always cover the level of detail requested. If were to repeat the exercise, there would need to be recognition that WBC may have to make a different type of contribution to WoBC.<br>SD: perception of self-neglect/hoarding and how it is categorised seemed to be key. This was supported by JH; a definition needs to be agreed by the SAB.<br>SB: observation that to support people who are self-neglecting there is a need to develop relationships and trust; with the limited resource in adult social care, what is the role of the voluntary sector in working with adult social care in developing those relationships and working alongside to gain trust outside of a statutory body? WoBC had been considering this regarding hoarding and how the voluntary sector could be engaged (whether that be a particular agency) in terms of building those relationships and developing those relationships, whilst adult social care would not be absolving its responsibility or accountability for these people.<br><br>LM: confirmed that as an appreciative enquiry the LA's, plus health had been in attendance but the voluntary sector (including Healthwatch) had not been able to attend.<br>SD: agreed that like WBC would be very difficult to get 3 RBC practitioners in attendance for a whole day.<br>LP: in the 3-month period 160 SG self-neglect cases had been identified for WoBC, which is a high number for a small borough; whilst there will always be some subjectivity around self-neglect many of the cases were referrals from emergency services, which were not truly about self-neglect but more about a mental health crisis (suicidal ideations or someone being under the influence of alcohol or drugs) - as not sure where to refer they end up on a SG pathway; quantity v quality dilemma.<br>SD: what is the strategic role of the SAB in regard self-neglect?<br><br>KB: Sussex University are leading on self-neglect on a major NIHR (National Institute for Health and Care Research) project; the 2-year project is to come up with national guidelines. KB to provide the contact details to LM (as West of Berks ahead of the game) as would be very beneficial to get involved and shape the work.<br>GP: observed that Hoarding Disorders UK (based in Newbury) partner with Cats Protection, Cruse Bereavement Care, RSPCA etc; the capacity of LA's to cope is not the concern of the voluntary sector (who may have no understanding of a threshold) but will wish to raise any concerns.<br><br>SD: **summarised** to acknowledge the good work that was done; to thank the organisations that took part (whilst acknowledging that there were 3 cases from WoBC, both RBC and WBC contributed in other ways); the need to strategically discuss as a Board what is a self-neglect referral; discussions need to be had about the setup of any future appreciative enquiries (whilst a good process, what are the expectations); the data and how things are categorised (how we get that and how we help other partners share the responsibilities with us and how we ensure that those that need safeguarded get safeguarding and those that need Community Care Assessments get them and all those that need channelling to other agencies or support to get the right support). Data to be discussed later in the agenda. There are still issues coming up about mental capacity (which hopefully KB will be able to offer some guidance on) and there is still a large piece of work for the Learning and Development sub-group re the training required. |
| **5** | **Minutes of Last Meeting and Action Log Paper 3 and Paper 4**<br><br> <br>4. SAB Action Log<br>March 2022 V.1.0.doc |

<table>
<tr><td></td><td>LM took the Board through Paper 4:<br><br>Mental Health Governance Update<br>a) Update on Mental Health Governance was due in December’s SAB<br>a) Agreed to defer to March 22 SAB, but report was not ready: awaiting confirmation from CCG if the report will be available for June 22.<br><br>A long-standing risk management measure (on risk and mitigation log) about mental health governance; a 6-monthly report had been requested. LM to speak to KB about the risk management log; AM will now follow-up.<br>SD: should be escalated to James Kent, as mental health is a growing issue (around mental capacity and assessments); SD/LM/KB to discuss.<br><br>John SAR<br>a) Bring back updates on learning from this SAR to future SAB – LM<br>b) In progress, involved organisations have been asked to complete a learning from SARS audit that will be presented to the SAB in March 22. Deferred until June 22, issues in capacity had meant that not all partners could provide an update on learning from this SAR within the timeframe.<br><br>Now on June agenda (everyone should now be aware).<br><br>Update to the SAB on the local development for the Integrated Care System<br>Request made by the SAB to have an update, was deferred from December 21 to March 22 and then to June 22, as Debbie Simmons Interim Chief Nurse, Buckinghamshire, Oxfordshire & Berkshire West ICS has confirmed that their ICS structure has been delayed and that they are not able to provide an update to the SAB. This is in view of the ICB national date being put back from 1.4.22 to 1.7.22 and the legislation not going through parliament until the end of this month.<br><br>SD: to be escalated to James Kent for an update, as comes into force 01/07/22: AM to follow up.</td></tr>
<tr><td>6</td><td>Subgroup Updates – Paper 5<br><br> <br>5. Subgroups update to the Safeguarding A<br><br>LM: reported that there are issues with the chairing arrangements; to discuss with KB. Discussed at the Board Executive; if no names coming forward will need to be allocated to organisations (SD concerned about low levels of offers; although some had been received but needed the appropriate Chair for each sub-group); any further offers to LM by the end of the week. Needs to be finalised by end of April. KB happy to review once Chairs in place, as the sub-groups are very similar to other SAB’s.<br><br>SD: new Chairs can be offered an appropriate level of support. Will be discussed at the next Executive Group (prior to the June meeting).</td></tr>
<tr><td>7</td><td>Dashboard – Paper 6 and Paper 7<br><br>No update required on the main dashboard (paper 6) as it is updated annually (there for information only); no comments were received.</td></tr>
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7. SAB KPI's 21-22 Q3 V.1.0.pdf

LM: **Paper 7*;*** felt it would be helpful to start with 3.3 Total number of SG concerns for individuals started in the period (per 100, 000 population).

SBr: flagged up that WBC had changed their way of recording because of the volume of cases; changed in early stages of Q3; the decision was taken to make some changes to the process of triaging and recording some concerns raised by our emergency service partners, where the referral was clearly not related to a safeguarding matter - those concerns were triaged in the normal way but if they were clearly unrelated to any safeguarding matter they were not logged as a formal safeguarding concern reported under the statutory framework; however, they were still forwarded to appropriate teams and services for action as a social welfare concern. 92 cases were filtered out and referred through as social welfare concerns for action. This change in process is under review as it will skew comparisons to the 2020/21 data and increase the % rate of conversion; those referrals from TVP, RBFR and SCAS which were clearly not SG were weeded out. The volume per se of SG concerns appeared to have increased across the board.

LP: reported that WoBC SG numbers were going up in-line with the national picture; SG Hub was set up 2 years ago which will normally increase numbers so year on year figures were up (for this reason but primarily due to the national trend); also reported inappropriate referrals for SG (from emergency services) – different language to SBr. This is a big piece of work which is being discussed at the safeguarding leads group with colleagues in police and ambulance service. There was shared desire to work on this, but it will not be easy to resolve. WoBC also have another piece of work that they wish to do with the care providers in their borough; the differences between a care quality issue versus a safeguarding issue (will be working on this in the next 6 months): care quality team was moved to sit under SG, which gave a good opportunity to work collaboratively. Anecdotally (although need to check the numbers to confirm this) there appears to be an increase in pressure ulcers referrals from within providers services (which is a possible Covid effect), and also an increase in financial exploitation in the community (whether that is about online scamming with the increased use of the internet during periods of lockdown, coupled possibly with more loneliness which makes some people a bit more vulnerable to being exploited financially or otherwise).

JL: reported the same issues but used different language; there are lots of things that are safeguarding that may need a different pathway (people within mental health crisis, people with care and support needs, who need an assessment or reassessment). Some child safeguarding gets transferred through to adult and RBC had now seen quite a number that were just for information, which is quite an uncomfortable position, as the Section 42 is a very targeted service. Were also seeing a lot of duplication of other processes e.g. if a section 136 is used in terms of police power, that will then result in a Mental Health Act assessment, so do not need to receive a safeguarding alert as the AMP's (Adult Mental Health Practitioners) were already aware; have worked with GN and her team in relation to people who have gone absent from hospital, so hopefully now have a different approach (a different process and threshold agreed). Also reported concerns around GDPR and data protection responsibilities and being clear that generally have people's information with their consent and then the legal gateway for having information without consent is if it is believed that there is a safeguarding issue (work being done on this and the system is being refined). In RBC about to test the referral module; the internal record system is also in the final stages of discussion of moving the single point of contact to the RBC Contact Centre.

SD: commented on the tension locally and nationally around concerns about consent, when referrals come in that are SG but were not being looked at as they do not have consent; the kind of elements around GDPR, but also about the duties and responsibilities (there needs to be a balance around ensuring that people are not left at risk). SB agreed with this articulation (bearing in mind that PC is not around).

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| | SD: RBC have decided that every referral is appropriate, but it is about deciding how it is dealt with; the same issue as others but RBC is at different place and development within the organisation due to all the changes in the team.<br><br>SR: was concerned about the issue of quality of referrals from TVP; appeared that several different names are engaging in conversations with different organisations (this does not filter down to him at an LPA level). A big concern to him (although a tricky issue); **SR** to take away and find out the best people to communicate this with (and to stop dual referrals) and to ensure that this is fed to the front-line; may need to bring back to the Executive Board.<br>JL: work is being done with SCAS (South Central Ambulance Service) and RBC have been invited to their testing site, where a whole new process is being introduced across the 9's and 111 service and patient transport).<br><br>SD: are there other issues around performance data?<br>LM: are there maybe local variations in reporting? (although nationally should be the same); RBC maybe logging everything, are WoBC maybe doing pre-screening? LP confirmed that if it is flagged as SG (even if not) will be opened as such. The only variation is referrals from SCAS where they have the option to choose welfare (would go straight to welfare) or SG. WoBC and RBC both now offer a consultation advice line (if not sure encouraged to ring up first and ask).<br>SBr: confirmed that WBC are different; they do not record everything initially flagged as a statutory SG concern if it clearly is not. This decision was made due to capacity as there is only one person who does all the recording. They have had an advice line for a long time and the approach has always been to encourage people to call in so that they can have a conversation if they are not sure whether something constitutes safeguarding or not; everything gets recorded but in a different way; statutory concerns and other concerns reported. The approach is a little different, but they still do have a documented record of everything that comes through the SG pathway and the two routes that the concerns are sent to (this process and the decisions made will be reported in their Annual Report).<br><br>SD: **summarised;** thanked everyone for their contributions; work was on-going with SCAS and SR to pick up the issue of SG referrals from the Police; recognised that WBC do have a different recording method to the other 2 LA's – this is also being looked at from the ADASS (Association of Directors of Social Services) perspective. This will be important for clarity when Assurance restarts in April 2023. |
| **8** | **SAB Progress Updates: Business Plan, Learning from SARs/Audit Tracking and Risk and Mitigation Log - Papers 8,9,10**<br><br> <br>8. SAB Business Plan 21-24 V.2.6.docx<br>LM: summarised the content of **Paper 8:** there was an updated version of the Business Plan, but capacity issues have caused delays in getting items actioned, although progress was being made. The *self-neglect priority* had been embedded (a lot of work was being done on this); there was a meeting in May to look at the MARM (the Multi-Agency Risk Management Framework) and the self-neglect "threshold" (that term was due to be considered then). With regard the *pressure care priority* LM reported that they were starting to get a feel on this, and some assurance reports were due to come to the Board in June. The *organisational safeguarding priority* will be started properly once most of the work is complete on self-neglect. Are our priorities still right as set a year ago?<br><br>SD: suggested maybe an in-person awayday early in the year to refresh and review (especially as KB would then be in post); for now, continue the existing work bearing in mind there had been 2 years of covid but had still delivered.<br>KB: agreed with this suggestion and would like to have a business planning day to review, are the right things being done or should things be done a little different now moving into the post covid world? |

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| 9 | **Timetable for Annual Report 21/22 – Paper 11**<br> <br>11. Annual Report 21-22 Timetable.docx<br>LM: summarised the content of **Paper 11;** the proposed timetable of the Annual Report 21/22 – it was the same as the previous year, but the dates had been changed. Had been able to publish in December 21, the earliest since she had been in post. Draft reports from the statutory partners of their safeguarding annual reports would suffice, as there is governance that the reports need to go through; would help with the preparation for the SAB overarching report. Time is needed to be able to be spent on the data.<br><br>SD: explained that each statutory partner produces its own report as there are 3 LA's with different reporting mechanisms (as RBC still in a Committee rather than a Cabinet) and then the Independent Chair produces a front page with a general report backed up by the other reports, which goes on the website. The non-statutory partners are included in the general report because of their vital role. It is a challenge administratively and this could also be discussed at the business planning day.<br><br>SR: agreed that he will need to provide a highlight report that LM can discuss with DI Millie Tanner (Thames Valley Police).<br><br>SD: it was **agreed** that all would work to the timetable and produce their own reports; once that data had been provided then might be able to consider a standardised format going forward and maybe having a template. |
| 10 | **Information Items**<br>- **Budget – Paper 12**<br>- **SCAS Assurance – Paper 13**<br><br> <br>12. Mar 22 Budget Monitoring V.1.0.docx 13. 2022.03.02 Paper for SLG- SCAS CQC R<br>SD: explained that **Paper 12** (the Budget) is a report about the contributions that are being made by each partner and there probably needs to be a review of this going forward**;** will need to be discussed with KB as the new Chair. Wanted to flag this up as early on in the new financial year, the contributions and the amount of money will need to be discussed and whether there should be an increase from partners and what that means and if there is not then what the SAB would then not be able to do - this will be a challenging debate certainly very early on, probably in June about the contributions and sustaining it. Currently have a very good service with only a part-time Business Manager and one person for admin support more recently, considering that the Business Manager covers 3 local authority areas which is a huge task and probably also need to consider how many days are funded for the Independent Chair.<br><br>LM: explained the background to **Paper 13** on SCAS Assurance; it was highlighted at the SAB Executive Group in February that SCAS had had a focussed safeguarding CQC (Care Quality Commission) inspection, and they were asked to make immediate improvements. The SAB decided that they needed some assurance around SCAS and to understand what had been identified as an issue and what work was underway. LM had been advised to contact the CCG and Jane Thompson, who she had spoken to, had helpfully provided this report. As SCAS covers such a wide area, it was agreed that this report could be shared with the Board to offer some assurance. The report suggests that a lot of governance work and training needs to happen in order for SCAS to meet the CQC standards.<br><br>SD: as the regulator is now doing monitoring which will cover SG and safety, the Board needs to be informed of progress.<br>SB: commented that as AH is missed but no longer attending the Board, it would be really beneficial to have |

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| | someone for SCAS attend the June Board – **LM to action** and also representation longer-term needs to be considered (KB agreed it was critical that someone attend to say how they are responding to the CQC Inspection, given that so much of it is around SG).<br><br>SD: explained that the last information item was around carers and SG and a briefing for people who work with carers that the LGA have produced:<br>Carers and safeguarding: a briefing for people who work with carers \| Local Government Association<br>TB had been involved in this work and SD encouraged everyone to disseminate this to their front-line staff, as it is very much an issue. One of the things that is still not known is the longer-term effect of lockdowns and whether there has been hidden abuse as a result of people being under immense stress and isolated. |
| **11** | **AoB and Goodbye to Teresa Bell**<br><br>LA: from an operational point of view, although probably not relevant here, explained that the EDS (Emergency Duty Service) had started reviewing their whole adult safeguarding role within the emergency duty team and are looking to do some quite intense training.<br>SD: fedback that this was very helpful to know.<br><br>LM: launching a training calendar from 1st April – any relevant information to be forwarded to LM.<br>LA: acknowledged the good work that LM does, particularly as only a part-time role – a sentiment agreed by SD.<br><br>SD: said goodbye to TB and welcome to KB.<br>Meeting finished at 12:24 |
| | **Date of next meeting: Wednesday 15th June 2022, 10-1pm (subsequently changed to Wednesday 8th June)** |