



Southampton Local Safeguarding Adults Board Strategic Plan 2019-22

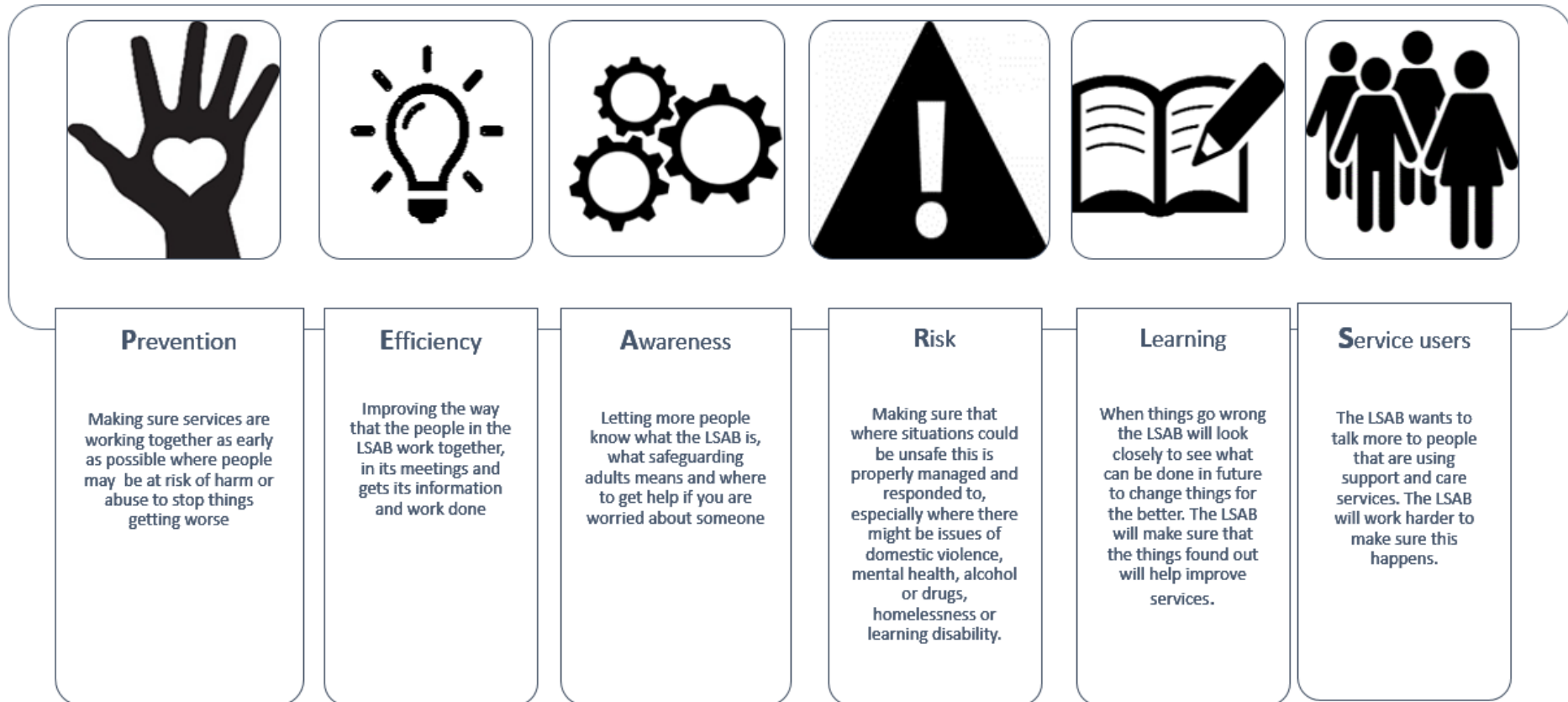
Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

Introduction

This Strategic Plan outlines the work to be undertaken by Southampton Local Safeguarding Adult Board during the period 2019-22, it details how over this time the LSAB will work on key themes and priority areas to evaluate current service provision. The plan should be viewed alongside the LSAB's Annual Report which give details of the actions taken by the partnership to address the priorities identified in earlier plans and the current position in Southampton in relation to the LSAB's work. These can be viewed on the LSAB website: www.southamptonlsab.org.uk.

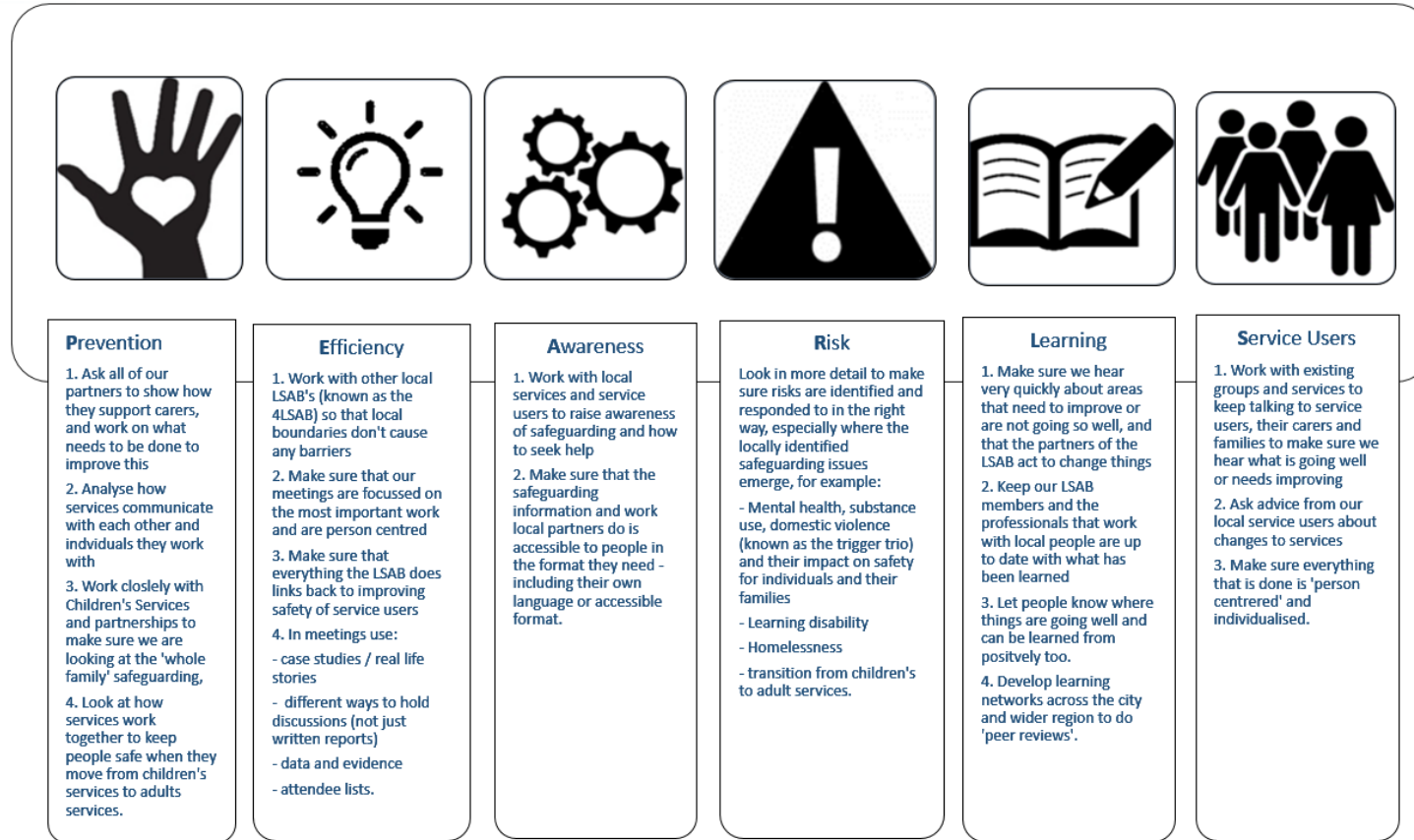
Priority Issues

The LSAB has agreed its shared priority areas for the 3 year period as represented in the following diagram, produced as part of an easy read version of this strategic plan. These priorities can be represented by the acronym PEARLS:



Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

The priority areas and the detailed work needed to progress action within them are classified as either 'business as usual' or for specific work development to be progressed within the 3 year period. The following diagram explains the work that will take place, the plan that follows provides the specific details and ways this will be delivered in year 1 – 2019-20. The plan includes reference to actions that will be taken in response to learning from case reviews and audit activities undertaken by the LSAB.



The LSAB has agreed its priority themes for this year following review of learning gained and areas of joint concern between the partners. The LSAB meets each quarter, the meetings will be formatted using these agreed priorities as follows:

Topic	PEARLS Category
Q1 Mental Capacity Act and Multi agency risk management	Risk
Q2 Family Approach to safeguarding	Prevention
Q3 Self-Neglect and interface with homelessness, alcohol and substance use	Risk
Q4 Making Safeguarding Personal	Service Users

Monitoring of Success:

Progress against this plan will be reviewed and monitored by the LSAB, progress against actions will be regularly reported to the Main Board and to the Executive Business Group of the LSAB, which is shared with the Childrens Safeguarding Board. Where necessary and appropriate the Chairs of each sub group will highlight areas of concern and good practice to the Executive for further action.

4LSAB's The Southampton LSAB also works within the '4LSAB' area of Southampton, Portsmouth, Hampshire and Isle of Wight. The 4 areas share common safeguarding policies, procedures and guidance for staff to work to. Southampton LSAB participates in a number of cross area groups as represented in the diagram at the end of this document.

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

1. PEARLS Area: Prevention

Timescale: Quarter 2

Action	Lead	Timescale	Outcome	How can we measure this?
Family Approach to be the theme for Q2 LSAB meeting	LSB Team LSAB Chair	Q2 LSAB Meeting	A holistic family approach will enable better outcomes for Southampton's children, young people, adult's families and carers. Staff have a greater understanding of joint working within Adults and Children's Safeguarding and of the impact of abuse and neglect in childhood and progressing into Adulthood.	Meeting delivered on theme
Promote Family Approach toolkit to Southampton practitioners via launch and conference event	LSB Team	July 2019		Conference delivered and toolkit launched to Southampton professionals
Ensure the impact of Averse Childhood Experiences (ACE's) is understood and influences practice in Southampton	LSAB partners	Q2 meeting to consider this		Check understanding via professionals survey and training needs analysis
Evaluate success of 4 area Family Approach tools and project and identify next steps for this work	4 area Family Approach project group	Q2 LSAB meeting to receive details		Check knowledge and use of toolkit via professionals survey and evaluation of user feedback
Receive findings and develop an improvement plan in response to joint LSCB and LSAB Transition Audit	LSAB partners	Q2 LSAB meeting to receive this Improvement plan by September 2019		Audit and finding reports to June LSAB and LSCB.

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

2. PEARLS area: Efficiency

Timescale: Q1-4

Action	Lead	Timescale	Outcome	How can we measure this?
Ensure that providers of services are required to retain and make available all records and information relevant to safeguarding reviews regarding cases with which they have been involved, even after their contracts have ended. (Source: Marie case review)	ICU / CCG leads LSAB Chair	By Q3 LSAB meeting	Retention and storage of records in accordance with appropriate GDPR, Data Protection and Freedom of Information Act protocols and principles.	Requests made and successful provision of records from agencies when requested as part of statutory case review work
Work across 4LSAB area to ensure geographical boundaries do not provide any barriers to safeguarding	IAWG	Q1-Q4	The LSAB works effectively with other strategic partnerships to ensure joined up working in key areas	Attendance and engagement with 4LSAB meetings and sub groups by Southampton LSAB partners
Ensure that LSAB meetings include a person centred focus including case study / real life examples on themes being addressed at meetings	LSB Team and LSAB Chair	Q1-Q4	To ensure that LSAB members are aware and acknowledge of the lived experience of adults and families in Southampton who experience abuse and neglect	Case Study delivered at relevant meetings
Agree ways meetings can be contributed to beyond papers and reports	LSB Team LSAB Chair	Q1	Improved understanding by LSAB members of key priorities and safeguarding issues in Southampton	Efficient use of time in meetings and LSAB members survey to review
Collate relevant data and evidence supporting key themes and priorities – ensuring this is appropriate	4LSAB QA group LSAB Chair	Q1-Q4	Performance information is used to monitor safeguarding effectiveness and improve multi-agency responses	Data and evidence collect and presented in meaningful way to support key themes and priorities

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

3. PEARLS area: Awareness

Timescale: Q1-4

Action	Lead	Timescale	Outcome	How can we measure this?
Continue to promote 'how to seek help' messages through existing mechanisms and activities	LSB Team	Q1-Q4	The community feel confident in identifying abuse and know how to report concerns	Monitoring of concerns reported via SCC Adult Social Care Connect/MASH
Ensure information is available in accessible formats and languages regarding safeguarding	LSAB Members LSB Team	Q1-Q4	Service users and carers are safeguarded from abuse and neglect	Information and resources are available in accessible formats and languages
Engage in Safeguarding Awareness Week via South East LSAB network	LSB Team	November 2019	Increased positive feedback from service users / carers about their experience of safeguarding processes.	Awareness raising activity coordinated and delivered in line with key local safeguarding priorities and national campaign
Develop an animation to describe Adult Safeguarding and where to seek help	4LSAB managers	Q1	Continuous improvement in the outcomes for service users/carers People have access to a range of safeguarding information including how to raise concerns, which is user friendly, accessible to all and in a range of formats	Animation is launched and available to the 4LSAB network and members of the public

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

4. PEARLS area: Risk

Timescale: Q1

Action	Lead	Timescale	Outcome	How can we measure this?
Mental Capacity Act and Multi Agency Risk Management procedures to be the theme for Q1 LSAB meeting	LSB Team LSAB Chair	Q1 LSAB Meeting	Increase staff awareness and confidence across the sector of how to work with adults, carers and families who present with cross cutting safeguarding concerns	Meeting theme delivered
Consider the interface between Self Neglect, Alcohol, Substance Use and Homelessness theme for Q3 LSAB Meeting	LSAB partners	Q3 LSAB Meeting		Meeting theme delivered
Deliver training and support around the Mental Capacity Act and its application (Source: Adult P)	LSAB members LSB team	Q1-Q4	Staff confidence in application of the Mental Capacity Act MCA guidance which is clear and accessible on the LSAB website. Training sessions available to explore application of MCA in complex situation Clear and consistent recording by practitioner regarding MCA assessment.	Staff survey and evaluation of knowledge of MCA shows increased awareness of how to apply MCA in complex cases
Quality assure the use of MARM (Multi agency risk management framework) via Audit / data assurance	4LSAB QA Group	TBC	Practitioners feel confidence to manage those cases where S42 threshold not met but safeguarding concerns are complex and require coordinated approach	Scrutiny of data and audit activity which demonstrates practitioners are using the MARM

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

			Service Users' care and support needs are considered by multiagency with improved outcomes to keep them safe from risk of harm and abuse	
Promote the use Risk Management Framework and the Care Programme Approach to assure agencies adopt effective and joined up multi-agency risk management and care approaches which meet the needs of adults with complex and sometimes competing needs. (Source: Marie Dixon and Adult P Reviews)	LSAB Members LSB Team	Q1	Increase staff awareness and confidence across the sector of how to work with adults, families and carers who present with cross cutting safeguarding concerns are not necessarily met.	Practitioners awareness and us of the MARM to manage cases where S42 threshold not met but the service user has complex and conflicting needs.
Work with the children safeguarding boards and Community Safety Partnership to support frontline professionals seeking to manage longstanding high risk complex domestic abuse cases where multiple risks and additional risks are emerging. (Source: Adult F and Adult G Review)	LSAB Chair with other partnership chairs LSAB Members LSB Team	Q1	The LSAB works effectively with other strategic partnerships to ensure joined up working in key areas. Staff have a better understanding of how to work and identify the risk of self neglect and/or the interface other high risk safeguarding and improve outcomes for service users.	Collaborative working with Community Safety Partnership and other strategic partnerships
Seek assurance from agencies regarding understanding of self neglect as a tangible risk if the individual has mental capacity or not. (Source: Adult P review)	4LSAB QA Group	TBC	Staff are confident in managing Self neglect cases Service users appropriately safeguarded and supported	Check understanding via professionals survey and training needs analysis
Review "Guidance on responding to Self Neglect and	SCC Adult Safeguarding Service Manager	Q1		Guidance to reflect current updates to legislation and

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

<p>persistent Welfare Concerns” 2016 to take into account current research, case law and legislative interpretation of the Care Act and Mental Capacity Act. (Source: Adult P)</p>	<p>LSB Team</p>			<p>research and include interpretation of MCA and Care Act.</p>
<p>Reinforce reporting routes for all agencies concerned about an adult at risk.(Source: Adult P)</p>	<p>LSAB members</p>	<p>Q1-Q4</p>	<p>Provide holistic multi-agency risk sharing and support a wider and more coordinated response including if necessary community police, environmental officers, landlords and outreach services.</p>	<p>Data collected regarding safeguarding adult concerns reported from agencies and improved quality of safeguarding referrals submitted.</p>

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

5. PEARLS area: Learning

Timescale: Q1-4

Action	Lead	Timescale	Outcome	How can we measure this?
Develop cross border peer review of LSAB learning and work	4LSAB QA Group	Q4	Agencies work in partnership with 4LSAB partnership to identify trends and areas for improvement	Peer review completed and findings delivered
Share learning across 4LSAB group to ensure shared opportunities to improve are harnessed	IAWG	Q1-Q4	A better understanding across the partnership of local and pan Hampshire safeguarding issues and priority areas for development. Implementation and monitoring of actions and learning from statutory and discretionary case reviews	Learning from reviews and audits shared across 4LSAB
Explore options to help agencies to work together to recognise when the risk of diagnostic overshadowing is elevated, and be explicit about measures taken to avoid it (Source: Adult H)	LSAB / Health Leads	TBC	Practitioners have increased awareness of diagnostic overshadowing when working together with learning disability and safeguarding concerns	Survey of understanding completed
Seek assurance that commissioning of DVA services identifies responses to perpetrators with strong links into other specialist services where appropriate and include detailed profiling to	SCC Adult Social Care, Hampshire Police, IDVA service and Southampton Safe City Partnership	TBC	Commissioned services will meet the needs of perpetrators where relevant and needed according to learning from case reviews and the M4 evaluation	Improved provision to meet the needs appropriately of perpetrators of Domestic Violence and Abuse.

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

understand behaviours and the barriers to change (Source: Adult F and Adult G)				
Remind agencies of escalation policy (Source: Adult P)	LSAB Members	Q1-Q4	<p>Increased application and use of escalation policy.</p> <p>Practitioners who feel confident to challenge each other and other agencies about safeguarding response and decision making.</p>	<p>Evidence of escalation policy being used via feedback from practitioners and LSAB being aware of proactive challenge of decision making within partnership</p>

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

6. PEARLS area: Service Users

Timescale: Q4

Action	Lead	Timescale	Outcome	How can we measure this?
Undertake a multi-agency audit to identify the extent and quality of professionals' understanding and practice of "voice of the client" including use of strengths based approaches and impact of this on assessment, planning and outcomes. (Source: Adult R)	4LSAB QA	TBC	Increased engagement with adults, families and carers with the safeguarding process and outcomes.	Audit completed and findings delivered
Mental Capacity Act and Multi Agency Risk Management Framework procedures to be the theme for Q4 LSAB meeting	LSB Team	Q4	Increased awareness and understanding of implementation of the framework. Identification of good practice within the partnership and areas for improvement.	Themed meeting delivered
Work with 4LSABs to develop MSP action plan and quality assurance activities	4LSAB QA Group 4LSAB WFD Group	Q2 Workshop	Better cross area working and improved understanding of MSP activities pan Hampshire including identification of good/best practice	MSP QA and WFD group activity
Deliver survey of practitioners regarding MSP activities	4LSAB QA Group	Q4	4LSAB will have a base line understanding of practitioner confidence of MSP and how this is integrated in to their practice	Practitioners survey completed
Ensure service user input to all LSAB meetings	LSB Team	Q1-4	To ensure that LSAB members are aware and acknowledge of the lived experience of adults, families and carers in	Service User input arranged for each LSAB meeting via case study or attendance at meeting

Southampton Local Safeguarding Adult Board Strategic Plan 2019-22

			Southampton who experience abuse and neglect	
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Key to abbreviations:

Board / LSAB:	The full board of the Local Safeguarding Adult Board
LSB	Collective name for Local Safeguarding Board / team in Southampton – working across the adults and children’s safeguarding boards
Exec	The joint business group for LSCB and LSAB in Southampton
QA:	Quality Assurance
WFD:	Workforce Development
4LSAB:	Hampshire, Isle of Wight, Portsmouth & Southampton Local Safeguarding Adults Boards
HWBB:	Health & Wellbeing Board
DVA:	Domestic Violence and Abuse
HBV:	‘Honour’ Based Violence
FGM:	Female Genital Mutilation
FM:	Forced Marriage
MSP:	Making Safeguarding Personal

