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HEALTH AND WELL BEING BOARD Agenda - supplemental

Date Tuesday 12 November 2019

Time 2.00 pm

Venue Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL

Notes

- 1. DECLARATIONS OF INTEREST- If a Member requires any advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Mark Hardman in advance of the meeting.
- 2. CONTACT OFFICER for this Agenda is Mark Hardman Tel. 0161 770 5151 or email
- 3. PUBLIC QUESTIONS Any member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the Contact officer by 12 Noon on Thursday, 7 November 2019.
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Item No

7 Children's and Adults Local Safeguarding Boards - Business Plans Updates (Pages 1 - 70)

A paper relating to the Adults' Board is attached.





Report to HEALTH AND WELLBEING BOARD

Oldham Safeguarding Adults Boards Annual Report and Business Plan.

Portfolio Holder:

Councillor Chauhan: Cabinet Member for Health and Social Care

Officer Contact: Mark Warren

Managing Director Health & Adult Social Care Community Services

(DASS)

Report Author: Abigail Pemberton

Strategic Safeguarding and Safeguarding Adults Board Manager

Ext. 622 6401

07/11/2019

Purpose of the Report

The purpose of the report is to present the Oldham Safeguarding Adults Board (OSCB) Draft Annual Report 2018-19 and 2019-20 Business Plan to the Health and Wellbeing Board for information.

Executive Summary

Oldham Council has a statutory duty under the Care Act 2014 to run the local safeguarding adult's board, whose purpose is to strategically lead on and assure adult safeguarding within a designated local area through both long term and annual strategic planning.

Annual report 2018 -19

The Care Act 2014 and the Care and Support Statutory Guidance requires that Safeguarding Adults Boards must publish an annual report which provides an assessment of the performance and effectiveness of local services in their safeguarding activity.

Within this 2018-19 Annual Report Oldham Safeguarding Adults Board details the partnership's safeguarding activity over the 12 month period and assesses the impact of this activity against the boards annual Business Plan for 2018-19.

Moving into 2019 - 20 represents phase 2 of the boards 3 year strategic plan 2018 – 2021. The report concludes by identifying the phase 2 strategic safeguarding priorities for the next year. These are:

- Prevention and wellbeing
- Transitions
- Making safeguarding personal
- Integration and safeguarding
- Domestic abuse
- Prevent

And the delivery of the safeguarding review and peer review recommendations.

Business Plan 2018-19

Guided by the priorities outlined in the Strategic Plan 2018-2021 Oldham Safeguarding Adults Board has produced an annual business plan that defines the actions to be undertaken in year two to support the achievement of our aims by the end of year three.

The attached business plan is the Q2 version highlighting the activity undertaken in each of the priority areas and by the subgroups of the board.

Recommendations/Requirement from the Health and Wellbeing Board

To note the annual report 2018 -19 and Business Plan 2019-20 and provide appropriate challenge where required.

It is worthy to note that the ability to deliver some areas of the business plan is currently impacted by reduced staffing and staff capacity. The creation of the new Strategic Safeguarding Service will build in additional capacity to support the delivery of the business plan.



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Oldham Adult Safeguarding Board



Annual Report April 2018 – March 2019

Published: November 2019

Author: Abigail Pemberton, Safeguarding Adults Board Manager

Issued: November 2019

Review Date: April 2020

Oldham in context

Safeguarding is about people's human rights, their health and wellbeing and supporting people to live free from abuse and neglect.

There are many social factors which contribute to the causes of abuse and neglect.

For many Oldham citizens life is good, and they are able to protect themselves from the risk or experience of abuse and neglect.

There are also factors which increase vulnerability to abuse and neglect including deprivation and poor levels of health and wellbeing which continue to affect many Oldham Citizens.

- 58.8% of Oldham's population are aged 18-64
- 15.9% are aged 65+
- 22.7% of the areas in Oldham are amongst the 10% most deprived areas in England
- Oldham's healthy life expectancy and overall life expectancy are significantly lower than England's averages.

Oldham Safeguarding Adults Board are committed to addressing the causes of abuse, preventing abuse and ensuring that protection and support to recover from the experience of abuse is available to the citizens of Oldham.

Oldham Safeguarding Adults Board

Oldham Safeguarding Adults Board is a partnership of organisations whose aim is to safeguard adults who are vulnerable to, at risk of or are experiencing abuse and neglect. As a statutory body the primary role of Oldham Safeguarding Adults Board is to strategically lead adult safeguarding within Oldham. The board is also required to assure itself that organisations and agencies across Oldham are effectively ensuring the safety and promoting the interests of adults who are vulnerable to abuse and neglect.

Oldham Safeguarding Adults Board is comprised of both statutory and non-statutory members. We are required to produce and publish a strategy every three years which outlines the priorities of the board, and an annual business plan which details how we will achieve our aims.

Our partnership approach is that our shared vision will be achieved by working together in partnership as communities, organisations and affiliated boards to maximise effective, forward looking strategies which safeguard adults.

The strategy and workplans underpinning our vision remain flexible in approach. Where new risks are identified, or key aspects require review, the strategy and workplans are amended to support the most effective means of preventing abuse and neglect and promoting the wellbeing and safety of adults.

This annual report evaluates our effectiveness in achieving our aims in 2018-19 and will identify our future plans and where strategy will focus and develop going forward.

Our principles and priorities 2018/19

Our collective values as a board are that:

- It is a human right to live a life free from abuse and neglect.
- Individualised, outcome focused safeguarding and public protection is the responsibility of the board partnership and the wider community.
- Preventative practice reduces the risk of abuse or neglect to adults with care and support needs.
- Multi agency working supports excellence in safeguarding practice.
- A holistic approach is at the heart of safeguarding practice.
- Individual rights to both to take risks and receive protection should be respected.
- Safeguarding is everyone's business.
- Partnership agencies are responsible for holding each other to account.
- Achieving excellence in safeguarding is a continuous process which occurs through a culture of learning.

The underpinning principles that we work to are those of empowerment, prevention, partnership, proportionality, protection and accountability.

Our Priority areas of work for 2018 /19 have been:

Prevention and wellbeing

The board recognise that preventative safeguarding has the capacity to enhance resilience to abuse and neglect and empower individuals and communities to safeguard themselves. In 2018- 19 the board therefore gave priority to developing a prevention sub group and prevention strategy. We planned to focus on prevention through community engagement which supports early identification of new safeguarding issues, engagement with the development of the prevention offer for adults across Oldham, and to lead on the delivery of key messages to front line staff.

Transitions

In 2018 – 19 the board planned to continue to maintain oversight of the transition's agenda and priorities via links to existing working groups.

It was recognised that the boards plan to expand its prioritisation of this area of work from a focus on learning disabilities to all areas of need, and the boards consideration of the need for a joint transitions' subgroup with the Local Safeguarding Children's Board would form part of the phase two our three year strategy going forward into 2019-20.

Making safeguarding personal

The Making Safeguarding Personal (MSP) approach is an agenda for change aimed at achieving a cultural shift in the way we work with adults who are experiencing or at risk of abuse and neglect. It emphasises the need to move away from process led safeguarding practice and systems, to person centred, interventions-based practice which uses preventative, wellbeing and safety approaches to meet the desired outcomes of adults at risk.

The approach requires all organisations to engage with people about the outcomes they want from the point of first contact and drives safeguarding work which supports people to be in control and can make decisions for themselves about their wellbeing and safety. In 2018 – 19 the board therefore gave prioritisation to the creation of a making safeguarding personal subgroup and the development of an engagement strategy with the citizens of Oldham.

Integration and safeguarding

In 2018 a new model of care that brought together health and social care to improve outcomes for local people was implemented in Oldham. Oldham Cares is the banner under which Oldham's health and social care commissioners and providers work together on an integrated approach to health and social care in the borough. Integration in Oldham has presented both opportunities and challenges which continue to be shaped by ongoing dialogue. In 2018 – 19 the board recognised the need to give priority to leading the dialogue in relation to the impact of and opportunities created by integration for safeguarding adults.

Domestic abuse

In 2018 – 19 the board planned to continue to maintain oversight of the Domestic Abuse agenda and priorities via links to existing working groups.

Prevent

In 2018 – 19 the board planned to continue to maintain oversight of the Prevent agenda and priorities via links to existing working groups.

What has the board done 2018/19

In May 2018 Oldham an adult safeguarding peer review with Stockport which addressed the following areas:

The Efficacy and Quality of the All Age Multi Agency Safeguarding Hub

Key learning points

Stockport Said...

- A joint adult and children's MASH helps staff understand the family journey and avoid duplication and lack of consideration of the full picture.
- Colocation leads to strong multi agency collaboration
- Having an early intervention response embedded in the MASH was seen as good practice.

Oldham reflections....

- Oldham welcomes this independent feedback, particularly in the context of the cluster work and ensuring MASH continues to provide safeguarding oversight and prevention work.
- Oldham has worked hard to strengthen application of the Care Act in the MASH to ensure better understanding of where cases meet the S.42 threshold for enquiry.
- Whilst Stockport cited the need for independent reviewing officers in Stockport, this may or may not be needed in Oldham, where a culture of empowerment at Social worker level is gathering momentum.

Recommendations

Stockport Said....

- OMBC should consider the impact of the move to clusters very carefully.
- OMBC and partners should understand the impact of Greater Manchester Police's Investigation and Safeguarding Review and work closely together to minimise the impact on the MASH.
- Consideration should be given to a mental health worker and housing worker being based in the MASH.

Oldham reflections.....

- Oldham welcomed this insight (based on learning from Stockport's locality working) and will consider the relationship, roles and responsibilities and interdependencies between the MASH and cluster teams.
- Oldham reflected on the excellent relationship with the police in Oldham, and the engagement in the MASH has been seen as a positive. However, it was acknowledged that there has been some disengagement in certain groups and settings, (Including strategy meetings), which is resulting in safeguarding cases not having police insight/intervention.

Key actions to take forward:-

• Oldham Director of Adult Social Services to take forward GMP engagement issues at NW ADASS

Outcomes and experiences for people – Deprivation of Liberty Safeguards

Key Learning Points

Stockport Said....

- In Oldham, the lack of signatories to scrutinise and authorise deprivations is significantly impacting on the situation.
- Currently the Learning Disability and Mental Health Head of Service is the only active signatory.
- Integration will create more senior posts which will enable more opportunity for trained signatories.

Oldham reflections...

- Oldham is in the process of training additional staff to become signatories recognising that this has been a weakness for some time.
- Oldham has received the same advice regarding managing the back up of applications and has taken the decision to put on hold cases that haven't been assessed and focus on existing high and medium priority cases.
- Oldham to review Liberty Protection Legislation, ahead of Mental Capacity Amendment Act implementation in 2020.

Recommendations

- It would be useful to review process and determine at what point in the system waiting lists should start.
- More active signatories should be available for sign off of Form 5s.

Key Actions to take forward:-

- Ensure new authorisers are fully trained and allocated to help reduce the current caseload and reviewed/audited soon after by the quality subgroup.
- Oldham Director of Adult Social Services to pick up wider legislative changes at NWADASS.

Outcomes and experiences for people – Case File Audit

- Stockport said...
- OMBC to assure themselves that all meetings including strategy meetings are appropriately recorded and defensible decision making is described.
- Some third party records were written in people's notes. OMBC to consider whether 'Group recording function' would be more appropriate.
- OMBC to assure themselves that risk assessments are completed along with action plans about how risk will be mitigated

Oldham reflections......

- Oldham will reflect on efficacy of checks and balances in terms of sign off arrangements.
- Oldham have Mental Capacity Act (MCA) training in place but there has been historic problems of partner engagement.
- Oldham to consider role of Clusters and identifying MCA champions so that MCA become part of the operating culture.
- Oldham has recently agreed to audit a % of cases as a result of two new members of staff coming in to the service.
- Oldham acknowledged improvements to risk planning is needed and these will be picked up via the case audit work and addressed with staff as an area of practice improvement.

Recommendations:

- OMBC to consider how quality checks and balances are managed including regular audits of cases to review the quality of decision making and recording.
- OMBC to consider how to audit and oversee the electronic system which requires management sign off. It was identified that some managers sign off their own decisions.
- OMBC / PCFT to consider undertaking more work around capacity assessment training

Outcomes and experiences for people – Health Watch

- Key Learning Points
- A strong commitment and relationship with HWO that will only ensure the service users perspective is considered so that improvements to be made to the service.
- Visibility within the care homes will promote a robust pathway of engagement with service users.
- A strong desire from HWO in devolving ways in which to further engage those who are impacted by the services offered, and a keen aspiration to work with neighbouring Healthwatch services.

Recommendations

- The review team would welcome more accessible documentation being made available to the wider public.
- Consider effective methods of gathering and developing feedback from users to improve people's experience of safeguarding.
- Consideration is given to ensure that service users' voices are heard, and mechanisms are in place for the translation of action across the partnership, and to ensure that arrangements are fed back to the service user and where appropriate, to the wider population.

Oldham reflections...

- Oldham welcomed this feedback, though acknowledged some personnel changes have enabled a better memorandum of understanding and clarity of roles and responsibilities.
- Oldham will reflect on the service user voice issue and have made inroads in ensuring such insights are included within emerging performance frameworks.

Key actions to take forward: -

Continue to develop this relationship within relevant decision making forums and ensure consistent application of Making Safeguarding Personal by staff.

Contribution of Health Services - Pennine

Key Learning Points

- It was noted that there is a presence from PCFT within the MASH in the form of a safeguarding nurse, which offers a different dimension to the assessment/screening process.
- The current practice of Council staff working within the Integrated Mental Health Teams, using the Council recording system enables the Council to have a clearer oversight of Care Act compliancy.
- The PCFT governance lead oversees complaints and incidents; there are twice weekly meetings across the trust to examine incidents and a monthly governance assurance meeting; however, it is not clear how this feeds into the SSAB.
- The new policy was developed in conjunction with staff and this has led to a welcome and positive shift in culture.

Recommendations

- Separate recording systems is likely to heighten the risk of key information being missed by professionals
- PCFT should work with their Organisation Development to review and implement a robust training strategy.
- The 'NHS Safeguarding Self-Assessment Tool' should be completed to reflect the lack of confidence around staff ability to address safeguarding issues and an action plan designed to ensure that training is built into the business plan

PCFT should ensure learning from previous incidents, such as Safeguarding Adult Reviews, is considered more, so that preventative measures can be implemented sooner with the intention to reduce incidents from occurring.

Recommendations

- The review team were informed there was a skill gap in the Prevent and Channel strategy, this is an area for development and the membership should reviewed to consider representation from mental health services.
- The Team Around the Adult model should be assessed to ensure that ownership of tasks / issues is fully understood.
- The Manager of the community nursing team should consider visiting one of the integrated teams in Stockport for further shared learning of how DN and SW approach safeguarding issues jointly through shared duty and triage meetings

Contribution of Health Services - CCG

Key Learning Points

- Evidence of good support from Designated Nurse to practitioners from other agencies to understand their safeguarding duties.
- Good engagement on a Greater Manchester level as a member of the Greater Manchester Designated Nurses Safeguarding adults network.
- Designated Nurse demonstrated excellent knowledge and Interaction at the OSAB and was witnessed supporting the chair with outcomes and actions.
- Good relationships seen with multi agency partners.

• Good escalation processes in place for trusts which are not meeting there assurance contracts.

Recommendations

Stockport Said...

- Oldham CCG should consider whether the right level of seniority of staff attends board in the light of the fact that the Designated Nurse is there as an advisor to the board.
- Oldham CCG should consider how to strengthen oversight process for smaller providers; this involves a separate small provider GM assurance tool.
- Oldham CCG should assure itself that the issues identified within Pennine Care NHS FT are being addressed promptly and effectively.

Oldham reflections...

• Oldham concurred on the quality and insight of the CCG representative in an advisory capacity and will consider how in addition another CCG representative can be sought to fulfil strategic requirements of the board.

Key Actions to take forward: -

As part of the OSAB Annual review consider membership and engagement issues.

The Safeguarding Adults Board and the relationships between partners

Key Learning Points

- Developed links with Oldham Children's Boards were strong, particularly with the transitions agenda.
- OSAB is working well with good attendance from partners with an improving strategic focus.
- Partnerships are strong and getting stronger.
- The Director of Adult Social Care and his senior management team are committed to the safeguarding business. This ethos infiltrates throughout adult social care with a demonstration of strong leadership.

Recommendations

- Consider the development of induction packs to ensure they are available for new board members; this would be a good resource for new board members.
- The implementation of a full financial forecast that would demonstrate the level of financial commitment from both statutory and non-statutory partners.
- Consideration should be given to the sub group structures and thought given to amalgamate membership of sub groups, and to review the frequency of meetings.
- The peer review team recommend that OSAB spend time in refreshing their memorandum of understanding, of what it means for Oldham to have a consistent track record of attendance, with clear terms of reference so that individual organisations could be held to account.

Oldham reflections...

- Oldham liked the idea of induction packs and the Statement of commitment which could be refreshed annually and used when new members join.
- Oldham has been proactive in refreshing the Performance Sub Group, including its TOR and is currently considering a multiagency dashboard.

Key actions to take forward:-

- To learn from the board development work at Stockport, including the adoption of the above products where appropriate.
- Consider wider review of sub groups

Stockport said..

- Develop a Safeguarding website that is available to professionals and the wider public.
- Promote wider public awareness of safeguarding that offers accessible information to a range of people from different language backgrounds.
- Assist CQC to engage more with OSAB.
- Consider including a communication strategy on the agenda as a standard item to ensure that the matter of how to tell people what Safeguarding Adult outcomes are discussed and agreed.

Oldham reflections..

- Consider wider role/relationship of CQC not specific to Oldham per se.
- Communications have already been identified as an area of improvement and a new apprentice has been recruited to look at partnership comms.

Key actions to take forward:-

• Comms strategy for the board, based on what is reasonable and within the resources available.

Workforce and the Neighbourhoods - Neighbourhoods

Key learning points

- Strong evidence of Making Safeguarding Personal being embedded within the teams with good examples of practice.
- Clear definition of duties for staff around safeguarding.

Recommendation

- Consider if there is a need to monitor risks regarding staffing levels and how this impacts on case management of complex cases and prevention of abuse through active case management
- OMBC should consider building up a library of case studies where people's experiences can be collected to share best practice examples with other workers
- OMBC and PCFT should consider how to mitigate the risk of having two separate systems.
- Consider using a Risk Register for cases where workers are concerned about a person's wellbeing so they can be 'monitored'
- Consider how MSP can be promoted within the wider workforce and economy.

Workforce and the Neighbourhoods – Quality Assurance and Safeguarding Hub

Key Learning Points

• The move to the CCG building was strengthening relationships with health colleagues.

Recommendations

Stockport said...

- OMBC should consider reviewing the DoLS process with the aim of slowing down allocation until there is assurance that Form 5s will be signed off promptly. They should also consider how to increase the number of active signatories.
- OMBC should consider how to strengthen links with the MASH team specifically around police engagement with safeguarding investigations.
- OMBC should review the capacity for undertaking safeguarding investigations and supporting care homes within the team.
- OMBC / OSAB should consider how to assure themselves of the quality and consistency of Section 42 investigations and case conference out coming, not just within the QUASH team but across the wider Oldham services.

Oldham reflections...

- To reflect on how care home allocation can be better distributed across the team.
- Build confidence and resilience within the team around DOLS.
- Consider how the team can re-ignite links with MASH.
- Consider current lack of police engagement and how this can be managed operationally and at a strategic level.

Key actions to take forward:-

• Consider the above in light of Safeguarding Review taking place and doing so in a way that acknowledges impact of change to date.

In Summary

- The panel saw evidence of commitment and enthusiasm in all areas visited. Staff were knowledgeable and helpful and keen to demonstrate both the good work that had been done and their awareness of the gaps in service that needed to be addressed.
- There were many similarities between the issues faced in Stockport and many of the recommendations reflect the challenges that the public sector faces with increasingly demand and increasing complexity across the adult agenda.
- The panel felt there was scope for joint working to consider how we address the challenges we face.

The Safeguarding Adults Board Subgroups and priority areas delivery on the annual business plan

The Safeguarding Adults Review subgroup

The SAR subgroup screened three new referrals in 2018-19 and a SAR was recommended for all three people.

One of these reviews was completed during 2018 - 19 alongside the completion of two ongoing reviews.

The learning from the completed SARs completed in 2018-19 can be summarised as:

SAR 1

- The use of standard engagement processes which anticipate people's full cooperation and engagement is not suitable or successful for all people.

 Assertive outreach approaches are needed to support some people to engage with services who can support them with their health, wellbeing and safety.
- Professionals within the safeguarding partnership would benefit from a framework for working with adults who have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services.
- Peoples diagnoses can evolve over time. A working diagnosis [the latest diagnosis] together with historical information should be clearly identified by professionals and used to inform risk assessments and care plans which support a person's wellbeing and safety.
- When a person's mental capacity is in question, the completion of formal decision to assess mental capacity and time specific mental capacity assessments can help to formulate risk assessments and care plans and assists in the provision of appropriate services.
- Prompt recording, grading and formal sharing intelligence is necessary in order to ensure that professionals have the right information to inform decision making. Healthcare staff need to understand what intelligence gradings mean and be able to apply that knowledge to their risk assessments.
- Actions from multi agency meetings need to be agreed by all present and be Specific, Measurable, Achievable, Realistic, Time bound. Processes need to be in place to notify professionals not present at meetings that they have been allocated an action prior to the minutes being available.

• Where a mental health assessment is planned to consider detention under the Mental Health Act immediately prior to a person's release from prison, in the event that a decision not to detain under the Mental Health Act is made, a contingency plan should be developed to support the individual and manage their release and engagement with services.

SAR 2

- When Information sharing between agencies is completed it is not always in a clear manner.
- When making referrals to other agencies and organisations referrers should be clear about the purpose of the referrals and expectations of the outcome of the referral and ensure that they have fully considered all and made all appropriate referrals for support and signposting opportunities.
- Agencies should be clear on their roles and responsibilities in supporting an individual's wellbeing and safety and the roles and responsibilities of other agencies that can support people's safety.

SAR 3

- A person may come into contact with many agencies on a frequent basis, but not fully meet the criteria for, or engage with any of the agencies for ongoing support. A multi-agency approach with a co-ordinating lead professional role is required to support a person's safety in these circumstances.
- A person who presents with behaviours that pose a high risk to their safety, agencies should be routinely demonstrating through their recording that mental capacity to make decisions about these behaviours has been considered and assessed.

Actions:

The publication of all three SARs in 2019 -20.

The actions and recommendations below will be incorporated into the into Oldham Safeguarding Adults Board business plan and activity for 2019- 20 to support learning to be embedded in practice across Oldham's Safeguarding Partnership.

- The development of a multi-agency self-neglect policy and a Risk Management protocol.
- The implementation of multi-agency audits examining how the principles of the Mental Capacity Act are embedded in the practice of the organisations with the Oldham safeguarding partnership to assure Oldham Safeguarding Adults Board that all agencies have the necessary knowledge and understanding of the requirements of the Mental Capacity Act to discharge their statutory responsibilities.
- A multi-agency Mental Capacity Act training plan should be developed comprising of information about the legislation and practical advice about applying the legislation in practice to assure Oldham Safeguarding Adults Board that General Practitioners are being offered, and are participating in, training to increase awareness and knowledge of Mental Capacity Act requirements.
- Oldham Safeguarding Adults Board should receive assurance that all of its member agencies have clear policies and a proactive approach to working with families. This should include sharing information; care planning; appropriate levels of decision making (that are Mental Capacity Act compliant); pathways for end of life care.
- Oldham Safeguarding Adults Board should receive assurance that General Practitioners are fully conversant with the requirements of Mental Capacity Act in relation to matters of consent and are supported in delivering the principles of Making Safeguarding Personal.
- Oldham Safeguarding Adults Board should be assured that all agencies know when and how to escalate safeguarding concerns. They should also be assured that multi-agency discussions regarding safeguarding concerns are built into local care planning and delivery.

The Operational Policy and Procedures subgroup

The operational Policy and procedures subgroup have experienced some challenges throughout 2018 -19 with capacity and resource constraint.

As a result, the subgroup hasn't achieved all the activity the Board had hoped. The main focus of the subgroup in 2018 -19 has been on policy and procedure development and included a review Oldham's Multiagency Safeguarding policy and procedures and fully updating these, reviewing the ADASS Person in a Position of trust (PIPOT) policy and commencing work on a multi-agency PIPOT procedure for Oldham, and commencing work on a self-neglect policy which will sit alongside a Multi-agency Risk Management protocol. Completion and delivery of these policies and procedures will continue into 2019 -20. The sub group will also place a renewed focus on operational development.

The Prevention and Wellbeing Subgroup

The prevention and wellbeing subgroup were created in 2018 -19. Terms of reference for the subgroup activity were agreed and the group began to work with a focus on supporting adult safety and wellbeing. The initial work completed by the group was undertaken to gain an understanding of what was in place to support the prevention of abuse and neglect in Oldham. The subgroup has reviewed the outcomes of a review of the prevention offer in Oldham, community based initiatives, thriving communities and enablement work. The subgroup also began work on an understanding what good preventative safeguarding looks like and the options on how to deliver this in Oldham. A framework for Adult Safeguarding Prevention was established which outlines different cohorts of people and what sort of prevention activity would be required to have a meaningful impact on reducing the risk of and vulnerability to the risk abuse or neglect at the earliest possible point. The subgroup also began to contribute to the development of a prevention strategy and began planning awareness raining events around early intervention for delivery in 2019-20.

The Making Safeguarding Personal Subgroup

The making safeguarding personal subgroup were also created in 2018 -19 with the key focus on raising the profile of making safeguarding personal and promoting participation. The groups work is the start a conversation with the citizens of Oldham on what is important in preventing abuse and neglect, supporting wellbeing and how citizens should be protected when they need such support. Terms of reference for the subgroup activity were agreed and mapping of existing engagement with service users across the partnership was completed and its findings reviewed. The group undertook an options appraisal for how engagement with Oldham Citizens can be undertaken by Oldham Safeguarding Adults Board and an action plan created. This plan will now be implemented in 2019 – 20 and into 2021 through close alignment to the prevention and wellbeing subgroup.

The Performance subgroup

The work of the performance subgroup in 2018 – 19 focused on assuring the board that effective leadership and partnership working are taking place across the safeguarding adult's partnership. Four Performance Indicator documents were created, a 2018/2019 performance dashboard indicator list was

created, the group also provided a quarterly Performance Dashboard and accompanying Performance Report for Oldham safeguarding Adults Board, and the summary of annual safeguarding activity for the annual report.

The Quality Assurance and Audit Subgroup

The work of the Quality Assurance and Audit Subgroup in 2018 – 19 has also focused on assuring the board that effective leadership and partnership working are taking place across the safeguarding adult's partnership. The terms of reference for the subgroup were reviewed and updated. A core set of products and tools for the audit of cases and assessment and assurance of quality in safeguarding activity undertaken across the partnership was developed. The subgroup members completed Oldham's Adult Safeguarding peer review report, plus an overall report summarising finding from both Oldham and Stockport. They also undertook a safeguarding case file audit around the theme of the Mental Capacity Act and delivered the findings to the board. Further planned audits were placed on hold to allow the delivery of the Adult Safeguarding Peer Review with Stockport and whilst a full review of the Adult Safeguarding arrangements in Oldham occurred.

The Workforce Development subgroup

The work of the Workforce development subgroup in 2018 – 19 focused on raising awareness of and embedding Oldham's multi-agency Safeguarding Adults Policy, Procedures and Adult Social Cares Safeguarding Practice Guidance into front line safeguarding practice. The ability to deliver the remainder of the Subgroups objectives has been affected by capacity and resources the subgroup has not achieved all the activity the board had hoped. These issues have now been resolved and the subgroup will continue to work on the revised delivery of a workforce development strategy in 2019 – 2020.

The Public Relations and Communications subgroup

The work of the public relations and communications sub group has focused on raising the public profile of adult safeguarding and partnership work throughout 2018 -19. A communications network across the adult safeguarding partnership has been created and the pre-work needed to develop a multi-agency Safeguarding Adults Board brand, independent Oldham Safeguarding Adults Board website, and the promotion of its purpose commenced. This work is intended to continue jointly throughout 2019 - 2020 and into 2021 as part of the boards 3-year strategy and will take place through close partnership with the Oldham's Safeguarding Children's partnership.

Domestic Abuse

Oldham Safeguarding Adults Board continued to receive assurance into how the work of the Domestic Violence Partnership contributes to the safeguarding Adults Boards strategy. The board were provided with updates from a report summarising victim pathways and provision, identifying gaps, and on the creation and progress of a domestic abuse action plan.

Prevent

Oldham Safeguarding Adults Board continued to receive assurance in relation to the prevent agenda and priorities through consideration of the messages from the Annual report on Prevent. Regular updates were received on the Greater Manchester rollout of Operation Dovetail. The board were provided with assurance that a programme of engagement activity to build community understanding and confidence in Prevent and that staff in partner organisations are being trained on Prevent in order to understand their responsibilities for safeguarding.

Integration and Safeguarding

Alongside significant benefits of the integration of health and social care the need for a full review of Oldham's Safeguarding Adults arrangements was recognised as an outcome of integration. Further to this, the Mental Capacity (Amendment) Act came into legislation in 2019.

This safeguarding review was delivered from November 2018 and concluded in January 2019 at Oldham Safeguarding Adults Board (OSAB) development day. 22 individual recommendations were made regarding how the current local model can be strengthened and improved. These can be summarised as:

- Recommendations regarding our local implementation of our statutory requirements for a Safeguarding Adults Board, including changes to format, frequency, support, and communications. These include proposals for a twice annual joint Safeguarding Forum with Children's safeguarding colleagues, examining the overlapping elements of our agendas, and a refresh of Sub Groups.
- Recommendations regarding the establishment of a multi-agency Strategic Safeguarding service to replace the current service that sits with Commissioning. This will be aligned to the Multi Agency Safeguarding Hub (MASH), but provide greater strategic capacity for policy, audit, workforce development and assurance. A refreshed Deprivation of Liberty function, and a Board Business Unit will also feature.
- Recommendations relating to operational adult safeguarding activity, such as referral pathways, expanding our local approach to the management of safeguarding activity to include NHS-employed colleagues, and the role of the MASH and the hospital-based Integrated Discharge Team.
- Recommendations relating to workforce development and training for adult safeguarding and mental capacity.

Adult Safeguarding activity in Oldham

843

safeguarding concerns were received by the local authority Of the safeguarding concerns received

43.7% were for males

56.3% were for females

Safeguarding concerns by age range:

18-64	46.5%
65-74	14%
75-84	20.3%
85-94	15.8%

95+

403

Statutory
Safeguarding
enquiries were
commenced

142

None statutiry Safeguarding enquiries were commenced 310

Safeguarding enquiries were concluded

In the concluded enquiries
30% of individuals

at risk lacked capacity

In the concluded enquiries the outcome of action being taken was:

Risk removed: 40.6%

Risk remained: 9.7%

Risk reduced: 49.7%

Concluded safeguarding enquiries by category of abuse:

3.2%

Neglect / acts of omission: 28.8% Financial or material abuse: 19.8%

Psychological abuse: 13.8%

Physical abuse: 18.3%

Discriminatory abuse: 2.3%

Sexual abuse: 6%

Self neglect: 2.5%

Domestic Violence: 6%

Organisational abuse: 1.8%

Sexual exploitation: 0.5%

Modern Slavery: 0.3%

Concluded safeguarding enquiries by location:

Residential Care homes: 28.4%

Nursing Care homes: 9.7%

Own home: 43.2%

Acute hospital: 3.2%

Other location: 9.4%

Community: 4.5%

Mental Health Hospital: 0.6%

Community hospital: 0.3%

in a community service: 0.

Safeguarding in action

Shirley's story

Shirley is a 52-year-old female who lived alone. She had been diagnosed with Huntington's Disease for 6 years. There were concerns about her physical health and Shirley was refusing to have any medical investigations, she was neglecting her personal care and was not eating or drinking properly. There were significant risks to Shirley's health and safety identified as part of a safeguarding enquiry.

3 experienced professionals worked with Shirley over a significant period of time to develop an honest and trusting relationship. They assessed that she lacked mental capacity in relation to decisions about her care and treatment and considered her mental health needs through a Mental Health Act assessment. An advocate was involved to ensure her views were represented.

As risks to physical and mental health continued to increase an application to the court of protection was made. Specialist support was identified, and the Judge agreed for Shirley to move to a specialist placement.

She is now very settled. Her relationship with her family has improved and she also has a good relationship with the staff that support her. Her physical and mental health and wellbeing needs are being met and she has been sitting out of bed and has taken a few steps for the first time in over a year.

Margaret's story

Margaret lived alone in rented accommodation with no informal support around her. Her property was becoming hazardous to herself and others due to the amount of belongings which were discarded on the floor and she needed support with her mobility and personal care. Over the years she had been known to social care but had not engaged with them.

A safeguarding concern was raised by the fire service and a self-neglect safeguarding enquiry began to consider Margaret's wellbeing, the risks she faced to her safety, the risks to others, what she wanted to happen in relation to her wellbeing and safety and what actions were also needed to protect others.

During the enquiry, Margaret had a fall in her home which resulted in a hospital admission and temporary support to allow her time to recover from an injury.

Through a transparent safeguarding enquiry that supported a relationship to be built between Margaret and the professionals supporting her she is now working in partnership with her landlord and Social Worker to support her to return safely to her property and on a future goal of building and maintaining relationships that will ensure she can maintain her tenancy and live well in a safe environment.

Future Plans

The recommendations of the review of safeguarding arrangements in Oldham were fully endorsed by the Safeguarding Adults Board in January 2019 and delivery will take place through three phases of activity over 2019 -20: an initial mobilisation phase, a second transition phase, and a third and final consolidation phase. A programme team, including Programme Board arrangements are in place to direct, coordinate and deliver the programme. The Programme Board will report directly to the board for the duration of its meeting.

Recommendation 1: A restructure of the Adult Board arrangements, including reducing meeting frequency and removing the Executive Group

Recommendation 2: The creation of a joint Safeguarding Forum to focus on the assurance and oversight of safeguarding across Children's and Adults

Recommendation 3: The amalgamation of appropriate Sub Groups across Children's and Adults

Recommendation 4: A new Board Business Unit to support the Board and its Sub Groups

Recommendation 5: A renewed focus on Communications, with investment to mobilise this

Recommendation 6: Endorse an ambition for the Board to continue to identify and explore opportunities for greater integration and alignment with Children's Safeguarding

Recommendation 7: Creation of a new multi-agency Strategic Safeguarding Service, aligned to MASH, and replacing and enhancing elements of the previous Quality Assurance & Safeguarding Hub. ASC Commissioning HoS to no longer lead.

Recommendation 8: Strategic Safeguarding Service includes the Board's Business Unit and Strategic Safeguarding Leads

Recommendation 9: Strategic Safeguarding Service includes a revised DoLS function, which now includes two dedicated Best Interest Assessors / Approved Mental Capacity Professionals

Recommendation 10: Strategic Safeguarding Service includes a small team of specialist Safeguarding practitioners who provide a link between practice and strategic activity

Recommendation 11: Endorse an ambition to explore opportunities and appetite to develop the Strategic Safeguarding Service into an all-age offer

Recommendation 12: Removal of the dedicated Residential Safeguarding function from within existing centralised arrangement, with all residential and community safeguarding activity to be

undertaken in the Cluster teams, with the exception of specific scenario`s to be undertaken in MASH and IDT

Recommendation 13: No such thing as a wrong front door; referrals made directly through professional relationships, or MASH where triage to identify an appropriate team is required, with all contacts recorded in Mosaic

Recommendation 14: A strengthened pre-referral process, including guidance and resources for 'referrers'

Recommendation 15: Empower NHS employed practitioners (Community and Acute) to undertake the Safeguarding Adults Manager (SAM) role

Recommendation 16: MASH to strengthen links with Clusters and Specialist teams and become a resource for professionals to access specialist support and guidance

Recommendation 17: Invest attention in developing the required 'enablers' for improved safeguarding, such as secure communications channels between agencies and a clearer business support offer

Recommendation 18: Endorse an ambition to build the support, confidence and knowledge required for safeguarding to truly be 'everybody's business' through the expansion of safeguarding enquiry delivery responsibility more widely across the borough

Recommendation 19: Develop a safeguarding and MCA training framework tailored to different levels of responsibility

Recommendation 20: Develop a safeguarding and MCA workforce development offer around initial training, refresher training, and workforce support and development

Recommendation 21: Identify safeguarding, MCA and Best Interest workforce development and training coordination capacity for the Business Unit

Recommendation 22: Establish a differentiated workforce development and training resourcing model whereby statutory partners fund SAM and Enquiry Officer training with wider partnership funding for referrer training (plus an equivalent for MCA)

The creation of the new strategic safeguarding service will increase strategic capacity to deliver on both the recommendations of the safeguarding review and the remaining recommendations to be implemented form the Stockport peer review.

Sub group activity will continue to focus on the strategic objectives and priority areas outlined in Oldham Safeguarding Adults Board three-year strategy 2018 – 2021.

Single Agency Statements

All Board members have written reports for Oldham Safeguarding Adults Board highlighting their agency's Safeguarding work over 2018/19 and their future plans. The full single-agency statements will be published on our webpage to accompany this report.

Safeguarding is everybody's business.

Anyone who has concerns that an adult is at risk of abuse, harm or neglect should report the concerns to:

Oldham Multi agency Safeguarding Hub (MASH)

Tel 0161 770 7777

Email: adult.mash@oldham.gov.uk

Oldham

Adult Safeguarding Board



Business Plan April 2019 – March 2020

Published: May 2019

Author: Abigail Pemberton, Safeguarding Adults Board Manager

Issued: May 2019

Review Date: April 2020

1. Introduction

The context of Adult Safeguarding in Oldham:

The local integration of commissioning and health and social care services in Oldham was implemented in 2018. Alongside significant benefits the need for a full review of Oldham's Safeguarding Adults arrangements was recognised as an outcome of integration. Further to this, the Mental Capacity (Amendment) Act has come into legislation in 2019.

This safeguarding review was delivered from November 2018 and concluded in January 2019 at Oldham Safeguarding Adults Board (OSAB) development day. 22 individual recommendations were made regarding how the current local model can be strengthened and improved. These can be summarised as:

- Recommendations regarding our local implementation of our statutory requirements for a Safeguarding Adults Board, including changes to format, frequency, support, and communications. These include proposals for a twice annual joint Safeguarding Forum with Children's safeguarding colleagues, examining the overlapping elements of our agendas, and a refresh of Sub Groups.
- Recommendations regarding the establishment of a multi-agency Strategic Safeguarding service to replace the current service that sits with Commissioning. This will be aligned to the Multi Agency Safeguarding Hub (MASH), but provide greater strategic capacity for policy, audit, workforce development and assurance. A refreshed Deprivation of Liberty function, and a Board Business Unit will also feature.
- Recommendations relating to operational adult safeguarding activity, such as referral pathways, expanding our local approach to the management of safeguarding activity to include NHS-employed colleagues, and the role of the MASH and the hospital-based Integrated Discharge Team.
- Recommendations relating to workforce development and training for adult safeguarding and mental capacity.

All recommendations were endorsed by the Board and delivery will take place through three phases of activity: an initial mobilisation phase, a second transition phase, and a third and final consolidation phase. A programme team, including Programme Board arrangements are in place to direct, coordinate and deliver the programme. The Programme Board will report directly to the OSAB for the duration of its meeting.

The Oldham Safeguarding Adults Board (OSAB) has identified its strategic objectives, priorities and areas of focus within the OSAB Three-Year Strategy Statement April 2018 – March 2021. These are as follows:

1.1. Strategic Objectives

As a partnership we will:

1.1.1. Focus on Safety & Wellbeing

Focus on safety and wellbeing, supporting Oldham to define how it will prevent the abuse and neglect of adults.

1.1.2. Seeks Assurance of Effective Leadership & Partnership Working

Seek assurance that effective leadership and partnership working is in place to prevent abuse and neglect and respond to adults who are at risk of or experiencing abuse and neglect.

1.1.3. Raise the Profile of Making Safeguarding Personal

Raise the profile of the Making Safeguarding Personal approach and lead culture change for safeguarding adults in Oldham.

1.1.4. Promote Participation

Promote participation, listening to and engaging with people who have experienced abuse or neglect, gaining the perspectives of stakeholders, and seeking assurance that individualised, empowering outcomes are being achieved.

1.1.5. Raise the Public Profile of Adult Safeguarding

Promote safeguarding adults to the public through effective communication, including benchmarking the local perceptions of confidence that the public has in our safeguarding efforts.

1.1.6. Ensure Safeguarding Adults is a Key Part of the Integration Agenda

Ensure that safeguarding adults is actively recognised, considered and responded to as a key part of the integration agenda for health and social care in Oldham.

1.2. Priorities.

1.2.1. Prevention and wellbeing

Prevention of abuse is a vital part of the boards three year strategy. The board recognises that preventative safeguarding protects adults from neglect and has the capacity to enhance resilience enabling individuals and communities to identify and prevent abuse and safeguard themselves.

In 2018 – 19 the creation of a prevention and wellbeing board subgroup has supported the prioritisation of this objective. Subgroup activity has focused on research on lessons learnt from safeguarding cases and building close links to the making safeguarding personal subgroup. Phase 1 activity has set the foundations in place to support an understanding of what good preventative safeguarding looks like locally.

For 2019 – 20 the board continues to give priority to a safeguarding prevention strategy. It will focus on prevention through community engagement which supports early identification of new safeguarding issues, engagement with the universal prevention offer for adults across Oldham, promoting approaches to enable adults to protect themselves, and consistent approaches to information sharing, training and delivery of key messages to multi-agency front line staff.

1.2.2. Transitions

Throughout 2018 – 19 the board have maintained oversight of the transitions agenda via links to existing working groups.

In 2019 – 20 the board will expand its prioritisation of this area. A continued focus on learning disabilities will be maintained, whilst emerging priorities from the prevention and wellbeing sub groups' research activity will support identification and prioritisation of further key areas of transition from an adult safeguarding perspective. The board have now committed to a joint transitions subgroup with the Local Safeguarding Children's Board which will act in a co-ordinating role to identify the robustness and sustainability of current transitions offers, develop focus, and ensure accountability in delivery across partnership organisations.

1.2.3. Making safeguarding personal

The Making Safeguarding Personal (MSP) approach is an agenda for change aimed at achieving a cultural shift in the way we work with adults who are experiencing or at risk of abuse and neglect. It emphasises the need to move away from process led safeguarding practice and systems, to person centred, interventions based practice which uses preventative, wellbeing and safety approaches to meet the desired outcomes of adults at risk.

The approach requires all organisations to engage with people about the outcomes they want from the point of first contact, and drives safeguarding work which supports people to be in control and to make decisions for themselves about their wellbeing and safety.

In 2018 – 19 the creation of a making safeguarding personal board subgroup has supported the prioritisation of this objective. Subgroup activity focusing on establishing terms of reference, mapping existing service user engagement across the safeguarding partnership, developing an action plan and building close links to the prevention subgroup has prepared the way for the next phase of activity.

In 2019 – 20 phase two activity will focus on service user and carer engagement, the co-production of a local making safeguarding personal model, support delivery through front line practice and the continued drive towards culture change.

1.2.4. Integration and safeguarding

The integration of community health and social care services across Oldham took place in 2018 as part of the development of the Oldham Cares Integrated Care Organisation.

The launch of the Oldham Cares ICO has seen the integration of CCG and social care commissioning, which in Oldham currently includes strategic adult safeguarding services.

Operationally safeguarding is now delivered through a generic model by integrated community health and social care services on a locality basis. This integration activity has seen teams collocated across five locality 'clusters', alongside centralised health and social care teams for Learning Disability and Mental Health and an Integrated & Urgent Care team based at the Royal Oldham Hospital.

Where all current safeguarding arrangements are considered transitional Oldham has taken a proactive approach to defining its ambitions for an integrated approach to adult safeguarding through external peer review with Stockport in 2018 and a full internal review of its safeguarding systems in November 2018 - January 2019.

The ambition to enhance the current safeguarding system through deeper integration is now endorsed by the safeguarding adults boards support for:

- The creation of a new strategic safeguarding service.
- Building the confidence and knowledge required to expand safeguarding enquiry delivery responsibility more widely across the borough
- Exploring additional integration opportunities and alignment with Children's Safeguarding.

A safeguarding review Implementation group will now act as working group to drive the implementation of the safeguarding review recommendations and report and be accountable to the board for its progress.

In order to ensure that safeguarding adults remains a key consideration for the Integration agenda the board will continue to lead dialogue to develop on the opportunities and address the challenge which arise as integrated health and social care services are defined and delivered in Oldham. This work will be informed through ongoing engagement in horizon scanning and through a developing understanding of a wider evidence base around integration both locally and nationally.

1.2.5. Domestic abuse

Throughout 2018 -19 the board has maintained oversight of the domestic abuse agenda and its priorities via links to existing working groups and through quality audits focusing on domestic abuse.

Phase 2 activity for 2019-20 supports additional focus on this priority area. The board have endorsed the ambition to enhance focus in this area through agreement to establish a joint domestic abuse subgroup with the Local Safeguarding Children's Board.

1.2.6 Prevent

The board will continue to maintain oversight of the Prevent agenda and priorities via links to existing working groups.

2. Delivery of the Business Plan

This Business Plan details how these strategic objectives, priorities and areas of focus will be delivered upon over the 2019/2020 financial year.

2.1. Delivery of the Business Plan

Delivery of these strategic objectives and priorities will be driven by the following sub-groups, supported by the Safeguarding Adults Board Manager, the SAB Executive and following the implementation of the safeguarding adults review recommendations the Strategic Safeguarding Forum. In order to link the agendas and priorities across the OSAB and the LSCB, joint sub-groups, where appropriate, are in place. The sub-groups are as follows:

Adult subgroups

- 2.1.1. Safeguarding Adult Review Chair Janine Campbell (Oldham Cares)
- 2.1.2. Performance Chair Matt Drogan (OMBC)
- 2.1.3. Making Safeguarding Personal Chair Karen Lloyd (Oldham Cares)
- 2.1.4. Quality Assurance and Audit Chair Abigail Pemberton (Oldham Cares)
- 2.1.5. Operational, Policy & Procedure Chair Janine Campbell (Oldham Cares)
- 2.1.6 Prevention & Wellbeing Leads Julie Farley (Health watch) & Yvonne Lee (Oldham Age UK)

Existing joint subgroups

- 2.1.7 Workforce Development Joint Chair Sue Massell (Oldham Cares) (Joint with LSCB)
- 2.1.8 PR and Comms Chair Danny Inglis (GMP) (Joint with LSCB)
- 2.1.9 Transitions Chair Merlyn Joseph (OMBC) (Joint with the LSCB)

Each sub-group will have in place a delivery plan, demonstrating how it will deliver on its priorities and monitoring progress.

Delivery of these strategic objectives and priorities will be further enhanced through the creation of the following new joint sub-groups:

2.1.10 Domestic Abuse - Chair (to be confirmed)

- 2.1.11 Complex safeguarding- Chair (to be confirmed)
- 2.1.12 Mental capacity Chair (to be confirmed)
- 2.1.13 Early Help and MASH Chair (to be confirmed)

Each sub-group will put in place terms of reference, identify priority areas for phase two activity, and develop an action and delivery plan, demonstrating how it will deliver on its priorities and monitor progress.

Where additional delivery groups are already established, these will report back to the SAB via the nominated board member, through the safeguarding Adults Board Manager, SAB Executive and Strategic Safeguarding Forum. These include groups in relation to:

- 2.1.14 Integration & Safeguarding Lead Mark Warren (Oldham Cares)
- 2.1.15 Domestic Abuse Bruce Penhale (OMBC)
- 2.1.16 Prevent Lead Bruce Penhale (OMBC)
- 2.1.17 Safeguarding Review Implementation Group Lead Lia Chelminiak (Oldham Cares)

2.2 Reporting

Reporting on Business Plan progress will be undertaken on a regular basis via the Board Manager, Executive Board and Strategic Safeguarding Forum. Subgroups will be required to submit bimonthly highlight & exception reports for review and, where required, discussion. Groups and areas of work around priorities will be required to report on an appropriate basis, as agreed separately with the Chair.

3. Business Plan

Priority areas not covered by board sub groups

Strategic Objective Linkage		Date	Lead Body & Representative	Outcomes of delivery	RAG
Ensure Safeguardi Adults is a Part of th Integratic Agenda	continue to be the responsibility of the DASS, with the integration of safeguarding	From April 2019 onwards	Oldham Cares Review implementation working group	Strategic Safeguarding Service will be in place and delivering safeguarding review recommendations	

Ensure	Opportunities to improve safeguarding performance, activity and processes arising from the creation of the strategic safeguarding service and safeguarding review recommendations implementation are identified and acted upon, in the best interests of the partnership, and with Making Safeguarding Personal at the core.	Ongoing	Oldham Cares Review implementation working group		
Safeguarding Adults is a Key Part of the Integration Agenda	All newly develop contractual requirements and specifications, for jointly commissioned services, reflect responsibilities of both commissioners and providers in relation to safeguarding	Ongoing	Oldham Cares Strategic Commissioning Function – Helen Ramsden	Planning in progress for new jointly commissioned contracts for care home placements, care at home and extra care housing, to be implemented from April 2019.	
	Activity relating to safeguarding and quality concerns in care homes is improved by benefiting from cluster alignment and colocated expertise working in a more coordinated way	Ongoing	Oldham Cares Strategic Commissioning Function – Helen Ramsden	Improved outcomes for providers and residents.	
Ensure Safeguarding Adults is a Key Part of the Integration Agenda	Mental Health Integration: health & social care have been integrated for a number of years, but the precise structure continues to be reviewed and will be further linked to the primary care clusters as part of overarching integration of Oldham Cares.	March 2019	OMBC / Oldham Cares Strategic	Identification of revised system and data arrangements.	
Seeks Assurance of Effective Leadership & Partnership Working	A Mental Health Review was undertaken in 2017 and improvements to safeguarding were identified as a key area, with specific requirements for data improvements and training. Monthly meetings between the DASS and the	ivial Cil 2019	safeguarding Service John Moran	Updated training timetable.	

	independent chair of the board will provide additional assurance.				
Ensure Safeguarding Adults is a Key Part of the Integration Agenda	Learning Disability services integration – the service, collocated in October 2017 will, through a workforce redesign, be a single line managed service, with PCFT as lead provider. An audit of safeguarding practise will be undertaken and appropriate training and guidance provided to ensure statutory responsibilities are met. Monthly meetings between the DASS and the	Ongoing	Oldham Cares	Teams co-located from October 2017. Recruitment ongoing. Statutory safeguarding duties and policy and procedure requirements met. Individuals supported to live safely free	
	independent chair of the board will provide additional assurance.			from abuse and neglect.	
Ensure Safeguarding Adults is a Key Part of the Integration Agenda	5 integrated clusters have been in place from July 2018, the clusters will consist of health and social care staff. Cluster based working across health and social care will ensure those Oldham residents at risk of harm in the community are supported with a person centred integrated approach. Ensuring making safeguarding personal is central to good practice. Monthly meetings between the DASS and the independent chair of the board will provide additional assurance.	Ongoing	Oldham Cares & PAHT Jayne Ratcliffe	Statutory safeguarding duties and policy and procedure requirements met. Individuals supported to live safely free from abuse and neglect.	

		1			
Ensure Safeguarding Adults is a Key Part of the Integration Agenda Seeks Assurance of Effective Leadership & Partnership Working	The Social care Lead at the hospital will raise the profile of the safeguarding adult's agenda across all hospital wards. This includes working with health colleagues to identify pathways to the Integrated Discharge team (IDT). Safeguarding Adults will be highlighted as one of the pathways to ensure the patients are referred to the team is a safeguarding concern is identified The integration activity will seek to ensure safeguarding (including referrals, responses, communication with those involved) continues to be prioritised Monthly meetings between the DASS and the independent chair of the board will provide additional assurance.	March 2019	Oldham Cares & PAHT Jayne Ratcliffe	Referral pathway for safeguarding referrals clear and visible for all referrers and alerters. Safeguarding pathways in place to identify the links between the MASH, IDT, specialist teams and the clusters. Safeguarding concerns responded to effectively across the partnership in accordance with statutory requirements, policy and procedure. Individuals are supported to live safely free from abuse and neglect.	
Ensure Safeguarding Adults is a Key Part of the Integration Agenda	Ensure all social care staff receive mandatory safeguarding training from April 2019	April - Sept 2019	Oldham Cares	Well trained workforce evidenced via training take-up updates	
Ensure Safeguarding Adults is a Key Part of the Integration Agenda	Ongoing audit of the impact of integration on the safeguarding agenda in Oldham	Sept 2019	Oldham Cares	There is potential for the Policy, Procedures & operational Sub-Group to support in providing tests and questions that support the audit	

DOMESTIC ABUSE Lead Body & Strategic Priority Linkage **Key Actions** Date Evidence of Action Taken and Date RAG Representative Seeks assurance of effective Prepare domestic abuse partnership annual May 2019 Domestic Violence leadership and partnership and Abuse report working Partnership (DVAP), **Bruce Penhale** 2 Promote participation Secure White Ribbon Award for the Dec 2019 Domestic Violence Partnership as part of raising awareness and Abuse about violence against women and girls, and Partnership (DVAP), responding effectively to this Bruce Penhale Focus on Safety and Wellbeing Produce and make publicly available a clear Sept 2019 Domestic Violence guide setting out the support offer available and Abuse Promote participation to victims at different levels of risk. Partnership (DVAP), Tanya Farrugia 4 Focus on Safety and Wellbeing Undertake a desktop audit of agencies' use of July 2019 Learning and the DASH risk assessment for domestic abuse Improvement Seeks assurance of effective and the outcomes following the assessment Subgroup leadership and partnership to ensure that all agencies are appropriately working assessing the risk associated with domestic abuse and referring families appropriately for support 5 Focus on Safety and Wellbeing Review participation in multi-agency Dec 2019 Workforce domestic abuse training and undertake an Development and Seeks assurance of effective evaluation of the impact of the training on Training subgroup leadership and partnership practice working

ENT					
Strategic Priority Linkage	Key Actions	Date	Lead Body & Representative	Outcomes of delivery	
Seeks assurance of effective leadership and partnership working	Annual report on Prevent to Safeguarding Adults Board	May 2019	Preventing Extremism and Promoting Social Cohesion (PEPSC) Steering Group, Bruce Penhale		
Focus on safety and wellbeing	 Implement the Greater Manchester rollout of Operation Dovetail in Oldham (local authority led approach to Prevent safeguarding) Build links with GM Channel team, particularly Channel Co-ordinator responsible for Oldham and handover open cases Amend Oldham Prevent safeguarding policy and procedures to reflect new Greater Manchester model and Counter-Terrorism and Border Security Act 2019 Establish standing Channel Panel to replace existing arrangements Working with other GM districts, develop Prevent quality assurance arrangements 	Sept 2019	PEPSC Steering Group, Bruce Penhale		
Promote participation Raise public profile of adult safeguarding	Undertake programme of engagement activity to build community understanding and confidence in Prevent	March 2020	PEPSC Steering Group, Bruce Penhale		

PREV	PREVENT									
	Strategic Priority Linkage	Key Actions	Date	Lead Body & Representative	Outcomes of delivery	RAG				
	Focus on safety and wellbeing	Deliver programme of training for staff in partner organisations to ensure understand of their responsibilities for Prevent safeguarding	March 2020	PEPSC Steering Group, Bruce Penhale						
	Focus on safety and wellbeing	Establish system for evaluating impact of Prevent training	March 2020	PEPSC Steering Group, Bruce Penhale						

Sub Group 1: Safeguarding Ad	ult Reviews				
Strategic Objectives Linkage	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	Progress and Evidence (Review at 6 months) RAG
Seeks Assurance of Effective Leadership & Partnership Working	SAR models and approaches to be brought to board for discussion and decision on which models will be used going forward.	March 2019	SAR sub group Janine Campbell	Confirmed SAR model agreed for local use	Model to be agreed per review.
Seeks Assurance of Effective Leadership & Partnership Working	Update SAR protocols and processes to support a robust approach and incorporate additional forms of review.	April 2019	SAR sub group Janine Campbell	Confirmed protocols and procedures agreed and visible to all partners	Policy in place. Awaiting development of SAB webpage. All partners have received a copy of the policy and templates.
Seeks Assurance of Effective Leadership & Partnership Working	Share learning from 2018 -19 SARs across Safeguarding partnership	April 2019	SAR sub group Janine Campbell	Learning actions incorporated into partnerships safeguarding strategy	Recommendations from previous reviews need to be reviewed and updates provided to SAB.
Seeks Assurance of Effective Leadership & Partnership Working	Consider all SAR referrals and conduct SAR when statutory criteria is met	ongoing	SAR sub group Janine Campbell	Promote effective learning and improvement action to prevent future deaths or serious harm occurring again	Ongoing SAR's and regular screening of referrals.
Focus on safety and	SAR subgroup chair to present completed	ongoing	SAR sub group	Promote effective learning and	Outsanding

wellbeing	SAR case studies at cluster leads meeting.	Janine Campbell	improvement action to prevent future deaths or serious harm	action.
			occurring again	

SUE	SUB GROUP 2: PERFORMANCE									
	Strategic Objectives	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	Progress and Evidence (Review at 6 months) RAG				
	To provide intelligence leadership across the partnership, inform practice and service improvements	Review performance products including dashboard and indicator suites to ensure fit for purpose and in line with new OSAB priorities	July 2019	Performance Sub Group Matt Drogan (Chair)	Tailored and streamlined documentation to improve areas of focus and decision making.	Revised products to be brought to Board on 13 th November				
		Continue to provide a Performance Dashboards on a quarterly basis to the Board, identifying performance trends and highlighting data quality issues.	May 2019 – report for Q4 July 2019 – report for Q1 November 2019 – report for Q2	Performance Sub Group Matt Drogan (Chair)	Dashboard reports and supporting analysis	May – Complete July – Complete November – on target for 13 th Nov				

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		March 2019 – report for Q3			meeting
	Work with Team Managers to share and understand emerging trends at an early stage and agree next steps in terms of timely challenge and responsibility for taking forward improvement conversations.	Quarterly	Performance Sub Group Matt Drogan (Chair) and Team Managers	Improvements to understanding of performance issues and potential solutions	Has been done through performance clinics at Q1
	Refer key areas of enquiry to the Quality Assurance and Audit Sub Group Chair to determine appropriate areas for audit based on emerging hypothesis	Quarterly	Performance Sub Group/Audit Sub Group Matt Drogan (Chair	Audits identified and undertaken by Audit and Scrutiny Sub Group and the results of which fed back in to performance sub group, training and workforce development sub group, operations, policy and procedures sub group and/or Board depending on risk likelihood and impact.	Matters have been referred – audits on hold at present
	Share timely Adult Safeguarding intelligence and comparator information from Safeguarding Adults Collection (SAC) highlighting key issues for Oldham	November 2019	Performance Sub Group Matt Drogan (Chair)	Benchmarking to help support potential future improvements	Work still to be undertaken on this
	Provide a summary of 2018/2019 updates on delivery against Annual Business Plans	January 2019	Performance Sub Group Matt Drogan (Chair)	Annual Performance report	To be provided in Jan

Sub	Subgroup 3: Making Safeguarding Personal									
	Strategic Objectives Linkage	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	Progress and Evidence (Review at 6 months)				
	Raise the profile of making Safeguarding Personal	Enable service users and carers to evaluate and audit the Oldham MSP model to ensure meaningful personalised outcomes for service users.	Sept/Oct 2019	MSP subgroup with the support of the Prevention and Wellbeing subgroup Karen Lloyd Julie Farley Yvonne Lee	Group of people with lived experience was identified and attended the Rats in the Sofa Event	G				
	Promote participation	Define the MSP target groups and levels of safeguarding incidents by group to provide a framework to map existing service user engagement groups and services.	March 2019	MSP subgroup with the support of the Prevention and Wellbeing subgroup Karen Lloyd Julie Farley Yvonne Lee	As above	G				
		Review and assess findings from the mapping exercise and determine what service user groups could be engaged by the OSAB.	March 2019	MSP subgroup with the support of the Prevention and Wellbeing subgroup	People with lived experience have been identified and will be contacted to complete ongoing user participation	G				

			Karen Lloyd		
			Julie Farley		
			Yvonne Lee		
	Host an event to enable service users and carers to review and shape the Oldham safeguarding model	Sept/Oct 2019		Aims and learning outcomes for the Rats in the Sofa event were developed and used at the event	G
	Involve service users in discussions about how to support and empower people to resolve circumstances that put them at risk.	Sept/Oct 2019		Consultation has commenced and will progress in the next quarter	А
	Support the development of Safeguarding Adults/MSP champions within the partnership.	Dec 2019			R
	Support the development of practice guidance to support practitioners in ensuring MSP is applied across a range of agencies.	Dec 2019			R
	Support the link MSP has with the wider personalisation, engagement with service users and prevention agendas.			The Exec subgroup have agreed for the Prevention and Wellbeing and MSP subgroups to become one subgroup of the Board	А
	Make links with other sub groups of the OSAB where necessary.	Ongoing	Links have been made and are being utilised	As above	G
	Support the evaluation and audit of the implementation of the MSP model.	Dec 2019			R

Sub	Group 4: QUALITY ASSURAN	CE & AUDIT				
	Strategic Objectives Linkage	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	Progress and Evidence (Review at 6 months)
	Seeks Assurance of Effective Leadership & Partnership Working	Agree updated Terms of Reference	April 2019	QA & A Sub Group	Confirmed or updated Terms of Reference	The Q&A subgroup has been placed on hold due to capacity for delivery. single agency Q&A reporting to board for assurance purposes
	Seeks Assurance of Effective Leadership & Partnership	Establish forward dates of Sub Group meetings	April 2019	QA & A Sub Group	Schedule of meetings confirmed	

Working					
Seeks Assurance of Effective Leadership & Partnership Working	Develop a Sub Group Communications Strategy & Plan to communicate the work of the Sub Group to partner practitioners	May 2019	QA & A Sub Group	Communications Strategy & Plan	
Seeks Assurance of Effective Leadership & Partnership Working	Agree an indicative forward plan of Case File Audits for the coming year. These are expected to include MCA and DoLS, and MSP in the first instance	May 2019	QA & A Sub Group	Indicative forward plan of case file audit themes	
Seeks Assurance of Effective Leadership & Partnership Working	Complete the delivery of the first case file audit (theme TBC)	June 2019	QA & A Sub Group	Case file audit findings report	
Seeks Assurance of Effective Leadership & Partnership Working	Complete the delivery of the first case file audit (theme TBC)	Sept 2019	QA & A Sub Group	Case file audit findings report	
Seeks Assurance of Effective Leadership & Partnership Working	Complete the delivery of the first case file audit (theme TBC)	Dec 2019	QA & A Sub Group	Case file audit findings report	
Seeks Assurance of Effective Leadership & Partnership Working	Complete the delivery of the first case file audit (theme TBC)	March 2020	QA & A Sub Group	Case file audit findings report	
Seeks Assurance of Effective Leadership & Partnership Working	The sub group will deliver on the following SAR recommendations: Following the roll out of self-neglect training offer by the workforce development sub group establish a cycle of audits to assess the impact of training. Agencies to provide assurance that the Mental Capacity Act is embedded into	ongoing	QA & A Sub Group	Case file audit findings report Promote effective learning and improvement in service delivery to prevent future deaths or serious harm occurring again.	

practice via the subgroup completing a Mental Capacity and best interests focused audit.		
Established baseline for Mental Capacity Act compliance and quality and work with the mental capacity sub group re the findings and the development of an action plan of requirements.		

SUB GROUP 5 : OPERATIONAL, POLICY & PROCEDURE

Strategic Objectives Linkage	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	RAG
Focus on Safety & Wellbeing	Review membership and terms of reference of operational, policy and procedure subgroup	April 2019	Operational , Policy and Procedure subgroup Janine Campbell	Engagement event booked for March 2019.	
Focus on Safety & Wellbeing	Establish forward dates of Sub Group meetings	April 2019	Operational , Policy and Procedure subgroup Janine Campbell	Schedule of meetings confirmed	
Focus on Safety &	To review the revised safeguarding	Ongoing	Operational, Policy	Review paper summarising	

Wellbeing	procedures and materials, with a focus on implications for wider multi-agency policies, and any required adaptations as health and social care integration continues		and Procedure Subgroup Janine Campbell	reflections and recommendations	
Focus on Safety & Wellbeing	To review any multi-agency policies and procedures as agreed by the SAB.	Ongoing	Operational Subgroup Janine Campbell	Self-neglect policy and procedure commenced and ongoing. Person in a Position of Trust policy and procedure commenced and ongoing. Multiagency risk assessment tool and procedure commenced and ongoing.	
Focus on Safety & Wellbeing	To ensure collaboration with the relevant subgroups in order to publicise new policies and agree any learning requirements.	Ongoing	Operational Subgroup Janine Campbell	Link to new MCA subgroup to publish and review existing policy and procedure.	
Focus on Safety & Wellbeing	The Subgroup will discuss operational topics and areas for development. Any potential organisational concerns will be escalated to the executive subgroup as will any barriers to improving outcomes for adult at risk in Oldham.	Ongoing	Operational Subgroup Janine Campbell	Exception and highlight reporting	
Focus on Safety & Wellbeing	The sub group will work with the appropriate agencies to deliver on the following SAR recommendations: The development of a multiagency forum to discuss adults who are or may be at high risk of harm. Increase adult safeguarding health and	Ongoing	Operational Subgroup Janine Campbell	Promote effective learning and improvement in service delivery to prevent future deaths or serious harm occurring again.	Ongoing progress. MRM protocol and meetings being established. However will require the strategic

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mental health representation in MARAID and CMHT to attend and have regular input into cluster meetings. The sub group will maintain contact appropriate agencies to obtain the outcomes of: EEPPA review – Oldham Cares End of life care review – Health wate And share these outcomes with boad Specific mental capacity and consent training for primary care. Making Safeguarding personal briefit for primary care. Review of information sharing policy procedure between Police and social care. Review existing provision of director Oldham services, recommendations made for any further development needed, and information made avaid to the multi-agency safeguarding partnership. The sub group will deliver on the following SAR recommendations: Multi agency safeguarding policy and procedure to be reviewed and revise appropriate and work with the PR at Comms subgroup to communicate as	ch and al Ongoing ry of all able as and	Operational Subgroup Janine Campbell	Promote effective learning and improvement in service delivery to prevent future deaths or serious harm occurring again.	safeguarding service before dissemination of protocol. MCA and consent training delivered to 4/5 GP clusters. Just awaiting a date for the 5 th GP cluster. Self-neglect policy finalised. Awaiting strategic safeguarding service before implementation.
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changes.		
Development of a multiagency self- neglect policy and risk management protocol and work with the PR and		
Comms subgroup to roll out. SAB receive assurance that all agencies have a proactive approach to working with families.		
Development of 7-minute briefings for all completed SARs and work with the PR and Comms subgroup to roll out.		
Multiagency MCA policy reviewed, updated and published.		

Strategic Objectives	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	Progress and Evidence (Review at 6 months)
Seek Assurance of Effective Leadership and	Produce a framework for the Adults Safeguarding Prevention Strategy clearly setting out target groups and codesign a vision of what good preventative safeguarding looks like in practice. The framework will identify the principles for delivering safeguarding prevention in partnership with individuals, communities and partner agencies across Oldham Framework to include:	December 2019	P&W Sub Group And MSP Sub Group	The process to agree the vision for what good preventative safeguarding looks like in Oldham is led and shaped by vulnerable adults/adults with lived experience, carers and families. The Oldham Safeguarding Prevention Strategy reduces safeguarding incidents by influencing and shaping commissioning decisions, informing public campaigns and workforce training to	
Partnership Working	 Sample review of case studies to identify types and optimum point of prevention intervention that could have avoided/enabled earlier identification of safeguarding situation. Data on types of abuse, reported incident levels over 3 years and profile by cluster to identify intelligence led trends and provide baseline measuring effectiveness of prevention over time. In partnership with MSP Sub Group 	May 2019 June 2019	Sub Group Lia /Abi/Julie	support early identification and prevention.	
		June 2019	Lia /Abi/Julie		

	family to roll play safeguarding examples and solutions and agree vision of what good safeguarding looks like.	June 2019	MSP Sub Group Made by Mortals		
Focus on Safety & Wellbeing	Map the outcomes and commissioning intentions from the Early Help Review and community based initiatives, against the Safeguarding Prevention Framework. Summarise the findings.	July 2019	Bruce Penhale Chair JF	To integrate the principles of preventative safeguarding into mainstream preventative commissioning decision making processes.	
Focus on Safety & Wellbeing	Review and map the current Thriving Communities and community enablement work against the Safeguarding Prevention Framework. Summarise the findings.	July 2019	Yvonne Lee Chair JF	To integrate the principles of preventative safeguarding into mainstream community enablement/development work.	
Focus on Safety & Wellbeing	Review and map the current safeguarding prevention offer/policies in place across Social Care, Primary Care and ROH and Pennine Acute hospital settings	September 2019	Healthwatch Chair JF	To integrate the principles of preventative safeguarding into mainstream acute health service provision.	
Seek Assurance of Effective Leadership and Partnership Working	Assess the potential impact of the SAB wider work streams on adult safeguarding prevention intentions. Finalise the Safeguarding Prevention Strategy. The strategy will include target groups, coproduced vision for what good	December 2019	W&P Sub Group Chair JF	To summarise the vision and findings from the mapping and casework review as a strategy to inform the future direction of the OSAB prevention workstream. The Strategy will feedback the view of vulnerable adults, carers and families to ensure their voices are	

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	safeguarding looks like, intelligence led data, summary of all the findings, recommended actions to address gaps through preventative commissioning, public campaigns, training, key timelines and accountable leads.		Abi Pemberton /Lia Chelminiak	heard and to show how their views have made a difference.	
Focus on Safety & Wellbeing	Implement the Safeguarding Prevention Delivery Plan which will set out contributions to the Early Help and Thriving Communities prevention offer through community engagement work streams and dates to review impact. The DP will also support consistent awareness raising, training, public campaigns and key messages to front line staff across voluntary and statutory partner agencies.	Ongoing	W&P Sub Group Chair JF	Reduction in the number of safeguarding incidents.	

SUE	GROUP 7: WORKFORCE DEVELO	DPMENT				
	Strategic Objectives Linkage	Key Actions	Date	Lead Body & Representative	Outcomes from delivery	RAG
	Focus on safety and wellbeing	To raise awareness of and embed the multi- agency Safeguarding Adults Policy, Procedures and practice Guidance	ongoing	Workforce development subgroup and all partner organisations	Updated safeguarding Adults Policy, Procedures and practice guidance visible and accessible to front line practitioners. Quality audits evidence best practice.	
		To raise awareness of the National Competency Framework for Safeguarding Adults and the Mental Capacity Act	ongoing	Workforce development sub group and all partner organisations	National competency framework incorporated into health and social care supervision.	
	Seeks Assurance of Effective	To develop a robust evaluation of all safeguarding adults learning and development across the partnership	ongoing	Members of the SA WD subgroup with the support of the Performance subgroup	Baseline of all learning and development used to inform further strategy.	
	Leadership & Partnership Working	To develop a recording procedure to capture how partnership organisations ensure their workforce is competent in safeguarding adults work	ongoing	Members of the SA WD subgroup with the support of the Performance subgroup	Partnership organisations are accountable for supporting workforce competence and are able to assure the board of the competency of their workforce.	
	Focus on safety and wellbeing	Develop a safeguarding and MCA training framework tailored to different levels of responsibility	April 2019 ongoing	Workforce development subgroup and strategic safeguarding service	Safeguarding and MCA training framework informing the delivery of safeguarding and MCA training across the partnership.	

Focus on safety and wellbeing	Develop a safeguarding and MCA workforce development offer around initial training, refresher training, and workforce support and development	April 2019 ongoing	Workforce development subgroup and strategic safeguarding service	Enhanced training re commissioned and delivered. Training for referrer, alerter, enquiry officer, mca assessors and SAM roles commissioned.	
Seeks Assurance of Effective Leadership & Partnership Working	Identify safeguarding, MCA and Best Interest workforce development and training coordination capacity for the Business Unit	April 2019 ongoing	Review implementation group and strategic safeguarding service		
Seeks Assurance of Effective Leadership & Partnership Working	Establish a differentiated workforce development and training resourcing model whereby statutory partners fund SAM and Enquiry Officer training with wider partnership funding for referrer training (plus an equivalent for MCA)	April 2019 ongoing	Review implementation group and strategic safeguarding service	Partnership funded workforce development strategy	
Focus on safety and wellbeing	The sub group will deliver on the following SAR recommendations: To develop a multi-agency self-neglect workforce development offer and work with the quality and audit subgroup to establish a cycle of audits to assess the impact of training. To develop a multi-agency safeguarding training offer. To develop multi agency safeguarding supervision sessions.	ongoing	Workforce development subgroup and strategic safeguarding service	Promote effective learning and improvement in service delivery to prevent future deaths or serious harm occurring again.	

Strategic Objectives Linkage	Key Actions	Date	Lead Body & Representative	Outcome form delivery	RAG
Raise the Profile of Making Safeguarding Personal Raise the Public Profile	To develop a multi-agency brand for the board; promoting its purpose. Initially this will be through revision of the website	tbc	PR & Comms Sub Group	Brand guidelines including logo and colour palette	
	Develop a safeguarding communications and engagement strategy based on the three-year strategy, identifying key messages, stakeholder groups, and identifying preferred communication channels (of which, online is expected be one). This will include scope to respond to communications needs that emerge throughout the period, from the Board and sub groups	tbc	PR & Comms Sub Group	Communications Strategy & Plan	
of Adult Safeguarding Promote Participation Promote Participation	Develop a dedicated website, structured to facilitate the communications priorities outlined in the strategy	tbc	PR & Comms Sub Group	New website	Plan
	Explore potential for linking a public site with a portal arrangement for specified members to access shared resources Incorporate web analytics into the site design, to enable tracking of access and use of site pages, and review as required	tbc	PR & Comms Sub Group	Private domain of the website for practitioners	

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Deliver a public awareness campaign regarding identifying adult safeguarding, and how to report concerns	tbc		Campaign materials	
Development of communication materials, as required, in appropriate formats as per the Strategy	tbc	PR & Comms Sub Group	Campaign materials	

bgroup 9 : TRANSITIONS					
Strategic Priority Linkage	Key Actions	Date	Lead Body & Representative	Outcome from delivery	R/
Focus on safety and wellbeing	Maintain a continued focus on children's with disabilities to adult social care transitions commencing through mapping of the current transitional offer.	March 2019	Transitions sub group and PMO support	Review on robustness and sustainability of current transitions offers available to board.	
Seeks Assurance of Effective Leadership & Partnership Working	Co-ordinate existing children's and adults social care working groups to develop focused activity, promote positive outcomes and ensure accountability across partnership organisations.	April 2019	Transitions sub group and PMO support	Highlight reports to board	
Focus on safety and wellbeing	Identify other emerging transitions priorities through consideration of LSCB transitions priorities, partnership contributions and the prevention and wellbeing sub groups' research activity.	March 2019 ongoing	Safeguarding adults board Prevention and Wellbeing subgroup	SAB agree further strands of transition to focus on through strategic plans.	
Focus on safety and wellbeing	Map the current transitional offers for additional transitions priorities as agreed by board	May 2019	Transitions sub group and PMO support	Review on robustness and sustainability of current transitions offers available to board.	
Seeks Assurance of Effective Leadership & Partnership Working	Co-ordinate the work of existing working groups to develop focused activity, promote positive outcomes and ensure accountability across partnership organisations	July 2019	Transitions sub group and PMO support	Highlight reports to board	

Additional subgroup plans will be added throughout 2019 – 20 upon creation of the follow joint subgroups with the Local safeguarding Children's Board:

Mental Capacity Act and Liberty Protection Safeguards

Complex and Contextual Safeguarding

Early Help / MASH

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