Oldham
Adult Safeguarding Board

Oldham Partnership

Annual Report
April 2018 – March 2019

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Forward from the Independent Chair

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 sub group.
- 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+	3.2%

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:

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