South East Region

Peer Review - Oxfordshire

24th - 26th June 2015

1. Introduction and background

1.1 As part of the South East Directors of Adult Social Services (SE ADASS) sector led improvement initiative, Oxfordshire requested an external view of the Oxfordshire Adults Safeguarding Board (OSAB). These reviews are intended to support Adult Social Care and partners - supporting the improvement of services and performance, whilst not straying into regulatory territory.

1.2 Following discussions with the Oxfordshire County Council (OCC), the Director (DASS) and Deputy Director of Adult Social Care, it was agreed that the review would address the following key lines of enquiry:
- Is the Board Care Act compliant?
- How do partners work together to ensure adults at risk are protected?

The agreed outcomes:
- To provide a report for the Board that details what could make the Safeguarding Adult Board more effective.

1.3 The review team comprised:
- Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council
- Angie Turner, Head of Adult Safeguarding, East Sussex County Council
- Nick Sherlock, Head of Safeguarding, Kent County Council
- Jane Simmons, SE ADASS Programme Lead, Sector Led Improvement

1.4 Steve Turner, Oxfordshire Safeguarding Adults Board (OSAB) Business Manager, Jo Taylor-Palmer, OCC Interim Area Service Manager, Safeguarding, Diane Dillon, OCC Senior Administrator and Steve Thomas, OCC Performance and Information Manager provided excellent support prior to and during the review. The OCC Engagement Team provided support to service users attending focus groups.

1.5 The team held a number of interviews and focus groups with:
- Commercial and voluntary sector care service providers
- Healthwatch
- NHS providers and commissioners
- Oxfordshire Safeguarding Adults Board:
  - Chair
  - Some sub-group chairs
  - Board members
  - Business Manager
  - Strategic Safeguarding Partnership Manager
- Oxfordshire Safer Communities Partnership
- Oxfordshire County Council:
  - Leader, Lead Member for Adult Social Care and Chair of Scrutiny
  - Adult Social Care (ASC) staff, including the Director of Adult Social Services (DASS), managers, operational and finance staff
- Safeguarding leads from across partner organisations
- Service Users
- Voluntary sector organisations

1.6 Prior to the fieldwork, questionnaires were sent to Board and non Board members. Five questionnaires were received from Board members and 43 from non members.

1.7 The review team were provided with a range of information about the Board. This included:
- Governance arrangements (e.g. Terms of Reference for the Board and sub-groups; Draft Constitution)
- Minutes of the meetings
- Reports to Scrutiny Committee (OCC)
- Policies and procedures
- Performance returns and evaluation reports

1.8 At the start of the visit the review team met with the Lead Councillor, Director of Adult Social Services, current Board Chair and managers and safeguarding leads from OCC. They provided an overview of Oxfordshire, including broad information about demographics and particular issues facing the County. The Board chair also spoke about what the OSAB does well; doesn't do well; areas for development and challenges.

1.9 The Review Team would like to thank all those people who gave their time to attend focus groups and interviews and hope that their comments and insights are reflected in the report. As part of these discussions, as agreed, the Review Team confirmed that the OSAB would ensure that they received feedback on issues and actions.

<u>2. The Oxfordshire Safeguarding Adults Board:</u>

2.1 The peer review took place during a period of change for the Board:
- The current chair was due to leave and a new chair had not been appointed
- A new Joint Safeguarding Business Unit (adults and children) has been formed and includes:
  - OSAB Business Support Manager providing support for the Board (the previous post holder left in July 2014 and has only recently been replaced)
  - Strategic Safeguarding Partnership Manager, appointed in mid May, to work across both adult and children's Safeguarding Boards
  - Board Administrator (to be appointed)

This Unit, employed by OCC will provide support to the OSAB and the Local Safeguarding Children's Board, ensuring that any synergies are exploited to the full.

2.2 The current OSAB has membership from a range of partner organisations:
- Bullingdon Prison
- District Council representative
- Health:
  - Clinical Commissioning Group (CCG)
  - NHS England (NHSE)
  - Oxford Health NHS Trust (OHNHST)
  - Oxford Universities Hospitals Trust (OUHNHST)
  - South Central Ambulance Service (SCAT)
  - Southern Health NHS Trust (SHNHST)
- Oxfordshire County Council (OCC):
  - Adult Social Care (ASC)
  - Safer Communities Unit
  - Trading Standards
  - Drug & Alcohol Team
  - General Litigation Team

- Oxfordshire Age UK
- Probation
- Thames Valley Police

2.3 The Board has a number of subgroups:
- Deprivation of Liberty Safeguards (DOLS)
- Dignity in Care
- Learning and Development
- Monitoring and Evaluation
- Policies and Procedures
- Serious Case Reviews (SCRs)

All sub-groups are chaired by Board members or their representatives.

The Business Support Manager has recently met with sub-group chairs to ascertain meeting schedules, Terms of Reference and proposals about how meetings could be managed in the future. A report recommending a reconfiguration of the groups is to be discussed at the next OSAB.

2.4 One Serious Case Review was undertaken in 2014 and the review team were provided with notes and the action plans. The Review Team were also informed about OSABs involvement in other high profile cases impacting on adult safeguarding.

3. Good practice:

3.1 The Review Team were struck by the positive and openly constructive discussions that took place during the review. People seen were clear about the deficits and enthusiastic about taking the Board forward.

3.2 Political leadership for safeguarding was seen to be high, and those politicians who met the team demonstrated a clear commitment to safeguarding. The Safeguarding Annual Report was discussed at the Council's Scrutiny Committee during the visit and the high level of engagement undoubtedly sets the scene for safeguarding across the County. Scrutiny Councillors assure themselves through this and had clear expectations about how their work could be enhanced.

3.3 OCC teams were motivated to provide a good safeguarding service and saw the Safeguarding Team as key to supporting this. The Safeguarding Team and particularly the Manager were seen as the leaders of safeguarding within the Council.

Staff were very receptive to receiving multi agency training and saw positive outcomes from this approach. There were also good relationships reported at a "grass roots" operational level, which encouraged some innovative local initiatives. Generally staff were positive about safeguarding work in Oxfordshire.

3.4 The new Joint Safeguarding Business Unit was welcomed and it was thought to be a good opportunity to look at synergies across adult and children safeguarding, learning from each other and where appropriate working together on issues. The OSAB and the Business Unit will however need to guard against a focus on children's safeguarding to the detriment of adults.

A Board Business Support Group will also aid the development of the OSAB and will lead on the development of web based information, a newsletter (from information generated by training) and will look at how the public can be better informed about adult safeguarding.

3.5 Care service providers and partners wanted more involvement in developing a coherent approach to safeguarding, ensuring that the Board takes a leadership role in the development of a vision for safeguarding across the County and that service users are at the heart of determining how they wish to be supported (in line with Making Safeguarding Personal) at the start.

3.6 The Service user group were pleased to have the opportunity to comment on safeguarding and were very keen to be involved in understanding and sharing key messages from the OSAB. There were suggestions from the group on engagement such as " advertising contact numbers in GP surgeries, hospitals and pubs", as well as having a lay person on the OSAB and the use of " Sting Radio[1]" for OSAB members to have a slot. There was also the suggestion that the OSAB ought to have a public meeting to which key service user groups would be invited to.

3.7 Voluntary Sector members were positive about safeguarding arrangements in Oxford. Although at times staff did find it difficult in accessing the correct staff around complex matters. This was an issue raised by the Housing sector members of the Group. They felt that the SAB could do more to engage the Voluntary sector in its work and given the opportunity were enthusiastic about working with SAB to promote safeguarding.

Some felt the SAB was a bit remote. Age UK did not share this view as they have a representative on the SAB. A significant criticism of the Oxfordshire was the way they implemented the decision to dissolve Partnership Boards without discussion with those involved. This issue was raised at both the service users group and the voluntary sector group by different organisations.

3.8 Commercial Care Providers demonstrated a commitment to be seen as part of the solution when concerns were raised and wanted to work alongside safeguarding teams. They understood their overall responsibilities for ensuring the care and support services they run meet the required standards of care, and for responding to these issues effectively as they arise.

4. Areas for development

The Review Team identified five specific areas for development:

1. Governance arrangements
2. Board vision, strategic plan and work programme
3. Evidence
4. Assuring consistent practice
5. Capacity

4.1 Governance

The Peer Review Team identified the following key issues that should be addressed:

- Review the role of the board and subgroups:
- statutory responsibilities

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[1] Sting Radio - this is a radio station run by and for people who have a learning disability. See www.stingradio.org

- agree the role of the Board in the context of other Boards, partnerships and governance arrangements
- confirm accountabilities
- Review membership of the Board and agree expectations of members
- Agree how membership and accountability works
- Ownership of the Board

4.1.1 Ensuring that the OSAB is Care Act compliant has been one of the priorities for the new Business Support Manager. A draft Constitution (undated) had been written for discussion at the OSAB. Until this time the 'Terms of Reference & Responsibilities for Member Organisations' dated June 2014 is still in place and understandably not Care Act compliant.

4.1.2 A new Board chair will be appointed by partners shortly. The draft Constitution makes a number of proposals about how this role will be managed including that accountability will through the Chief Executive Officer (CEO) of OCC to the Leader. 'The ultimate responsibility for the effectiveness of the OSAB rests with the leader of Oxfordshire County Council. The Head of Paid Service of the Council is answerable to the Leader' (of the Council).

The OSAB might wish to consider how this will operate in practice and how the relationship between the Chief Executives (or equivalent) of Thames Valley Police and Oxfordshire Clinical Commissioning Group (CCG) as the statutory partners will operate within current arrangements.

It is intended that the chair is appointed for a three year term. The Review Team did not see the proposed contract, but OCC Head of Paid Service, Director of Adult Social Services and statutory partners might want to consider including reviews at three and six months to ensure that any issues relating to the performance of the Board or the individual are addressed in a timely manner.

4.1.3 Membership - The shape and seniority of partners, able to speak on behalf of their organisations or act as representatives of membership organisations; the voice of the public and carers and how the wider partnerships are involved in the Board needs to be considered. This should include discussing how the Board can balance making the OSAB sufficiently lean to deliver its strategic vision and being inclusive.

- Voice of the public - There is recognition that this is an area that requires further development and a recognition that the OSAB 'need to…seek the views of service users…linking with other bodies…go to them'. There is some confusion about this currently:
  - Two people interviewed were clear that Healthwatch provided this and were involved with the OSAB, a representative from Healthwatch however said that the organisation had not been invited to take part in the Board.
  - Another person mentioned that the Dignity in Care sub-group (chaired by a voluntary sector organisation) provided the formal route to links with the public.
- Service users involved in the focus group were keen that engagement with service users and public should not solely focus on Healthwatch.
- Voluntary sector - The role of voluntary sector organisations, as either providers of care or representative organisations for patients and service users, needs further debate and clarification.
- Acting as representatives - The Chair and the Board will need to ensure representatives are clear about their roles and consider wider engagement with those not directly represented. Safeguarding Adult Boards are considering a range of methods to ensure that there are opportunities for wider engagement e.g. annual safeguarding summits

- There is a growing Personal Assistant market and as an unregulated part of the care system, the OSAB might wish to consider how it engages these providers of care.

4.1.4 Ensuring transparency to how Board members link to their own governance arrangements is crucial. It was not always clear how partners report the work of the OSAB or raise specific issues with their own organisations. When determining accountabilities for Board members, some thought should be given to how these are developed and evidenced.

4.1.5 The Care Act sets out the requisite skills and experience necessary for SABs to act effectively. Members should be able to:

- speak for their organisations with authority
- commit their organisation on policy and practice matters
- hold their organisation to account
- influence the development of their agency's to account
- influence the development of the agency's practice
- contribute to the development of robust and effective monitoring and performance functions

The Review Team was not able to judge whether the current Board members had the the skills and experience necessary. One person did however express concerns about the seniority of people attending the Board and whether they had sufficient influence in their own organisations. Given the Boards new statutory footing, the new chair will wish to meet with the CEOs of all partner organisations to establish whether the OSAB member meets the above requirements and has sufficient influence to effect any changes required.

4.1.6 The draft Constitution proposes that the newly invigorated Board should ensure that the synergies are exploited between partnerships. This was seen as a positive initiative and one that needed urgent attention. The review team noted some confusion about the responsibilities of different partnerships and the impact this could have e.g Domestic Homicide Reviews and the links between these and Safeguarding Adults Reviews (previously Serious Case Reviews). Although the information provided to the team suggested that this was the Local Children's Safeguarding Boards responsibility, most people spoken to seemed unaware of this. Making clear these links would ensure that there is clarity about the role and function of each group in relation to the OSAB.

4.1.7 Current Terms of Reference for subgroups are in the main undated and not written in a consistent style. Discussions between the Business Support Manager and current chairs of the subgroups, looking at the focus, meeting schedules, membership and proposal for the future have now taken place and the number and scope of the sub-groups will be discussed at the OSAB. This will include that accountabilities are clear and Terms of Reference are written in a consistent style. As part of this discussion the OSAB might also consider how it will ensure that sub-groups are supporting the OSABs overall vision and work programme. In order to do this there needs to be a discussion about ensuring that realistic expectations are set and sufficient resources provided to meet these expectations. The Learning and Development sub-group for example will need resources from partners to focus on training for Care Act compliant multi-agency procedures and to ensure that all partners are aware of Making Safeguarding Personal.

4.1.8 As part of the visit, the Review Team were provided with the minutes of OSAB meetings. Comments about the meetings were included in questionnaire responses and a number of people discussed agenda setting, minutes and conduct at meetings. Agenda setting and in one case minutes provided to Board members was seen as a weakness. In part it was suggested that this was

due to the lack of support provided to the Board (the Review Team were told that there had been no formal support for 14 months) and the over reliance on Adult Social Care staff.

The new Business Support Team will be able to provide support to this process and together with the new chair will be able to ensure that meetings have forward plans, actions are noted and followed up, sub-groups are clear about expectations and a work programme (for the OSAB and individual sub-groups) agreed.

4.1.9 The Review Team were provide with copies of the Safeguarding Adults Review Group minutes (previously Serious Case Review) and noted that some actions did not appear to be dealt with between meetings, or feedback provided. Agreeing and following up actions (whether they are outstanding or have been dealt with) would ensure that this group and the OSAB does not leave itself open to criticism. A Serious Case Review (MC) had the appropriate action plan and this format could be replicated for the wider OSAB.

Some concern was expressed by OSAB members and OCC staff that the current chair of the OSAB also chairs the Serious Case Review Group, largely the Review Team understood, because partners had not offered to do this. Whilst it is commendable that these meeting were able to take place, who chairs this meeting needs to be addressed with some urgency.

Also noted was that the SAR Group met with prison team in Huntercombe to discuss lessons learnt from a Serious Case Review. Again whilst this was seen as a supportive action, the role of the OSAB in relation to prisons of this type needs to be clarified for all Board members. (see note from NOMS that clarifies safeguarding in prisons).

4.2 Vision, strategic plan and work programme

It was felt by the Review Team that the Care Act, changes to the OSAB and improved support arrangements could provide the catalyst to develop a clear vision and plan. The Team believed that there are three key activities for focus:

- Develop a vision, strategic plan and outcomes
- Engagement on the plan and sign off
- Work programme to include:
  - priorities and evidence
  - Peer Review
  - Annual Report and feedback (learning)
  - allocate the work and timescales (sub-groups)

4.2.1 The Review Team were told that the current OSAB lacked an overall vision or strategic plan, weaknesses include ‘Lack of scrutiny and challenge’ and one person wanted to see ‘…stronger leadership, leading toward (consistent) agenda setting, priority setting, action planning’ and that the Board had ‘struggled with scope and focus’; ’lack of discussion of strategic issues’ ; ‘lack of leadership from the chair’. The Review Team thought that the lack of direction from the whole Board and the lack of a Business Manager for 14 months has not helped to ensure it has had a strategic direction or aided the smooth running of the Board. As a result the Board has not focused on the Care Act as much as it could have.

People interviewed were however very positive about the future and one person said the OSAB and sub-groups have ‘some gaps.and challenges, but changes will help to deliver a new way of working’,

4.2.2. Developing the Board as a statutory body, ensuring that members have ownership is key to ensuring that the Board focuses on developing its vision for the County and agrees a strategic plan.

4.2.3 Getting the basic management arrangements right, being clear about what support is available was seen as key. The Peer Review Team suggested using the result of the review and the requirements of the Care Act as a basis for the development of a work programme for both the Board and sub-groups.

4.2.4 Having an oversight of the data available to Board members was highlighted as a priority and would ensure that the Board was able to make decisions about its future direction. Some members also wanted there to be a gear shift towards proactively looking at key safeguarding and associated issues including:

- Modern slavery and human trafficking
- Comparison and benchmarking with national SAB
- Learning from homicide reviews

One Board member would like further discussion about Female Genital Mutilation (the responsibility of the Children’s Safeguarding Board) and the Prevent Strategy (part of the UKs counter-terrorism strategy and primarily the responsibility of the Community Safety Partnership).

Board and sub-group members were also keen to understand the impact on safeguarding to any changes to organisations (general activity; re-structures etc) and to factor this into any work programme.

4.2.5 The work programme needs to engage the wider community of interest. It requires sign off by Board members and their members organisations or constituents before final agreement which will then need to be endorsed by Healthwatch. Timescales to do this are tight and the OSAB might wish to agree what is going to be achievable for 2015/16 and how it can engage more widely with the public and partners to develop a plan for 2016/17.

<u>4.3 Evidence</u>
The Team saw some good data about safeguarding, but this was limited to Adult Social Care. There did not appear to be an agreement about what data partners would provide to enable the Board to understand and make decisions about safeguarding strategy across the County.

4.3.1 Given the wide range of data collected by OSAB partners the Peer Review Team proposed that the OSAB:

- Agree a core data set:
  - purpose of the data to be collected
  - national reporting requirements
  - local priorities
  - accepting that information collection will be a challenge

- Qualitative information:
  - case file audits
  - customer and stakeholder feedback
  - complaints
- Benchmarking

4.3.2 One person talked about the need for the Board to 'Develop a framework, measuring (us) against a set of standards', another that the Board does not focus on data across all partner organisations and that data is primarily from ASC. There is '….insufficient data analysis….insufficient detail in relation to outcomes and service changes…'. There was also concern that the partners were not looking at information from all organisations. There had been for example 'no collaborative presentations regarding issues facing vulnerable people. e.g. the Learning Disability presentations were a series of verbal presentations by individual organisations rather than a synthesis and debate about how well services were working across boundaries to safeguard'.

4.3.3 It became clear from discussion that this was an area of concern for a number of Board members and partners. All Safeguarding Adult Boards appear to be struggling with the plethora of data collected and there needs to be some acknowledgement that there is not the 'perfect' data set.

4.3.4 Some Board members talked about the use of 'heat maps' looking at where safeguarding is occurring, or at systems to identify particular addresses where there are issues. Initiatives such as these can provide a focus for partner's performance and data leads.

4.3.5 A number of people noted that some data leads are linked into regional and national groups and have opportunities to examine what data is collected in other areas. Given, as one person suggested, this will be key to ensuring that the Board is 'focused on the right things'. This area of work will require urgent commitment from all partners.

4.3.6 The Review Team discussed the need to ensure that qualitative information, particularly feedback, is provided to the Board. There were examples of this in Board papers, but a more systematic approach in both the collation and reporting from partners could be valuable. This could include complaints and plaudits and undertaking or commissioning customer and stakeholder feedback surveys.

Making stronger, formal links with established organisations, Healthwatch in its statutory role, and other patient, service user and carers organisations would provide information about the impact of safeguarding arrangements and changes that may be required.

4.3.7 Alongside the development of a data set and agreements about how the voices of those people using services are gained, thought needs to be given to ensuring that OSAB can benchmark safeguarding activity against other OSABs. Some organisations (e.g. Adult Social Care) have clear ways to do this but it is suggested that data from all other partners is explored to see what information currently collected and benchmarked could be used.

4.4 Assuring consistent practice

From discussions, the Review Team identified a number of areas where there were gaps in consistent practice. These broadly fell into the following areas:

- Review policies, procedures and practice guidance
- Care Act (Making Safeguarding Personal)
  - self-funders
  - thresholds
- Communication
- Learning and development
  - opportunities for multi-agency training
- Multi-agency audit

4.4.1 In April 2015 the OSAB Policy and Procedures Group set up a Task & Finish Group to review all current procedures and ensure they are in line with the Care Act. A number of policies and procedures have already been through a re-drafting process (e.g. Safeguarding Adult Review, Confidentiality Protocol and Information Sharing Protocol). Others are reported to be on target for completion shortly. These will be discussed and agreed at the OSAB in August.

The Review Team were not clear proposed policies and procedures will have been agreed by partners organisations and how the OSAB can assure themselves that where necessary they have been through the appropriate governance structures. It was also unclear to what extent representatives from all partner organisations have been involved in developing new policies and procedures.

Commercial care providers were concerned about new policies and procedures being written without any discussion with them. This was a particular issue when changes require providers to amend or re-write their own policies. As many providers are relatively small this can be time-consuming and onerous. They have asked that this be acknowledged and appropriate timescales set at the outset.

4.4.2 Self-funders - A key area requiring further examination is how self-funders are dealt with. The Review Team were told that if safeguarding issues were reported by, or on behalf of self-funders, in some cases OCC staff referred people back to individuals relatives to deal with. This is a major area of risk for OCC as the decision to carry out a safeguarding enquiry does not depend on the persons eligibility to receive local authority services but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect.

4.4.3 Threshold documents - The local authority has a duty to make enquiries if the three key tests [2]in the Care Act appear to be met. There was a lack of clarity across stakeholders and operational teams regarding the thresholds for responding to individual safeguarding concerns. There was also confusion when information should be treated as a safeguarding concern, what is an enquiry and who can carry out an enquiry. OCC and the OSAB may wish to assure themselves that all staff are fully aware of this.

4.4.4 The OSAB did not appear to have visibility outside of the members of the Board and sub-groups. Questionnaires received from non-members of the Board and focus group members were not aware of the Board or its activity. Given the importance of its work, the OSAB might want to

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[2] Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) -
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

consider developing a communication and marketing plan. This could include discussions about how partners might work together to ensure that the public are aware of adult safeguarding and where to obtain support. It was suggested that ideally partner organisations Communications Teams they could be tasked with working together to ensure that messages are consistent and co-ordinated. There was a plea that the OSAB 'develop an simple guide for (adult) safeguarding … what to do/where to go'.

4.4.5 Training, particularly from the OSAB about the Care Act and the implications for safeguarding had apparently been scarce. Information and training about the Care Act for the OSAB took place before the draft regulations and guidance had been published and Board members had not re-ceived any training on the implications for safeguarding. Commercial care providers also reported that they had received no information about the Care Act or its implications for safeguarding. Larg-er care providers had accessed their national teams, but smaller providers had struggled to find information pertinent to them.

4.4.6 Support for the Learning and Development Sub-Group stopped when the person supporting the OSAB left in 2014. A new chair has recently been agreed and support is now provided by the Business Support Manager. The new chair also chairs the Learning and Development Group for Children's Safeguarding and it has been agreed that where there are linkages training will be across adult and children's safeguarding.

This re-invigorated group and more particularly the combination of the new chair and Business Support Manager have:

- held one meeting
- agreed a new ToR
- provided support for partner organisations to run safeguarding training and learning events from Serious Case Reviews (multi-agency briefing event about Bullfinch and a joint learning event about domestic abuse)

The sub-group is currently developing a work programme particularly focusing on multi-agency training, which has had not taken place for some months.

4.4.7 There were particular areas of concern for both the voluntary sector and commercial providers about how safeguarding is managed across the County. One person talked about need-ing to be 'part of the dialogue….solving the problem'. They appear to have good communication with the OCC Safeguarding Team - 'strong, responsive team….not threatening…just right' but most were not aware of the Board or sub-groups, did not know if they were represented and had no way of ensuring that any specific practice or other issues were picked up. They were also unclear what standards were required and how these are benchmarked across the County.

4.4.8 Commercial care sector providers are invited to OCC wide commissioning and contract meetings but there appeared to be no or limited opportunities for them to discuss safeguarding practice issues, with each other or with OCC, the NHS and CQC. Many would welcome this oppor-tunity as they felt they could be in a position to learn from each other and provide useful feedback to agencies. In particular providers were not aware that they could report any safeguarding issues about OCC and the NHS … 'you can't safeguard against the Council…'. The review team were given a number of examples where providers had asked for service users to be moved as they

were abusive, but this has not been actioned and as a result the care provider had then been involved in a safeguarding investigation. This area of practice will need further review.

4.4.9 Ensuring that providers are aware when poorly performing staff move on is crucial to the success of their businesses. Care providers in Oxfordshire have an informal network but are often prevented from knowing about potential employees as some care providers refuse to provide references, just stating that X has worked for them. OCC and the CCG might wish to look at this as part of their contract for service.

4.5 Capacity

In order for the OSAB to be effective, the Review Team determined that the Board need to:

- Assess resources required for delivery:
  - existing capacity
  - Board budget
  - core organisational responsibilities
- Action plan (from Peer Review) and Board work programme

4.5.1 'The County Council is the principal provider of both financial and staffing resources to the Board'. This includes payment to the OSAB chair, salaries and on costs for the Business Manager, Strategic Safeguarding Partnership Manager and the yet to be appointed Administrator. Adult Social Care also fund room hire for meetings and support events associated with adult safeguarding. There have been discussions in the past with OSAB partners about resourcing the Board, but this issue has not been resolved. Arrangements for supporting the LSCB are well established, and there were comments about the inequity between the resources provided for the two Boards (£40k against £350k).

4.5.2 Other partners commit resources in kind to sub groups (attendance at the Serious Case Review, Policy and Procedure and Training sub groups) and the CCG support an experienced and skilled training manager to chair and lead on training activity associated with the Board.

It was acknowledged during the review that for some partners (e.g. Police, Fire and Rescue, Ambulance) cover large geographical areas and are expected to attend and provide resources for numerous adult and children's safeguarding boards. One person wanted to see the OSAB 'Promoting a shared responsibility'.

These will need to be factored into any discussions about resourcing the Board and its work programme.

4.5.3 The OCC lead safeguarding manager and performance lead also appear to provide a significant amount of information for the Board. Whilst partners are clearly active in addressing risks and ensuring safety in their own services, this inevitably leads to meetings and agendas being dominated by the ASC '..primarily still ASC reporting to the Board', and in the past months when there appeared to be a disconnect between OCC and the activity of the Board which had led to a "gap in support to the Board'. The reduction in Board resources has led, it appears, to a diminution of Board effectiveness, leading to gaps being filled by the Board chair and ASC.

4.5.4 Partners need to become more active contributors in cash and kind if the OSAB is to meet the new duties in the Care Act and to better reflect that Adult Safeguarding is everyone's business.

As part of the new Chairs role it is suggested that there are discussions about what all agencies are doing in respect of the OSAB.

5. Is the OSAB Care Act ready?

5.1 The statutory objective of SABs is to "help and protect adults in its area in cases of the kind described in s42(1)" This section "applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.
(3)"Abuse" includes financial abuse; and for that purpose "financial abuse" includes—
(a) having money or other property stolen,
(b) being defrauded,
(c) being put under pressure in relation to money or other property, and
(d) having money or other property misused".

5.2 The Care Act and Support Statutory Guidance requires each Local Authority to set up a Safeguarding Adults Board which has three core duties:

- To publish a strategic plan for each financial year:
  - developed with local community involvement and consulting the local Healthwatch
  - is evidence based, making use of 'all available evidence and intelligence from partners'.
- To publish an annual report during the year to achieve its main objective and implement its strategic plan detailing:
  - what each member has done to implement the strategy
  - detail findings of any Safeguarding Adults Reviews and subsequent actions
- Conduct any Safeguarding Adults Reviews in accordance to s44 of the Act

5.3 In addition the guidance includes a range of specific actions about the running of Boards, including roles and responsibilities, holding partners to account, developing strategies and training. The following table sets out these specific areas, identifies areas of good practice and where changes could be considered.

5.4 As the team were on site for three days, there may be gaps in information or interpretation:

Is there a Safeguarding Adults Board in place and providing support?	The Care Act requires that a Safeguarding Adults Board is established in each Local Authority areas. The OSAB has been in place for a number of years, attended by a a range of partner organisations and independently chaired. The current chair is leaving and a new chair is to be appointed by partners in early July. A Joint Strategic Partnership Safeguarding Manager (adults and children) and Business Support Manager have been appointed recently. These arrangements however continue to be principally resourced through Adult Social Care services.	The new chair, with statutory partners need to consider how OSAB arrangements are supported in the future. This should include how partner organisations provide support. The OSAB was seen as the poor relation to children's safeguarding, differently funded and supported. There was a general view that some consideration should be given to balancing the resources provided by the statutory partners. A review of sub-groups, including how they are resourced needs to be reviewed urgently. In particular in order to ensure that practitioners are aware of new multi-agency procedures are embedded into practice, training need to be adequately resourced.
Membership and skills	The Care Act states that the Local Authority which set up the SAB, CCGs and the Police in the Local Authority area are statutory partners. These three organisations are represented on the OSAB and sub-groups. The Care Act suggests a number of other partners can be invited to join the Board. The OSAB includes a range of other partners from across the County. The Care Act also sets out the requisite skills for SABs to act efficiently and effectively. Members should be able to: • speak for their organisation • commit their organisation on policy and practice matters • hold their organisation to account • influence the development of their agency's practice • contribute to the development of robust and effective monitoring and performance functions.	When the new chair is appointed, it is suggested that there is a review of Board members and expectations. This could include: • discussion about right level of decision makers • distinction between Board members and people who are dealing with specific issues or reporting on agreed actions • the inclusion of the carers and service user voice should be reviewed to ensure that it is directly linked to the Board (Healthwatch). Consideration needs to be given to how the: • commercial care and health sectors • service users • voluntary sector will be engaged in the OSAB, ensuring that membership organisations are able to be representative and feedback loops are well established.

Strategic Plan	This is the first time that SABs are required to publish a Strategic Plan each financial year. Many Boards are therefore in the same position as the OSAB.	The Review Team were provided throughout with information and ideas that could be form basis for strategic planning. OSAB and incoming chair to consider business planning identifying priorities for action.
Annual report	SABs are now required to publish a report about Board activity on a yearly basis. This should be achieved by working in partnership and should be agreed with Healthwatch.	Develop a mechanism through the OSAB structures for formal consultation. Consultation needs to be wider than present and thought needs to be given to how the voluntary sector and patient/service user groups are engaged.
Identifying key roles and responsibilities	SABS need to assure themselves that all members, including those on sub-groups understand their roles and responsibilities.	The draft Constitution sets out responsibilities of OSAB members. Included is that members who represent other organisations will conduct themselves. Further work might be required to ensure that there is a written agreement about how this relationship will operate. This would be of particular importance to membership organisations (e.g. commercial care providers and voluntary sector organisations).
Challenge between partners/ holding partners to account	This is key to ensuring that the OSAB works effectively and although is primarily the role of the chair, clarity about arrangements could be included in the Constitution.	A Draft Constitution has been developed for discussion at the Board. It was unclear how partners will conduct themselves and conflict managed. A proposal that the chair of the Board holds CEOs of partner organisations to account has been suggested. A discussion with CEOs of the statutory partners about how business is currently dealt with may ensure that issues can be resolved quickly and appropriately.
Effective links with key partnerships	The OSAB has developed a map of partnerships they work with.	Consideration needs to be given to the full list of potential partnerships and an agreement made about how links to the OSAB will be made. Crucially there needs to be an agreement about which partnerships deal with specific issues e.g. Domestic Homicide Reviews.
Analysing and interrogating data	Partners need to provide data to support making strategic decisions about safeguarding.	The OSAB need to review and agree a data set. The OSAB need to identify and agree key indicators that will be regularly analysed and considered by the Board. It is suggested that a small group of meaningful indicators could be used to start with.

Arrangements for Peer Review and Audit	All SABs are now required to have in place arrangements for Peer Review and Audit.	The current peer review should enable the OSAB to look at issues it might want to address and the Board could consider how it might wish to review whether it has completed all actions agreed. An area for further work might be the development of a self audit for partners, and Board arrangements. There was a suggestion that additional resources would be required for this activity. The OSAB might wish to discuss what arrangements other Regional SABs have put in place to undertake this. A number are led by operational safeguarding leads from across the partnership.
Developing policies and procedures with other agencies and taking into account views of adults who have care and support needs	The development of the Multi Agency Policy and supporting documentation needs to consider how it can engage with all partner organisations including commercial and voluntary sector care providers and the public.	Work has begun to look at all policies and procedures and it is proposed that these are discussed at the OSAB in August. Some consideration needs to be given to ensuring that these procedures have been widely considered, and discussions about how the policy will operate in practice both across the workforce and with partner agencies/ stakeholders. Engagement, public participation and communication staff from partner agencies could provide the necessary skills and support.
Preventative strategies - aiming to reduce instances of abuse and neglect	The OSAB need to be aware of how current preventative strategies are being undertaken and, using data available, develop a clear co-ordinated strategy.	Self-neglect was highlighted by a number of practitioners as needing addressing. The OSAB could consider developing a multi-agency self-neglect policy to complement the revised safeguarding procedures.
Strategies to deal with grievances; complaints; professional and administrative malpractice in relation to safeguarding	Procedures and policies for contracted, commissioned and directly provided services should include safeguarding.	The review team were not able to review the relevant policies and procedures. Partners might wish to consider whether their policies and procedures include safeguarding vulnerable adults and commissioners/contract managers might wish to ensure that contract for service includes a reference to safeguarding. There was no specific reference for dealing with complaints about the OSAB or the Chair. This might be something that the partners would wish to consider.

Making enquiries	New duties have been placed on partners to carry out s42 enquiries and more broadly Making Safeguarding Personal and the need to ensure that the individual is engaged in the safeguarding process from the start - managing risks through family networks, neighbours etc. All partners are required to have a Dedicated Adult Safeguarding Manager (DASM)	The revised Safeguarding procedures should incorporate the MSP approach to help embed this in the work of practitioners. The procedures should also provide clarity on thresholds as well as an enhanced menu of responses. Multi agency training will assist in translating this approach to an outcomes way of working within the new legal framework. An update on which partners have established a DASM role may be an area that the OSAB should explore.
Strategies to deal with impact of race; ethnicity; religion; gender; gender orientation;	The OSAB did not have a strategy to address this.	Consideration could be given to including this as a specific aim/function of one of the groups. The OSAB will also need to ensure that this is included in all strategies and that these are linked to human trafficking, modern slavery and discrimination.
Confidentiality	Each SAB needs to have a confidentiality agreement setting out when and what to share.	The OSAB have a draft Confidentiality Agreement in place. This needs to be formally agreed and a communication plan agreed and actioned in order that all practitioners are aware of its contents.
Identify types of circumstances giving grounds for concern and when they should be considered as a referral to social services	SABs and ASC must work with partners to ensure that multi agency policy and procedures are clear to all agencies, not solely statutory partners but voluntary and commercial care organisations.	This is included in the multi-agency procedures. Links between commercial care organisations and the OSAB needs to be strengthened in order to ensure that there is clarity about how and when care providers should refer to social care.

Information - accessible to partner organisations and the public	Each SAB should ensure that information is available to the wider public about what safeguarding is and where people can get help. Partners need to have available all necessary information to work together and keep updated about policy development.	Some concerns were expressed about the difficulties of accessing information about safeguarding, although it was acknowledged that the proposal to develop an adult safeguarding site would help this. OCC publish information about how to access ASC services, but the OSAB have no public facing information. Healthwatch and other public and patient participation groups are crucial to ensuring that this information is culturally sensitive and reaches all parts of the Counties communities. The Joint Safeguarding Business Unit are developing web based information for partner organisations, including updated policies and procedures, updates on initiatives and activity across the County. The Business Unit might want to consult with operational colleagues about what information they may wish to have access to. They might also want to consider including links to national organisations that focus on safeguarding (e.g. SCIE).
Mechanisms for monitoring and reviewing the implementation of policy and training	The OSAB need to agree how it will assure itself that all OSAB policies are fit for purpose and meet the requirement of the Care Act and other legislation. Training for partners needs to follow any changes to policy or procedures.	The OSAB might wish to include this in any forward work plans.
Promote multi-agency training	This training is based on multi-agency policies and procedures and needs to occur across all partner organisations.	The OSAB multi-agency policy and procedures are out of date and multi-agency training has not taken place for some months. The L&D group have responsibility for this but it was reported to run on *'goodwill and is not sustainable'.* Following the agreement of the multi-agency safeguarding policy a programme of training all partner organisations needs to be resourced and agreed.