Oxfordshire Safeguarding Adults Board (OSAB)
Key Messages from The OSAB Chair – December 2017

The Oxfordshire Safeguarding Adults Board met at County Hall in Oxford on 14 December 2017 and the Chair Pam Marsden would like to share the following messages with you:

The Board received a report following a review undertaken after the suicide of a young man known as Student A in 2013 whilst at the University. There had been significant delays in producing this report which was now the subject of an ongoing complaint from his family. The Board were given a copy of a document from Student A's mother outlying her concerns with the report to inform their decision making.

His tragic death did not meet the criteria for a Serious Case Review[1] under previous legislation IE pre-Care Act 2014 but it was considered that a learning review would be appropriate. A representative from the University was present for this item and helpfully was able to answer questions and receive proposed additions/amendments to the action plan. There was a lengthy discussion and with some minor changes to the action plan, the report and recommendations were agreed by Members without further alteration. It was also agreed that as the outstanding actions were for the University this should be overseen through the University's own internal governance arrangements and the Chair was asked to write formally to the University to request this.

Subgroup Report

The Board was advised that there were no decisions to be made in relation to any of the subgroups.

1) Safeguarding Adult Reviews

There have been no new cases referred since the last Board meeting. The Board was advised that the currently open Safeguarding Adult Review would not be available until after the Coroner's Hearing in February.

2) Policy and Procedures

Policies signed off in the last quarter: Working with people who do not engage or are deemed ineligible for services.

During the same period **w**orking groups have considered and progressed policies in relation to: Missed Visits, Allegation**s** against **S**taff and Financial abuse.

Policies reviewed have included the Threshold of Needs Matrix.

3) Training

5 courses have been held since the last Board in September. The first Level 3 safeguarding for managers course will be held in February 2018. The review of the 27 London Borough Safeguarding Adult Reviews will form part of the learning for 2018.

[1] Updated in the Care Act 2014 to be a known as a Safeguarding Adult Review

4**) Vulnerable Adults Mortality Panel**
Four cases have been considered since the last meeting and to date no new themes have emerged. The future of the group will be reviewed once the Learning Disabilities Mortality Review programme (LeDeR) process is firmly in place to avoid duplication.

Oxford Health NHS Foundation Trust Single Agency Report
Moira Gilroy, Safeguarding Adults Manager, Oxford Health NHS Foundation Trust, presented a report to the September OSAB on the work of the Trust in relation to safeguarding and associated concerns. Today she presented an update. To note was that the 2 outstanding actions from the Care Quality Commission (CQC) action plan had been completed and in relation to the outstanding reviews of those with Continuing Health Care needs, plans were in place to ensure all are completed.

Thames Valley Police (TVP) Single Agency report
Mark Johns provided an overview of the work of TVP. The Force are now investigating a rising number of deaths in Care Homes. The protocol on how to manage Care Home crimes and deaths has been revised in TVP and Mark was asked by Board members to share this document.

TVP are also coordinating a domestic abuse perpetrator programme funded by the Police and Crime Commissioner as part of their work around repeat offending.

They have increased their focus on tackling Modern Slavery. It seems that most common forms of modern Slavery in Oxfordshire is sexual exploitation (women brought to Brothels to work), the forced labour of vulnerable adults and drug dealers using the homes of vulnerable adults to deal drugs**.** In the first 9 months of the year 177 people have been suspected of being a victim of modern slavery and referred to the national referral mechanism for support. Partnership networks have been established and there is improved intelligence gathering using infographics for each local authority/police area. A discussion took place about the partnership arrangements which some felt were not yet working as well as they could and some felt did not always have the right level of membership. Mark agreed to get some further clarity on the governance and accountability of the groups.

Dignity in Care
The Dignity in Care Report was noted and led to a discussion about The Carers Pledge. Kate Terroni agreed to arrange a meeting to progress this with partner organisations.

Housing Provider Representation
A discussion took place about the importance of housing provider representation on the Board. CEOs of Housing Providers will be approached to establish who leads on safeguarding for their organisation with the aim of developing a list of contacts to ensure a better route to cascade for example training opportunities and information more generally and ultimately give the Board assurance that housing partners are aware of their responsibilities in the area of safeguarding.

Performance, Information & Quality Assurance (PIQA) 6 Monthly Dataset
This item led to a good discussion around information and how it is used. Mel was asked to provide numbers of cases audited rather than percentages and the numbers of DBS checks that are not compliant and how this is managed. A discussion took place around again, the numbers of concerns

and enquiries and the reasons around the decrease in both. The Chair thanked all of those involved in developing the dataset. An example of another authority's dataset for their annual report was considered by the Board and it was agreed that the March Board would review a number of different approaches to enable a decision on the best way forward. The Local Authority comparator annual return was also considered and again Mel was asked to provide figures to help the Board understand more fully the data before them.

Individual Agency Update

Sam Foster advised the Board that Oxford University Hospitals NHS Foundation Trust just had an Inspection by CQC from which there is considerable learning for all partners and the need for an action plan. It was agreed that Sam would set up a task and finish group to ensure partners were aware of the issues and the learning and actions could be shared and worked on together.

Finally I am writing this just as Xmas approaches but I am aware that you will be reading it in the New Year! I do hope that you have had a good and restful break and are feeling refreshed and ready for the year ahead.

With my very best wishes

Pam Marsden
Independent Chair OSAB