Divisions Affected -

PEOPLE OVERVIEW AND SCRUTINY COMMITTEE
18 SEPTEMBER 2025

OXFORDSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2024-25

Report by Corporate Director of Adult Social Care

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   i. Note the findings of the Oxfordshire Safeguarding Adults Board (OSAB) Annual Report 2024-25. It is a requirement of statutory guidance that this report is shared with the Local Authority hosting the Safeguarding Board in their area.

Executive Summary

2. The Oxfordshire Safeguarding Adults Board (OSAB) member organisations work to protect adults who have needs for care and support, making sure they are safe from abuse and neglect. This report covers what OSAB and its partners did between April 2024 and March 2025.

3. **What did OSAB do this year?**

- OSAB focused on four main things: improving how staff work, preventing abuse, checking the quality of safeguarding, and learning from past cases.
- The Board and its smaller groups met regularly to check progress and make sure everyone was working together.
- Most planned actions were finished on time, and any ongoing work is being tracked.

4. **What did the subgroups achieve?**

- **Policy and Practice:** Updated important safeguarding policies and created a new guide to help staff decide when to raise a safeguarding concern.
- **Quality Assurance:** Kept an eye on safeguarding data. There were more concerns reported this year, but this shows people are more aware and willing to speak up. The team also got better at helping people achieve the outcomes they wanted.

- **Engagement:** Made sure people with lived experience had a say, raised public awareness, and helped create a new Domestic Abuse Strategy.
- **Case Reviews:** Looked into serious cases and deaths among homeless people. Lessons learned were shared with staff, and OSAB's approach was recognised nationally as good practice.

5. **What did partner organisations do?**

- **Oxfordshire County Council:** Improved how quickly and well they respond to safeguarding concerns.
- **NHS:** Worked together to improve referrals, trained staff, and shared information better.
- **Police:** Set up a new team to help vulnerable adults and improved how they share information.
- **Fire & Rescue:** Included safeguarding in home visits and helped set up a group to support people who hoard.
- **District Councils:** Improved safeguarding in housing and community safety, and trained staff.
- **Healthwatch and Charities:** Made sure the voices of people using services were heard and helped raise awareness.

6. **What did we learn from case reviews?**

- Reviews showed the need for staff to be curious, work flexibly with people who are hard to reach, share information better, and act quickly.
- OSAB made changes based on these lessons, like improving how repeat concerns are flagged and making sure all agencies are involved in meetings.
- Reports from these reviews will now stay online for up to seven years so everyone can learn from them.

7. **How has safeguarding changed over 10 years?**

- Safeguarding is now much stronger, with better teamwork and more people knowing how to get help.
- There are new challenges, like more complex cases, more people needing help, and new risks such as self-neglect and online scams.
- The COVID-19 pandemic made things harder, increasing isolation and safeguarding concerns.

8. **What's next?**

- OSAB wants to make sure lessons and resources reach frontline staff, set up a formal risk register, work more closely with children's safeguarding, and focus more on preventing abuse before it happens.
- The Board will keep improving, learning, and working together to keep adults in Oxfordshire safe.

Annual Report - Introduction

9. The Oxfordshire Safeguarding Adults Board (OSAB) was established in April 2015 under The Care Act 2014. Its main objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults with care and support needs in its area.

10. This report covers OSAB's work from 1 April 2024 to 31 March 2025, addressing:

- **Main Objectives & Strategic Plan Implementation** – What the Board and its subgroups did to achieve their goals.
- **Member Agency Actions** – Contributions each partner made to implement the strategy.
- **Safeguarding Adults Reviews (SARs)** – Findings from any reviews of serious cases and actions taken in response.
- **Decade in Review** – Notable positive and negative changes in adult safeguarding over the past 10 years.
- **Looking to the Future** – Suggestions for 2025-26 onwards.

Main Objective and Strategic Plan Implementation (2024–25)

11. **OSAB's Main Objective:** *"To safeguard adults with care and support needs in Oxfordshire by coordinating effective multi-agency action and ensuring continuous improvement in preventing and responding to abuse and neglect."* In 2024–25, OSAB pursued this overarching goal through a strategic plan focusing on **four priority areas**. These included improving frontline practice, enhancing prevention and engagement, strengthening quality assurance, and learning from experience. The Board updated its **Strategic Plan for 2024–2027**, incorporating feedback from members and progress on previous actions. This plan includes a roadmap for the year, aligning subgroup workplans and partner efforts with OSAB's main objectives.

12. **Board Meetings and Governance:** The OSAB and its subgroups met regularly to monitor progress against the strategy and workplans to drive implementation.

13. For example, at each Performance, Information & Quality Assurance (PIQA) meeting, the group reviewed data on safeguarding activity (e.g. number of concerns raised, types of abuse, outcomes) to identify trends and risks. The board observed that the average number of safeguarding concerns rose to around 676 by March 2025, indicating increased awareness and reporting. Care homes and provider agencies remained the top sources of safeguarding concerns coming into the system.

14. However, they also have one of the lowest conversion rates (the number of concerns that meet the criteria for a statutory safeguarding enquiry). The

person's own home remained the most likely place for a safeguarding incident to occur. referrals, and the Board urged all partners to create targeted prevention efforts accordingly.

15. All subgroups of the Board track delivery of their work via an **Action Log**. This log captured tasks from prior meetings (such as developing new policies, improving training, or completing reviews) and progress is requested for each meeting. The majority of actions were completed on schedule, and ongoing items (e.g. launching a risk register for the Board) were carried forward with clear deadlines.

16. The Full Board ensured **multi-agency collaboration** by having each subgroup Chair and partner agency report on their work. No significant inter-agency escalations were reported in this period, showing good cooperation. The Board's Independent Chair and the recently appointed **Independent Scrutineer** provided external oversight, challenging the Board to keep improving. For instance, the Scrutineer highlighted areas for potential improvement such as formalising a Board risk register. They have also led on work to develop principles for working with people who are self-neglecting by drawing on both academic research and the experience of local practitioners.

17. **Subgroup Activities:** OSAB carries out much of its work through specialised subgroups. In 2024–25, these subgroups were very active in implementing the strategic plan:

Policy, Practice & Procedure Subgroup

18. This subgroup (chaired by Thames Valley Police) led on updating local safeguarding policies to reflect best practice. A major piece of work was revising the old "Thresholds" guidance into the new **Safeguarding Adults Consideration (SAC) Framework** to aid professional decision-making. The document is a tool to help professionals understand what may constitute a safeguarding concern requiring a referral into the Local Authority, who have responsibility for conducting safeguarding enquiries. Members agreed to replace the term "thresholds", which was felt to be limiting, with this new framework emphasising professional judgement. By September 2024, the SAC Framework was finalised and launched on the OSAB website.

19. The subgroup also undertook a comprehensive review of multi-agency safeguarding procedures, adapting the Pan-London policy to suit the Oxfordshire context—a significant undertaking given the document's length of 146 pages. In order to manage this process efficiently, responsibilities were allocated among participating agencies, with a six-week deadline established for completion of the final revisions.

20. **As a result** key policies were updated or in progress by year-end, including a revised **Self-Neglect and Hoarding Policy** (with consideration to split it into separate policies for clarity). The subgroup focused on how to effectively communicate these changes to frontline staff; for example, members agreed to issue communications briefs and use practitioner forums to embed the new SAC Framework terminology.

Performance, Information & Quality Assurance (PIQA) Subgroup

21. PIQA monitored safeguarding data and performance indicators across the partnership. In 2024–25, they noted a **steady increase in safeguarding concerns** being reported – on average 30 per day, spiking to 40–60/day early in the week, which put significant strain on teams. The subgroup drilled into data such as sources of referrals, with provider agencies, care homes, Police and South Central Ambulance Service (SCAS) consistently being the highest referring cohort, and urged the Board and subgroups to target efforts based on these insights. This resulted in reports to PIQA from SCAS and Police about their efforts to understand and then reduce the numbers of unnecessary concerns coming into the system. The impact of this will be monitored through 2025-26.

22. Under the leadership of the County Council's Head of Services for Adult Safeguarding, several quality improvements were implemented within Adult Social Care: by early 2025 the team was **meeting required timescales** for allocation of enquiries for investigation. This resulted in more timely Section 42 enquiries and better outcomes tracking – in fact, the Board was pleased to see the proportion of cases where the adult's desired outcomes were achieved rose to 90%, a significant improvement over the previous years (for example, the rate was 72% in 2018-19). PIQA also oversaw specific audits (e.g. on Mental Capacity assessments in complex cases, and on repeat referrals involving self-neglect) and ensured learning from these audits fed into frontline practice. By February 2025, the data was beginning to show the positive impact of these changes, with improvements in meeting target times for safeguarding processes. The Board recognised self-neglect as a growing area of concern and discussed it alongside hoarding, instructing the Policy subgroup to refine guidance and training on this topic during 2025-26. Additionally, the Board created the Principles of Self-Neglect Task and Finish group to better create a more focussed understanding of self-neglect within safeguarding.

Engagement & Inclusion Subgroup

23. The Engagement subgroup works to ensure that the Board hears from the community and raises awareness of adult safeguarding. During 2024–25, this subgroup carried out a range of activities, outlined below.

24. It facilitated input from **people with lived experience**. For example, representatives from My Life My Choice (a local self-advocacy group) attended and contributed. They offered to help create **easy-read materials** for the public to explain safeguarding, ensuring accessibility (noting a small charge for this service). This led to a plan for a public-facing, plain English summary of the Annual Report, which members agreed was important for transparency. This plain English summary will be trialled with this year's Annual Report and published on the OSAB website.

25. The subgroup members shared "current safeguarding issues" from their perspectives. One meeting discussed the new **"Right Care, Right Person"**

approach (a national initiative clarifying which agency should respond to certain welfare situations). Members debated its local impact – for instance, whether it affected police willingness to conduct welfare checks. Some had positive experiences after additional training e.g. city council staff saw improved responses by directing calls appropriately). Others noted concerns about occasional gaps such as difficulty getting police to attend some welfare calls. These insights were fed up to the Board so that any multi-agency issues, like clarification of roles, could be addressed.

26. Partner agencies in this subgroup also reported on **public awareness campaigns** and training. Healthwatch Oxfordshire and Age UK, for example, participated in spreading safeguarding messages to the public, while many subgroup members organised activities during National Adult Safeguarding Week in November. The subgroup emphasised explaining "what is safeguarding" in simple terms. Following public consultation about the Annual Report, they recommended that it should include data about the prevalence of the different types of abuse reported in Oxfordshire, the outcomes of safeguarding interventions, and trends over time. This reflects the subgroup's role in making safeguarding work understandable to the general public and service users.

27. **Co-production progress**: The subgroup took on an action to assist in co-producing Oxfordshire's new Domestic Abuse Strategy with input from those with lived experience with domestic abuse (working alongside Public Health). By involving lay members and advocacy groups, they aimed to ensure strategies are informed by real experiences.

Safeguarding Adults Review (SAR) Subgroup

28. This subgroup oversees reviews of serious cases to identify learning. It also reviews cases of deaths of homeless individuals, known locally as Homelessness Mortality Reviews (HMRs), which are conducted under the discretionary SAR process. They are carried out like this to ensure there is a robust legal framework for the Board conducting the review and to give the reviews an equal standing to any other case review the Board conducts.

29. In 2024–25 the SAR Subgroup considered several referrals for review and steered ongoing review processes. The **findings from case reviews** are in their own section of the report below.

30. The subgroup examined new cases to decide if they met the criteria for a formal Safeguarding Adults Review. For borderline cases, they introduced a structured scoping form to gather more information and ensure consistent decisions.

31. **National recognition:** OSAB's approach to SARs and HMRs has been cited positively beyond Oxfordshire. The Independent Scrutineer reported that the joint SAR/HMR process received national recognition for effective practice. The work around HMRs has also been noted as good practice by the Ministry for Housing, Communities & Local Government (MHCLG). This suggests that

the Board's learning and review mechanisms are considered a model, thanks to clear processes and active partner engagement.

32. By year-end, the subgroup had several review reports either completed or nearing completion. **All findings from reviews were translated into action plans** for the agencies involved. The Board also incorporated all the learning into the **Learning from Reviews Workshops** to help disseminate learning from reviews to a broad audience of frontline professionals. For example, one action from a recent SAR was to update the Board's **escalation policy** to higher management when agencies aren't attending important multi-agency meetings – a gap identified in a review. This update was implemented so that in future, if a critical partner is missing from safeguarding discussions, it is quickly raised to senior managers to avoid communication breakdowns.

33. ***In summary, OSAB and its subgroups actively worked on their main strategic priorities throughout 2024–25.*** They revised and rolled out key policies, scrutinised performance data to drive improvements, engaged communities and service-users in safeguarding, and conducted reviews to learn from serious cases. **Progress was monitored and documented** through the Board and the groundwork laid this year (policy updates, frameworks, and identified improvements) positions the Board to continue strengthening safeguarding practice in line with its objectives.

Actions by Each OSAB Member to Implement the Strategy

34. OSAB is a multi-agency partnership, including Oxfordshire County Council (Adult Social Care), NHS Integrated Care Board and provider trusts, Thames Valley Police, District Councils, Fire & Rescue, Healthwatch, and voluntary sector organisations (like Age UK), among others. **Member agencies took concrete steps in 2024–25 to deliver the Board's strategy in their own sphere.** Some of the notable contributions are outlined below:

35. **Oxfordshire County Council (Adult Social Care):** The Council's adult safeguarding team made significant operational improvements this year, addressing issues that align with OSAB's priorities on effective practice. Under the Head of Service for Adult Safeguarding, the team instituted daily check-in meetings to review new concerns and ensure prompt action. Staff were required to spend more time in the office (three days a week) to facilitate better team communication and oversight of decisions. By late 2024, this had led to faster turnaround on safeguarding enquiries and improved consistency. **Result:** By the February 2025 PIQA meeting, the Council reported that its safeguarding team was "in a strong position" – motivated staff, recent specialist training completed, and adherence to statutory timescales now being achieved. If a referring partner wasn't getting feedback, they were encouraged to contact the manager directly – demonstrating a new openness to resolving issues quickly. These actions by the Council fulfil strategic aims around **strengthening safeguarding processes** and **Making Safeguarding Personal**, as evidenced by the rise in outcomes achieved and positive staff feedback.

36. **NHS Health Partners:** Health organisations on the Board (the Buckinghamshire/Oxfordshire/Berkshire West Integrated Care Board, Oxford University Hospitals NHS Trust, Oxford Health NHS Trust, South Central Ambulance Service, etc.) contributed through both system-wide initiatives and internal improvements. For instance:

- **Healthcare Safeguarding Leads Collaboration:** The designated safeguarding leads from the hospital trust – Oxford University Hospitals, (OUH) and community/mental health trust (Oxford Health) worked together on difficult issues such as improving the "conversion rate" of safeguarding concerns into Section 42 enquiries. An action was agreed for the OUH lead, Oxford Health lead, and Council manager to meet outside OSAB meetings to develop a plan to improve appropriate referral conversions. This indicates health partners actively engaging in quality improvement in line with the Board's performance priorities.
- **Training and Awareness:** Oxford Health ran Mental Capacity Act (MCA) training and focused on professional curiosity in safeguarding – a theme flagged by the Board. OUH ensured its staff received updates on referral pathways (like when to involve social care versus police, in line with *Right Care, Right Person* guidance discussed at OSAB). The Integrated Care Board's Adult Safeguarding lead presented data and insight to the PIQA subgroup and championed issues like reducing DoLS (Deprivation of Liberty Safeguards) backlogs, which relates to one of the Board's strategic priorities around law compliance and risk management. Health partners also strengthened **information-sharing**: one achievement was the circulation of a new information-sharing agreement to clarify what can be shared between agencies for safeguarding.
- **Service Improvements:** Specific improvements were reported, such as the **South Central Ambulance Service (SCAS)** revising its safeguarding referral form to be more effective in triaging the type of concern.

37. **Thames Valley Police:** The police, as a core OSAB member, took forward multiple initiatives supporting the Board's strategy of prevention and protection of adults:

- They established a new **Harm Reduction Unit (HRU)** focusing on cases involving vulnerable adults who may be involved in or victims of crime and anti-social behaviour. In late 2024, this unit became fully operational, with dedicated officers and new processes to better link police intelligence with partner agencies. For example, the HRU launched "Custody 25", a project embedding part-time link workers and navigators in police custody suites (in locations including Abingdon and Banbury). These workers help identify detained individuals with possible care/support needs or neurodiversity (like

ADHD) and connect them to services – even providing on-the-spot aids like distraction packs in custody to calm those with vulnerabilities. This directly advances OSAB's objective of safeguarding adults in all settings, by intervening early during criminal justice contact.

- The police also improved **information-sharing and transparency** with OSAB. A Detective Chief Inspector now regularly updates the Board on police safeguarding referrals. Additionally, the force addressed backlogs in processing domestic abuse disclosures (Clare's Law requests).

- On a strategic level, the Police representative (who chaired the Procedures subgroup) championed cross-cutting improvements like the new accolades procedure (to recognise good practice) and ensuring **alignment with the Children's Partnership.** The Independent Scrutineer highlighted the need for better links between the Adult Safeguarding Board and Children Safeguarding Partnership post some structural changes, and police along with other members agreed to explore joint approaches where appropriate. This reflects a forward-looking stance to implement the Board's plan in a holistic way.

38. **Oxfordshire Fire and Rescue Service:** The Fire & Rescue Service contributed to OSAB's strategy mainly through prevention and outreach. The Partnerships & Safeguarding Manager at Fire & Rescue actively participated in the Engagement and PIQA subgroups. Firefighters continued to incorporate adult safeguarding checks into their **Safe and Well visits** in people's homes – if crews encountered an at-risk adult (for instance, someone showing signs of self-neglect or confusion) during fire safety checks, they made safeguarding referrals as needed. This year, Fire & Rescue's safeguarding lead worked with the Board to ensure their referral pathways were aligned with the new SAC Framework (so that fire personnel use the updated guidance on levels of risk). They also helped address issues around **hoarding**, which is both a fire hazard and a safeguarding concern. Fire officers are often first to spot hoarding; hence Fire & Rescue co-founded a new **Hoarding Support Group** with council and health colleagues in Cherwell district to coordinate support for individuals who hoard. This on-the-ground action directly implements the Board's strategic aim of early intervention and partnership working for complex cases.

39. **District and City Councils:** The district councils (Cherwell, South Oxfordshire, Vale of White Horse & West Oxfordshire) and Oxford City all sit on OSAB and made important contributions, particularly in housing and community safety – key factors in adult safeguarding:

- **Housing and Homelessness:** With the rise in safeguarding concerns related to homelessness (as highlighted by OSAB's Homelessness Reviews), the districts stepped up coordination. For example, Oxford City Council's Community Safety Manager raised the profile of safeguarding within

community safety partnerships, ensuring that vulnerable adults (like rough sleepers) are discussed at both housing forums and OSAB.

- **Local Initiatives:** Cherwell District led on the aforementioned hoarding pilot project, bringing together mental health, environmental health, and housing staff to engage a person with extreme hoarding behaviour (the success of which was shared as a case study at the Board). Their efforts resulted in a grant to help in hoarding cases and development of a multi-agency hoarding protocol. Such ground-level initiatives by council members directly implement OSAB's objective to **prevent harm by multi-agency collaboration**.
- District council officers also ensured training for their staff (like housing officers) on identifying and reporting safeguarding issues was up to date. They outlined actions such as improved safeguarding referral processes in housing departments and joint visits with police for complex anti-social behaviour cases where adults at risk were involved.

40. **Healthwatch Oxfordshire:** As the consumer champion for health and care, Healthwatch ensured the **voice of service users** remained in focus. In OSAB meetings, the Healthwatch representative reminded the Board to consider the experience of adults going through safeguarding processes. This aligned with the Board's strategic aim to hear from those with lived experience. Healthwatch's push for plain language also influenced the Board to commit to a **Plain English Annual Report summary**, making the Board's work more transparent to the public.

41. **Voluntary Sector Partners:** Age UK Oxfordshire and other voluntary partners like Connection Support and My Life My Choice played critical roles:

- They acted as a **bridge to the community**, bringing issues from people we support to OSAB's attention (e.g. My Life My Choice highlighted difficulties people with learning disabilities face in safeguarding processes, and Connection Support flagged systemic issues encountered in supporting a client which led to a SAR referral).
- Voluntary partners also delivered parts of the strategy by **outreach and empowerment**. For example, Age UK held community awareness sessions about financial abuse prevention and provided feedback to the Board on older persons' safeguarding needs. Connection Support, which works with people facing housing crises, improved its internal protocols as noted and shared that learning through OSAB to encourage other providers to do the same.
- These organisations often piloted innovative support approaches: one member (**Elmore Community Services**) reported to the Engagement subgroup on a new community-based approach to engage isolated individuals early to help reduce loneliness, aligning with OSAB's prevention objective.

42. The synergy of these efforts is evident – for instance, while the Council improved internal safeguarding response times, the NHS trained staff on

recognising abuse, the Police intervened earlier with at-risk individuals, and community partners offered advocacy and feedback loops. All these contribute to the common strategic goal: **better safeguarding outcomes through effective partnership**.

43. Notably, joint working between agencies increased. A good example is how partner agencies responded to **self-neglect**: The sharp rise in self-neglect cases (often involving elements of hoarding or substance misuse) prompted a unified response. Social care, healthcare, mental health, fire service, and housing all coordinated under OSAB's guidance – updating the Self-Neglect and Hoarding Policy together, sharing, and ensuring frontline teams across organisations knew what support to offer. This collaborative approach by all members exemplifies implementing the Board's strategy in unison.

Findings of Safeguarding Adults Reviews (SARs) and Subsequent Actions

44. During 2024–25, OSAB conducted or continued several Safeguarding Adults Reviews and Homelessness Mortality Reviews. **These in-depth reviews examine cases where an adult tragically died or was seriously harmed, and multi-agency lessons can be learned.** The key findings and the actions taken as a result are summarised below. All published reports can be accessed on the OSAB website, and a learning compendium is being developed to bring together all the learning from all reviews (from this and past years) to form a single reference document for professionals.

45. **Learning Themes:** Across the SARs/HMRs considered this year, some common themes emerged:

46. **Quality of Frontline Practice:** SARs reinforced the importance of professional curiosity and not taking things at face value. For instance, in one case, it was noted that having a system flag for individuals who are referred multiple times might have prompted professionals to dig deeper into recurring issues. Learning from this, the Board has requested the Local Authority to explore enhancements to case management systems to better highlight repeat concerns.

47. **Working with "difficult to engage" individuals:** Several reviews involved adults who either declined services, had chaotic lifestyles, or mental capacity fluctuating due to substance misuse. Reviews found that traditional approaches sometimes weren't effective. Consequently, OSAB partners are adopting more flexible engagement strategies – for example, using outreach navigators (as the police Harm Reduction Unit does) or multi-agency case conferences, and ensuring that if one agency can't engage someone, another (with a trusted relationship) takes the lead. In the BD case, positive feedback on the persistence of outreach teams was highlighted, encouraging all agencies to persist creatively with hard-to-engage clients.

48. **Information Sharing and Coordination:** Gaps in communication were a finding in at least one SAR – e.g. occasions when important information wasn't passed between agencies promptly, or key agencies (like ambulance services or certain care providers) not being fully involved in planning. The Board has quickly addressed this by updating protocols. By March 2024, an agreement on inter-agency information sharing was drafted and circulating for sign-off. Also, OSAB emphasised the expectation that all relevant agencies attend safeguarding meetings or otherwise contribute; if not, it should be escalated to ensure continuity of care.

49. **Timeliness of Interventions:** Delays in services being put in place or assessments being conducted were identified as a factor in worse outcomes. While some systemic issues like waiting lists are challenging, the OSAB used its influence to push for faster responses where this is possible. For example, Oxford Health reviewed how they manage their waiting list for complex needs and consider if interim support can be given while waiting.

50. **Hoarding and Self-Neglect:** A specific insight came from cases of severe self-neglect/hoarding. A SAR highlighted that such cases benefit from a **multi-disciplinary approach** and strong legal literacy on the part of organisations so they are aware of the fill range of legal powers that can be used to protect the person. Oxfordshire's SARs echoed national findings that self-neglect cases need a skilled, relationship-based approach. In response OSAB updated the Self-Neglect and Hoarding Policy (reviewed in January 2025) incorporated SAR lessons – for example, OSAB created clearer guidance on assessing mental capacity over time for people who self-neglect due to addiction and mapped out all available support services so practitioners know what to try next if initial offers are refused. The Board also decided to split Self-Neglect and Hoarding into distinct sections/policies, acknowledging that while related, each can occur independently and may require tailored strategies. As noted earlier, a hoarding task group was set up and a partnership grant is being used to directly help individuals (one outcome of a case review where housing and mental health sectors realised more practical help was needed).

51. **Mental Capacity and Consent:** Some SAR cases involved questions about mental capacity and the balance between respecting an adult's choices and protecting them. Reviews found instances where assessments of capacity were done, but perhaps needed revisiting as circumstances changed. For example, when early stage dementia or other circumstance where fluctuating capacity was a factor, capacity should be assessed more than once.
Subsequent actions: OSAB disseminated a reminder of the 2021 Alcohol Change UK guidance on assessing capacity in people with alcohol dependence to front-line teams. The Board's Learning & Development subgroup (in discussions about its future) identified that **cross-training** with the Children's Board on issues like executive capacity and self-determination

could be useful, given similar challenges in adult self-neglect and youth contexts. This will feed into future training plans.

52. **Agency-Specific Improvements:** Each SAR produces recommendations for specific agencies. All OSAB member organisations have taken these seriously:
    - For example, **Probation Service** involvement in a case led to a reflection on record-keeping; Probation committed to refresher training for officers on documenting and flagging safeguarding concerns.
    - In one review, the **Police** recognised that on some occasions officers did not submit safeguarding alerts to the county's MASH when attending incidents. As a result, the Police representative agreed to meet with the Detective Inspector in charge of domestic abuse to ensure officers are reminded and supervised in making those referrals every single time. That action was recorded and is being tracked by the SAR subgroup.

53. **Publication and Dissemination:** OSAB decided this year to **extend the availability of SAR reports** on its website. Previously, published reports were taken down after 18 months per an old policy. The Board reversed this, agreeing to keep past SAR reports online for up to 7 years so that lessons remain accessible to practitioners and the public over a longer period. This came from a question raised by a Board member and demonstrates OSAB's commitment to openness and ongoing learning. Additionally, an **"easy-read" or summary version of SAR reports** is considered when appropriate, to share findings with family members and people accessing our services in a sensitive, understandable way.

54. **In summary, the SARs and other reviews undertaken in 2024–25 yielded critical lessons, which OSAB has acted upon diligently.** Many of the "further actions" mentioned in this section – improving flagging of repeat concerns, faster multi-agency escalation, better communication of changes to frontline staff – have already been set in motion via the Board's action plans. The Board recognises that the real measure of success is seeing practice change on the ground as a result of these reviews. To that end, OSAB held a series of **Frontline Practitioners Learning Events** (the Learning from Reviews Workshops referenced earlier) during the year (noted by the Independent Scrutineer as being well-received) where case studies and SAR findings were discussed with operational staff. This kind of direct dissemination is being built into the Board's routine. The Independent Scrutineer will continue to monitor how well these SAR lessons are being implemented and will report to OSAB on any gaps. Overall, the SAR process is a cornerstone of OSAB's strategic plan implementation – ensuring the Board not only responds to incidents but turns them into opportunities to prevent future harm.

Changes Over the Last 10 Years

55. Over the past decade, the landscape of adult safeguarding in Oxfordshire (and nationally) has evolved significantly. **Overall, the trajectory has been one of improvement and expansion in safeguarding, but is accompanied by new challenges.** Key changes include:

Positive Developments:

56. **Stronger Statutory Framework:** Ten years ago, Safeguarding Adults Boards were just becoming a statutory requirement (with the Care Act 2014). Since then, OSAB has matured into a well-established body with clear roles. The introduction of an Independent Chair and now an Independent Scrutineer, and defined subgroups, has professionalised safeguarding governance. This has led to more consistent multi-agency collaboration than a decade ago, when arrangements were more ad-hoc.

57. **Increase in Awareness and Reporting:** Public and professional awareness of adult safeguarding has grown greatly. In 2015, many cases of abuse or neglect likely went unreported due to stigma or lack of knowledge. Now, mandatory training in organisations and public campaigns mean people recognise and report concerns more readily. The data reflects this: safeguarding concern rates have risen (to 676 in March 2025), but this is considered a positive in terms of visibility – "It's better to light a candle than curse the darkness." People know help is available, which is a success of years of engagement work.

58. **Better Outcomes for Individuals:** The approach to safeguarding has shifted to be far more person-centred. The push for Making Safeguarding Personal (MSP) in the last decade is paying off – as noted earlier, 90% of individuals or their advocates are now being asked about and achieving the outcomes *they* want from the process. Ten years ago, the focus might have been more on process than outcomes; now the conversation with the adult is central. There are many examples where individuals have been empowered – e.g., an adult at risk being supported to make choices about their living situation rather than agencies deciding for them. This cultural change is a huge positive shift.

59. **Multi-Agency Working & Information Sharing:** A decade back, different agencies often worked in silos due to data protection fears or lack of forums to meet. Today, there is far more *real-time* collaboration – the Multi-Agency Safeguarding Hub (MASH) has been embedded, joint training occurs, and there's a far clearer **protocol between OSAB, the Community Safety Partnership, and the Health & Wellbeing Board** mapping each other's roles (established in 2014 and built upon). The result is less duplication and fewer cases "falling through the cracks" between agencies than in the past.

60. **Addressing New Topics:** Over 10 years, OSAB has broadened its scope to address emerging issues. For example, financial scamming of elders, online abuse, modern slavery and exploitation, and domestic abuse in adults with care needs are now firmly on the Board's agenda – topics that would have

been less discussed a decade ago. The Board's involvement in homelessness mortality reviews is another example of how safeguarding practice has extended into non-traditional areas to protect very vulnerable groups.

Next Steps and Further Work

61. **Higher Demand and Complexity:** As highlighted, the volume of safeguarding concerns has increased substantially over the decade. While partly due to better reporting, it also reflects real rising need – aging population with complex health issues, mental health and addiction issues becoming more apparent. The cases OSAB deals with now often have multiple intersecting issues for example, an older person with dementia *and* an unpaid carer who is struggling, possibly leading to neglect. Managing these layered complexities can stretch services.

62. **Resource and Workforce Pressures:** Over the last 10 years, austerity measures and budget constraints in public services have undoubtedly impacted safeguarding. Local authority budgets for adult social care have been tight, NHS services are under strain, and voluntary sectors have had funding uncertainties. Turnover of experienced staff is an issue and the recruitment and retention of care staff and social workers remain a challenge into 2025. OSAB partners have done admirably to "do more with less," but the strain shows, for example, in waiting times in some services.

63. **New Types of Risk:** Some negative trends emerged in society that affect safeguarding. For instance, **self-neglect** was not even formally recognised in policy until about 2014; now it constitutes a large proportion of cases and is very challenging to resolve. Similarly, the growth of **county lines drug trafficking** over the past 10 years has drawn vulnerable adults into exploitation, requiring safeguarding responses in scenarios that previously would have been seen purely as criminal or social issues. Technology, too, has introduced risks like online scams or abuse via social media that weren't on the radar before. The safeguarding system has had to catch up to these, sometimes after harm has occurred.

64. **Pandemic Impact:** As reported in the LGA's COVID-19 Adult Safeguarding Insight Project work, it is worth noting the COVID-19 pandemic had lasting negative effects on adult safeguarding. Isolation increased, some services became remote, and hidden harm likely grew. Locally, the OSAB's data in the years since shows elevated concerns around self-neglect and mental health, arguably aggravated by the pandemic's social aftermath. This event stands out as a significant setback for adults with needs for care and support, and it will require ongoing action to mitigate its effects (for example, rebuilding social support networks).

65. **Expectations and Accountability:** There is greater scrutiny on safeguarding now (which is positive), but it means agencies face higher expectations with limited means. For example, every SAR brings a spotlight. In the last decade, media and regulatory attention on adult safeguarding failings (such as high-

profile neglect cases nationwide) have increased pressure. OSAB has to maintain public confidence that adults are safe, which is an ever-demanding task as complexities grow.

66. In reflecting on these changes, OSAB has shown it can adapt – the Board today is more proactive, data-informed, and collaborative than it was 10 years ago. However, challenges such as sustaining the workforce, preventing burnout, and innovating within tight budgets are ongoing.

Looking to the Future

67. While OSAB made solid progress this year, the Board is candid about areas needing further development. The Scrutiny Committee's interest in future actions is timely, as OSAB itself has identified and begun to address several key improvements for the coming period:

68. **Improve Frontline Awareness of Lessons and Resources:** A recurring point in Board discussions was ensuring that all the good work on policies, procedures, and SAR findings actually reaches front-line practitioners in an impactful way. There remains some uncertainty at the frontline about new initiatives – for instance, a **Learning-from-Practice** survey suggested some staff weren't sure how lessons from subgroups are shared with them. OSAB should continue to strengthen communication channels: more briefings, newsletters, or short videos could reinforce new policies (like the SAC Framework) and learning points from reviews. Frontline staff feedback mechanisms (such as regular practitioner forums or feedback forms after using new guidance) can help the Board gauge what's working or needs clarification. Essentially, *closing the loop* on learning is a top priority going forward.

69. **Establish a Formal Risk Register:** The Independent Scrutineer recommended OSAB develop a **Risk Register** to log and monitor risks to the Board's objectives. This would include, for example, risks like "High volume of referrals exceeding capacity" or "Lack of SAR authors" or "Changes in partner funding affecting safeguarding resources". By having a risk register, the Board can proactively manage these – assigning owners to each risk and mitigation plans (like recruiting more specialist staff or seeking funding for certain initiatives). The Board agreed and in January 2025 tasked all members to send in thoughts on key risks, for the Strategic Partnerships Manager to compile a draft register. The suggestion here is to expedite this: the Scrutiny Committee could support by asking for a status update on the risk register at the next review. This tool will improve OSAB's strategic oversight and resilience.

70. **Deepen Partnership with Children's Safeguarding Partnership:** Changes in the children's safeguarding arena were noted, specifically restructuring of the Oxfordshire Safeguarding Children's Partnership (previously Oxfordshire Safeguarding Children's Board). This was done after an extensive review of the statutory requirements laid out in guidance for local children's

safeguarding partnerships. Given many issues like transition from children's services to adult services, domestic abuse in families, or contextual safeguarding (like exploitation) span both groups, the OSAB would benefit from closer ties. A further action is to formalise regular information exchange or even joint projects with the Oxfordshire Safeguarding Children Board. One idea is a **joint annual conference on a cross-cutting theme**. Reviving this discussion now the OSCP has been restructured would be valuable, as it reinforces holistic family safeguarding approaches.

71. **Focus on Prevention and Early Intervention:** The data indicates more people are being safeguarded, which is good, but prevention could stem the tide. OSAB should build on its Engagement subgroup work to launch **public awareness campaigns** especially targeted at prevention of scams, financial abuse, and self-neglect. For example, a county-wide campaign on self-neglect (signposting how people can seek help early, perhaps via GPs or community groups) could be beneficial given the spike in cases. Also, continue expanding initiatives like the hoarding support network – and evaluate if similar networks are needed for other issues (like for care providers to share learning on frequent falls or pressure ulcer safeguarding referrals, etc.). The more the Board can help agencies problem-solve early, the better outcomes for individuals.

Final Thoughts

72. Over the past year (2024–25), OSAB and its partners have worked diligently to meet their main objective: safeguarding Oxfordshire's vulnerable adults by implementing a robust strategic plan. They achieved a lot – from policy reform and enhanced training to direct action from reviews – and this directly benefited adults in our county (e.g. quicker help, more person-centred support). Each member agency played its part, demonstrating the strength of a multi-agency approach. The Board has also been candid in self-reflection, identifying what needs to improve.

73. Going forward, the recommendations and further actions highlighted in this report – better frontline communication, establishing a risk register, addressing resource gaps, and reinforcing prevention – should form the focus of OSAB's work in the next year. The Scrutiny Committee can take confidence in OSAB's positive trajectory and provide support by monitoring these developments and helping unblock any barriers (such as advocating for resources or inter-agency cooperation as needed). With continued commitment, learning, and partnership, Oxfordshire's Safeguarding Adults Board will be well-equipped to handle both present demands and future challenges, ensuring adults at risk are supported and protected effectively.

Staff Implications

74. There are currently no staff implications for this report.

Equality & Inclusion Implications

75. The Safeguarding Adults Board in its planning, monitoring and evaluating of its work and the work of its partners, ensures equality and diversity issues are being appropriately considered from the outset.

Sustainability Implications

76. There are no sustainability implications.

Risk Management

77. [The report needs to show how risks and opportunities to the Council have been considered as part of the development work - particularly for a policy decision, strategy or project involving major change. The report needs at least to include a summary of the assessment and of any action to be taken to minimise risks. A more detailed risk assessment for major change or complex proposals should be made available (eg in the Members' Resource Centre). For guidance on the scope and process of risk management see Risk Management]

Consultations

78. The content of the report has been shared and consulted upon with all member organisations of the Safeguarding Adults Board.

Karen Fuller, Director of Adult Social Care

Contact Officer: Steven Turner, Strategic Partnerships Manager, 01865 328993, steven.turner@oxfordshire.gov.uk

September 2025