Oxfordshire Safeguarding Adults Board

Annual Report 2025–26

1 April 2025 to 31 March 2026

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Foreword from the Independent Chair

Welcome to the Oxfordshire Safeguarding Adults Board (OSAB) Annual Report for 2025–26. This report sets out what the Board and its member organisations have done over the past year to help protect adults in Oxfordshire who have care and support needs and who, because of those needs, may be unable to protect themselves from abuse or neglect.

This has been a year of extraordinary change in the national landscape: the interim findings of Baroness Casey's independent review of Adult Social Care, and the Government's commitment to establish a National Safeguarding Adults Board; the reorganisation of NHS structures, including significant changes to our Integrated Care Board; consultation on Local Government Reorganisation in Oxfordshire; and proposals to reform further policing. Against that backdrop, the strength of Oxfordshire's adult safeguarding partnership has mattered more than ever. Throughout the year, the Board has kept a deliberate focus on the people behind our work: the adults whose lives, and in some cases whose deaths, have taught us what we must do better.

There is much in this report of which the partnership can be proud, including the Care Quality Commission's assessment of Oxfordshire County Council's Adult Social Care as 'Good', with safeguarding identified as an area of strength; the publication of our Principles for Safeguarding Interventions for People Experiencing Self-Neglect; the launch of the MARM+ approach (see page 10) for people at high risk who sit below statutory safeguarding thresholds; and a substantial programme of Safeguarding Adults Reviews and Homeless Mortality Reviews completed with care and rigour. There has also been transparency about where we could do things better, including the backlog of unprocessed referrals identified within the local authority during the autumn, which was escalated openly to the Board, resolved at pace, and has led to lasting changes in how referrals are triaged.

I want to record the Board's particular thanks to Tamsin Jewell, who steps down this year after nine years as our Lay Member and as chair of the Engagement Subgroup. Her independent challenge and her insistence that the voice of people with lived experience remains at the heart of the Board's work have shaped this partnership for the better.

My thanks go to all Board members, subgroup chairs, the Board team, and above all to the practitioners across Oxfordshire who safeguard adults every day. I commend this report to you.

1. Introduction: purpose of this report

Safeguarding Adults Boards have three core duties under the Care Act 2014: to publish a strategic plan setting out how the Board will meet its main objective and what each member will do to contribute; to publish an annual report; and to arrange Safeguarding Adults Reviews (SARs) where the statutory criteria in section 44 of the Act are met.

This report is published to meet the requirements of the Care Act 2014, Schedule 2, paragraph 4, and Chapter 14 of the Care and Support Statutory Guidance. It sets out, for the year 1 April 2025 to 31 March 2026:

- what the Board has done during the year to achieve its objective and to implement its strategic plan;
- what each member organisation has done during the year to implement the strategy;
- the findings of Safeguarding Adults Reviews which concluded in the year, and details of reviews which were ongoing at the end of the year;
- what the Board has done to implement the findings of reviews, and, where the Board has decided not to implement a finding, the reasons for that decision.

In line with the statutory guidance, this report will be sent to the Chief Executive and Leader of Oxfordshire County Council, the Police and Crime Commissioner for Thames Valley and the Chief Constable, Healthwatch Oxfordshire, and the Chair of the Oxfordshire Health and Wellbeing Board, and will be presented to the local authority's People Overview and Scrutiny Committee. It will be published on the OSAB website alongside an Easy Read summary, prepared with the support of the Engagement Subgroup, so that the report is accessible to the widest possible audience.

As in previous years, the Board has chosen a narrative style for this report. Feedback from partners and from scrutiny last year was that a readable, plainly written account helps senior leaders and frontline staff alike to understand and share the Board's work. An easy-read version is in production for the public. A glossary of terms and abbreviations is provided at Appendix B.

2. About the Oxfordshire Safeguarding Adults Board

2.1 Our objective

The Board's objective, set by section 43 of the Care Act 2014, is to help and protect adults in Oxfordshire who have needs for care and support (whether or not the local authority is meeting any of those needs), who are experiencing, or are at risk of, abuse or neglect, and who, as a result of those needs, are unable to protect themselves against the abuse or neglect or the risk of it. The Board seeks assurance that safeguarding arrangements across the county are in line with Making Safeguarding Personal (that they are effective, person-centred and outcome-focused), and that partners learn and improve when things go wrong.

2.2 Membership

The Board's statutory core partners are Oxfordshire County Council, NHS Thames Valley ICB (formerly Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)), and Thames Valley Police. The wider membership reflects the breadth of the safeguarding system in Oxfordshire and during 2025–26 included: the five city and district councils (Oxford City, Cherwell, South Oxfordshire, Vale of White Horse, and West Oxfordshire, the latter supported by Publica); Oxford Health NHS Foundation Trust; Oxford University Hospitals NHS Foundation Trust; South Central Ambulance Service; the Probation Service; HMP Bullingdon; Oxfordshire Fire and Rescue Service; Public Health; Healthwatch Oxfordshire; and voluntary and community sector partners including Connection Support and Age UK Oxfordshire. During the year the Board welcomed the Department for Work and Pensions (DWP) as a member, reflecting the growing national focus on the DWP's safeguarding role, and strengthened links with the Prevention of Homelessness Directors' Group and the Making Every Adult Matter (MEAM) programme.

The Board is chaired by an Independent Chair, Dr Jayne Chidgey-Clark, and is supported by an Independent Scrutineer, Dr Dawne Garrett, whose work programme is described in Chapter 6. The Board has also benefited throughout the year from the contribution of its Lay Member, Tamsin Jewell, who provides independent, unaffiliated challenge and has chaired the Engagement Subgroup. The Board's business is supported by the Strategic Safeguarding Partnerships Manager, Steve Turner, and a Board Support Team.

2.3 How the Board organises its work

The Full Board met six times during 2025–26: on 21 May, 23 July, 30 September (the annual in-person meeting), and 19 November 2025, and on 21 January and 18 March 2026. The Board's work between meetings is carried out through its subgroups:

- the Business Group, which supports the Chair in planning the Board's work, monitoring the strategic plan, and managing governance;
- the Safeguarding Adults Review (SAR) Subgroup, which manages SARs, including discretionary SARs such as Homeless Mortality Reviews (HMRs), and the interfaces with Domestic Homicide Reviews and other statutory review processes;

- the Performance, Information and Quality Assurance (PIQA) Subgroup, which oversees safeguarding data, audits and quality assurance;
- the Learning, Development and Training (LDT) Subgroup, re-established in 2025 with a refreshed membership and remit, and prepares, commissions, and provides safeguarding-related training and learning across the partnership;
- the Policies, Procedures and Practice (PPP) Subgroup, which maintains multi-agency policies and horizon-scans emerging practice issues; and
- the Engagement Subgroup, which leads community engagement, public awareness and the voice of people with lived experience.

2.4 Strengthening our governance during the year

The Board made three significant improvements to its own governance in 2025–26. First, in June 2025 the former subgroup chairs' meeting was reconstituted as the Business Group, with a widened membership designed to ensure that all key perspectives, including Adult Social Care, are represented in the planning of the Board's work. The Group deliberately retains a supportive rather than decision-making role, so that decisions remain with the Full Board and duplication is avoided.

Second, the Board developed and, at its March 2026 meeting, adopted a strategic Risk Register. This is deliberately framed as a Board-level assurance tool, articulating risks to the Board's ability to discharge its statutory functions rather than duplicating partners' organisational risk registers. It is treated as a live document, reviewed through the Business Group, and includes explicit mitigations relating to Local Government Reorganisation: the Board will seek ongoing assurance on executive accountability for safeguarding, continuity of statutory functions during any transition, maintenance of independent scrutiny, and safeguarding workforce stability. Partners noted that few comparable board-level risk registers exist nationally, and the Board intends to share the approach through regional and national networks.

Third, the Board progressed a Joint Working Protocol with the Oxfordshire Safeguarding Children Partnership and other strategic partnerships, prompted in part by findings from a joint targeted area inspection that cross-partnership awareness of shared risks was insufficient. An informal summit of Oxfordshire's partnership chairs was convened during the autumn to map common risks, pressures and opportunities, and the protocol work continues into 2026–27. The Board also reviewed the embedding of 'Think Family' across its work with the Children's Partnership.

3. The year in context

The Board cannot assess the effectiveness of local safeguarding without understanding the environment in which partners are working. In July 2025, the Board made national changes a standing agenda item, so that every meeting includes structured feedback from partners on the local impact of national reform. The most significant developments during the year were:

3.1 The Casey Review and a National Safeguarding Adults Board

Baroness Casey's interim review of Adult Social Care, considered by the Board in March 2026, identified longstanding systemic weaknesses, including the absence of national-level oversight of safeguarding adults arrangements in contrast to the more developed national structures for children's safeguarding. The review recommended the urgent establishment of a National Safeguarding Adults Board and a review of existing statutory duties and powers under the Care Act, including powers of entry and whether current frameworks give practitioners sufficient leverage in high-risk situations. The Secretary of State endorsed these recommendations, committing to a national board chaired by the Chief Social Worker for Adults and reporting to the Minister of State for Care. Board members welcomed this as a step change in the profile of adult safeguarding, while noting the importance of understanding how national arrangements will align with local assurance. The Independent Chair will feed learning from the National Chairs' network back to the Board as arrangements develop.

3.2 NHS reorganisation

The NHS 10-Year Plan, the abolition of NHS England, and a required reduction of around 35 per cent in Integrated Care Board running costs have had a direct effect on safeguarding leadership locally. During the year, BOB ICB confirmed that it would cluster with a neighbouring ICB, with Thames Valley ICB forming from April 2026. Although the current leadership and representation has not changed, and this has allowed for work to continue and for there to be consistency of a 'health' voice in the membership of both the Board and sub-groups. The Board has received updates at every meeting, and the ICB's self-assessment (Chapter 11) is candid that priorities for the new organisation must be ratified by its incoming executive team. Separately, the announced abolition of Healthwatch England and the transfer of local Healthwatch functions to local authorities and ICBs raise questions about the future of independent patient voice; Healthwatch Oxfordshire continues business as usual pending legislation, and the Board will monitor the implications for independent scrutiny of care.

3.3 Local Government Reorganisation

Oxfordshire is subject to proposals for Local Government Reorganisation (LGR). At its March 2026 meeting the Board took the unusual step of hearing presentations on all three proposed models, one-, two-, and three- unitary configurations, specifically examining how each would sustain safeguarding accountability, partnership arrangements and governance. The Board did not advocate for any model. Instead, the Chair consistently reframed discussion towards assurance: whichever model is chosen must demonstrate clear executive accountability, preserved independent scrutiny, uninterrupted statutory safeguarding functions, explicit transition planning, and workforce stability. The Board submitted a response to the statutory consultation on this basis, and LGR-related risks are now held on the Board's Risk Register.

3.4 Policing and other national reform

The Police Reform White Paper signals a potential reduction in the number of police forces in England and Wales from 43 to between roughly 12 and 18, alongside changes to Police and Crime Commissioners. Thames Valley Police has briefed the Board on the possible implications and on significant budget pressures. The Board has also tracked: the Government's review into grooming and exploitation; sustained parliamentary scrutiny of the DWP's safeguarding practice, including the recommendation of a statutory safeguarding duty for the Department (the DWP presented its five-year safeguarding improvement programme to the Board in January 2026); updated national guidance on deaths of people experiencing homelessness, which changed the criteria for reviews (Chapter 5); and the transfer of responsibility for Drug and Alcohol Related Death Reviews (DARDRs) into local review structures, which in Oxfordshire will be hosted by the Board's SAR Subgroup from 2026–27 with dedicated Public Health funding.

Throughout these changes the Chair has asked partners to maintain transparency with one another about proposed changes so that impacts on other organisations, and above all on people with care and support needs, are understood early. The Board's horizon-scanning reports, prepared by the Board team for each meeting, have been repeatedly praised by partners and are cascaded within member organisations.

4. Delivering our Strategic Plan

4.1 The Strategic Plan 2025–27

In July 2025 the Board approved its Strategy and Action Plan for 2025–27, developed with subgroup chairs so that every subgroup workplan aligns with the Board's priorities and timelines. At its heart, the Strategy and Action plan is a full learning cycle: the Board's central commitment is that learning from reviews, audits, data and the experience of people with care and support needs is reliably identified, shared, embedded in practice, and evaluated for impact. The plan's priorities include:

- Identifying the learning: integrating learning from Board members' own governance and quality assurance, and facilitating cross-agency learning as a matter of routine;
- Sharing the learning: ensuring clear routes from reviews and audits into multi-agency training and directly to frontline practitioners;
- Embedding and evaluating the learning: building robust mechanisms to assess whether changes made as a result of learning have actually improved practice;
- Collaborative problem-solving: understanding and strengthening escalation routes for complex cases that sit across or between agencies; and
- Strategic governance: establishing effective executive-level connection across Oxfordshire's safeguarding landscape, including with the Children's Partnership and community safety structures.

In January 2026, the Board reviewed progress and concluded that delivery was generally on track, with only minor adjustments required and no major risks identified. The sections below, and the subgroup chapters that follow, describe the main achievements against the plan.

4.2 MARM and the launch of MARM+

The Multi-Agency Risk Management (MARM) framework supports adults with complex needs (often involving self-neglect, substance use, mental ill-health or homelessness) whose circumstances do not meet the threshold for a statutory section 42 enquiry, but who still face a high level of risk. The MARM Officer reported to PIQA twice during the year. Reporting in December 2025 covered 33 new referrals in the period, of which 23 did not meet the threshold (most because concerns were already being addressed by Adult Social Care or met statutory criteria), with 15 people open to the MARM pathway. Several people progressing through the MARM process have attended the meetings themselves, and have asked to attend again. The MARM officer has identified that the process works best when the person themself attends, which is a tangible expression of Making Safeguarding Personal. Identified complexities in presentation include people with co-occurring mental health and substance use needs (dual diagnosis), housing options for people with complex needs, and the availability of mental health expertise at MARM meetings.

Building on this foundation, and in response to a proposal from the MEAM programme for a 'Creative Solutions Forum', the Board chose not to create a new panel but to extend the existing framework. MARM+ was launched in January 2026, enabling the partnership to take on work relating to individuals who fall below statutory safeguarding thresholds but carry high associated risk, drawing in members of MEAM, homelessness services and other partners to find solutions, with case leadership to pass to

partner agencies over time. Two people had been referred before the January Board meeting; the Board judged this measured start as appropriate and will continue to monitor activity levels and manageability during 2026–27 before deciding whether criteria or capacity need to change. This is a deliberate test-and-learn approach rather than a permanent commitment.

4.3 Measuring quality and impact

Two linked pieces of work matured this year. PIQA finalised a Quality Assurance Framework for the Board, aligned with the equivalent framework in the Children's Partnership, which sets out how the Board gains assurance, including outcome measures rather than raw performance indicators, and embeds the question of how adults feel after a safeguarding intervention. At the Board's request, the Independent Scrutineer produced an Impact Measurement paper, agreed in January 2026, which establishes consistent definitions and shared language across the partnership, distinguishing audit, sampling and other evaluative approaches, so that partners of every level of experience can take part in quality assurance on a common footing. Both documents now underpin the revised partner self-assessment and peer review process described in Chapter 11.

4.4 Other strategic plan actions

- Recorded interviews with Board members were agreed as a means of making the Board's work more visible and accessible, with guidance developed by the Chair and Board Manager.
- The Engagement Subgroup reviewed the public directory of services to consider a simplified, more accessible version for the public.
- The Board agreed to defer a formal peer review challenge exercise pending the CQC assessment of the local authority, and revisited the question once the CQC report was published; peer self-assessment has instead been embedded within the revised annual self-assessment process.
- Direct lines of communication with the chief executives of statutory partners, and senior strategic meetings across Oxfordshire's partnerships and boards, replaced the previous action on MASA attendance, reflecting where strategic adult safeguarding influence can genuinely be exercised.

5. What the data tells us

5.1 Safeguarding activity in 2025–26

Demand for adult safeguarding in Oxfordshire continued to rise. Data reported to PIQA during the year showed the number of safeguarding concerns received running approximately a third higher than the previous year, at more than 200 concerns per month on average and the highest levels recorded since 2016. Between May and August 2025 alone, around 2,500 concerns were received. Importantly, the proportion of concerns converting to section 42 enquiries also rose year on year, from around 22 per cent to around 26 per cent at points in the year, suggesting that the increase reflects genuine need and improved recognition rather than only inappropriate referrals, although monthly conversion varied (26 per cent in April 2025, 22 per cent in May 2025, and around 20 per cent across May to August). Total referrals into the local authority's front door across all routes rose from around 11,000 to around 18,000.

The safeguarding activity recorded by the Local Authority, as the body with the statutory responsibility for safeguarding, is as follows:

Counts of Safeguarding Activity	Count
Total Number of Safeguarding Concerns	10865
Total Number of Section 42 Safeguarding Enquiries	1584
Total Number of Other Safeguarding Enquiries	553

In previous years, The Board has been asked about the demographics of those experiencing safeguarding. As such, the following tables have been included to provide a fuller picture of those experiencing safeguarding issues in Oxfordshire:

Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+	Not Known	Total
Individuals Involved In Safeguarding Concerns	2959	824	1468	1520	316	0	**7087**
Individuals Involved In Section 42 Safeguarding Enquiries	626	190	289	268	39	0	**1412**
Individuals Involved In Other Safeguarding Enquiries	222	70	103	92	13	0	**500**

Counts of Individuals by Gender	Male	Female	Not Known	Total
Individuals Involved In Safeguarding Concerns	3096	3971	20	**7087**
Individuals Involved In Section 42 Safeguarding Enquiries	605	802	5	**1412**
Individuals Involved In Other Safeguarding Enquiries	273	227	0	**500**

Counts of Individuals by Ethnicity	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known	Total
Individuals Involved In Safeguarding Concerns	5243	101	189	130	91	37	1296	**7087**
Individuals Involved In Section 42 Safeguarding Enquiries	1121	25	38	26	21	10	171	**1412**
Individuals Involved In Other Safeguarding Enquiries	399	7	13	12	3	4	62	**500**

	Concluded Section 42 Enquiries			Other Concluded Enquiries				
Counts	Source of Risk			Source of Risk				
	Service Provider	**Other - Known to Individual**	**Other - Unknown to Individual**	**Service Provider**	**Other - Known to Individual**	**Other - Unknown to Individual**	**Total Section 42**	**Total Other**
Physical Abuse	45	133	161	7	51	37	**339**	**95**
Sexual Abuse	6	41	70	0	11	12	**117**	**23**
Psychological Abuse	17	230	216	5	106	69	**463**	**180**
Financial or Material Abuse	23	225	206	4	99	62	**454**	**165**
Discriminatory Abuse	0	5	13	0	4	2	**18**	**6**
Organisational Abuse	42	38	58	6	10	12	**138**	**28**
Neglect and Acts of Omission	177	212	294	37	71	78	**683**	**186**
Domestic Abuse		209			83		**209**	**83**
Sexual Exploitation	0	13	20	0	2	4	**33**	**6**
Modern Slavery	0	7	13	0	3	2	**20**	**5**
Self-Neglect		407			199		**407**	**199**

The most frequent sources of referral remained care homes, health services and the police. Themes highlighted to PIQA during the year included a rise in domestic abuse concerns relating to women aged 20 to 40; rising self-neglect concerns among people aged over 50, with district council data showing hoarding-related casework up by around 25 per cent over two years; and increases in referrals from care homes relating to unwitnessed falls and pressure ulcers. Only a minority of concerns convert to statutory enquiries, and partners were candid that a 'notification culture', where the same event is reported to multiple agencies, and referrals reflecting unmet care needs rather than safeguarding, both add noise to the system. Understanding and improving the quality of referrals has therefore been a standing priority (section 5.3).

5.2 Member Transparency on Data Issue

In September 2025, the local authority identified a backlog of more than 2,200 police and ambulance notifications which had accumulated, some for up to three months, in an email inbox within the Social and Health Care customer service function. The issue was escalated immediately to the Board's September meeting by Social and Health Care. A corporate response was mobilised with chief executive and senior leadership oversight, with additional staffing procured. By January 2026, the backlog was cleared, with every case reviewed. Although no case in the backlog resulted in a SAR or HMR, the service was clear with the Board that this was incidental. By January 2026, all new referrals were being read and triaged within one working day, intake processes had been redesigned to remove duplication, training had been improved, and higher rates of recruitment were agreed to protect resilience. Partners have been asked to support the system by marking communications as 'urgent' or 'notification only', and the Board sought commitment statements from members that this had been cascaded. The Board will continue to seek assurance on the sustainability of the front door in 2026–27, including the planned use of automation to support triage. The Board Members appreciate the transparency in raising and sharing this and the actions taken to resolve it, which also acted a good role modelling for transparent working practices across the organisations.

5.3 Quality of referrals and audit activity

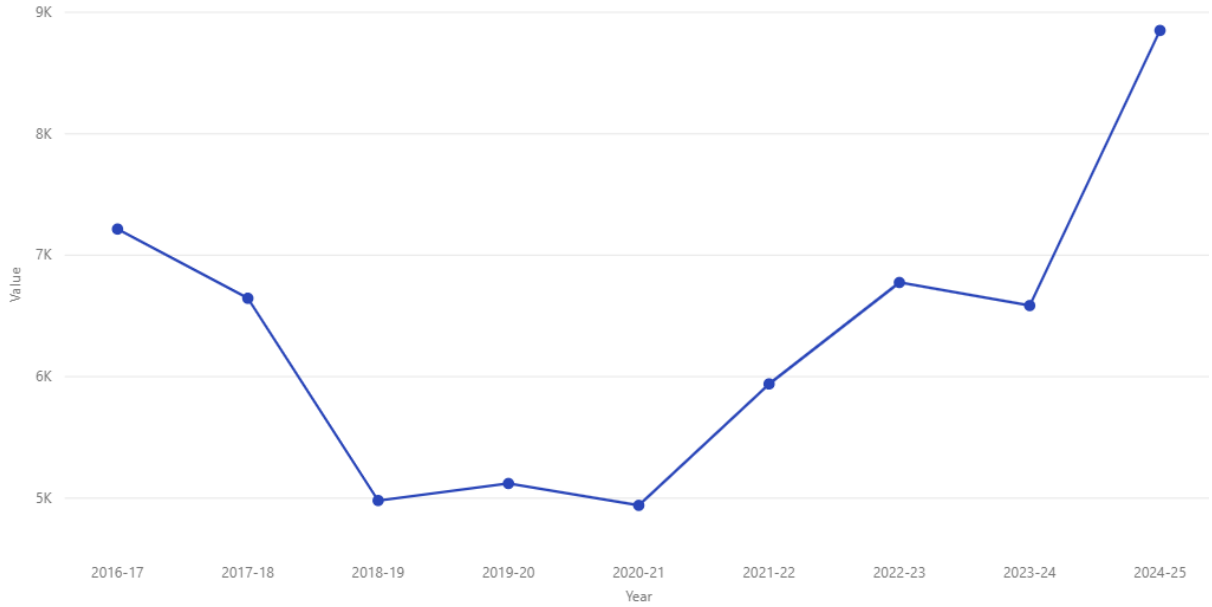
PIQA worked on an initiative to create a rota of focused agency-level audits, allowing for specific and actionable findings from referral themes. Oxford Health presented an audit of five referrals across mental health and community services, showing largely timely referrals with clear recording of care and support needs, but weaker and less consistent recording of consent, an honest finding that mirrors the wider partnership picture. South Central Ambulance Service reported an improvement plan for referral quality, including strengthened training for call handlers and a move to digital referral routes. The local authority planned an audit of concerns that do not meet threshold criteria, delayed by the autumn backlog and rescheduled into 2026. Audit findings across the year consistently indicated that the application of Mental Capacity Act assessments, particularly executive functioning, and the consideration of advocacy require continued attention; PIQA's assessment is that this reflects confidence and opportunity to apply training rather than lack of awareness, and partners are responding through action plans, re-audit cycles and targeted Mental Capacity Act learning sessions.

5.4 Building a better dataset

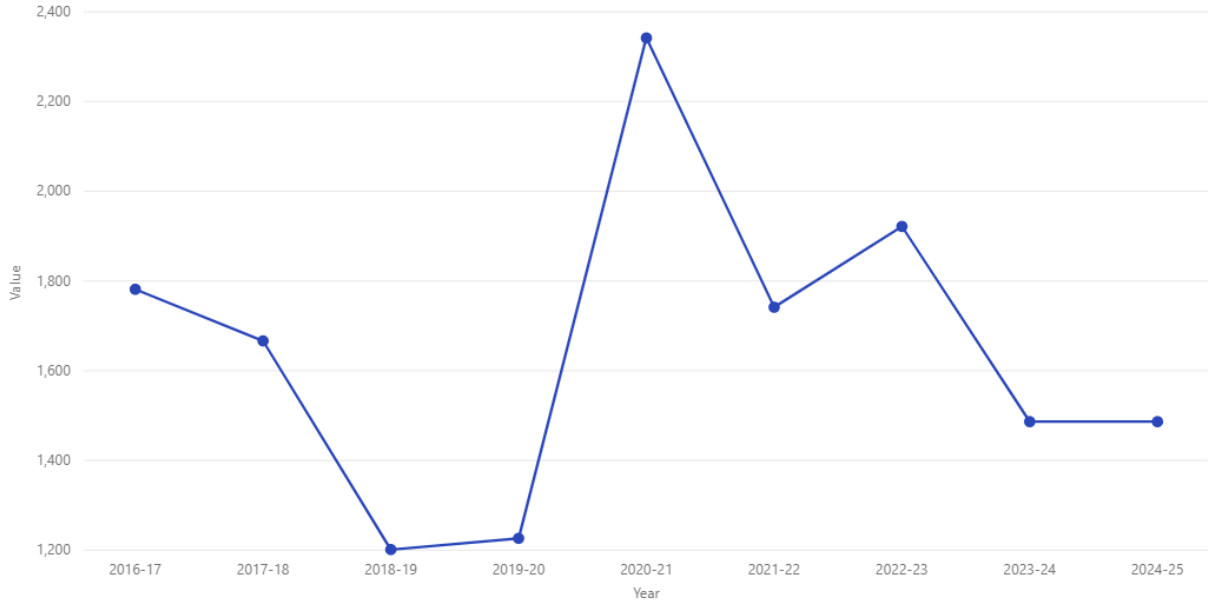
PIQA has invested significant effort in the Board's future dataset. The local authority's Power BI safeguarding dataset has been redeveloped with filtering, methodology notes and alignment to the national Safeguarding Adults Collection, with health data separable by organisation. In December 2025, PIQA held a dedicated information workshop, scoping what data the whole partnership, not just the local authority, holds and what the Board genuinely needs for assurance, guided by proportionality and meaningfulness rather than volume. This work, together with the Quality Assurance Framework, will produce a regular performance and quality report to the Full Board from 2026–27. The Board is aware that its current data cannot yet provide a full picture of the partnership's workstreams; being explicit about that gap, and fixing it, is itself an assurance activity.

5.5 Safeguarding Across the Years

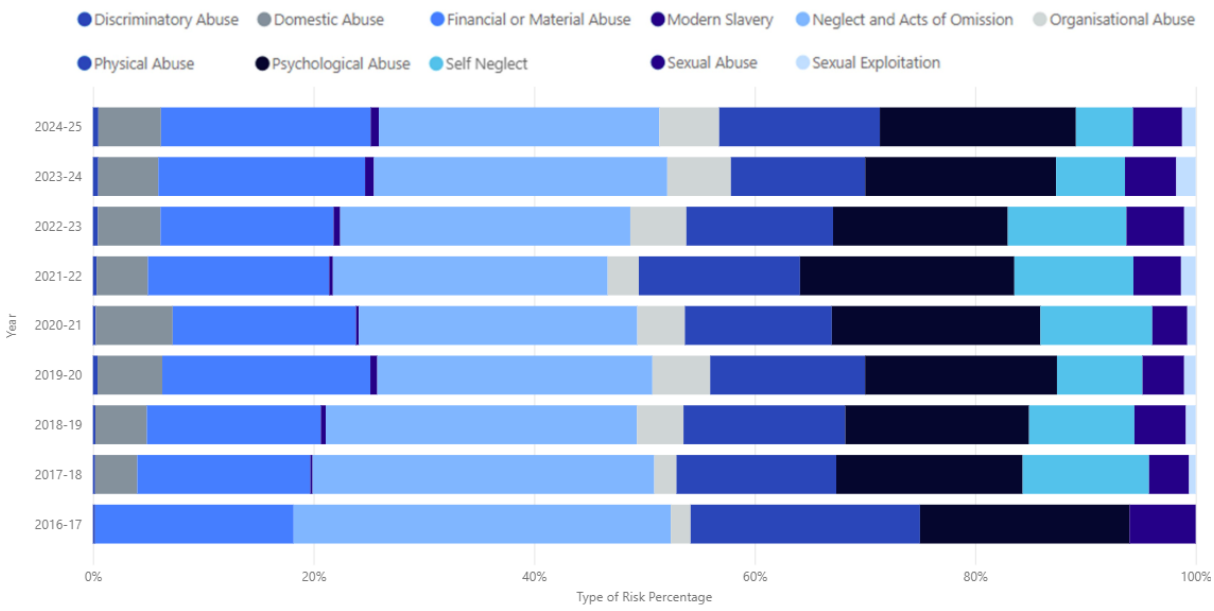
In 2025-26, the total number of safeguarding concerns was 10,865. When we put this in context of the total number of concerns over the past 10 years, we see a continued upward trend that has emerged since COVID-19:



Despite this upward trend in concerns, the number of safeguarding enquiries has not tracked this trend. The 2025-26 figure is 1,584 safeguarding enquiries. This puts the figure as a slight increase on the previous two years but still below the figure since COVID. It should be noted that if we look back to 2016-17 and 2017-18, the 2025-26 figure is not out of line. The line chart below shows change over time.



If we look at the trends in the types of abuse over the years, the categories have broadly remained the same year on year. The percentage breakdown for 2025-26 is an almost identical match with the years from 2022-23 and before. The variance in self-neglect has not been investigated but does align with the broader promotion of the MARM process, which may be a contributory factor.



6. Safeguarding Adults Reviews and Homeless Mortality Reviews

6.1 Our approach

Section 44 of the Care Act 2014 requires the Board to arrange a Safeguarding Adults Review (SAR) where an adult with care and support needs has died or suffered serious harm as a result of abuse or neglect (known or suspected), and there is concern that partner agencies could have worked more effectively to protect them. The Board may also arrange discretionary reviews in other cases where there is multi-agency learning. In Oxfordshire, the Board additionally undertakes Homeless Mortality Reviews (HMRs): locally-developed, proportionate reviews of the deaths of people experiencing homelessness, so that learning is captured from their lives and deaths . Oxfordshire's HMR programme remains at the forefront of national practice, and this year the Board aligned its scoping with the updated national position, under which reviews focus on people at high risk of death who were known to agencies for at least six months. Applying the new criteria retrospectively to 21 referrals from 2024–25 confirmed the existing programme's judgements, with only two closed cases that would have been assessed differently.

All reviews are managed through the SAR Subgroup, chaired by the Head of Adult Safeguarding at the ICB, with the dedicated HMR Coordinator managing the homelessness reviews. During the year the subgroup introduced a strengthened governance process under which draft overview reports receive formal senior leadership sign-off in every involved agency before anonymisation and publication. Partners have told the Board this supports internal review, early identification of learning needs, and constructive challenge between agencies before reports enter the public domain. Pseudonyms are used throughout to protect the identity of the people concerned; unpublished and ongoing cases are described in aggregate only.

6.2 Reviews concluded in 2025–26

The Board approved four Homeless Mortality Review reports for publication during the year. Each is, or will be, available on the OSAB website in full anonymised form with an accessible summary. A short summary of the people who were subject to a review can be found below. **Section 6.5 covers the learning from the reviews**.

Harry

Harry was an man in his 50s. The review generated significant learning about the safety of staff and community members working alongside people in crisis and prompted a distinct workstream with Thames Valley Police and voluntary sector partners on staff and community safety, on which the Board received a follow-up report. Because children were involved with agencies connected to Harry's case, the learning was also formally shared with the Oxfordshire Safeguarding Children Partnership, in line with the Board's Think Family commitment.

Jenny

Jenny was a woman in her 50s with a long history of housing support who entered the homelessness pathway following complex financial and personal circumstances. Her review was approved by the

Board in March 2026, subject to a minor clarification in the public summary, raised through lay challenge, regarding references to her children.

Kane

Kane was a man in his 30s. His review, approved in March 2026, identified the safeguarding risks associated with large backdated benefit payments and the heightened vulnerability to financial exploitation and abuse that can follow, alongside learning about aggression, environmental risk, and the safety of professionals working in high-risk settings. The findings have directly informed the Board's engagement with the Department for Work and Pensions, which has provided named escalation contacts for financial abuse and 'cuckooing' concerns in Oxfordshire.

Leos

Leos was a man in his 60s. His review, approved in March 2026, captured positive examples of practice as well as areas for improvement, particularly examples of professional persistence and communication. This review deliberately captured what practices worked well in the case of Leos; reviews that only catalogue failure teach practitioners to fear scrutiny rather than engage with it.

Other Reviews

In addition, the reviews of Florian and Eric, approved at the end of 2024–25, were published at the start of this year. Learning from Eric's review about the assessment of people transitioning from 24/7 supported accommodation to dispersed accommodation was followed through during the year, with a review of the transition process and of every agency's incorporation of the learning.

6.3 Reviews ongoing as of 31 March 2026

The table below summarises the position at year end. This has been a year of exceptional review activity: the subgroup has repeatedly reported the sustained volume and complexity of cases and the cumulative impact on partner agencies, which the Board has acknowledged and kept under review.

Review	Type	Position as of 31 March 2026
Ivy	HMR	Overview report signed off by agencies; final anonymised report and summary in preparation for Board approval and publication. Learning shared with the Children's Partnership.
Matthew, Paul and Oliver	HMR (amalgamated)	Three thematically linked reviews conducted through a single joint process examining temporary accommodation, staff support and risk assessment. Anonymised and summary reports in preparation.
Nadine	HMR	Overview report signed off; anonymised and summary reports in preparation.
Four further HMRs	HMR	Multi-agency review meetings completed during autumn 2025; draft overview reports at senior sign-off or final drafting stage.
Two HMRs (desktop)	HMR	Proportionate desktop reviews in progress following return of scoping information.
One HMR	HMR	Proceeding to full review with a new triage-meeting model, the first case to use this approach.

Review	Type	Position as of 31 March 2026
Three potential HMRs	HMR	On hold pending cause of death, a criminal trial, and a provider Patient Safety Incident Investigation respectively, and will be reconsidered when those processes conclude.
SAR 'A'	SAR	Independent author appointed after earlier difficulty securing authorship; documentation reviewed and panel process nearing completion.
SAR 'B'	SAR	Independent author identified; documentation reviewed and panel process nearing completion.
SAR 'C'	SAR	Escalated from the HMR programme to a full SAR focusing on hospital discharge and support for C as an amputee living alone, and on the interface with Right Care Right Person.
SAR 'D'	SAR	Author being sought; the subject's wish not to participate is being respected while the statutory review proceeds.
SAR 'E & F'	SAR (desktop)	Desktop review circulated; comments received and being incorporated ahead of a final sign-off period.
SAR 'G'	SAR	Learning under consideration regarding an out-of-area placement discharge and divergent mental capacity assessments between the placing and receiving areas.

6.4 Decisions not to proceed

The statutory guidance requires the Board to explain decisions not to implement findings or not to proceed with reviews. The Board is transparent about these judgements:

- A referral concerning an elderly couple, in which the husband, who had dementia, killed his wife before taking his own life, was carefully scoped with all agencies. The subgroup concluded there was no evidence of multi-agency failure or learning and the statutory criteria were not met; the decision and reasons were fed back personally to the referring district council.
- The death of 'AA', a man who died shortly before taking up a long-term tenancy, did not meet HMR criteria. Rather than closing the case, the subgroup asked the involved provider, Connection Support, to conduct an internal review and present it to the subgroup, which it did in August 2025. The review found well-recorded support, appropriate professional curiosity and proportionate inter-agency working, and identified positive learning about record-keeping and risk-assessment skills. The subgroup has adopted this provider-led review-and-present model for future cases that sit below review thresholds but merit examination.
- A case referred from another area's board, concerning a person placed in Oxfordshire, was reviewed with local agencies, who accepted the findings; the learning was assessed as principally relevant to the placing area, and no separate Oxfordshire action was required.
- One case initially considered as an HMR was accepted instead by the relevant Community Safety Partnership as a domestic homicide-related review.

6.5 Learning from reviews

Recurring themes across this year's reviews will be familiar to safeguarding partnerships nationally, and the Board's response is described in section 6.6:

- *Self-neglect, and the assessment of executive function within mental capacity assessments*: people may be able to describe what they should do while being unable to carry it out, and assessments that miss this gap create risk.
- *Homelessness and multiple disadvantage:* the interaction of housing instability, substance use, mental ill-health and physical illness, including the adequacy of temporary accommodation, support during moves to independent accommodation, and palliative and end-of-life care for people with complex needs.
- *Professional curiosity and multi-agency working:* role clarity, escalation between agencies, and the courage to ask further questions.
- *Advocacy:* ensuring access to advocacy is actively considered, and recognising when family members may not be best placed to act as advocates.
- *Financial abuse and exploitation:* including the risks that follow large backdated benefit payments and 'cuckooing'.
- *Transitional Safeguarding:* between children's and adults' services, between 24/7 and dispersed support, and on discharge from hospital or out-of-area placements.

The Board's strategic plan is explicit that identifying learning is worthless unless it changes practice. During 2025–26 the Board built a substantially stronger implementation architecture:

- A Summary of Learning document, drawing together repeated themes across HMRs, was produced and agreed in October 2025 and shared with all member agencies. Each agency is asked to return a formal commitment statement setting out how it will address the learning relevant to it, and agencies are explicitly not asked to respond to learning that does not affect them. The subgroup is extending the same commitment mechanism to follow-up actions from individual reviews.
- Where a learning theme recurs (i.e., professional curiosity), the SAR subgroup now asks first whether previous actions have had time to embed, and if they have, if/why they were ineffective, rather than layering new actions on old. A scrutiny process has been laid out to evaluate whether these processes have been effective over time, and whether an increase in theme identification is a reflection of increasing awareness or a real trend. Partners have challenged one another to avoid 'training' and 'supervision' becoming default answers that bypass genuine service improvement.
- The learning from reviews flows into the LDT Subgroup's training programme (Chapter 10), and each partner now presents to LDT in rotation on how it disseminates and applies review learning internally.
- Work is underway, reported to the Board in March 2026, to develop a clear mechanism for partners to evidence how learning from reviews has been successfully implemented, closing the loop from finding to changed practice; this will be finalised during 2026–27.
- Recurring findings on mental capacity and advocacy will now be discussed explicitly with independent review authors so that recommendations are consistent and actionable.

The subgroup has also innovated in method: amalgamating three thematically similar reviews into a single joint process, which participants found more efficient and more revealing than three separate reviews; trialling proportionate desktop reviews; introducing a triage meeting before commissioning full reviews; and inviting presenters from reviews to inform public health planning. Finally, the interface with Domestic Homicide Reviews has been strengthened through the Domestic Abuse Strategic Board following a year in which nine domestic-abuse-related death notifications were received in a single week, and the subgroup escalated regionally the pattern of deaths in temporary accommodation to test whether this is a national rather than purely local issue.

7. Independent scrutiny

The Independent Scrutineer, Dr Dawne Garrett, delivers a rolling programme of focused scrutiny agreed with the Board, and reported formally to the Board in May and July 2025 and through PIQA thereafter. The 2025–26 programme comprised:

7.1 Principles for Safeguarding Interventions for People Experiencing Self-Neglect

Prompted by the prominence of self-neglect in national and local reviews, the Scrutineer led the development of a principles document for first responders and frontline professionals, built on a year of local data and a survey of frontline workers.

The five principles are: **Making Safeguarding Personal** for people who self-neglect, including preferred communication, sensitivity to power dynamics, consistent access to advocacy, and recognition of carers and protected characteristics; **multi-agency and multi-disciplinary working**, including a coordinating chair function that can cut across agencies; **flexibility of service provision**, allowing for and encouraging multiple methods of outreach, care, and follow-up; **staff support and training**, including support for professional curiosity; and **commissioning and service development**. The Board approved the Principles in May 2025; a task and finish group completed dissemination and operationalisation during the year, producing resources partners can use in training and practice, with an accessible voiceover version published on the OSAB website. Evaluation mechanisms have been identified and incorporated into PIQA's quality assurance, with formal evaluation planned across 2026 and 2027. The work has attracted interest beyond Oxfordshire, and the Chair and Scrutineer have shared it with other Boards, including in dialogue prompted by Somerset's thematic review of self-neglect SARs.

7.2 Barriers to professional curiosity, and 'safe curiosity'

The Scrutineer's Barriers to Professional Curiosity Report was finalised and presented during the year, complemented by a partnership-wide Professional Curiosity Survey (which drew responses from children's as well as adults' practitioners) and a Learning from Reviews workshop. The synthesis, presented to the Board in September 2025, was clear: practitioners report high workloads, over-use of quick fixes, fear of blame, power imbalances, emotional burnout, leadership disconnects, and review processes that can feel mechanical and sanitised. The resulting framework, 'Curiosity and Learning to Improve Safeguarding Practice', sets out differentiated actions: for senior leaders, promoting a just culture, addressing workload pressures, encouraging near-miss reporting and modelling non-defensive responses; for team managers, protecting reflection time and providing psychologically safe supervision; and for frontline practitioners, fostering safe curiosity, peer support, and collaborative inter-agency relationships. Board members agreed to seek commitment statements from their organisations on safe curiosity, and a joint task and finish group with the Children's Partnership's quality assurance group has been established. The work has attracted national interest, and a professional curiosity webinar is in development.

7.3 Transitional safeguarding, Deprivation of Liberty Safeguards and other scrutiny

Scrutiny of transitional safeguarding, the journey from children's to adults' services and other transitions of care, continued throughout the year. This includes a presentation to PIQA on the Moving into Adulthood service, which supports around 405 young people with eligible needs, and work on the data challenges of tracking whether adults in safeguarding services were previously known to children's safeguarding. The scrutiny goals for Deprivation of Liberty Safeguards backlogs set in 2024 were completed. On care home referral conversion rates, the Board accepted the local authority's position that this is primarily a matter for the authority and the regulator, with ongoing feedback through PIQA rather than a standalone Board project, an example of the Board deciding deliberately where its scrutiny adds value and where it duplicates. The Scrutineer also authored the Impact Measurement paper (Chapter 4) and, at the year end, handed over the interim chairing of PIQA to the local authority's Head of Safeguarding with Oxford Health's Head of Safeguarding as deputy, strengthening the separation between scrutiny and operational assurance.

8. The work of our subgroups

8.1 Performance, Information and Quality Assurance (PIQA)

PIQA met five times in the reporting year. Its principal achievements, the Quality Assurance Framework, the redeveloped dataset, the December information workshop, the MARM oversight role, and the agency-by-agency referral quality audits, are described in Chapters 4 and 5. PIQA also received the transitional safeguarding presentation and dataset work, oversaw the self-neglect audit undertaken by Cherwell District Council (a 25 per cent rise in hoarding casework over two years, a slight male predominance in self-neglect reporting, and evidence that improved training in distinguishing neglect from self-neglect has increased recognition), and agreed that the Prevention of Homelessness Directors' Group will report its homelessness outcome measures to PIQA twice yearly rather than duplicating the analysis. From March 2026 the subgroup has a new chair and deputy chair and a mandate to deliver a regular performance and quality report to the Full Board.

8.2 Learning, Development and Training (LDT)

The LDT Subgroup was re-established in mid-2025 with new Terms of Reference, an agreed workplan aligned to the strategic plan, and a Learning, Development and Training Framework describing how learning moves from identification to frontline delivery. Its work, including quarterly training reports, the move to bite-size sessions, and rotating partner 'highlight reports' on how each organisation embeds learning, is described in Chapter 10. Learning from SARs is now explicit in the subgroup's objectives at partners' request.

8.3 Policies, Procedures and Practice (PPP)

The PPP Subgroup finalised the refresh of the multi-agency procedures document, continued the programme of policy work on hoarding, and led horizon scanning on emerging practice issues including assisted dying, the implications of artificial intelligence and robotics in care, devolution, and harm reduction. The subgroup reviewed the updated Pan-London safeguarding procedures (which now cover cultural competence, professional curiosity, digital risk, online harm and homelessness) to identify content for local adoption, alongside external materials such as Bromley's advocacy procedure and Cheshire West's self-neglect prompts. A new chair took office in February 2026, and the subgroup is trialling an innovative operating model; the subgroup will now have a reduced meeting frequency supported by digital governance for routine policy approvals, retaining face-to-face discussion for complex matters. The Board noted that this approach may hold lessons for and potential use in other subgroups.

8.4 Engagement Subgroup

A year ago, declining attendance at the Engagement Subgroup was a standing escalation to the Board. This year the position transformed: 18 organisations were represented at the January 2026 meeting, and the subgroup delivered the most extensive Safeguarding Adults Awareness Week programme to date (Chapter 11) alongside the Easy Read version of the annual report. The one persistent attendance gap, the commissioned advocacy provider, has been pursued through multiple routes and escalated through the Business Group, and advocacy engagement was re-established by the year end. The

subgroup began a review of its Terms of Reference focused on strengthening the capture of service-user voice, which members judge less developed than community-level engagement, and explored bringing community organisations, including African Families in the UK, into the subgroup. Oxford Health offered alignment with its developing lived-experience governance structures. Tamsin Jewell stepped down as chair after the year end, with the Board's Connection Support representative taking on the role, keeping the chairing of the subgroup outside the statutory agencies.

8.5 Business Group

The reconstituted Business Group met five times, supporting the Chair on agenda planning, the strategic plan, the risk register, the response to Local Government Reorganisation, subgroup escalations, and preparation for the National Chairs' and Managers' networks. It also handled matters including the Board's engagement with the national LeDeR (Learning from Lives and Deaths of people with a learning disability and autistic people) position (below) and Person in a Position of Trust (PiPoT) leadership arrangements in the local authority.

8.6 Holding the wider system to account

Beyond its own structures, the Board used its convening power during the year to seek assurance on system issues:

- **LeDeR** (Learning from Lives and Deaths of people with a learning disability and autistic people): the Board identified and escalated a backlog which had reached 206 unreviewed cases, driven by staffing loss and ICB reorganisation. The position was escalated within the ICB to chief executive level and by the Chair and Board Manager through the national chairs' and managers' networks. An interim Local Area Contact has been appointed, prioritisation and automation approaches agreed, and families contacted transparently. The Board was clear about its concern that learning drawn only from deaths, rather than lives, risks missing key insights, and has scheduled a further update for 2026-27. It should be remembered that there are internal review processes of the health organisation (PSIRF, PSII) in place and any identified learning is put into place together with additional front line staff training
- **Homelessness**: the Prevention of Homelessness Directors' Group presented its strategy and annual report to the Board, and the Making Every Adult Matter programme presented case-based evidence of what it takes to support people facing multiple disadvantage, which led directly to the MARM+ development.
- **Suicide prevention**: Public Health presented the county's suicide prevention strategy, noting around 350 deaths by suicide in Oxfordshire between 2017 and 2023, 75 per cent of them men, and its five focus areas including priority groups such as men in their thirties and survivors of domestic abuse. The Board pressed on the interface between domestic abuse and suicide and on data sharing with review processes.
- **Integrated Neighbourhood Teams**: the ICB presented the developing neighbourhood health model, and the Board pressed for safeguarding to be designed in from the start, including access to statutory records and measurement through conversion rates rather than raw counts of concerns.
- Following horizon scanning in November 2025, the Board issued **three formal assurance asks of partners:** that training on executive dysfunction in self-neglect is commissioned and delivered

and that local policies explicitly reference assessment of executive function; that a multi-agency protocol for cuckooing and home invasion exists or is in development with clear intelligence-sharing pathways; and that professional curiosity about housing status, including sofa surfing, and robust escalation pathways are embedded. Responses were tracked back through the Board during early 2026.

- **Community Safety:** The Board has continued to strengthen links with the Safer Oxfordshire Partnership, recognising the overlap between adult safeguarding, domestic abuse, exploitation, homelessness, substance misuse, cuckooing and community safety priorities.

9. Learning, development and training

9.1 The multi-agency training programme

The Board's multi-agency training programme is overseen by the LDT Subgroup and delivered by the Board's training lead with growing contributions from partner agencies themselves. The subgroupnow receives a quarterly training report covering bookings, completions, attendance and learner feedback. Illustrative activity reported during the year included, in a single quarter, 706 e-learning bookings with 629 passes across Level 1–3 safeguarding, Making a Safeguarding Referral and Modern Slavery; and a trauma-informed practice webinar series (trauma and language; trauma, stigma and belonging; advanced trauma-informed practice; and preventing burnout and secondary trauma) attended by 67 practitioners in its first two sessions, with feedback describing the sessions as relatable, supporting strengths-based development, and confidence-building, alongside requests for more scenario-based content which have been incorporated.

9.2 Accessible learning: the bite-size model

Attendance data and practitioner feedback showed that staff struggle to protect time for longer sessions, driving cancellations and no-shows. The LDT subgroup responded by introducing bite-size sessions of no more than an hour, beginning with a well-received MARM session during Safeguarding Adults Awareness Week, with a forward programme co-delivered by partner agencies covering topics such as hoarding, housing-related safeguarding, and modern slavery and exploitation. A blended model for Level 2/3 training, e-learning as a prerequisite followed by shorter face-to-face sessions built around case discussion, is in development. A pre-recorded learning disability awareness resource produced by My Life My Choice was promoted across the partnership, and culturally aware, trauma-informed e-learning for staff working with refugees and people seeking asylum is being explored.

9.3 Non-attendance

In March 2026, the LDT subgroup examined non-attendance, distinguishing unavoidable cancellations from no-shows, which carry direct licence costs (currently absorbed centrally), deny places to others on fully booked courses, and blunt the system's learning capacity. Options under evaluation for 2026–27 include organisational-level (not individual) reporting of attendance patterns, mandatory line-manager details in the booking system, line-manager notifications, and, informed by the Children's Partnership's experience of a non-attendance charge, whether financial recovery mechanisms would change behaviour without adding blame or administrative burden. The subgroup was deliberate that accountability must not be confused with blame, and that any response must be proportionate to workforce pressures.

9.4 Learning from each other

A rotating 'highlight report' now sees each member organisation present to the LDT subgroup on how it identifies, disseminates and embeds safeguarding learning. Oxford Health opened the series, describing learning prioritised in its annual plan, tracked through its risk management system, cascaded through committees, learning huddles, supervision groups, a monthly newsletter and thematic webinars, and reported to the ICB. The subgroup also pursued a shared understanding of

Level 4 safeguarding training, sharing organisational interpretations and addressing practitioner confidence in applying learning, particularly on mental capacity, which echoes the audit findings in Chapter 5.

10. Engagement, voice and prevention

10.1 Safeguarding Adults Awareness Week 2025

Safeguarding Adults Awareness Week in November 2025, on the national theme of prevention, was the Board's most extensive to date, described by the Chair of Engagement Subgroup as the most well-organised yet. The programme included a daily partnership newsletter; webinars including a session on preventing the next generation of rough sleepers; podcasts and case stories; the first bite-size MARM training; briefings across partner organisations; and public-facing activity including a local authority stall at Westgate Library in Oxford. The week also generated learning for the Board itself: most public conversations at the library concerned social isolation and loneliness rather than 'traditional' safeguarding categories, and the Board has agreed to consider social isolation within its future prevention activity. Honest evaluation identified that session timings limited turnout for some public events and that newsletter reach beyond the partnership was limited, which will shape the next year's planning.

10.2 Community engagement and the voice of lived experience

The Engagement Subgroup's recovery in attendance and reach is described in Chapter 8. During the year, the Board deepened engagement with community organisations, including African Families in the UK, whose route into the partnership is being developed through the Engagement Subgroup with clear ground rules, so that community voice is genuinely embedded rather than tokenistic. The Board also reflected on national safeguarding cases in which neighbours did not report concerns for fear of being perceived as discriminatory, and has emphasised in its public messaging that people should raise concerns even when uncertain. Strengthening the direct voice of adults with care and support needs, as distinct from community-level engagement, is a priority the subgroup has set itself for 2026–27, with Oxford Health offering alignment with its developing lived-experience governance structures. Work continues with advocacy providers, whose renewed engagement with the subgroup the Board welcomed, alongside recognition in reviews and audits that advocacy must be actively considered in safeguarding practice.

10.3 Resignation of the Lay Member

The Lay Member notified the Board during the year of her intention to step down after nine years as Lay Member. The Board formally recorded its thanks for her independent challenge, leadership of the Engagement Subgroup, and sustained focus on lived experience and public voice. The Board confirmed its clear support for retaining a lay role, alongside the Independent Chair and Independent Scrutineer, as a third strand of independence, and a role description and recruitment approach, drawing on partner and community networks, is being developed for 2026–27.

11. What our member organisations have done

11.1 A strengthened self-assessment and peer review process

In 2025–26, the Board substantially strengthened how it gains assurance from each partner that they are implementing the strategy of the Board. A revised self-assessment template was developed through PIQA and its children's counterpart, comprising 29 questions across seven domains: Leadership and Accountability; Strategy and Working Together; Service Delivery and Practice; Commissioning and Quality Assurance; Recruitment, Training and Learning; Listening and Personalisation; and Reflection and Improvement. Each response requires evidence from the past year, a RAG (red, amber, green) rating, and, for any amber or red rating, the actions being taken. Additionally, each return requires senior manager or board-level sign-off. Returns are followed by peer review discussions in small clusters of organisations, so that partners test and challenge one another's assurance rather than simply filing returns. This approach responds directly to many members' calls for more system-level scrutiny of each organisation's safeguarding arrangements.

11.2 The overall picture

Fourteen member organisations submitted self-assessment returns covering 2025–26. No organisation rated itself Red against any question. The great majority of ratings were Green, with Amber ratings concentrated, tellingly and consistently, in three areas: enabling diverse service-user involvement in designing and improving services; converting learning into demonstrable impact; and questions affected by organisational transition (most notably for the ICB and for organisations preparing for Local Government Reorganisation). The Board draws two conclusions. First, the fundamentals of safeguarding leadership, governance, policy and training are well embedded across the partnership. Second, the partnership's collective development areas, voice, impact, and resilience through change, precisely mirror the Board's strategic priorities, which gives the Board confidence that its strategy is aimed at the right problems. The Board also notes, as a matter of honest reporting, that a small number of returns were submitted without RAG ratings selected or were incomplete at the time of drafting, and these are being followed up through the peer review process.

NB: It should be noted that the returns were received in year 2026-27 but are commenting on work undertaken during 2025-26.

11.3 Member summaries

The summaries below are drawn from each organisation's own return and its contribution to the Board's work during the year. They are necessarily brief; the peer review discussions consider the full returns.

Oxfordshire County Council – Adult Social Care

The lead statutory safeguarding agency reported sustained commitment through clear governance, oversight of complex cases and a strong learning culture, evidenced most powerfully this year by the CQC assessment: an overall 'Good' rating (a score of 64 under the new assurance framework), with the safeguarding quality statement rated Good and governance and safeguarding described as strong, and a reduction in people waiting over 12 weeks for safeguarding enquiries from 286 to 18 despite a 33

per cent rise in demand (the service's own priority tracking shows enquiries over 12 weeks falling from over 70 to 16 in the year). The service was equally honest about its Amber areas: embedding co-production and diverse service-user involvement, converting constructive challenge and SAR learning into tracked improvement, and sustaining practice under rising demand and complexity, notably self-neglect and hoarding and provider-related concerns. Its priorities for 2026–27 include strengthening frontline practice and supervision, performance grip and quality assurance, and the response and transparency shown over the autumn referral backlog (Chapter 5) demonstrated its accountability to the partnership in practice.

Oxfordshire County Council – Public Health

Public Health, whose safeguarding role is principally exercised through commissioning, reported safeguarding embedded in all contracts and grants through dedicated safeguarding schedules, director-level representation on the Board, and leadership of the suicide prevention strategy presented to the Board in November. It was candid that its assurance is necessarily indirect, rating several commissioning-assurance questions Amber, and its priorities for the coming year are strengthening safeguarding oversight within contract management and more consistent embedding of learning across commissioned services. Public Health has also funded the coordinator post that will enable Drug and Alcohol Related Death Reviews to be hosted by the SAR Subgroup, and the Oxfordshire Migration Partnership prioritised the safety and voice of refugees across its delivery.

Oxfordshire County Council – Children's Services and Education

Children's Social Care reported a year of stabilisation and improvement: reduced reliance on agency social workers, a permanent senior leadership team for the first time in eight years, navigation of joint targeted area and SEND inspections, a review of the exploitation team, and an updated quality assurance framework, with development areas in service-user involvement and refreshing staff awareness of safeguarding contacts. Its participation in this Board's self-assessment reflects the partnership's Think Family commitment and the growing joint work on transitional safeguarding described elsewhere in this report.

Oxfordshire Fire and Rescue Service

The Service reported safeguarding embedded across prevention, protection and operational activity, particularly through Safe and Well visits and targeted work with vulnerable residents, with clear designated safeguarding lead arrangements aligned to county council policies. Its priorities centre on early identification of hidden vulnerability, including hoarding, social isolation and unmet care and support needs, themes that align closely with the Board's own findings this year. Through PIQA, the Service has also prompted the Board to reconsider the routine collection of Safe and Well visit data within the partnership dataset. The Service has also strengthened routes for identifying and escalating safeguarding concerns through Safe and Well activity, supporting earlier intervention for adults experiencing self-neglect, hoarding, social isolation and other vulnerabilities.

Thames Valley Police

The Oxfordshire Local Command Unit reported safeguarding as a visible priority driven through performance boards, daily management meetings and tasking, with increased supervisory oversight of vulnerability-related incidents and improvement in the quality of risk assessments, domestic abuse

submissions and referrals. The year's priorities included risk assessment quality in domestic abuse, capturing the voice of the child, and improving justice outcomes; priorities for 2026–27 focus on protecting those most at risk, preventing harm from domestic abuse, exploitation and fraud, and reducing repeat victimisation. TVP restructured to a single county-wide operating model during the year, absorbed significant budget pressure, and was open with the Board about the workload impact of the growing review programme. Its challenges back to the Board centre on timeliness and consistency of information sharing and joint training.

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

BOB ICB reported statutory accountabilities discharged in line with the NHS Safeguarding Accountability and Assurance Framework, system-wide policy development including a new stand-alone Prevent policy, and chairing of the Board's SAR Subgroup through a year of exceptional review volume. It has done this while planning its own reorganisation: its return is honest that, as a new clustered organisation from April 2026, safeguarding priorities must be ratified by the incoming executive, and that website and contact information for safeguarding leads needs re-establishing, both rated Amber with actions attached. The Board will seek early assurance from the new organisation on safeguarding leadership capacity and records its recognition of the ICB safeguarding team's contribution under sustained uncertainty for the coming year.

Oxford Health NHS Foundation Trust

Oxford Health reported Board-level safeguarding oversight through its Chief Nurse, priorities delivered on the Mental Capacity Act (including for 16- and 17-year-olds and improvements to electronic record forms for MCA, DoLS and best interests decisions), a structured learning architecture (annual planning, action tracking, learning huddles, supervision groups and thematic webinars) presented to the LDT Subgroup as the first partner highlight report, and developing structures for embedding lived-experience voice in governance. Its 2026–27 priorities put patients, families and carers first, focusing on domestic abuse, neglect and self-neglect, exploitation, Prevent, and Making Safeguarding Personal. Its challenge to the Board is to keep information simple and navigable, provide multimedia access to review learning, and pair innovation with disciplined, project-managed practice change.

Oxford University Hospitals NHS Foundation Trust

Oxford University Hospitals reported strong engagement across the partnership's groups, joint working on hospital discharge, where a high proportion of section 42 enquiries relate to discharge quality and improvement work is in hand with partners, and rising DoLS activity managed through effective cross-agency working. It was open about staffing pressures in its safeguarding and MASH health teams, with mitigation plans monitored through its Safeguarding Strategic Group, and its priorities include staffing, DoLS compliance following audit, and more face-to-face teaching built around complex case discussion. Its challenges to the Board concern the volume and duration of review processes and earlier escalation of the safeguarding impact when funding arrangements for services end.

Oxford Probation Service

Probation reported its safeguarding responsibilities discharged in line with the HMPPS framework, with priorities including refining self-serve safeguarding checks with robust quality assurance,

improving practice among trainees and newly qualified officers, strengthening the voice of the child in risk assessment, and better use of Board resources including the revised threshold of needs. Probation has also asked the Board for a multi-agency dataset and dashboard, a request that aligns directly with PIQA's data programme.

Oxford City Council

The City Council reported a well-established Safeguarding Champion network of 21 officers trained to Level 3 in both adults' and children's safeguarding, an annual all-staff safeguarding survey with strong response rates, and a completed review of safeguarding practice in its restructured Youth Ambition service. Its forward plan includes a referrals audit, a further service audit, and its 2026 staff survey. Through Board channels, it has led community safety engagement on exploitation and 'cuckooing', including securing named DWP escalation contacts, and it asked the Board to increase MARM capacity and offer bookable webinars sharing learning from reviews.

Cherwell District Council

Cherwell District Council has been among the most active district contributors to the Board's practice development this year: its self-neglect audit for PIQA evidenced a 25 per cent rise in hoarding casework over two years and improved staff recognition of self-neglect following targeted training, and its safeguarding lead has driven the partnership's hoarding policy work and the district-level perspective in MARM development.

South Oxfordshire and Vale of White Horse District Councils

The councils reported safeguarding is treated as business as usual, with corporate plan ownership, four Designated Safeguarding Leads and embedded processes, and highlighted the value of the new self-neglect and hoarding forum in bringing partners together. Their reported pressures (i.e., rising domestic abuse related death reviews, increasingly complex self-neglect, and mental health and suicide risk) match the Board's own data picture, and their priorities include appointing safeguarding champions/networks, and embedding learning from audits and peer challenge. Their asks of the Board are partnership-friendly data dashboards, clearer multi-agency thresholds messaging, and expanded joint training.

West Oxfordshire District Council and Publica

The council and its service delivery partner reported chief executive accountability for safeguarding with member-level sign-off of assurance reports, an updated safeguarding policy implemented, increased training completion, and the creation of a District and City Safeguarding Officer Working Group. It was honest about its development areas: supporting staff to distinguish wellbeing concerns from safeguarding concerns amid rising volume and complexity, and assurance over safeguarding within commissioned leisure and waste contracts. Oversight of safeguarding is transferring back into direct council delivery as part of Local Government Review preparations. Its asks of the Board include an induction pack for new representatives, a review of subgroups for relevance and duplication across the adults' and children's partnerships, and less jargon.

11.4 What members asked of the Board

The self-assessment asked every organisation what changes the Board itself should make. Recurring answers, better multi-agency data and dashboards; simpler, clearer communication with less jargon; more joint training and shared learning formats including webinars and multimedia; streamlined and less protracted review processes; clearer thresholds messaging; and stronger mechanisms to turn learning into measured impact, have been consolidated by the Business Group and are reflected in the Board's 2026–27 priorities in Chapter 12. A Board that asks its members to accept challenge must model the same behaviour.

12. Looking ahead: priorities for 2026–27

The Board's Strategic Plan 2025–27 remains the framework for next year. Within it, the Board has agreed the following focus areas for 2026–27:

1. **Safe transition through structural change:** seeking continuing assurance, using the Board's Risk Register, on executive accountability, continuity of statutory safeguarding functions, independent scrutiny and workforce stability through Local Government Reorganisation, the new ICB arrangements, and police reform; and engaging early with the new National Safeguarding Adults Board and any review of Care Act powers.
2. **Closing the learning loop:** implementing the mechanism for partners to evidence how review learning has changed practice; embedding commitment statements; evaluating the self-neglect Principles (2026–27); and delivering the professional curiosity webinar and safe curiosity commitments.
3. **Data and assurance:** delivering the regular PIQA performance and quality report to the Board, the redeveloped dataset, and the first full cycle of the revised self-assessment with peer review clusters.
4. **Drug and Alcohol Related Deaths:** integrating Drug and Alcohol Related Death Reviews into the SAR Subgroup's governance from 2026–27, using coroner-file-based methodology to minimise burden on agencies, and managing the cumulative workload of the review system, which partners have asked the Board to keep under explicit review.
5. **The Voice of Lived Experience and the Lay Member:** recruiting a new Lay Member; strengthening the direct voice of adults with care and support needs; developing community organisation participation; and exploring the Board's role in responding to social isolation as a safeguarding prevention issue.
6. **Responding to members' asks:** induction for new Board representatives, plainer communication, review of subgroup structures for duplication, and accessible multimedia learning from reviews.

The Board will report on progress against each of these in next year's annual report.

Appendix A: Glossary

Term	Meaning
BOB ICB	NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
CQC	Care Quality Commission
Cuckooing	The takeover of a person's home by others for exploitation or criminal activity
DARDR	Drug and Alcohol Related Death Review
DHR	Domestic Homicide Review (now Domestic Abuse Related Death Review)
HMPPS	His Majesty's Prison and Probation Service
HMR	Homeless Mortality Review: Oxfordshire's local review of deaths of people experiencing homelessness
LDT	Learning, Development and Training Subgroup
LeDeR	Learning from Lives and Deaths of people with a learning disability and autistic people
LGR	Local Government Reorganisation
MARM / MARM+	Multi-Agency Risk Management framework for adults at high risk below statutory thresholds; MARM+ extends this to complex multi-agency cases
MASH	Multi-Agency Safeguarding Hub
MCA / DoLS	Mental Capacity Act 2005 / Deprivation of Liberty Safeguards
MEAM	Making Every Adult Matter: partnership approach to multiple disadvantage
MSP	Making Safeguarding Personal: person-led, outcome-focused safeguarding practice
OSCP	Oxfordshire Safeguarding Children Partnership
PiPoT	Person in a Position of Trust
PIQA / PAQA	Performance, Information and Quality Assurance Subgroup (adults) and its children's partnership counterpart
PPP	Policies, Procedures and Practice Subgroup
s.42 enquiry	A statutory safeguarding enquiry under section 42 of the Care Act 2014
SAB	Safeguarding Adults Board
SAC	Safeguarding Adults Collection: the national statutory data return
SAR	Safeguarding Adults Review: a statutory review under s.44 Care Act 2014

Appendix B: Board Support Team

Strategic Safeguarding Partnerships Manager
Board Support Officer
Learning & Engagement Officer
Homeless Mortality Review Officer
Research & Intelligence Officer
Multi-Agency Risk Management (MARM) Officer

Appendix C: How to raise a safeguarding concern

If you are worried that an adult with care and support needs is being abused or neglected, or is at risk, please report it. In an emergency always call 999.

- Contact Oxfordshire County Council's Adult Social Care team to raise a safeguarding concern, or use the online reporting form on the Oxfordshire County Council website : https://www.oxfordshire.gov.uk/residents/social-and-health-care/social-and-health-care-information-professionals/raising-safeguarding-concern-0
- You do not need to be certain. Professionals would rather hear a concern that turns out to be nothing than miss one that mattered.
- Further information, published Safeguarding Adults Reviews and Homeless Mortality Reviews, the Board's strategy, and the Easy Read version of this report are available on the OSAB website.