Oxfordshire Safeguarding Adults Board

Annual Report 2020-21

Foreword

Joint statement from Karen Fuller and Alison Chapman, Vice-Chairs of the Oxfordshire Safeguarding Adults Board

"This report outlines the role and function of the Board, highlights the achievements of the Board and its partners during the year and shares lessons from our work that are vital for all organisations in Oxfordshire.

The current COVID-19 pandemic must be acknowledged. This year has been unprecedented and has impacted the lives of those in Oxfordshire and across the country in many ways. The public have experienced repeated lockdowns and restrictions, which we continue to live with as this report is being written. Many have experienced bereavements during this time. The loss of physical contact with friends and family has had a devastating impact on the mental health of many people. Professionals providing services to adults needing support and protection rose to the challenge and showed huge dedication to keep things running whilst also being subject to the same pressures as the general public. This commitment to the people of Oxfordshire from all sectors, both statutory services and voluntary and community groups, must be recognised and celebrated by the Leaders of organisations all across the County."

Statement from Rosalind Pearce, Executive Director, Healthwatch Oxfordshire

"Over the year Healthwatch Oxfordshire raised safeguarding alerts on two occasions and on both occasions, these were acted upon. Due to the nature of the alerts, we did not approach the people concerned to understand how their experience was. In the future we will further explore whether this is possible on occasions.

We fully understood the need for the OSAB to revert to an Extended Executive Group due to pressures on staff during the early months of the COVID-19 pandemic. Whilst the Extended Executive Group appeared to ensure that the work of the Board continued papers were not shared with the wider Board members. Towards the end of 2020 Healthwatch Oxfordshire wrote to the Chair of the OSAB asking when the Board was going to reconvene. In response invitations were sent to all Board members to the December Extended Executive Group and the Board met in full online in March 2021.

In June 2019 Healthwatch Oxfordshire carried out an exercise to see how easy it was for a member of the public to raise a concern about another adult – 'Safeguarding is every body's business.' Our report to the Board highlighted how difficult it was to reach the right access point using web searches, lack of single telephone number for people to a call and the complexity and length of the online form. Changes agreed by the Board were to be checked through a similar exercise in June 2020 which was delayed due to COVID-19 pressures until June 2021.

Healthwatch Oxfordshire continues to attend the OSAB, and joint chaired the Engagement Group with AgeUK Oxon during this period."

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Introduction

The Care Act (2014) requires each local authority to set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

- have needs for care and support (whether or not the local authority is meeting any of those needs)
- are experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect

The SAB has 3 core duties:

- it must publish a strategic plan for each financial year;
- it must publish an annual report of Safeguarding Adults Board activities; this should include information on the findings of Safeguarding Adults Reviews (SAR) completed during the year and the progress of any SARs still ongoing;
- it must conduct Safeguarding Adults Reviews in accordance with Section 44 of the Act.

Each SAB should:

- identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults
- establish ways of analysing and interrogating data on safeguarding notifications that increase the Safeguarding Adults Board's understanding of prevalence of abuse and neglect locally that builds up a picture over time
- establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements
- determine its arrangements for peer review and self-audit
- establish mechanisms for developing policies and strategies for protecting adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives
- develop preventative strategies that aim to reduce instances of abuse and neglect in its area
- identify types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority as an enquiry
- formulate guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and professional and administrative malpractice in relation to safeguarding adults
- develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect
- balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'
- identify mechanisms for monitoring and reviewing the implementation and impact of policy and training
- carry out safeguarding adult reviews and determine any publication arrangements;
- produce a strategic plan and an annual report
- evidence how SAB members have challenged one another and held other boards to account
- promote multi-agency training and consider any specialist training that may be required. Consider any scope to jointly commission some training with other partnerships, such as the Community Safety Partnership

COVID-19 and Safeguarding Adults Boards

The Department of Health & Social Care wrote to all Boards at the start of the pandemic to outline their expectations of the strategic partnership work they do during the pandemic.

In essence, the letter offered SABs the opportunity to suspend its core duties (as outlined above) for the period of the pandemic if there was a reasonable cause to do so. While these duties could be delayed, they were not removed and any missed work would have to be picked up eventually.

Within Oxfordshire, the Board Chair and Board Members felt that the continuation of the work of the Board was vital and that strategic leadership was needed more than ever during this period, so while there were slightly altered arrangements, the Board continued with its core duties throughout the year. The Board even added to its responsibilities by creating a new subgroup to review the deaths of anyone who is rough sleeping or is in temporary accommodation, an area of work that is explored in more detail later in this report. The Board meetings were held virtually throughout the year to ensure that the work continued as safely as possible, operating with an Extended Executive group in place of the Full Board group. The Extended Executive brought together the statutory partners as well as representatives from the two hospital Trusts and the lay member for the Board.

Who are we Safeguarding? *Demographic Information*

This information is taken from the Joint Strategic Needs Assessment for Oxfordshire, which can be accessed here: https://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

The Office of National Statistics (ONS) estimate of the population of Oxfordshire this year was 691,700. Of these,

- There are an estimated 131,400 people in Oxfordshire with a disability (19%).
- There are an estimated 128,126 people over 65 in the county (18.5%), 18,422 of which are over 85 years of age.

These figures are not mutually exclusive and there will be older people who have a disability.

As of April 2020, there were 6,197 adults in Oxfordshire receiving care from adult social care services. 60% of these were older people aged 65 or over. 15% were aged 90 or over. 27% of those receiving care were people with a learning disability. There are 127 residential and nursing home settings in Oxfordshire.

In the population, nearly 91% are white, 2% of mixed ethnicity, 5% Asian, 1.5% Black and 0.5% other groups (from the 2011 census). Within safeguarding this year, it appears all other ethnicities are represented within safeguarding proportionate to their representation in the general public, other than within those identified as Asian where this is a 2% difference. However, reviewing the percentages of concerns that go on to become enquiries, all ethnicities have a conversion rate around 58%, which suggests there is no bias in formal safeguarding processes.

This data will continue to be scrutinised in 2021-22, along with ethnicity data of service users and the census 2021 data to ensure an accurate comparison can be made.

Providing Leadership for Effective Safeguarding Practice: ***How the Board Works***

Much like the Oxfordshire Safeguarding Children's Board, the Safer Oxfordshire Partnership, and the Health & Wellbeing Board, the Safeguarding Adults Board is a strategic partnership group made up of senior staff from member agencies.

The Board is facilitated by an Independent Chair and supported by a small team. During COVID-19, the Learning & Engagement Officer was asked to return to frontline work within the operational safeguarding team, with their Board duties picked up by the Board Manager. The Independent Chair completed their tenure in March 2021 and the Board are actively recruiting a new Chair at the time this report was being prepared.

The partnership is made up of:

Completing the membership of the Board is a Lay Member, who provides another level of scrutiny and challenge to the work of the Board partners. As someone outside of the organisations represented at the Board, they offer another independent view on how services work together and help to ensure that our work is as accessible as possible to the broadest audience.

Structure of the Safeguarding Board

The structure of the Safeguarding Adults Board is outlined in the table below:

<table>
<tr><td colspan="2">Full Board
• Multi-agency partnership group, bringing together senior leaders from member agencies to agree on strategic safeguarding work and hold each other accountable for safeguarding practice
• Provides direction to all subgroups
•</td></tr>
<tr><td>Executive Group
• Drives the work of the Full Board between meetings
• Discusses urgent and emerging issues, problem solving as required to provide a clear direction and offer leadership support.</td><td>Safeguarding Adults Review Group
• Considers incidents and situations that require a multi-agency review called a Safeguarding Adults Review
• Manages the reviews once they are commissioned
• Leads on sharing the lessons from reviews</td></tr>
<tr><td>Vulnerable Adults Mortality Group
• Oversees the Learning Disabilities Mortality Review (LeDeR) process
• Leads on sharing the lessons from LeDeR</td><td>Training Group
• Shared with the Children's Board
• Oversees the safeguarding training for the Board
• Provides multi-agency training to Board partners and supports training for non-Board partners, such as community and volunteer groups</td></tr>
<tr><td>Procedures Group
• Oversees the multi-agency procedures
• Offers advice & guidance on single agency procedures</td><td>Engagement Group
• Oversees how the Board interacts with the wider community of people working with adults
• Inputs on Board publications</td></tr>
<tr><td>Performance, Information & Quality Assurance Group
• Scrutinises performance information from across the partnership, identifying emerging issues and concerns for the board within services
• Manages the quality assurance processes, such as the annual Safeguarding Self-assessment and the Supportive Learning Visits</td><td>Homeless Mortality Review Group
• Reviews the deaths of all people identified as homeless or in homeless accommodation at the time of their death.
• Provides lessons from these deaths to partnership groups, particularly the safeguarding board and the Countywide Homelessness Steering Group</td></tr>
</table>

Priorities for the year 2020-21

Boards are expected to set priorities for the year and work towards these through its partner agencies. These priorities must also be reported on within the Board's annual report.

The four priorities set last year were:

1. Move training to an accessible e-learning and webinar format
2. Improving our communication links with non-Board members
3. Sharing the learning from Safeguarding Adults Reviews
4. Maintaining high standards of strategic safeguarding work during COVID-19

The impact of the pandemic could not have been foreseen at the time the priorities for the Board were set. However, this report demonstrates that while COVID-19 has impacted how organisations have operated, these four priorities have been maintained and progress has been made in all areas. Evidence of this can be found throughout this report.

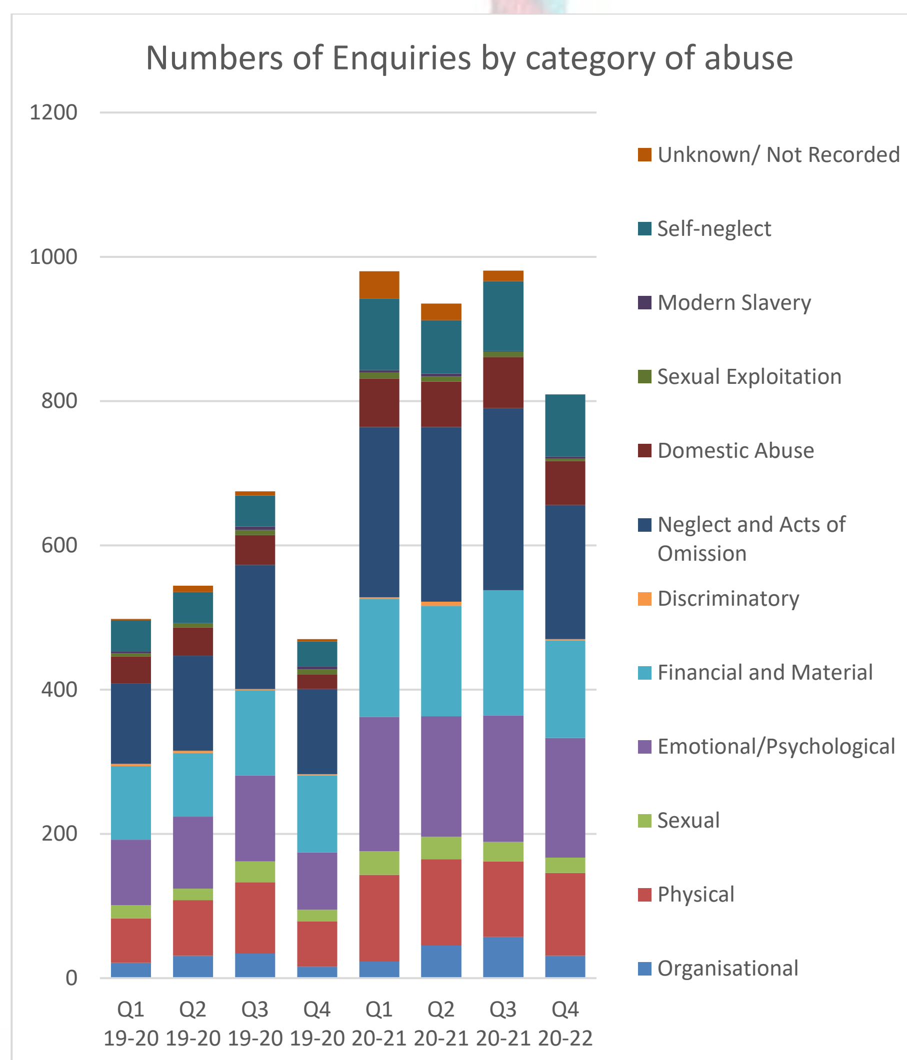
The Effectiveness of Safeguarding Arrangements

Safeguarding data

There are two stages to reporting a concern about abuse or neglect. These are referred to as a safeguarding concern and a safeguarding enquiry. Safeguarding concerns about abuse and neglect can be raised by anyone - the person themselves, their family, friends, a member of the public such as a neighbour, or a paid worker. These concerns are then assessed by the Safeguarding Team in the County Council who decide if it meets the legal criteria for a safeguarding enquiry. Where the adult is currently receiving services from Oxford Health NHS Foundation Trust, the safeguarding concern will be followed up by them as they have a Social Work Team embedded within their organisation

In Oxfordshire, there were 4,941 safeguarding concerns raised in 2020-21. This is a slight decrease from the previous year (5,116). Of these concerns, 2,254 went on to be safeguarding enquiries. Locally, there was a significant change to the safeguarding process at the start of the year as Oxfordshire implemented the Local Government Association safeguarding process, which meant more concerns became safeguarding enquiries, which led to the large change in conversion rate of concerns into enquiries (25% in 2019-20 to 46% in 2020-21).

The chart below breaks down the enquiries by the types of abuse. You may notice that the numbers for quarter 1 to 4 amount to more than 2,254. This is because an enquiry may involve multiple forms of abuse.



Making Safeguarding Personal data

Where it is possible, an adult at the centre of the enquiry, or their representative, should always be empowered to make decisions about their own lives and define what they want to happen. This includes when there are safeguarding concerns and how the person would like these addressed. This is referred to as Making Safeguarding Personal.

- 96% of adults who were involved in a safeguarding enquiry defined the outcome they wanted

- 98% of those adults reported that they were satisfied with the outcome of the safeguarding enquiry

- 92.5% of safeguarding enquiries resulted in the risks being removed or reduced

In 0.75% of cases the adult not satisfied with the enquiry **and** the risk remained (11 cases). In all these cases an audit was conducted by senior staff independent of the safeguarding enquiry to ensure that everything possible had been done to remove or reduce the risk and to satisfy the adult. In all cases, these adults had outcomes that could not be achieved by services (such as wishing to move to a different area, finding an exploitative adult child their own home, etc) and were not prepared to accept what help could be offered.

For those who struggle to be involved in the safeguarding process themselves, services are expected to ensure that an appropriate advocate is able to represent them through the process.

- 81% of those who were judged to lack capacity, as laid out in the Mental Capacity Act 2005, were supported by an advocate. It is a requirement of The Care Act 2014 that anyone lacking capacity is supported through the safeguarding process and where there is no-one appropriate within their family or friends it should be an independent advocate. The remaining 19% of people not supported by an independent advocate were supported by either family, friends or a trusted carer to act as advocate for the person.

Annual Safeguarding Self-assessment

The annual Safeguarding Self-assessment is a joint piece of work between the Adults Board and Children's Board. The purpose of the Safeguarding Self-Assessment is to formally request and gather information from member agencies on the safeguarding arrangements made in line with section 11 of the Children Act 2004, as well as the standards developed by the Local Government Association for Adult Safeguarding Services.

The assessment tool provides agencies with the opportunity to highlight areas of strengths in practice, identify areas for development, and provide evidence of the impact of policies and practice on children and adults with care and support needs in Oxfordshire. It is intended to be useful as a self-assessment tool to measure and provide assurance on the quality of the safeguarding arrangements that agencies have in place.

The self-assessment is supported by a peer review event, where the standards that have received the most mixed ratings are analysed in detail. For 2020, the peer review meeting focused on the following standards;

1. **Senior management have commitment to the importance of safeguarding and there is a clear line of accountability and a clear statement of the agency's responsibility towards children and adults with care and support needs**

2. **Effective complaints systems are in place, in line with current statutory guidance, for children and adults with care and support needs, staff & other people to make complaints and themes of these complaints are addressed.**

3. **Child / Service User friendly complaints information is used, which includes information on what safeguarding issues are and how to raise a safeguarding concern. This includes ensuring there are interpreting services available, if needed**

4. **Service delivery & development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of service users and their families.**

5. **Safeguarding and promoting the welfare of children and adults with care and support needs is central to all service development and these groups are actively involved in the design and development of services.**

6. **Children and adults with care and support needs from black and minority ethnic backgrounds and other diversity strands are appropriately consulted in the development of services.**

7. **There is a responsive process in place to act on unmet need, identifying where there are gaps and how these will be addressed**

Summary of Red, Amber, Green (RAG) ratings

Overall, the self-assessment returns submitted provide assurance that board member agencies across Oxfordshire have procedures in place to safeguard children and adults with care and support needs, are compliant with the standards examined, and committed to ensuring safeguarding practice is embedded in their day to day practice. For those areas where more work is required, there was a clear action plan provided by organisations.

Overview of Red, Amber, Green (RAG) ratings

Section	Questions	Red	Amber	Green
Leadership, Strategy and Working Together	13	0	15%	85%
Service Delivery and Effective Practice	7	3%	16%	81%
Commissioning Arrangements are Robust and Effective	6	3%	12%	85%

Peer Review

The Peer Review event is held each year for organisations to explain their return responses to a small group of their peers and to receive constructive challenge from them on how they could improve and to provide some moderation to the self-assessment ratings. The event was held virtually, due to the coronavirus pandemic, and there was good discussion in groups, both to provide scrutiny of evidence submitted in relation to ratings given, and in higlighting examples of good practice. There was also some discussion around the challenges and opportunities resulting from the pandemic, examples of how organisations and practitioners have worked creatively to provide support to vulnerable children and adults, and the high level of commitment shown to safeguarding in challenging circumstances.

The Peer Review groupings agreed the majority of submissions RAG ratings. Two agencies were unable to attend the peer review event itself but as their written submissions were agreed to be of a high quality, offering sufficient evidence to establish that an additional peer review event was not necessary.

Summary of findings from practitioner questionnaire

A questionnaire about safeguarding was sent to all Board Members for them to share with their frontline workers and we received 781 responses. Although this was a considerable reduction on the 1,764 responses the previous year, these came from a broad range of organisations and so it still provides a useful snapshot of the views of frontline workers about how safeguarding works within Oxfordshire. Agencies cited the demand on frontline staff during the COVID-19 crisis as a reason for not chasing responses to the same level as the previous year.

The key findings were as follows:

- 95% had undertaken safeguarding training within the last 3 years, the gap primarily due to staff turnover and new starters
- When making decisions regarding safeguarding concerns;
    - 63% refer to internal safeguarding policies
    - 45% consult with the safeguarding leads in their own agency
    - 39% use the local authority consultation service
    - 20% refer to the safeguarding board's policies/procedures

  (answers were not mutually exclusive, professionals were asked to tick as many as applicable)
- Slightly less than half of practitioners (48%) knew how to escalate an issue to one of the Safeguarding Boards.
- 75% felt that the leadership in safeguarding had been visible during the COVID-19 crisis.

Practitioner responses are consistent with assurances given in agency returns regarding compliance with the standards on training and internal policies and procedures.

Few practitioners report using multi-agency tools when making decisions in relation to safeguarding concerns they have, with only 13% referring to the Child Exploitation/Child Sexual Exploitation (CE/CSE) screening tool and the neglect tool, 14% to the domestic abuse pathway and 16% to multi-agency chronologies (which is a list of all agency involvements in chronological order), although the latter represents 100% increase on the number who reported using the chronologies last year (8%).

The boards challenged partners as to whether the low level of use of multi-agency tools was due to the majority of responses coming from statutory agencies who already have their own tools/assessments, or if there is further work for board members in raising awareness of, and promoting the use of multi-agency tools across the network. Members reported that it was predominantly due to them having their own tools, usually based on the multi-agency tools.

Overall responses to the questionnaire indicate that the work of the Boards is becoming more integrated into standard working practice and safeguarding is seen less as something done separately to our day jobs.

Summary of findings from the Impact Assessment

The Impact Assessment was amalgamated into the self-assessment in 2018, following a recommendation from the previous year's Peer Review. While the rest of the self-assessment is a check on an organisations' internal processes and procedures, the Impact Assessment is used to understand the issues facing organisations as a system.

Organisations were asked to identify the three key financial and organisational pressures in relation to safeguarding children and their families and adults with care and support needs. The top six are listed below:

1. **Increasingly complex individuals**
2. **Increasing volume of demand on services**
3. **Working with homelessness and the accompanying issues**
4. **Staffing issues – recruitment, retention and resilience**
5. **Restructuring services to meet needs**
6. **Securing the funding for the service**

Partners were asked to identify three key safeguarding themes from performance data. The six most common responses are listed below:

1. **Supporting people who fall outside statutory services' eligibility criteria or were not engaged with effectively**
2. **Financial abuse**
3. **Homelessness**
4. **Mental ill-health**
5. **Hoarding & Self-neglect**
6. **Neglect**

These issues have been shared with Directors within partner organisations for consideration during service review and development.

Overall Conclusions of the Self-assessment

Overall, the peer review groups felt that returns showed a strong level of critical self-analysis. There were some excellent examples of good practice and a very high level of evidence uploaded. The following were most commonly highlighted areas for actions to improve practice within agency returns;

- **Training -** Nearly all agencies highlighted a training need for their staff, although there was no common theme to these needs.
- **Policy & Procedure -** A number of the agencies highlighted an internal need to either review or develop policies or procedures on a variety of topics. Where there were multi-agency procedures already available, organisations stated that their reviews/developments would be in line with the expectations of the multi-agency procedure.
- **Multi-agency Procedures and Tools -** As in previous years, a number of agencies recorded an action to improve knowledge of or use of the multi-agency tools.
- **Monitoring Arrangements -** In light of the COVID-19 crisis, a number of organisations noted actions to monitor current arrangements to ensure they are fit for purpose and high levels of safeguarding and other service delivery can be maintained.

Vulnerable Adults Mortality Group work

This year has seen continued commitment to ensure effective communication and maintain good working relationships. The panel has supported a new rapid review process that critically reviews and seeks to identify any local issues and learning. It is through this scrutiny and constructive challenge, that we will continue to jointly work to improve services across Oxfordshire for those living with a learning disability.

Activity this year has been sustained and enhanced, using reviewers forced to work at home due to the pandemic. 41 notifications have been received and 61 case reviews have been completed, resulting an improvement in timeliness of review completion. 97% of reviews notified to Oxfordshire in 2020-21 were completed within the 6 monthly target set by NHS England.

The average number of notifications of deaths per month in 2019-20 was less than 4 and this has remained consistent in 2020-21. This represents a variance to the nationally reported data that has suggested an increase in deaths among the learning disability community. Locally the data has been cross referenced to ensure no individual was missed from the review process. Whilst there has been no specific learning identified to account for this the steering group has acknowledged that there are a very high number of small supported living settings, more family like units, which may have been a factor. In 2021-2022 living environments may be a feature of some more detailed analysis.

Learning from the LeDeR process has been a regular report component of the Learning Disability and Autism system wide group, that was set up as part of the COVID-19 reporting structures (bronze cell) and will be sustained to create a forum for ensuring providers and commissioners regularly review quality and effectiveness through a range of perspectives.

Hospital admissions in 2020-21 have been a challenge for all. During the pandemic it was necessary to ensure that there were adjustments made to support those living with a learning disability requiring hospital care. The rapid reviews undertaken led to changed visiting arrangements for those requiring additional support, changes to communications with care providers and families and the development of COVID-19 passports.

Learning has been shared in webinars, through a series called “ Wednesday at One”. This series consisted of 10 sessions, each with a key focus that explored healthy lifestyle issues, advanced/ proactive care planning and health care plans, understanding the individuals’ experience and supporting health needs such as epilepsy. On average 80 delegates joined each session from across the south east region from a diverse range of settings.

Key areas identified as requiring further improvement are:

1. Annual Health Checks (AHCs) and Health Action Plans (HAPs) / Education and Health Care Plans (EHCPs) need to be more closely aligned and linked so they inform each other, both being valued by all.
2. Transition from child to adult services needs to start with earlier discussions across teams and service, including primary care. This needs to include hearing the voice of the individual, their views and choices more consistently, whilst not excluding families.
3. Anticipatory care plans, and preparing for lifestyle changes needs to be more proactively supported across the system, including end of life choices, best interest decisions, advocacy and family roles.

A full annual report is published on the OSAB website: https://www.osab.co.uk/wp-content/uploads/2021/07/ITEM-05-LeDeR-Annual-Report-FINAL.pdf

Homeless Mortality Review Group work

In November 2020 OSAB received the report on the Thematic Review into Deaths of Homeless People. OSAB commissioned this review which focussed on the deaths of 9 people between November 2018 and June 2019 in Oxford.

One of the recommendations in this report was that a Homelessness Mortality Review (HMR) Process be set up that would look at all deaths of homeless people including people who had been homeless in the last 6 months. This would ensure that agencies reflected on their actions in all cases and that the systems learning was extracted and acted on in order to reduce the risks that may contribute to a premature death.

The Mortality Review panel was set up in December 2020 and has met monthly since. 27 deaths of homeless people were identified between March 2020 and February 2021. The Panel has therefore been working through these reviews. In the case of one person a full Safeguarding Adults Review has been conducted by external assessors. This report isn't yet complete but early learning is identified in this report.

A research piece conducted by the Museum of Homelessness asked every local authority area in the country for the deaths they were aware of between 1st Jan 2020 and 31st November 2020. From the 46 Authorities that responded, Oxfordshire's rate was ranked 5th highest.

Emerging Findings

There are some statistics outlined below:

- 85% were male, 15% female.
- 7% were street homeless at the time of their death. The others were in homeless accommodation.
- 68% were British, 25% were European and 7% were from outside Europe.
- 50% were under 43 when they died. The youngest was 23, the eldest was 65.
- 'Natural Causes' was the most frequent recording by the Coroner for those cases that were subject to an inquest. All bar two of these were under 50 years old at the time of their death.
- COVID-19 was not noted as contributing to any of the deaths.

The themes from the cases were as follows:

- Alcohol addiction was a feature for the majority of people and in some cases was a very long-term issue.
- Efforts to work with the person were often hampered by threats of and/or acts of violence while inebriated and some services that could offer help are not available to people while they are intoxicated.
- While a majority of these people attended the Emergency department with varying levels of frequency, the follow-up with the services outside of the hospital, such as addiction services, could be improved.
- More could be done to ensure these adults all have a registered GP.
- The use of interpreters for those for whom English is not a first language was inconsistent, particularly out of office hours.
- The reason for the increase in deaths from data reported by the Office of National Statistics for previous years is not obvious as none of the deaths were COVID-19-related. None of the deaths were attributable to the person being homeless, but rather related to the reasons they struggled to maintain accommodation e.g. excessive alcohol consumption, drug use, mental ill-health, etc.

The mortality review process is relatively new and requires significant commitment from all agencies involved, both in leading reviews but also in providing information to other lead reviewers. We will be able to make further conclusions once the process is better established and the Safeguarding Board will continue to receive regular updates on the work of this group.

Learning from Safeguarding Adult Reviews

There were three Safeguarding Adult Reviews active during 2020-21, two of which were completed and published that year, one of which is still on-going.

SAR 1 - Review of Nine Homeless Deaths

The published report can be accessed here https://www.osab.co.uk/wp-content/uploads/2020/11/Review-of-Homeless-Deaths-Full-Report.pdf

The SAR was commissioned following the deaths of nine homeless people in Oxford between November 2018 and June 2019. The ages of the people ranged from 26 to 57. The decision to undertake this discretionary review reflected the concern of OSAB members about the loss of lives of these individuals who all died in very difficult circumstances and at far too young an age, and a commitment to implement any safeguarding lessons across the health and social care system in Oxfordshire. A wide range of agencies who had directly served these individuals were involved in the review. Families of those that died were approached and several chose to add their perspectives to the review.

The review identified a lack of understanding of the needs of people who self-neglect, with practitioners not recognising or not understanding **repeated patterns of behaviour** and individuals were just offered more of the same. - There was concern about whether sufficient recognition was given to the impact of trauma and adverse childhood experiences and how these might be affecting current behaviour. The reviewers also wondered to what extent drug and/or alcohol abuse was being seen as an issue of lifestyle choice and unwise decision-making, with insufficient consideration given to mental capacity and possible mental health needs.

Case records revealed very few **mental capacity** assessments, despite their relevance to heavy users of drugs or alcohol as well as to other diagnoses held by some of these individuals (e.g. global cerebral atrophy). The reviewers also questioned the level of understanding shown by agencies into "executive capacity" (the ability to carry out decisions and intentions) which is often an issue for people who are seen as neglecting themselves.

The review found limited evidence of **risk assessment and mitigation** plans, especially multi-agency ones, for example, when someone was evicted from their hostel accommodation. Other transition points were also noted as requiring more careful multi-agency risk assessment and planning, such as leaving hospital or prison. Reviewers note "the need to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and trying to manage their emotional responses".

The review identifies that many of the individuals potentially had eligible care and support needs (under the Care Act 2014), yet most had not been referred for an **Adult Social Care assessment**. Possible barriers to referral for Adult Social Care, , need to be understood by the board.

Some of the individuals were known to have suffered **domestic abuse** and some were also perpetrators. It was not clear whether the usual channels for supporting victims of domestic abuse and managing perpetrators were available to them as homeless people, and the reviewers challenged the partnership to ask: "when domestic abuse happens on the street, rather than in a home, is this considered a safeguarding concern?"

The reviewers found examples where agencies worked together well, but also examples of **poor collaboration and fragmentation of services**, with a perception that too much responsibility was placed on accommodation providers to engage with other services and to coordinate their involvement. The clearest example of where improved multi-agency collaboration was needed was in relation to hospital discharge.

The report also refers to "**referral bouncing**", with a perceived reluctance to be "part of the solution". This sometimes resulted in the least formally qualified and experienced workers being left to deal with the most challenging and complex individuals.

There was no agreed format for convening or conducting **multi-agency meetings** nor a standardised approach to **risk assessment and management** plans. There were examples of plans developed without all relevant agencies involved, of plans formulated but not followed, and plans that were not reviewed or reformulated when events disrupted what had been agreed. In none of the nine cases did there appear to have been a nominated lead agency and/or keyworker to coordinate the multi-agency input for these complex individuals.

The review highlighted front-line staff were not recognising when a **safeguarding referral** was warranted. These clients had a range of physical and mental health problems that potentially translated into eligible 'care and support needs' (under the Care Act 2014) and, despite the services provided, these individuals remained in high risk and unsafe situations. Yet none of the nine people had been subject to a safeguarding enquiry. Alongside this, concern was expressed by operational staff of 'not being heard' when they did attempt safeguarding referrals.

The report recommends improving staff confidence in applying the **Homelessness Reduction Act 2017** and notes the absence of assessment under the **Human Rights Act 1998** for at least one individual with no recourse to public funds, who might then have been eligible for some support.

The review found a **lack of strategic agreement** between housing, adult social care and health agencies across Oxfordshire about priorities, and a lack of 'ownership' of homelessness as a shared responsibility of these agencies. The evidence reviewers found of the strategic approach being followed, often referred to locally as "the homeless pathway", was too crisis focussed and lacking support for recovery of the person.

There were difficulties with the commissioning of services for people experiencing homelessness which affected their access to mental health services in general, and especially to **services for 'dual diagnosis'** (substance misuse and mental health). The report references commissioning approaches in other areas that deliver integrated provision, and calls for a greater number of specialist multidisciplinary services offering more flexible and proactive support, some of which needs to be available out of standard office hours.

Recommendations

There were 15 recommendations, with an initial 22 actions being created to meet the recommendations. As the work of the group evolved, several actions were amalgamated. All the recommendations are laid out in the full report that is published on our website.

A summary of progress against the recommendations is provided below, and further details will be reported separately as part of learning and development updates from the board.

Leadership and ownership was required and a Countywide Homelessness Steering Group was tasked with developing potential governance options, this work is complex and ongoing because it crosses a number of multi-agency partnerships and boards. After the publication of this report, the homelessness services contracts were re-tendered and the recommendations and findings were built into contracts. The Board are also investing in a programme of training on trauma-informed practice that will be open to all practitioners.

Crisis have led a housing-led feasibility study for Oxfordshire (https://www.crisis.org.uk/about-us/media-centre/ground-breaking-approach-in-tackling-homelessness-to-be-adopted-across-oxfordshire/) which also recommended "a senior and multi-agency Homelessness Reduction Board operating at countywide level."

Work on updating the multi-agency policies and procedures that are relevant to the homeless community, including the self-neglect policy and the hard to engage policy has been progressing though a task and finish group supported by many partner agencies. A multi-agency process referred to as a Multi-agency Assessment & Risk Management (MARM) is being considered.

The Homeless Mortality Review group was established in December 2020. Much like the LeDeR process, the group reviews the deaths of all homeless people regardless of the cause of death, which may be entirely unrelated to their homelessness status. It's activity is reported within this annual report.

Work was completed on mapping existing services and identifying any gaps, this was used to inform the countywide strategy. The Strategic Lead for Domestic Abuse has been tasked with reviewing the services for women experiencing or at risk of homelessness due to domestic abuse in order to assure the board that they are supported and cared for equitably.

PIQA has been monitoring the outcomes of those safeguarding concerns and safeguarding enquiries that involve people who are recorded as being homeless. The proportion of concerns being made into an enquiry is being monitored closely to ensure that it aligns with those in the rest of the population. Over the next year any trends and issues will be raised with the Homelessness Steering group and the Board..

Key outstanding issues and relation to other work

Governance – as indicated earlier in this report, the issue of governance is still not resolved. The Countywide Homelessness Steering Group has been tasked with developing option. We are nine months on from the publication of the SAR where this was identified and while it is important the strands of work are aligned, it is vital that this is resolved as soon as possible. In the interim, any issues are being raised to the regular Chief Executives Meeting, although it is understood this is only the CEOs of the County and District Councils and doesn't involve other partners relevant to homelessness.

Domestic abuse and homelessness – at the time of its last meeting, there was still no report produced in regards to domestic abuse and homelessness. It was noted that the arrangements within the County Council around domestic abuse had undergone changes and that it is now overseen by Public Health.

Multi-agency Assessment & Risk Management – as was noted in this review, and is a feature of reviews nationally, there is often a lack of engagement or struggles to maintain engagement for some of our most vulnerable adults (this is not limited to those who are homeless). This is often coupled with a person bouncing between services, where they are willing to engage, to be told they do not meet service thresholds for assistance. The latest best practice model being shared nationally among Boards should go some way to assisting with this issue but it must be supported by the senior members at Board level. It requires allowing staff the time to attend the panel meetings where the cases may not be someone they are working work but where their professional expertise, whether that's mental health, social care, housing or any other service,

are vital to ensuring the options are fully understood and the risks for the person are fully explored and shared.

Conclusion

While there has been significant progress in most areas of the work, there are still some gaps that need to be addressed, particularly the issue of Governance. There is a huge amount of work being done by frontline workers and as reported by the Homeless Mortality Review group, there has been a significant drop in the rate of deaths since the start of this year. However, without the Governance issues sorted, the issues encountered by the frontline workers are primarily still being left with that organisation to resolve, which is not good multi-agency working.

The PIQA audit of the work around the recommendations will come to the December 2021 meeting, which should offer assurance to the Board that not only have the majority of the actions been completed but that they have had a positive impact on the partnership and how we work together on this complex, multi-faceted issue of homelessness.

SAR 2 - Adult J

The published report can be accessed here: https://www.osab.co.uk/wp-content/uploads/2020/08/SAR-Adult-J-Learning-Summary.pdf. Please note that this is just a summary report in respect of the family's wishes that the full report is not made public.

Background

Adult J resided on a canal boat and had lived in Oxfordshire on and off for several years since splitting with his partner who lived elsewhere in the Country. He self-reported to professionals that he was drinking heavily from the summer of 2016 and that he occasionally suffered from a low mood. In early 2016 Adult J got into a relationship with Adult K. There were clear indications of domestic abuse between partners, with both alternating the role of perpetrator and victim. This pattern repeated multiple times until his death in late 2018.

Adult J's history with services was described as challenging by professionals, with a noted unwillingness to engage with services or accept help that was offered. In the summer of 2017 Adult J suffered life-changing injuries which left him with severe injuries to his hands and impaired his mobility. He was hospitalised until he self-discharged towards the end of 2017 (against medical advice and without a care package being in place).

In late 2018 Adult J was found deceased. The cause of death was found to be acute alcohol intoxication. At the request of the family, the Oxfordshire Safeguarding Adults Board (OSAB) are only publishing a learning synopsis.

Findings and Recommendations

In Adult J's case, it may have been preferable to consider an approach outside the confines of expected policy responses and adopt a '**team around the adult**' approach. This approach (referred to a Team Around the Family in Children's work) focusses on assessing and meeting needs in order to prevent concerns escalating whilst also drawing upon the strengths of the family.

The aims of the Team Around the Family approach were incorporated into the Working With Those Who Won't Engage policy. This work is being further developed under the recommendations of the SAR into the deaths of homeless people.

Adult J's **self-neglecting behaviour** may not have received sufficient attention from agencies. In this case, Adult J's self-neglect appeared to arise from a complex interplay of factors including a sense of loss arising from reduced contact with his children, excessive use of alcohol, the impact of the severe injuries he sustained on his physical and mental health, the difficulty in re-adjusting to life on his houseboat and his exposure to violence, coercion and control in his relationship with Adult K.

The Board uses this case as a self-neglect case study in training to ensure that the lessons are learnt and shared. The Oxfordshire Clinical Commissioning Group has also used the case in their training sessions with GPs.

The issue of the **Domestic Violence Protection Order (DVPO)** provided a valuable 'breathing space' during which much positive work was done to support Adult J. However, to capitalise on this opportunity, it does require fairly rapid and sustained single agency and partnership working which may not always be achievable given the pressures of competing demands. Additionally, although the police quickly made a safeguarding referral to Adult Social Care, which was entirely appropriate, there is no indication that they actively managed or monitored the DVPO.

This report was shared with the countywide Safer Oxfordshire Partnership group that brings together the Community Safety Partnerships across Oxfordshire. The purpose of sharing the case was to ensure that professionals understood the circumstances which contributed to successfully exploiting the opportunities provided by the DVPO. It was also shared to highlight the issue below of information gathering for the Domestic Abuse Stalking & Harassment (DASH) risk assessment.

There were occasions when opportunities to conduct **DASH risk assessments** may have been missed. Additionally, the DASH risk assessment conducted by the Thames Valley Police was not informed by the Warwickshire incident, the details of which would have been available from PNC.

There were several missed opportunities in GP records to **record the name of Adult J's partner** and/or carer which, if had he been willing to divulge this information, would have been helpful in gaining as full an understanding as possible of the risk of domestic violence and abuse he faced. This was also included in the GP training sessions mentioned earlier.

The **Canal and River Trust** made two safeguarding referrals in this case which indicated positive levels of awareness of domestic violence and abuse, including coercion and control. However, the potential benefits of working in partnership with the Canal and River Trust were not fully utilised in this case. For example, the Trust appear to have had the authority both to allow Adult J to moor his houseboat in Oxfordshire for an extended period because of his level of disability and the authority to insist on Adult K moving her houseboat elsewhere when the DVPO prevented her from contacting Adult J and therefore fulfilling the role of his carer. Working more collaboratively with the Canal and River Trust may have helped to safeguard

Adult J. The Safeguarding Adults Board approached the Canal and River Trust to explore opportunities to further engage them in safeguarding vulnerable boaters from abuse or neglect. Issues which were explored included the flagging of houseboats by the police and overcoming difficulties in demonstrating a local connection when a boater might wish to leave the canals and move into supported housing.

Reasonable adjustments, as required by law, were not always considered for Adult J. The Oxfordshire Safeguarding Adults Board sought assurance that the agencies involved in this SAR had reviewed the reasonable adjustments made for people with disabilities in the light of the learning which has emerged from this review.

The delay in formally notifying Thames Valley Police of the serious incident that occurred in Warwickshire had the potential to increase the risk of domestic violence and abuse faced by Adult J following his discharge from Hospital. The Safeguarding Adults Board shared this report with **Warwickshire Safeguarding Adults Board** for any action they wish to consider relating to cross border communication of high risk domestic violence and abuse victims.

SAR 3 - Adult V

The following SAR is not finalised at the end of 31st March 2021. The learning and recommendations may not be the same as those that appear in the final published report but it is expected in the Care Act guidance that Boards report on unpublished SARs and learning to date.

It has been established from the details contained within the multi-agency chronology that V was a gentleman who had periods of time in his life when he struggled to maintain his health and well-being to an acceptable standard and was offered support on several occasions to achieve this.

He had not had any active ongoing involvement with services over this period of time and it is evident from the detail contained within the documentation that he did not to respond to professionals despite the numerous contacts they made via phone calls, letters and text messages, in respect of his health and well-being.

V stated to a professional on one occasion that he found it hard to keep "on top of things" and in October 2014 a referral to Adult Social Care highlighted areas of serious concern relating to self-neglect, which included his personal hygiene, his lack of food consumption and extremely poor living conditions.

There were occasions when V had to be prompted to pay his rent and the chronology verified that he was evicted on one occasion due to the condition of the property.

The period from 2014 to April 2020 highlights the general ongoing theme of professional concern for V regarding his general well being which included his ability to attend to his basic needs, his health, and his ability to sustain a tenancy. The aim of the Appreciative Inquiry was to look at where, how and why events took place and use professional hindsight and wisdom to design practice improvements.
The method of an Appreciative Inquiry uses a systemic methodology which refers to focussing on the interactions and relationships between professionals to help them address any interactions and to move on. It gives those involved with the process the chance to explore the circumstances and say what they think in a safe, non-judgmental environment. Professionals at the workshop came to a consensus regarding the learning points to be endorsed by the Oxfordshire Safeguarding Adult Board for all agencies involved with V

Board members to ensure that frontline professionals are mindful of the following learning points from this review:

- **Professional curiosity** – remembering to explore with an individual what is happening in their life and challenging when necessary.
- **Professional overreliance** - from the individual without exploring the presenting information from professionals.
- **Professional judgment** - applying the knowledge, skills and experience of professionals to develop an opinion.
- **Multi-agency working** - revisiting the benefits of shared responsibility, improving outcomes, problem solving and working within a holistic framework.
- **Mental capacity** - the existence of capacity should not preclude further investigation into a person's circumstances and choices.
- **Self-neglect** - partnership knowledge of self-neglect needs improving through training to address the fundamental principles of this behaviour.
- **Understanding professional roles and responsibilities** - in respect of "duty of care". Who "owns" the case and is taking the lead?

1. The Board should assure itself that the training offered to frontline workers includes the **fundamental principles of Self-neglecting behaviour and is clear and understood.**
2. The Board should consider producing a **7 minute briefing of the lessons** highlighted above for publication with the report.
3. The Board should consider a partnership audit that addresses the fundamental question of Mental Capacity and its application.
4. The Board should consider an audit to establish the level of partnership training that is offered to professionals.
5. The Board should assure itself that multi agency working is embedded across all services and is clear and understood.

OSAB Training Programme

Due to COVID-19, all training was moved to e-learning. This allowed professionals to continue to maintain high levels of training adherence without the risks associated with bringing large groups of people together. It also improved the accessibility to training as it could be done at the pace and time of the delegate rather than attending a face-to-face training session.

The training figures have risen from 1,146 delegates to 2,144 delegates. This is likely to rise again in 2021-22 as new NICE guidance places a greater requirements on care home staff to attend safeguarding training and to do so on an annual basis. The expectation of the Board and of most other organisations, including health bodies and council staff is that training is refreshed three-yearly.

Satisfaction rates with the training have not decreased despite the move to only providing training in an e-learning format (96% approval rating for the reporting year as well as the previous reporting year).
There was a huge increase in the number of volunteers undertaking the training this year, from less than 20 in 2019-20 to over 500 in 2020-21. This is suspected to be due to the number of voluntary and community groups that were set up to support those isolating at home during the pandemic. The Board worked with Oxfordshire All In, the central hub for community support groups within Oxfordshire, to promote the training to volunteers. The training was also made free for everyone to remove as many barriers as possible for accessing the training.

Conclusion

The Board Member partnership knows:

- The local safeguarding partnership has continued to maintain a high standard of work during a difficult year that has affected all partner organisations. There has been no increase in safeguarding concerns that point towards any failings of organisations to work together. Despite difficult working conditions, levels of safeguarding work have been maintained during this year, with the number of concerns raised being similar to previous years. The significant rise in safeguarding enquiries is due to a change in process within the Local Authority rather than an indicator there are significantly more safeguarding issues.
- The Making Safeguarding Personal approach has been championed throughout the year and there has been an improvement in the number of people who have defined what they wanted to happen as a result of the safeguarding work and who were satisfied with the work that was undertaken. This is excellent progress during a difficult year and demonstrates professionals are continuing to keep the person at the centre of their work with them, empowering them to make the decisions that are important to them and honouring that as much as they are able to whilst seeking to protect them.
- The annual Practitioner survey of Frontline workers has indicated that the majority of workers have felt there was clear leadership in regards to safeguarding during the last year. Workers have valued the safeguarding consultation service and its use has risen over the period.
- Most Organisations have maintained levels of safeguarding training amongst staff comparable with the previous two years. Health agencies have understandably reported under compliance due to their frontline role during COVID-19. The huge increase in training taken up by the voluntary sector during this period has been particularly welcome and we hope to maintain this level of interest and engagement with safeguarding training within voluntary and community groups.

There is still work to be done and these are the key messages for local leaders reading this report:

- **Leadership on homelessness** – Organisations must come together to agree the governance of homelessness at a countywide level. Operationally partners are doing a lot of things to improve work within their own organisations, there are areas of multi-agency work underway and a countywide strategy has been produced however, the governance and senior strategic leadership across the county has yet to be agreed.
- **Working with complexity** – the feedback from Board Members and frontline workers has highlighted for the last two years that the people that are being referred into services have increasingly complex issues. For some, these may not individually trigger a statutory response but when viewed holistically the issues clearly indicate there are risks. For others, they may trigger a response but are unwilling to engage with the services that could help them, thus leaving them at risk to themselves or from others. Multi-agency partnership work is underway to develop more integrated approaches and shared processes. It will require commitment from senior managers to enable frontline professionals to actively contribute provide their professional expertise, in order to support other teams develop skills and knowledge. The goal is to enable all services to work more effectively, proactively on improving outcomes for those they are working with..
- **Refreshing the links between strategic partnerships** – during COVID-19 the focus of organisations has rightly been diverted to ensuring those most vulnerable in our society are protected as much possible. This had the effect of reducing the focus on strategic partnership work during this period. The relationship between the strategic partnership groups within Oxfordshire (Children's Board, Health & Wellbeing Board and the Safer Oxfordshire Partnership) needs to be reviewed and refreshed.