OSAB

Oxfordshire Safeguarding Adults Board

2018-19 Annual Report

CONTENTS

FOREWORD

I am pleased to present the sixth annual report of the Oxfordshire Safeguarding Adults Board. It is my first for Oxfordshire as I became Chair in April 2019 and I am delighted to see all the good work that has been achieved prior to my arrival under the leadership of the former Chair, Pamela Marsden. I aim to contribute my experience from chairing other Safeguarding Adult Boards in the North of England and on good practice elsewhere in the UK, to build on the good work within the Oxfordshire partnership.

This report outlines the role and function of the Board which is set out in the requirements of the Care Act 2014. It highlights the risks faced by vulnerable people and most importantly what agencies both statutory and in the independent sector are doing to safeguard them.

We have been looking at the patterns in safeguarding activity to inform our priorities for improvement. We are particularly proud of our data around the numbers of safeguarding concerns which have decreased for the second year in a row through the hard work of partners and the increasing use of the consultation service. In the current climate where all agencies are experiencing increasing demands on their time, it is heartening to know practitioners are finding the consultation service valuable.

The Board works closely with the Oxfordshire Safeguarding Children's Board to ensure that we have a consistent view of safeguarding across the age groups and work together on issues that affect both adults and children in Oxfordshire. I look forward to the challenges of the year ahead for the Board with all the concerns there are for the lives of vulnerable people across the County. There has never been a time when safeguarding has been more important.

Dr Sue Ross
Independent Chair of the Oxfordshire
Safeguarding Adults Board

WHAT IS THE OXFORDSHIRE SAFEGUARDING ADULTS BOARD?

The Care Act 2014 says that Local Authorities must have a Safeguarding Adults Board in place from 1st April 2015.

The Oxfordshire Safeguarding Adults Board has provided leadership for adult safeguarding across the county since 2009. The Board is a partnership of organisations working together to promote the right to live in safety, free from abuse or neglect.

Its purpose is to both prevent abuse and neglect, and where someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Care Act says key members of the Board must be the Local Authority; the Clinical Commissioning Groups; and the Chief Officer of Police.

The three key members on the Oxfordshire Safeguarding Adults Board are:

- The Director of Adult Social Care, Oxfordshire County Council
- The Director of Quality, Oxfordshire Clinical Commissioning Group
- The Detective Chief Inspector, Protecting Vulnerable People, Thames Valley Police

The Care Act says these key members must appoint an independent chairperson who has the required skills and experience. Pamela Marsden was the Independent Chair of the Oxfordshire Safeguarding Adults Board from November 2016 - April 2019. She had many years of relevant experience as a Director within Adult Social Services outside Oxfordshire.

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience. Oxfordshire's Board has senior representatives from the following organisations:

Oxford University Hospitals NHS Foundation Trust

Oxford Health NHS Foundation Trust

Public Health England

Community Protection Services (Fire & Rescue, Trading Standards & Community Safety)

National Probation Service

Local Councillor with Adult Social Care portfolio

sovereign

healthwatch Oxfordshire

Oxfordshire age UK

Oxfordshire Association of Care Providers

CareQuality Commission

South Central Ambulance Service NHS Foundation Trust

HM PRISON SERVICE

Board Members are the senior people in each of the organisations with responsibility for safeguarding. Their role on the Board is to bring their organisations' adult safeguarding issues to the attention of the Board, promote the agreed priorities and work to embed learning throughout their own organisation.

The Board meets four times each year and alternate meetings include a joint meeting with the OSCB (Oxfordshire Safeguarding Children's Board) where our joint priorities can be progressed. The Board also has multi-agency subgroups focussing on specific areas of work.

WHAT HAS THE BOARD BEEN DOING THIS YEAR?

Improving Multi-agency Working

"working together to ensure people are safe through their life journey"

Training Subgroup (TSG)
Building on feedback from delegates at training, from issues arising in safeguarding concerns raised in Oxfordshire and from learning from case reviews from around the country, in 2018-19 the Board developed new Decision-making in Practice training materials.

Three sessions for care provider services on Making Safeguarding Personal were run over the year. The sessions were well received by delegates and further sessions have been arranged for 2019-2020. Feedback from the sessions has been used to improve what is already discussed around Making Safeguarding Personal in the other OSAB Safeguarding courses.

To support the work of TSG, the Safeguarding Adults Board has recruited a Learning & Engagement Officer. This Officer looks after all the training provided by the Board, ensuring it reflects the current issues in safeguarding. They will be supporting the engagement work the Board is planning for next year.

Vulnerable Adults Mortality (VAM) Subgroup
The VAM group was initially set up in response to the deaths of adults with a learning disability who died while in the care of Southern Health. Once the group have reviewed those deaths, it continued to meet to oversee the reviews required under Learning Disability Mortality Review (LeDeR) process.

As a result of the learning from case histories that came to the Vulnerable Adults Mortality Subgroup for analysis, changes were made to how record-keeping is reviewed and quality assured, with a particular focus on how mental capacity is recorded.

Performance, Information & Quality Assurance (PIQA) Subgroup

PIQA receives multi-agency performance information, including data on the use of advocates, a key mechanism for ensuring all work is in line with the principles of Making Safeguarding Personal (MSP).

Oxfordshire is acknowledged as a frontrunner nationally in the quality and quantity of its MSP data and practice. The Local Authority is part of a national pilot around the collection and use of MSP data.

The outcome of a safeguarding investigation is categorised as either having the risk reduced, removed or that the risk remains. The service user is also asked whether they are happy with the outcome of the safeguarding investigation. This year PIQA was concerned to find out more about those cases where the risk remained and the service user was recorded as not being happy with the outcome. Out of more than 1,200 investigations, less than 20 fell into this category. From the initial findings of audits into these cases, it appears they were service users who were unhappy an investigation was undertaken at all.

Full Board

Mental capacity is a recurrent issue in safeguarding cases and as such, the Full Board has been kept up-to-date on practice issues relating to mental capacity as well as potential changes to the Deprivation of Liberties Safeguards (DoLS). The Mental Capacity (Amendment) Bill received Royal Assent in May 2019 so the Board will receive further briefings on the implications during 2019-20.

Focussing on its own effectiveness, the Full Board also reviewed the membership of the subgroups and narrowed down the information requested from them. Each now has a set of questions that form the basis of the quarterly update to the Full Board.

The Full Board received presentations from the Multi-Agency Public Protection Arrangements (MAPPA) Coordinator to understand how those released from prison under license are monitored to protect the wider community.

As part of the Board's aim to hear more from frontline practice, practitioners from Adult Social Care and Oxford Health NHS Foundation Trust presented recent cases to the Full Board to highlight how complex the issues are facing those coming into safeguarding services.

Define and develop a multi-agency risk assessment tool

In 2018-19 the Board agreed it would look at developing a multi-agency risk assessment tool. The Board brought together a small group to work on this item but encountered numerous barriers to success. It became clear that the complexity of current risk assessment arrangements was based on genuinely different requirements and structures of diverse organisations, making a universal risk assessment tool impractical.

Monitoring Key Issues

"Ensuring progress is being made on the issues that matter"

The Board decided to monitor the thematic priorities identified by Board Members that remain at the forefront of safeguarding work but whose governance fell to other partnerships.

Prevention and early intervention – the strategy around this is owned by the Health & Wellbeing Board (HWBB). Board Member agencies were consulted on the strategy as it was developed. In 2019-20 the OSAB will request an update report from the HWBB on progress in this area.

Mental health service provision – the Joint Strategic Needs Assessment identified the continued increase in demand on mental health services in Oxfordshire. The OSAB will challenge the HWBB on how needs are being met if the lack of services results in an increase in safeguarding concerns. Public Health are overseeing the Suicide Prevention Strategy, which also forms part of the work around mental health.

Exploitation – modern slavery and exploitation is an increasingly important issue across the country and with several high profile cases in the county, it is of particular concern to organisations in Oxfordshire. Locally there is the Anti-Slavery Network and the Modern Slavery Partnership Group who are working towards reducing slavery and exploitation. The Modern Slavery Partnership Group is under the governance of the Safer Oxfordshire Partnership and also reports to the bi-annual joint Safeguarding Board meeting.

Service User & Community Engagement

"Presumption of person led decisions and informed consent"

Engagement Group

In 2018-19 the Board established an Engagement Group to improve the links between the Board, frontline workers, community groups, service users and other stakeholders. The group was set up to help develop accessible, clear and concise material to promote safeguarding.

The group has overseen the production of several posters, which are all available on the Board's website, promoting what to do if someone has a concern about themselves, a friend/relative or someone they are working with.

In 2018-19 the Full Board also recruited two lay members to provide another form of challenge to the Board. The lay members helped to review last year's draft annual report and rework several sections to make it as accessible as possible to a wider audience. The report was praised across the partnership and within the leadership teams of various agencies, including elected members.

Early Help Strategies & Initiatives

"It is better to take action before harm occurs"

The OSAB receives information from services around the work being done to prevent issues occurring. For example, the County Council Fire & Rescue Service provide their data on the Safe & Well visits they conduct. The data has shown that the service continues to achieve its targets in relation to the delivery of Safe and Well visits. The Fire & Rescue Service are looking at how they can improve their approach to targeting their Safe and Well visits to those who are most at risk through incorporating wider data and intelligence gathered by other partners into their risk profiling; for example, could data collected by the district councils on bin emptying be used to identify those with mobility issues and therefore those who might benefit from a Safe and Well visit?

The two Boards have run a safeguarding awareness session for elected members, along with producing a one-sided briefing about adult safeguarding for elected members with the key contacts in case a constituent comes to them with an issue.

The Safeguarding Consultation Service run by the County Council has continued to see increased use, proportional to the decrease in concerns being raised. This indicates the service is helping to identify concerns that do not meet the criteria for being a safeguarding concern before they are formally raised.

In 2019-20, the Performance, Information & Quality Assurance Group will audit the consultation service calls to understand more about who is using the service.

The two Safeguarding Boards have developed a joint training strategy for safeguarding across Oxfordshire. The aim of the strategy is to provide a consistent approach to safeguarding training across the workforce of Oxfordshire. The strategy is has been set to run for three years, with annual reviews to ensure it is still meeting the needs of the workforce.

Working with the Children's Board

"working together to ensure people are safe from birth until end of life"

The OSAB has worked jointly with the Children's Safeguarding Board on a number of priorities.

Multi-agency **Domestic Abuse** training is now up and running and consultation has just been completed on the next 5-year domestic abuse strategy.

A **Housing** network has been set up led by local housing providers, a multi-agency housing audit is underway and there is good safeguarding board representation.

Transitions work ensures that there is good cross-over between child and adult services and any concerns are quickly escalated.

In addition, **modern slavery issues** are reviewed to maintain a clear view of trends and ensure an effective response is being mobilised across the county.

HOW WE KNOW WE ARE MAKING A DIFFERENCE

Here are four examples of how the work of the Safeguarding Adults Board is making a difference to the residents of Oxfordshire.

All names have been changes to protect identities

Ben

Ben has a chronic mental health problem requiring regular medication. It came to the point that he was living in squalor (accumulations of rubbish and rotting food, house not cleaned at all, etc). He was isolated and had no social network. Ben was unable to make any changes to his situation by himself.

Through thoughtful and patient engagement with Ben, he was coaxed into agreeing to emergency respite care in a care home where he met people he liked. This was an opportunity to clean up his home. It was also an opportunity to explore with him his options about changing his situation. He now attends a day centre and has a social outlet.

Ben's mental and physical health have improved, as he himself is happy to acknowledge.

Adam

A concern was raised with the County Council's Safeguarding Team, that Adam, a retired clergy man, was under coercion to live with his daughter in Oxfordshire thereby making him estranged from his wife (who lived in another county) against his will.

As part of this arrangement, Adam was also unable to have private telephone conversations; telephone conversations were monitored with bugging devices by his daughter.

The Safeguarding Team spoke to Adam, his wife, and daughters. they found that Adam indeed lived in Oxford to please his daughter who had been helpful and supportive to him. He was saddened because it was contrary to his spiritual beliefs to live with his wife of over 50 years. He still desired to return to live with his wife and his wife wanted him back home. He was also sad that he had not been free to speak to his wife or pray with her by telephone. The Safeguarding Team facilitated Adam's return to his wife, which made him very happy.

Adam's daughter had complaints about the care provided to her father in the county where he had lived with his wife before coming to live with her. There were concerns about the care agency as there appeared to be no written agreement on what care would be provided, the care that had been provided was poor quality and the charges for what was provided were excessive (nearly £12,000 charged for 2 months care). However, they had felt there was no choice but to pay as there was no alternative provider.

The Safeguarding Team worked with the neighbouring authority to investigate these allegations. The allegations were partially substantiated and Adam confirmed that he received poor care from a particular carer but chose not to name the person because he did not want anyone to be punished. He was happy enough to be re-united with his wife.

The investigation found that the agency was not registered with Care Quality Commission (CQC). The agency is now being investigated by the CQC. The manager of the agency has learned lessons about care planning and working with statutory services to ensure their client's needs are met.

Carl

Carl has a long term physical illness which is affecting his cognitive ability and he is not always able to make relevant decisions.

He was admitted to hospital and he was unable to consent to this. His family were very concerned about his ability to cope with the risks of traffic if he went out alone, and an authorisation was put in place to stop him from leaving the hospital. Carl stated he felt incarcerated.

As he received treatment, Carl's abilities were changing. He was kept fully informed and involved with decisions about his treatment and hospital admission. This enabled the staff to reduce the restrictions in place as Carl's level of functioning changed. Things changed from Carl being prevented from leaving the hospital under any circumstances to being escorted to the local shops to buy day to day items. While he was clear that he'd prefer not to return to the hospital, he nevertheless agreed to do so.

Eric

The Fire Service raised a number of safeguarding concerns for Eric due to unsafe living conditions. This elderly gentleman lives in a very large house which has been his family home since birth.

The house is severely hoarded, poor electrical wiring, and rodent infestation. Eric lived in one room on the ground floor.

Safeguarding concerns were also raised by Thames Valley Police and Oxford City Council's Environmental Health department. All these agencies worked together for an extended amount of time to keep Eric living safely in his home for as long as possible.

However, as time passed, agencies became increasingly worried as Eric's living conditions deteriorated further. Following a fall and subsequent stay in hospital, Eric left hospital and went to a temporary placement in a care home. During his stay here, Eric's capacity was assessed according to the Mental Capacity Act, concluding that he did not have capacity to understand the risks in his home.

A 'best interest' meeting was held and the decision was taken that Eric would remain in a care setting where his basic needs were met. His property was made safe and passed into the care of solicitors who have Power of Attorney for him. Eric is thriving in his new environment. He is supported with personal care, enjoys hot meals and clean bedding, neither of which were available to him at home, and he has the stimulation of seeing other people daily.

Danielle

Danielle lives with her husband, her dementia is progressing and she never goes out. Her husband was not coping well and often left her alone for prolonged periods. She is distrustful of strangers and reported passers-by to the Police on numerous occasions.

The Fire Service visited jointly with Adult Social Care and the landlord, a housing association, to assess the risks and see what support could be offered to the couple. A multi-agency meeting was then called, attended by Danielle's husband, to work out how to address the problems in the best interests of Danielle.

The housing association agreed to help with repairs and an electrical safety check, Social Care helped Danielle's husband to get a phone line fitted to enable Assistive Technology to be installed, such as a falls pendant and linked smoke and heat alarms. A local personal assistant was identified and arrangements made to gradually introduce her to Danielle, allowing time for trust to build up.

When the Fire Service re-inspected the property, they were satisfied that the fire risks had been significantly reduced. Danielle is now safer in her own home and Danielle's husband feels supported to care for his wife more effectively.

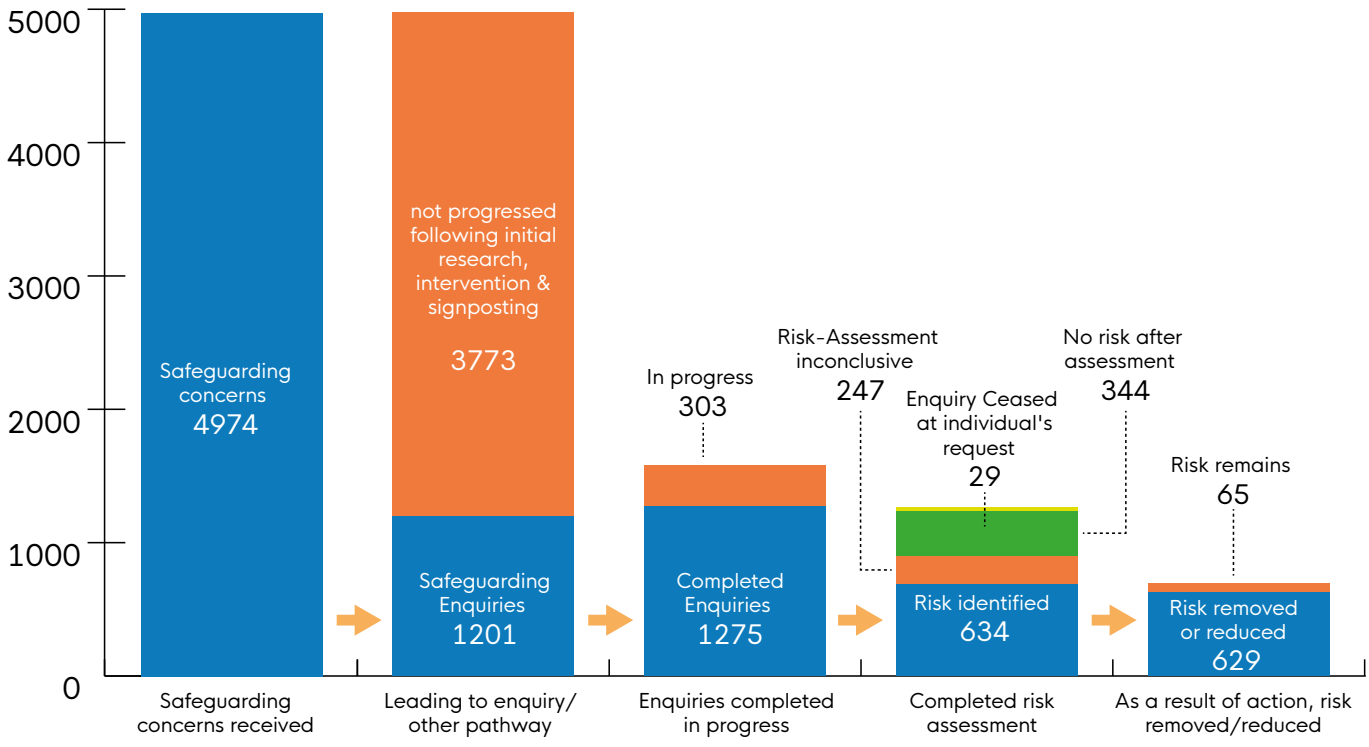
WHAT ARE THE NUMBERS TELLING US

The safeguarding journey - from raising a safeguarding concern to the outcome of safeguarding enquiries 2018-19

Population 18+ with/without care and support needs

495880
without care and support needs

43120
with care and support needs



RAISING OF SAFEGUARDING CONCERNS

We estimate that there are about 43,120 people who have care and support needs in Oxfordshire. This is five and half times the number of adults who received long term support from adult social care in 17-18 (7901)

In 2018-19, Oxfordshire received a total of 4974 concerns about cases of potential or actual harm or abuse. This is equivalent to around 9 concerns for every 1000 adults in the population or around 115 for every 1000 adults with care and support needs (although please note that not all concerns are raised by existing service users)

The 25% reduction in concerns since 16-17 is offset by an increase in consultation calls received by service from around 613 in 17-18 to 1757 in 18-19.

Most concerns (about 63%) were raised by health, carers or social care staff; the remainder were raised mainly by relatives, friends or neighbours, housing agencies and the police.

RESULTING SAFEGUARDING ENQUIRY PROCESS

A quarter (24.1%) of the concerns received were assessed as requiring follow-up under safeguarding procedures

This is because the people involved were assessed as Experiencing, or being at risk of, harm or abuse; and/or having care and support needs which prevented them from protecting themselves

Those concerns (3373) not followed up as safeguarding enquiries were followed up in other ways, notably referral to trading standards offices, domestic abuse support agencies, the police or the County Council's customer services team

OUTCOME OF ENQUIRY PROCESS

Safeguarding enquiries can take varying lengths of time to complete, depending on the issues and organisations involved. At 31 March 2019, 1275 enquiries had been completed in 2018-19. Some of these will have commenced in 2017-18. 303 of those started since April 18 were still in progress at the end of the year.

A risk was identified in 694 (54%) of completed enquiries in 2018-19; the risk assessment was inconclusive in 208 cases (16%), there was no risk identified in 344 (27%) and the enquiry was ceased at the individual's request in 29 (2%).

Where a risk was identified – the risk was removed or reduced in 629 (91%) of cases.

WHAT WILL THE BOARD WORK ON IN 2019-21?

A business planning meeting of the OSAB in May 2018 agreed the following strategic priorities for 2018-2021 with an annual review to ensure they still reflect the safeguarding picture in Oxfordshire.

Early Help Strategies & Initiatives

Improving Multi-agency Working

Monitoring Key Issues

Early Help Strategies & Initiatives

There are further refinements to be made to the annual self-assessment to understand more about the challenges around prevention & early intervention. Further work is needed to ensure the governance for all strands of early help is clear and understood across the partnership.

Improving Multi-agency Working

Disseminating the lessons from Safeguarding Adult Reviews will be key within 2019-20. The Performance, Information & Quality Assurance Subgroup are also planning a series of mini-Peer Review sessions between Board Member organisations of their safeguarding systems.

Monitoring Key Issues

Continue to monitor the thematic priorities identified by Board Members: mental health service provision; alcohol and drug abuse and modern slavery and exploitation. These are in addition to the agreed joint priorities for the Safeguarding Boards, currently housing, domestic abuse and transitions from child to adult services.

Service User & Community Engagement

For 2019-20, Engagement Group the group is supporting the Social Isolation & Loneliness Workshop being run in October 2019. This will be followed up by a series of meetings in each district area, bringing together community groups and services with those at risk of loneliness and those working with people at risk of loneliness.

They will also work on the Adult Safeguarding Awareness Week (18th November 2019).

GLOSSARY OF TERMS

Safeguarding
Safeguarding means protecting our right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and reduce the risk of abuse and neglect. When people have experienced abuse or neglect, safeguarding is about taking actions that are informed by the person's views, wishes, feelings and beliefs.

Making Safeguarding Personal
Making Safeguarding Personal starts with the principle that we are experts in our own life. Things other than safety may be as, or more, important to us; for example, our relationship with our family, or our decisions about how we manage our money. So, staff are always encouraged to ask 'What is important to you?' and 'What would you like to happen next?'

An Outcome
An Outcome is what you hope to get out of the conversations we have, and the work we do with you. Measuring outcomes helps the Board to answer the question "what difference did we make?" rather than "what did we do?"

Deprivation of Liberty Safeguards (DoLS)
Deprivation of Liberty Safeguards apply when a person in a care, or nursing home, or hospital, is subject to continuous supervision and control from staff, and is not free to leave; under the Supreme Court judgement known as 'Cheshire West', they are deprived of their liberty. Once identified, a deprivation of liberty must be authorised either by the Court of Protection order; or under the Deprivation of Liberty

Safeguards in the Mental Capacity Act 2005; or under the Mental Health Act 1983. If it is not authorised, under the law, it is an illegal detention.

Safeguarding Adult Review

A Safeguarding Adults Review must be conducted where an adult with care and support needs has died as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult.

A Safeguarding Adults Review (SAR) should also be conducted where an adult with care and support needs has experienced serious abuse or neglect as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

Boards can also choose to arrange a review into any other case of an adult in its area with care and support needs.