

Message from the Chair



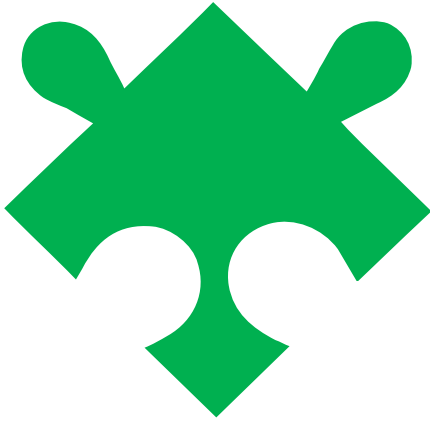
I am pleased to present the seventh annual report of the Oxfordshire Safeguarding Adults Board. It is my second for Oxfordshire as I became Chair in April 2019 and I am delighted to report on all the good work that has been achieved during the period.

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.

While it only affected us towards the end of the year, the current COVID-19 pandemic must be acknowledged. All agencies are experiencing unprecedented demands on their time and many support staff have been reassigned to frontline services. In response to this, I have made this annual report shorter and more focussed so as to take up as little time as possible when our focus, and that of our partners, must be on those vulnerable people of Oxfordshire.

Dr Sue Ross
Independent Chair
Oxfordshire Safeguarding Adults Board

Our Story

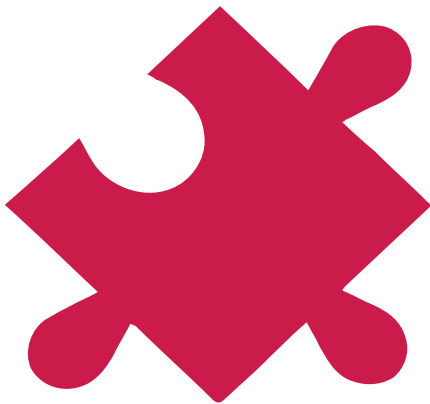


Safeguarding Adults Boards (SABs) were established under The Care Act 2014

An SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective



The Objective of the SAB is to help and protect adults in its area by co-ordinating and ensuring the effectiveness of what each of its members does.



The three core duties on SABs are to:

1. Conduct Safeguarding Adult Reviews
2. Publish a strategic plan
3. Publish an annual report



Partnership

The Board is a strategic partnership group

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

The Board is facilitated by an Independent Chair and supported by a small team.

The partnership is made up of:



How the Board works



- Multi-agency partnership group, bringing together member agencies to agree on strategic safeguarding work
- Provides direction to all subgroups

Executive Group

- Made up of partners who fund the Board
- Drives the work of the Full Board between meetings
- Discusses “emerging” issues or “stuck” issues

Safeguarding Adults Review Group

- Considers cases for a Safeguarding Adults Review
- Manages the reviews once they are commissioned
- Leads on sharing the lessons from reviews

Vulnerable Adults Mortality Group

- Oversees the Learning Disabilities Mortality Review (LeDeR) process
- Leads on sharing the lessons from LeDeR

Training Group

- Shared with the Children’s Board
- Oversees the safeguarding training of the Board and its partners

Procedures Group

- Oversees the multi-agency procedures
- Offers advice & guidance on single agency procedures

Engagement Group

- Oversees how the Board interacts with the wider community of people working with adults
- Inputs on Board publications

Performance, Information & Quality Assurance Group

- Scrutinises performance information from across the partnership
- Manages the quality assurance processes, such as the annual Safeguarding Self-assessment and the Supportive Learning Visits

Annual Safeguarding Self-assessment

The Safeguarding Adults Board, in partnership with the Children's Board, conduct an audit of safeguarding practice for all partner agencies.

Responses are also reviewed at a peer review event, which was held in February 2020.

The 2019-20 Return showed an improvement **across all audited areas**

95% of staff had undertaken safeguarding training in the last three years.

Over **1,700** frontline practitioners were involved in the survey that feeds into this process.

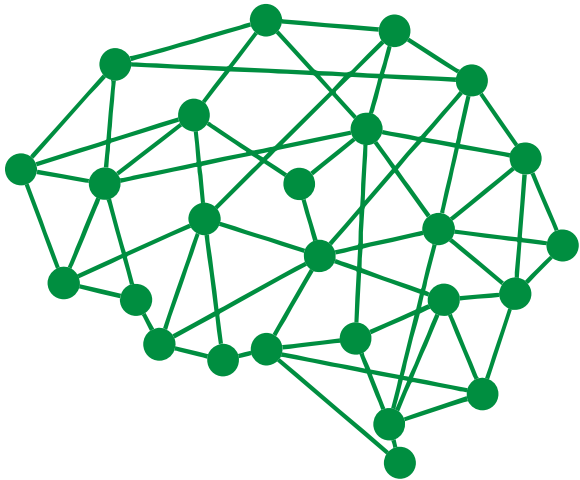
Partners identified **three key concerns** that impact on safeguarding:

- The support for people who do not meet the nationally defined threshold for social care support
- The information sharing, working agreements & communication between organisations
- The increased complexity and the demand on services

Partners also identified **housing and homelessness** as an issue across both Adult and Children's Safeguarding.

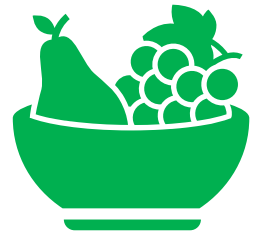
The Board have agreed to make this a joint priority in 2020-21

Deaths of Adults with Learning Disabilities



In 2019/20, there were **35 deaths of adults with learning disabilities** reported to the Vulnerable Adults Mortality Subgroup (compared with 40 in 2018/19). All were reviewed and there were two recommendations from the annual analysis of these deaths.

A number of deaths were associated with the consequences of lifestyle choices where it appeared that the individuals did not have access to information that they could understand and use. Learning Disability teams will lead a piece of work developing lifestyle information for individuals and those supporting them. This will be shared at an Oxfordshire-wide learning event.

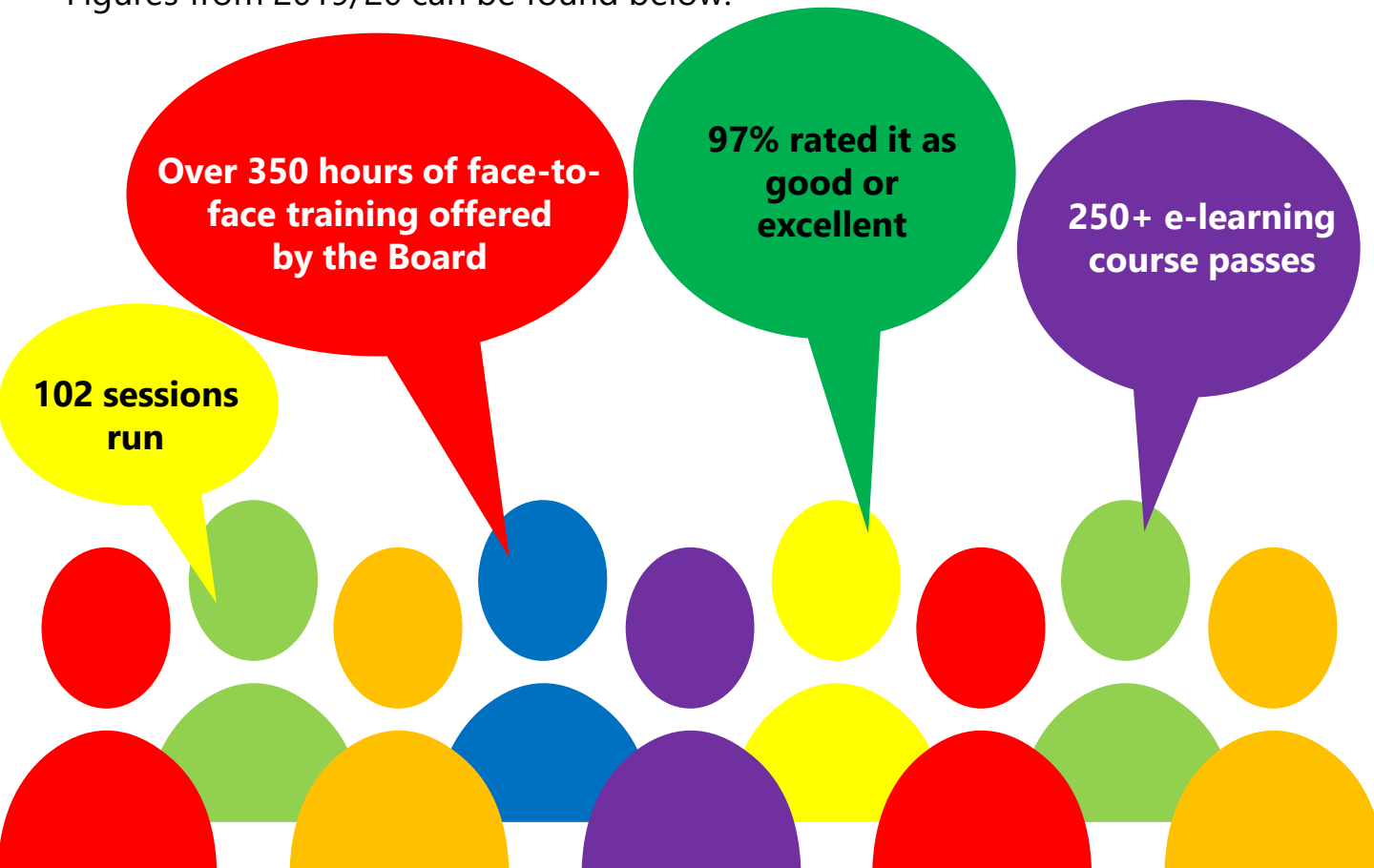


There was a lack of evidence that individuals had been able to access the same health screening as others in Oxfordshire. A project to enhance the information available to anyone with a learning disability, and to promote reasonable adjustments in the way testing can be accessed is being undertaken. The impact of this will be monitored by commissioners to ensure all individuals have equal access to health screening.

Safeguarding training we offer

Since 2017, the Oxfordshire Safeguarding Adults Board has worked with partners to offer a range of safeguarding courses. All these are bookable via the OSAB website.

Figures from 2019/20 can be found below:



Social Isolation & Loneliness

On 8th October 2019, the OSAB supported and co-funded "Let's Talk About Loneliness", a large conference on social isolation and loneliness.

The event was attended by over 200 people from a vast range of community and voluntary groups as well as colleagues from the statutory services. Feedback from the conference was very encouraging, with a high level of satisfaction with the speakers, which included our Chair, Dr Sue Ross.

With 20 workshops as well as the keynote speakers, there was something for everyone interested in helping reduce the chronic issue of isolation in Oxfordshire. Further work will be undertaken next year.

Other work in 2019-20

Performance Information & Quality Assurance Subgroup



As well as the performance monitoring and managing the annual safeguarding self-assessment, PIQA started a new review process referred to as a **Supportive Learning Visit**.

These visits involve a team of peers from partner organisations coming together for half a day to focus on one partner and how safeguarding works within their organisation.

Two have been conducted in 2019/20 and valuable lessons have been learnt by both organisations who have participated. This process will be continued in 2020/21.

The Safeguarding Adults Review (SAR) subgroup has considered seven cases for review.

Several of these involved people in the homeless community. As there was already a review underway, these cases were added to that review to improve the thematic learning. The review into deaths within the homeless community is expected to be published in Autumn 2020.

The group has overseen two Safeguarding Adult Reviews, which will also be published in the Autumn of 2020.

Safeguarding Adults Review Subgroup



Engagement Group

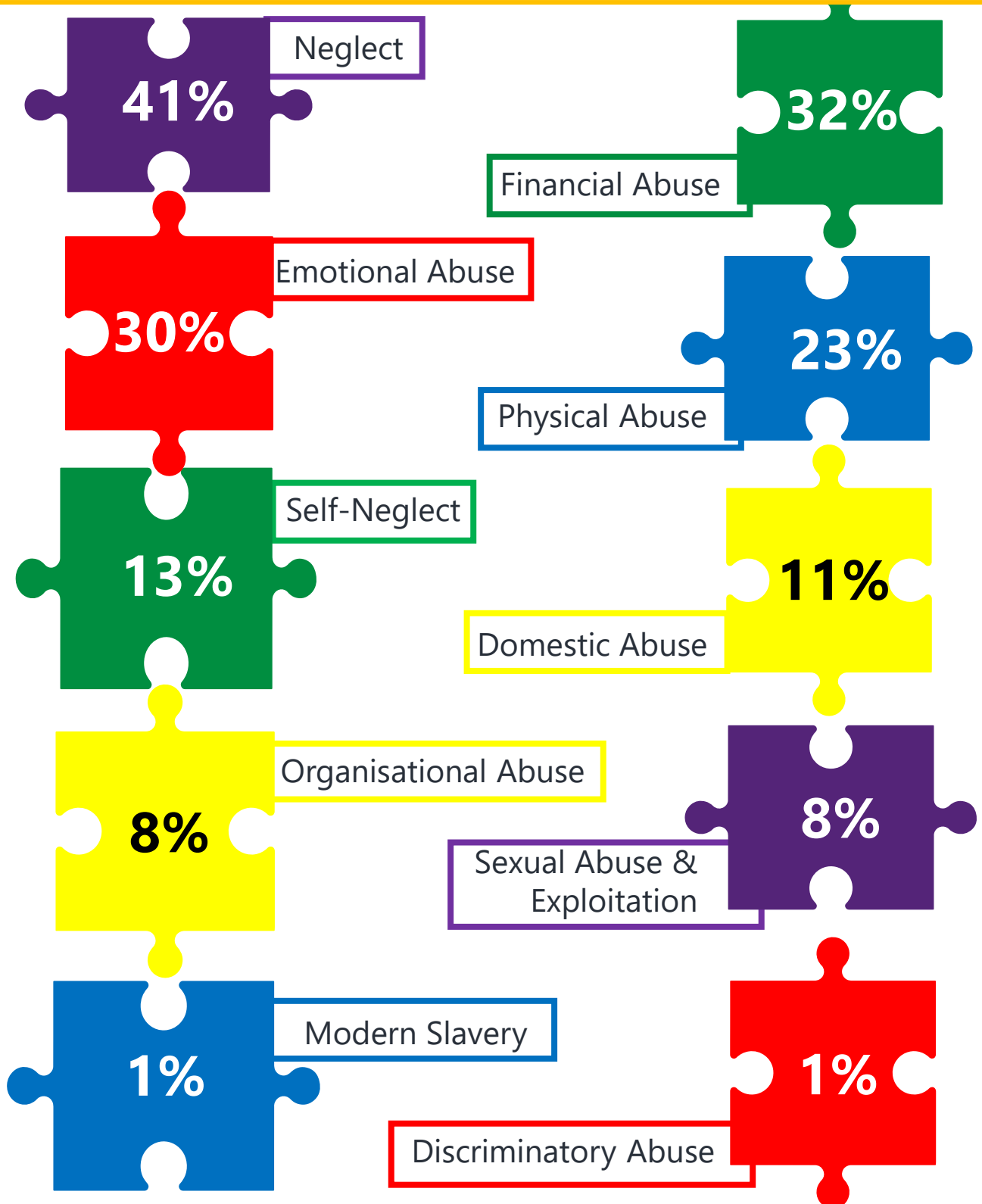


The group, through Healthwatch, conducted secret shopper exercise, the learning of which fed into how Oxfordshire County Council's front door service operates.

The Engagement group also oversaw a review of the OSAB website, as well as created flyers for the general public and for professionals around safeguarding, all available on our website

What Abuse is happening?

This information comes from safeguarding enquiries and the types of abuse, neglect & self-neglect identified by the referrer and the safeguarding team



The numbers will add up to more than 100% as each case can have multiple forms of abuse present. Comparative data from previous years can be found by [clicking on this link](#).

What the data says about our response to abuse

43,419

The estimated* number of adults in Oxfordshire with a care and support need

1,530

The number of consultation calls made about possible safeguarding concerns

5,116

The number of safeguarding concerns raised

1,296

The number of safeguarding enquiries, meaning 25% of concerns became enquiries I.E. they met the criteria for safeguarding as defined in The Care Act 2014

717

Of the enquiries, the number where risks were identified.

660

Of the risk identified, the number where the safeguarding work either removed or reduced the risk

57

The number where the risk remained after the safeguarding work

Adult Safeguarding is complex and people can make choices that we as professionals disagree with as it leaves them at risk. However, it is their basic human right to make these choices and while we can help them to understand possible consequences we cannot force them to live a safer life.

Of those where the risk remained, the number who said they weren't satisfied with the outcome of the safeguarding work. These three cases have been reviewed by the safeguarding service.

3

Journey for 2020-21

The start of 2020-21 saw the entire country plunged into a pandemic that is unprecedented in our lifetimes. COVID-19 has and will continue to have an effect on our services. Increasing levels of mental ill-health are anticipated as people struggle with higher levels of social isolation, loneliness and bereavement.

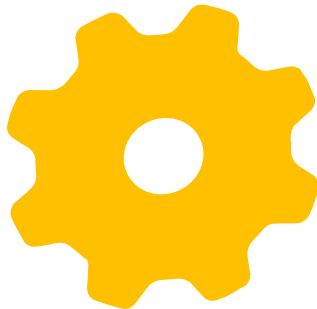
Care and healthcare services are having to develop innovative ways of reaching people in the current climate. People who would previously have got along without help are now relying on their community.

Our response to this during 2020-21 is to do what we can to innovate and broaden our reach. We plan to move more training online so that anyone, anywhere can access the vital training they need. We'll be sharing the lessons from reviews in new and exciting ways to reach those we haven't communicated with in the past.

Foremost, we will continue to monitor services to ensure they are protecting the most vulnerable in our society.

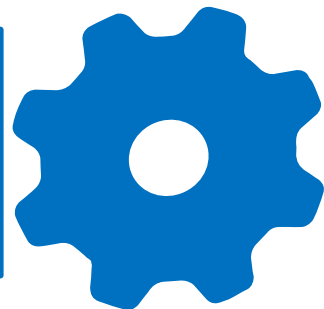
Priority One

Moving training to accessible e-learning and webinar formats



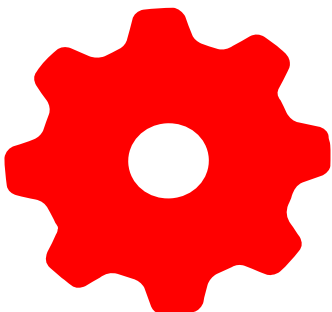
Priority Two

Improving our communication links with non-Board partners



Priority Three

Sharing the learning from Safeguarding Adult Reviews



Priority Four

Maintaining high standards of strategic safeguarding work during COVID-19

