Oxfordshire Safeguarding Adults Board 2016-17 Annual Report

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Executive Summary

The Oxfordshire Safeguarding Adults Board has made great strides in the last year in bringing together partners to better protect adults in Oxfordshire.

How well are we safeguarding people?

Within Oxfordshire we have seen a reduction in the numbers of adults going missing and an increase in the number of care providers rated as Good by the Care Quality Commission.

Our Fire & Rescue Service have conducted over 3,000 wellbeing checks on some of the most vulnerable in our society.

While there has been an increase in activity within safeguarding, we have also seen an increase in those who have had their risk reduced or removed by the interventions of the professionals.

Making safeguarding personal: how we measure it

As part of empowering those who are involved in safeguarding, 90% of people are now defining what they want to happen and a majority report they are satisfied with the outcome of the safeguarding work.

Safeguarding Board effectiveness

The peer review challenge session showed the Safeguarding Board had made “significant improvements across all areas of activity in a relatively short time”. The Board will work to maintain these high standards and has built the recommendations from the challenge session into the strategic plan for 2017/18.

Board Strategy 2017-18

The Board will work on increasing professionals’ understanding of safeguarding across the partnership and improve the levels of concerns that go on to become investigations. We will also work on how we engage those who have experienced safeguarding so the Board hears the voice of these experts by experience to improve our response to safeguarding issues and work to prevent them occurring in the first place.

Introduction by Pamela Marsden, Independent Chair

"I am delighted to present my first report as the Independent Chair of the Oxfordshire Safeguarding Adults Board (OSAB). Following the departure of the previous chair, Sula Wiltshire, Director of Quality/Lead Nurse Oxfordshire Clinical Commissioning Group and Deputy Chair of the OSAB, kindly agreed to become interim chair until my appointment. I would like to take this opportunity to thank her for her contribution and for the help she offered to me on my arrival in November 2016. I am also very grateful to other partners for their welcome to me in this role and their on-going support."

"This has been yet again a very busy year for all of the members of the OSAB. A number of procedures have been reviewed and a significant number of new policies have been agreed. We now have clear guidance around, for example, hoarding and self-neglect. During the year we also saw the adult social work service reconfigure their safeguarding service into a centralised team in order to meet increasing demand and create a more consistent response. Feedback has been positive and the learning from an evaluation in the autumn will help further refine their response."

"The Board was subject to a Peer Review in 2015 and a number of key areas of development were identified. The Peer Review team returned in January 2017 and were impressed with the progress that had been made and the leadership in place to drive the changes identified. The resulting action plan has been incorporated into the overall business plan detailed later in the report."

"Cooperation and commitment to the work of the partnership has been maintained despite the pressures within each individual agency. However, we always need to consider if we can do things differently to make better use of scarce resources and members time whilst ensuring we make a positive impact for those requiring our services. We now have much closer ties with the Oxfordshire Safeguarding Children Board (OSCB) and have agreed a number of joint meetings and priorities for the year ahead to include training, as this will help develop a common approach to safeguarding and support the 'Think Family' policy. The other joint priorities are domestic abuse and transitional arrangements for children who move to adult services, as these are seen as clear areas of risk that straddle the work of both Boards."

"Underpinning the Oxfordshire Safeguarding Adults Board (OSAB) is the work of the subgroups and I would like to thank all of those who take part in progressing the work of the Board. I would also like to thank Steven Turner our Board Business Manager and Diane Dillon, Board Support Officer for all of their hard work this past year. Finally, I would like to thank Members for their interest and enthusiasm and in particular Councillor Judith Heathcoat for her commitment to the safeguarding agenda."

"In 2016 the Government commissioned the Wood Review to consider the work of Local Safeguarding Children Boards. The review has reported its findings and if implemented will lead to fundamental changes. This would not explicitly impact on Safeguarding Adults Boards but there would be learning and unexpected opportunities as a result, so we will need to monitor developments and be mindful of any implications during the forthcoming year. The Law Commission has also reported on its findings and made recommendations on the Deprivation of Liberty Safeguards which again if accepted by Government will mean practice changes and will lead in the Commission's view to a less onerous system whilst still offering human rights protections."

"The report is important because it shows what the Board both as a partnership and through the individual agency activity aimed to achieve this past year on behalf of Oxfordshire residents and what it plans to do over the forthcoming year. What is clear is that the next year will be another challenging one. There is still a great deal more we need to do to reduce the risk of abuse and neglect in Oxfordshire. Our priorities for the forthcoming year are detailed later in the report but a significant development will be greater involvement of service users in the work of the Board and ensuring that the approach to those requiring our services is always person-centred and empowering. We also need to ensure we continue to refine and develop a data set which helps us evaluate our effectiveness."

"I look forward to continuing to chair the OSAB and I hope it will be a rewarding year where our aim of safeguarding the most vulnerable in our communities continues to be realised."

Who are we protecting?

The Care Act 2014 places duties on statutory agencies (e.g. social care and health) to protect adults with care and support needs.

Oxfordshire is the most rural county in the South East. It has a population of around 672,500 people, one third of which lives in towns or villages of less than 10,000 people. The population has grown by 10% in the last 15 years and there is a predicted increase of 13% over the next 10 years.

Population growth in Oxfordshire

Over the next 5 years we are expecting a growth in the elderly population in Oxfordshire and a further increase by 2030[1], detailed below.

Age Group	Next 5 years	2030
18-64	4%	9%
65-74	2%	20%
75-84	21%	43%
85+	17%	57%

In addition - with the growth in the elderly population - national estimates suggest the proportion of adults with a learning disability with eligible care and support needs will rise by around 2% per year. Many of these will have some or all of their needs met by their family and friends.

[1] Further information can be found in the Joint Strategic Needs Assessment 2017 https://mycouncil.oxfordshire.gov.uk/documents/s36717/HWB_MAR2317R05-%20JSNA.pdf

Making Safeguarding Personal

Making Safeguarding Personal means our approach to working with adults with care and support needs should be person-led and outcome-focused. It should engage the person in a conversation about how best to respond to their safeguarding situation in a way that enhances their involvement, choice and control as well as improving quality of life, wellbeing and safety.

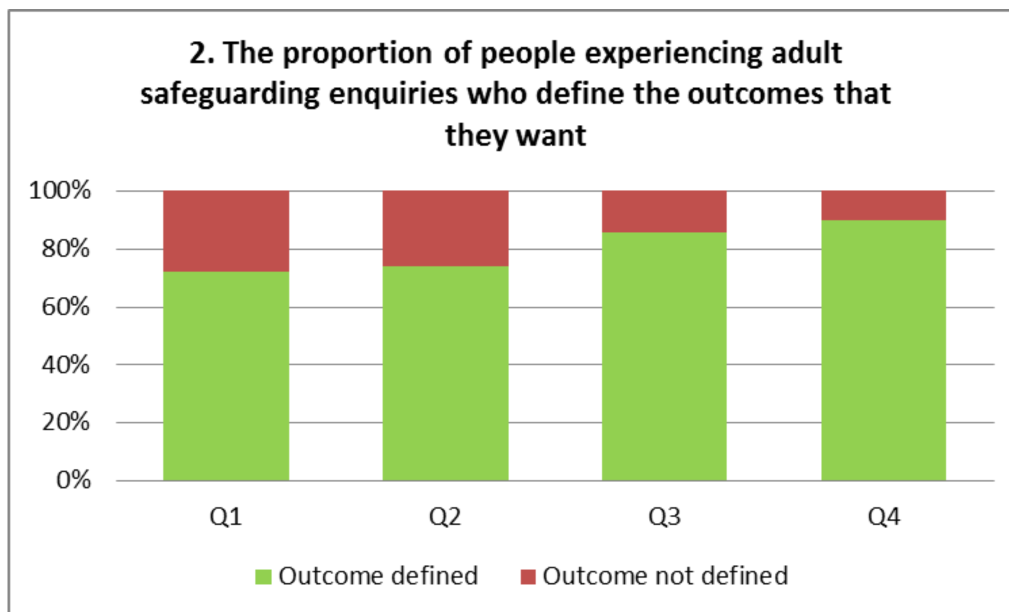
Six key principles underpin all adult safeguarding work:

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs.
- **Proportionality** – The least intrusive response appropriate to the risk presented.
- **Protection** – Support and representation for those in greatest need.
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** – Accountability and transparency in delivering safeguarding.

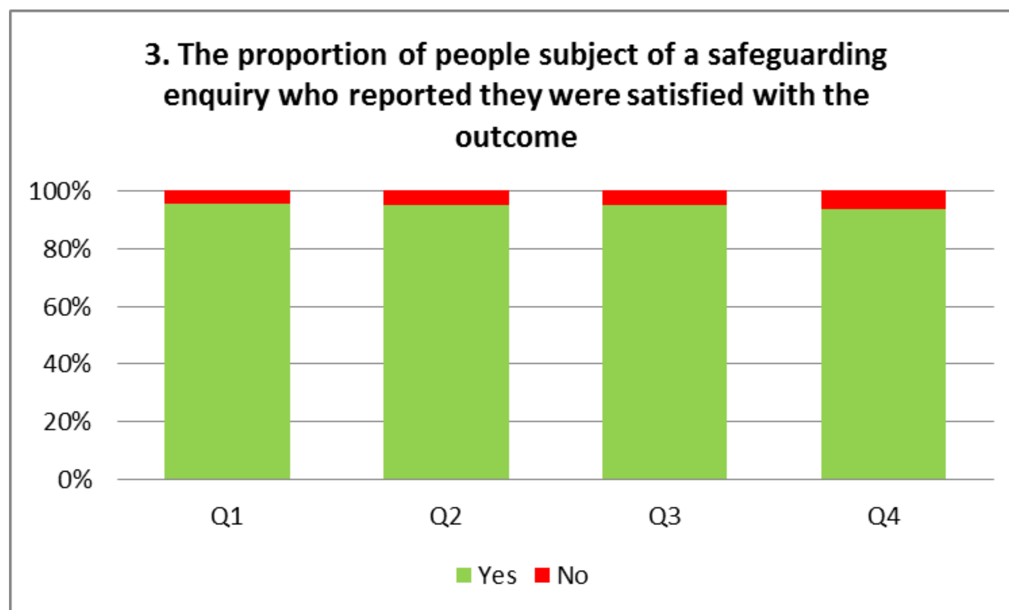
In addition to these principles, it is also important that all agencies take a broad community approach to establishing safeguarding arrangements. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

By the end of 2016-17, of those adults subject to the 1,778 safeguarding enquiries, 90% of people had defined the outcomes that they wanted in comparison with the start of the year figure of 72%.

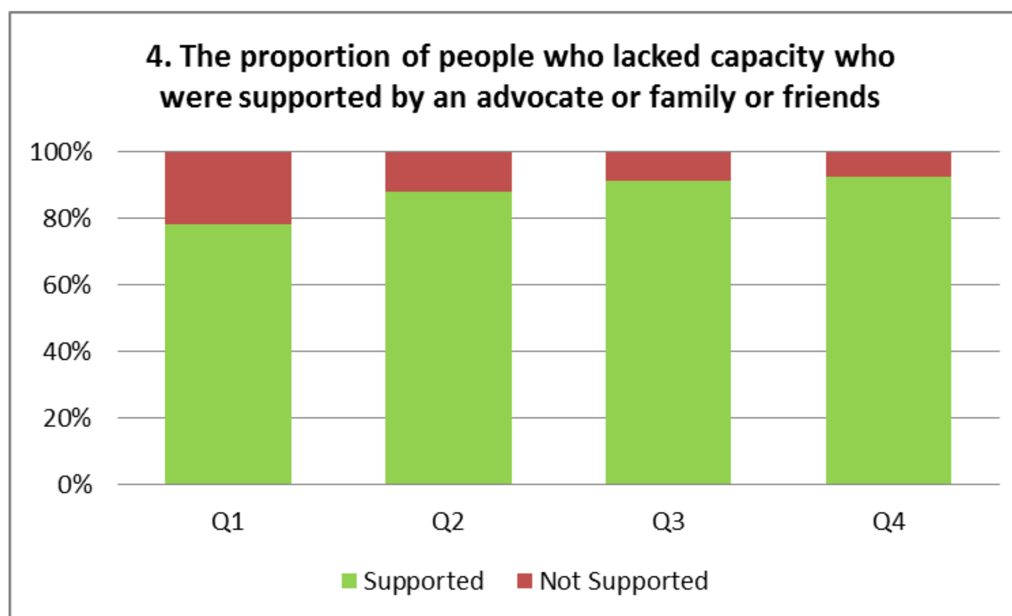
This increase is believed to be due to empowerment becoming more embedded in practice across the partnership, with professionals placing the adult firmly at the centre of all their actions to help protect them.



Most people who responded indicated that they were satisfied with the outcome of their enquiry. In all cases where people were not satisfied the Safeguarding Team followed up to see if there was learning for professionals on how we could better safeguard the person in future.

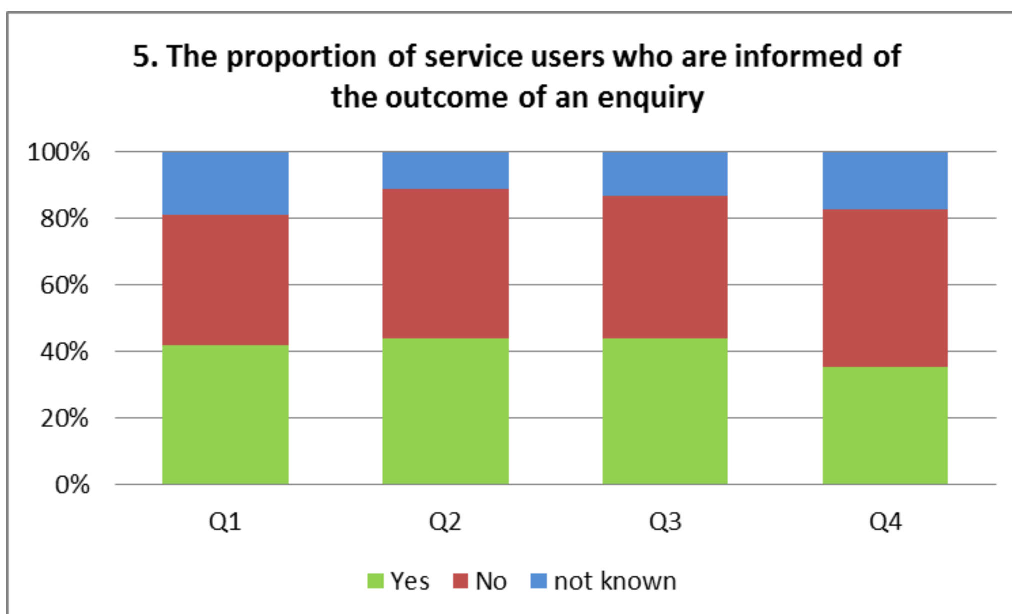


By March 2017, 97% of people who were recorded as lacking capacity, were supported through the enquiry process by an advocate, family or friend. Performance has improved throughout the year as Making Safeguarding Personal becomes more embedded. The focus on this will continue in 2017-18.

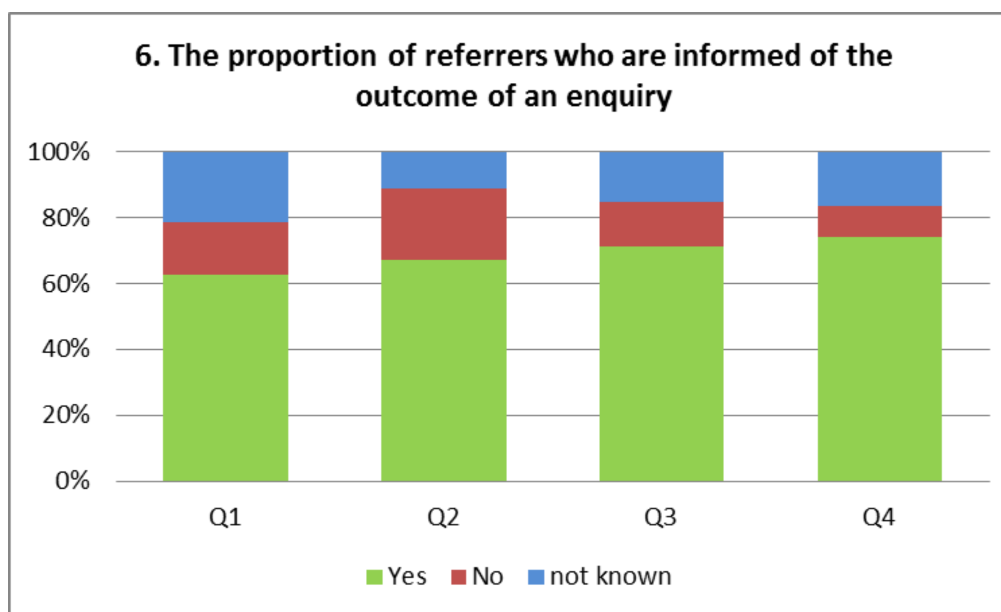


42% of service users and 68% of referrers had been informed of the outcome of their enquiry.

The reported figures only count the number of service users who are directly informed. Where an advocate is involved as the person has substantial difficulties participating in the safeguarding process, the advocate will be informed for them to relay to the person with care and support needs.

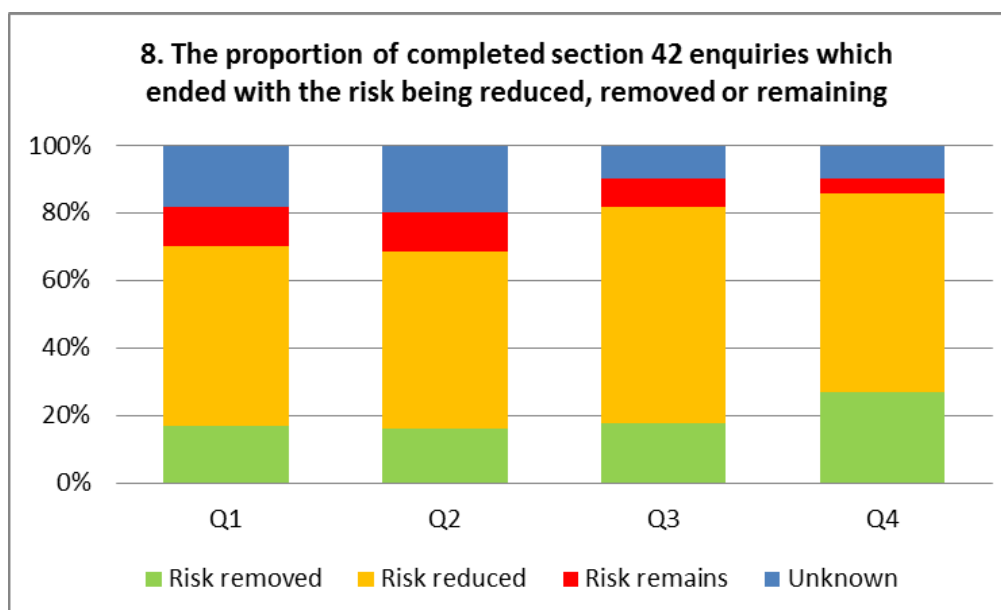


The number of referrers being informed of the outcome is steadily increasing and our focus is to constantly improve this.



For completed enquiries the risk was removed or reduced for 75% of enquiries. As the diagram shows, performance has improved quarter by quarter.

Following the principles of Making Safeguarding Personal which focus upon the outcome with the service user, the number of cases where the risk is reduced improved in each quarter. In the small number of situations where risk remained, this has been due to the individual making the choice not to follow the protection plan. In these cases, mechanisms were put in place to monitor so the risks are not increased.



Making Safeguarding Personal: a local case study

The Safeguarding Team received a concern from a professional about this service user's potential vulnerability with regards to a relationship with a male who was known to their service. They were concerned that the relationship was potentially exploitative due to the fact that the service user was very dependent on the male.

The Safeguarding Team therefore arranged to meet with both the service user and carer initially to discuss how they were coping with the current situation and find out whether they needed any additional support. They met with them separately, the purpose of this being to establish whether the service user was happy with the relationship and whether she felt safe.

A mental capacity assessment was completed and it was agreed that based on the information received she had capacity to consent to this relationship. The Safeguarding Team provided her with guidance around ways that she could receive support if she did not wish to continue with the relationship.

By doing this, the service user was able to make an informed decision about her life and relationships and both were informed of the support available to them.

How did the Social Worker help you?

"I saw [the social worker] once with [alleged abuser] and once alone. She made me feel comfortable – good at listening – caring – I did get a little annoyed by all the questions but that it is her job and she was just making sure I was safe"

How well did the Social Worker communicate with you?

"Very good and aware of my circumstances and conditions"

Is there anything the Social Worker could have done better?

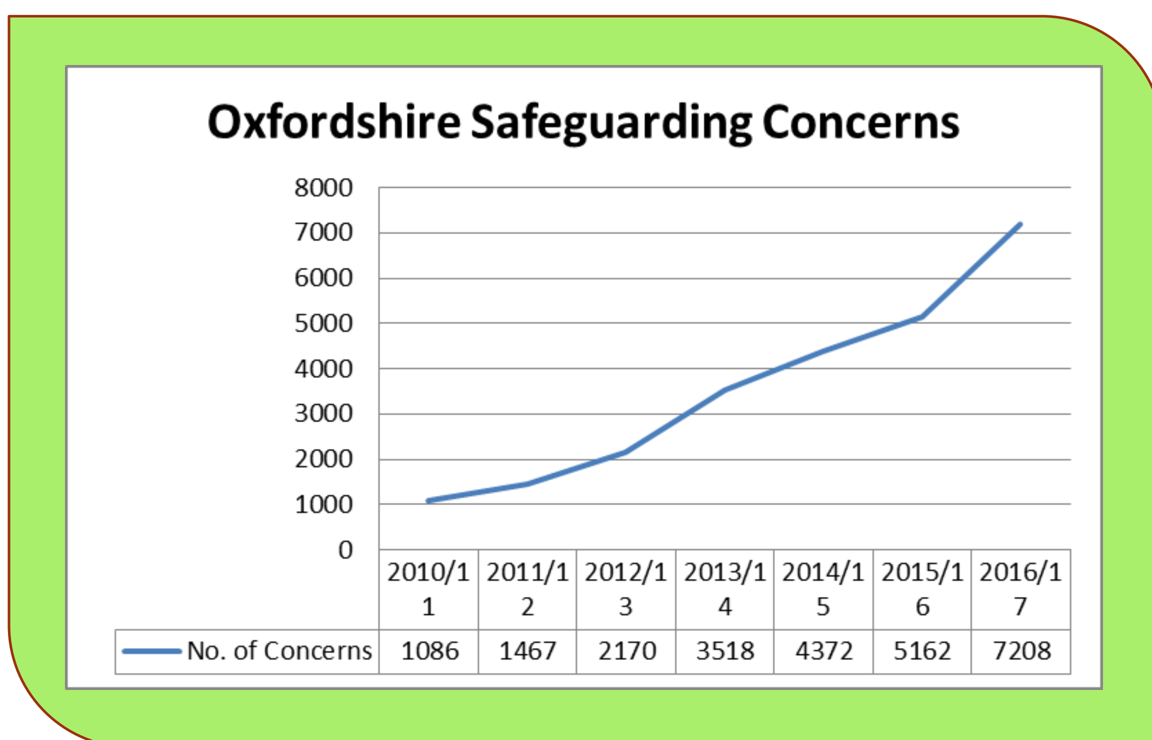
"No, she did everything to make sure I felt safe and comfortable – and to see if I could understand my money – she was concerned about [alleged abuser] – so took him outside to have a private chat with him to understand if he was an abusive person or not. She then came to see me on my own so that I could talk and say what I liked without [alleged abuser]'s presence."

Safeguarding Activity Data

Safeguarding Concerns

Oxfordshire received 7208 concerns, formerly known as “alerts”, in 2016-17. This was an increase on 2015-16.

The number of concerns has increased consistently over the period since 2010/11 and is now over 6.5 times the figure in 2010/11. This is thought to be because of a greater public awareness and simpler ways to raise a concern (80% of all concerns raised this year have been electronic) rather than an increase in instances of abuse and neglect.

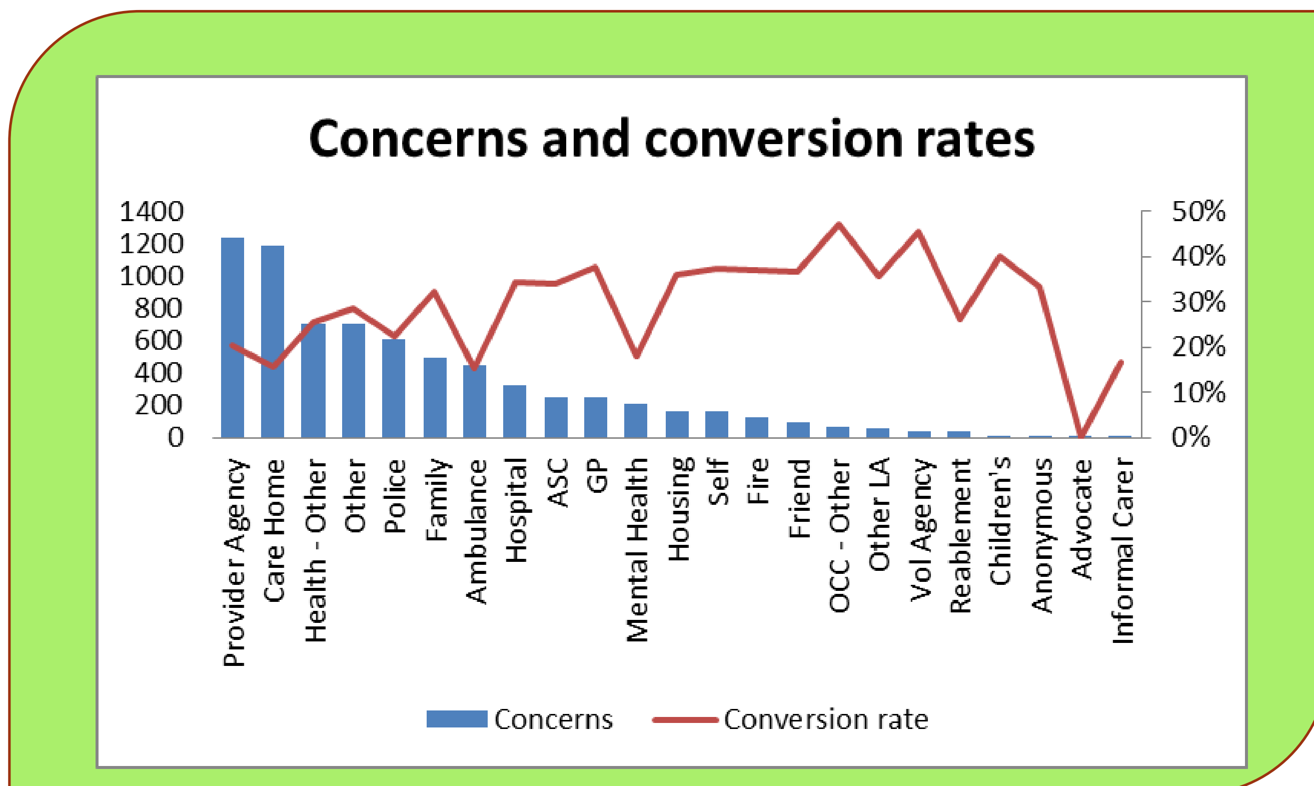


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
No. of Concerns	1086	1467	2170	3518	4372	5162	7208

Concerns and Conversion

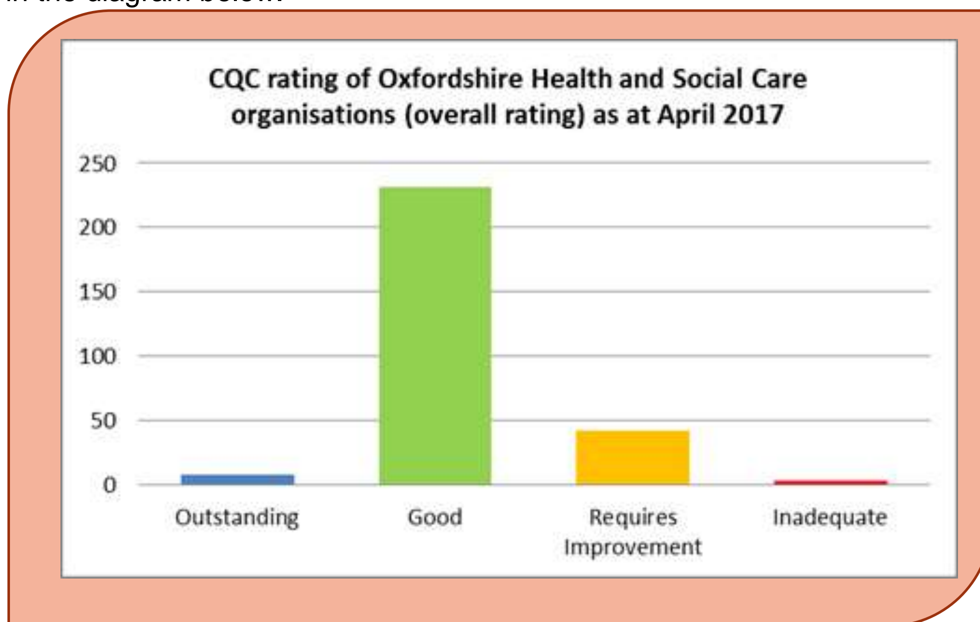
Oxfordshire care homes and provider agencies account for 34% of all concerns raised. Health Services account for a further 27%. 10% of concerns were raised by family, friends or the person themselves. The source of concern is not indicative of the alleged abuse. It is apparent that the conversion rate varies across agencies with higher conversion rates from concerns to enquiries raised by some agencies when compared to others. More information can be seen in the table below.

While there has been an increase in the number of concerns overall the percentage of concerns that require further investigation has fallen. Potentially it may be that as there is now a single countywide safeguarding service the initial investigation is more standardised and consistent, meaning cases are not going through to an investigation unnecessarily and thus the individual is made safe through alternative solutions.



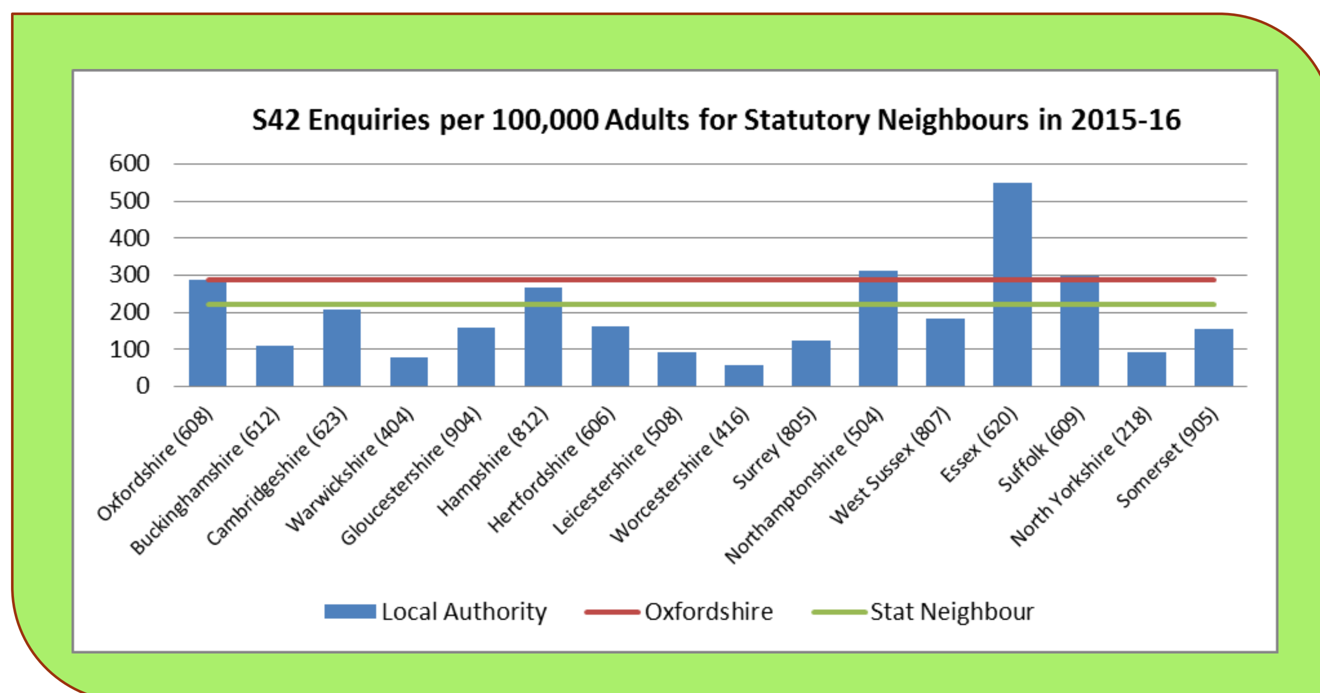
The Safeguarding Board has undertaken audits of the concerns raised by those agencies that have high referral rates but a low rate of conversion to understand why the rates are low. The Board will then commence targeted work with these agencies to improve rates.

It should be noted that Care Quality Commission (CQC) have rated over 90% of the Health and Social Care organisations in Oxfordshire as either good or outstanding, as can be seen in the diagram below.



Safeguarding Enquiries

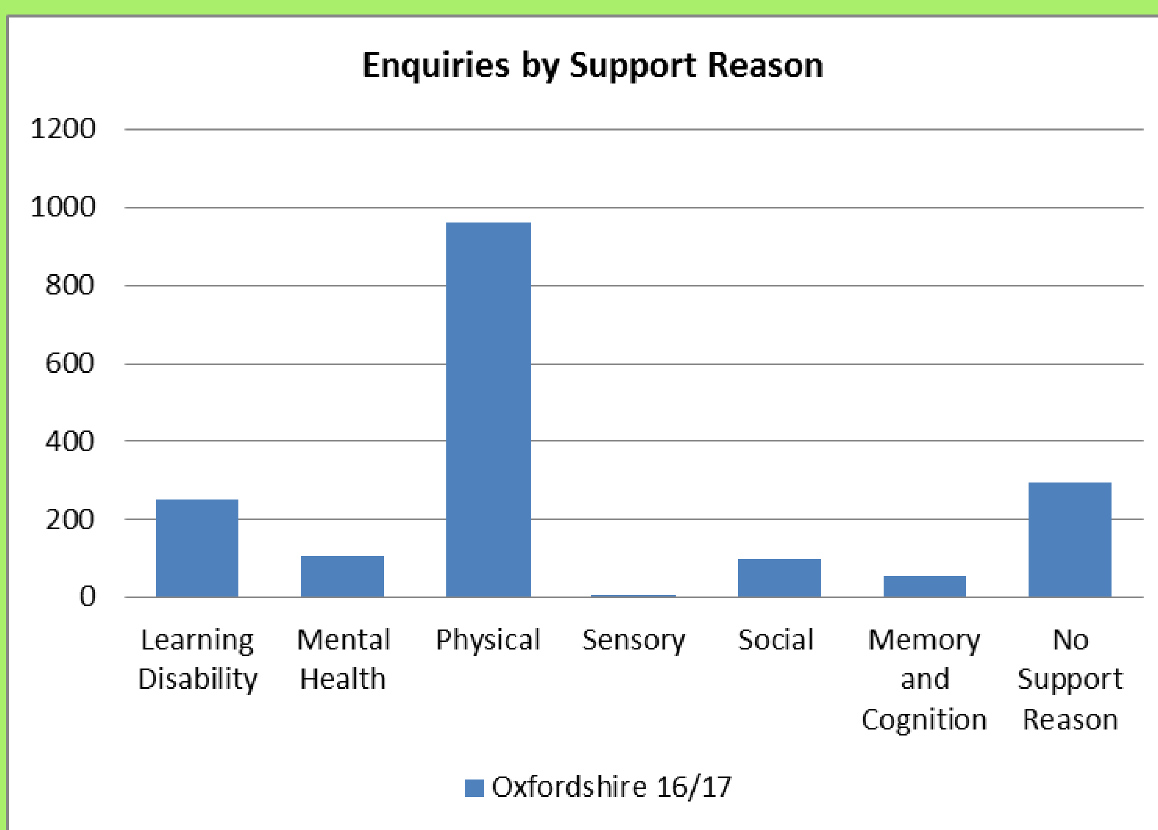
In 2015-16 there were 1542 enquiries (concerns requiring further investigation) which equates to 288 per 100,000 population compared with our statutory neighbours' figure of 222 and an England average of 239. In 2016-17, the numbers of enquiries in Oxfordshire rose to 1778.



In 2015-16, the conversion rate of concerns to enquiries was around 30%, in line with the national figure, but above our statistical neighbours. In 2016-17, only 25% of the concerns converted to a Section 42 enquiry. This is a 5% decrease compared to last year. We do know if that is in line with our statistical neighbours as we do not have as yet any comparative data for 2016-17.

Enquiries by Support Reason

Most people who are the subject of a safeguarding enquiry have care and support needs because of their physical disability. This is similar to the pattern recorded in 2015-16.



Enquiries by Category of Abuse

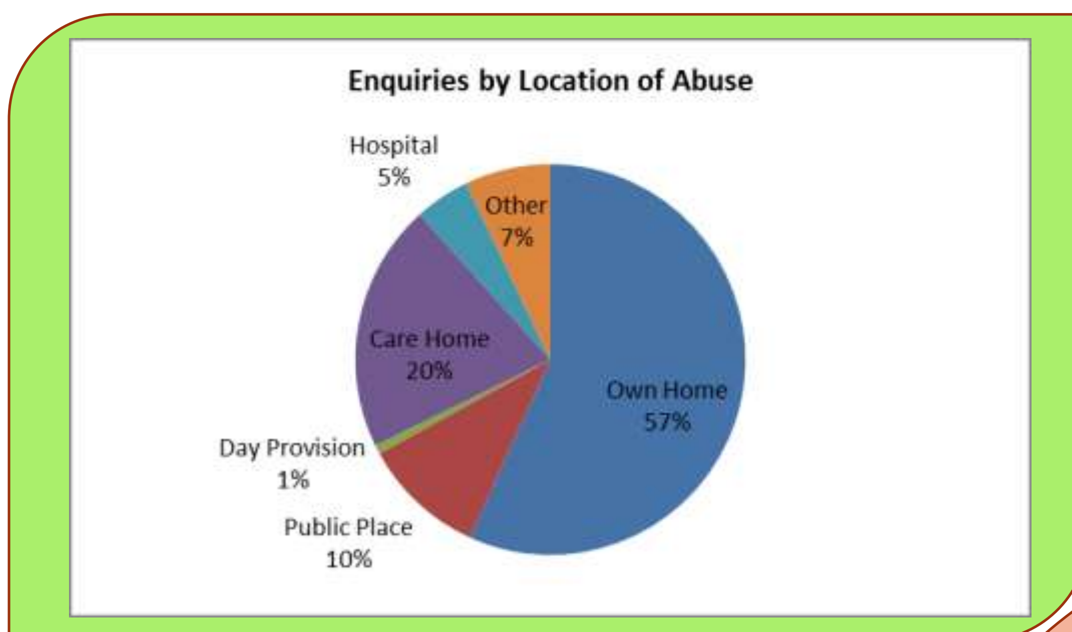
Enquiries by key categories of abuse are shown in the table below. This shows that there has been a rise in Oxfordshire in the numbers of enquiries due to psychological abuse, emotional abuse and also financial and material abuse. 1 in 3 cases are due to neglect and omission, which is in line with national figures for 2015-16.

Abuse Category	Oxon 15-16	Oxon 16-17
Physical	24%	21%
Psychological Emotional	13%	19%
Financial and Material	13%	18%
Neglect and Omission	46%	34%
Other (including discriminatory, institutional and sexual)	5%	8%

The Care Act 2014 introduced new categories of abuse including modern slavery, domestic abuse and self-neglect, but it is not yet possible to report accurately on these categories. Work is underway to ensure that we are able to report on these categories in future years.

Enquiries by Location of Abuse

57% of enquiries are about abuse which takes place in the home of the person. 20% were reported from Residential and Nursing homes.



People subject of Enquiries by Ethnicity

The numbers of people who are the subject of a safeguarding enquiry by ethnicity is shown below. There has been a reduction in the numbers of white people who are the subject of an enquiry but an increase in the numbers for whom ethnicity is not known or not declared. We are investigating the reasons for this and will address it in the coming year. There was only a slight increase in the numbers coming from a minority ethnic group.

Ethnicity	15/16	%	16/17	%
White	1331	86%	1140	77%
Mixed	5	0%	13	1%
Asian/Asian British	28	2%	26	2%
Black/African/Caribbean/Black British	17	1%	20	1%
Other Ethnic Group	6	0%	7	0%
Total Recorded	1387	90%	1206	82%
Not known or not declared	155	10%	270	18%
Total	1542	100%	1476	100%

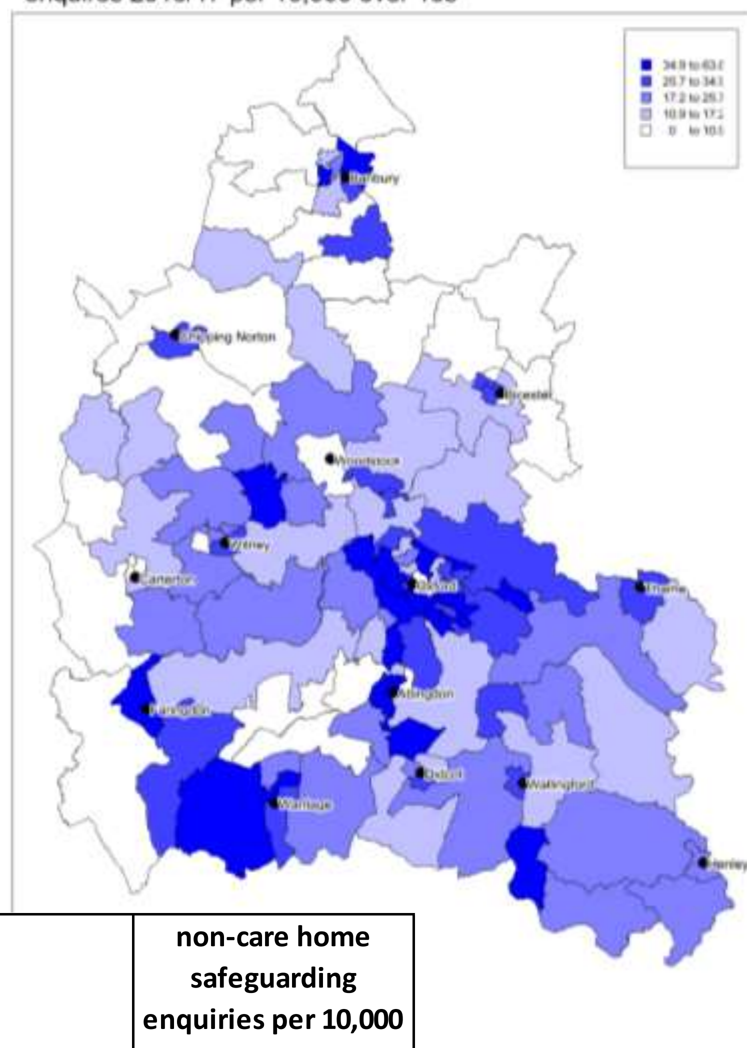
People subject of Enquiries by Age

The number of the people who are subject of a safeguarding enquiry by age group is shown below.

Age Group	15/16	%	16/17	%
18-64	480	31%	516	35%
65-74	220	14%	204	14%
75-84	322	21%	324	22%
85-94	441	29%	352	24%
95+	79	5%	69	5%
Total Recorded	1542	100%	1465	99%
Not known	0	0%	11	1%
Total	1542	100%	1476	100%

The relative numbers of enquiries per 10,000 of the population over 18 are depicted by ward (based on the postcode of the person abused) in the following map.

This is the first year we have reported this data and we will monitor the number of concerns by area to see if there is an increase or decrease in 2017-18. This information will help us set up local multi-agency safeguarding groups to help professionals respond appropriately to emerging concerns and spot patterns and trends.

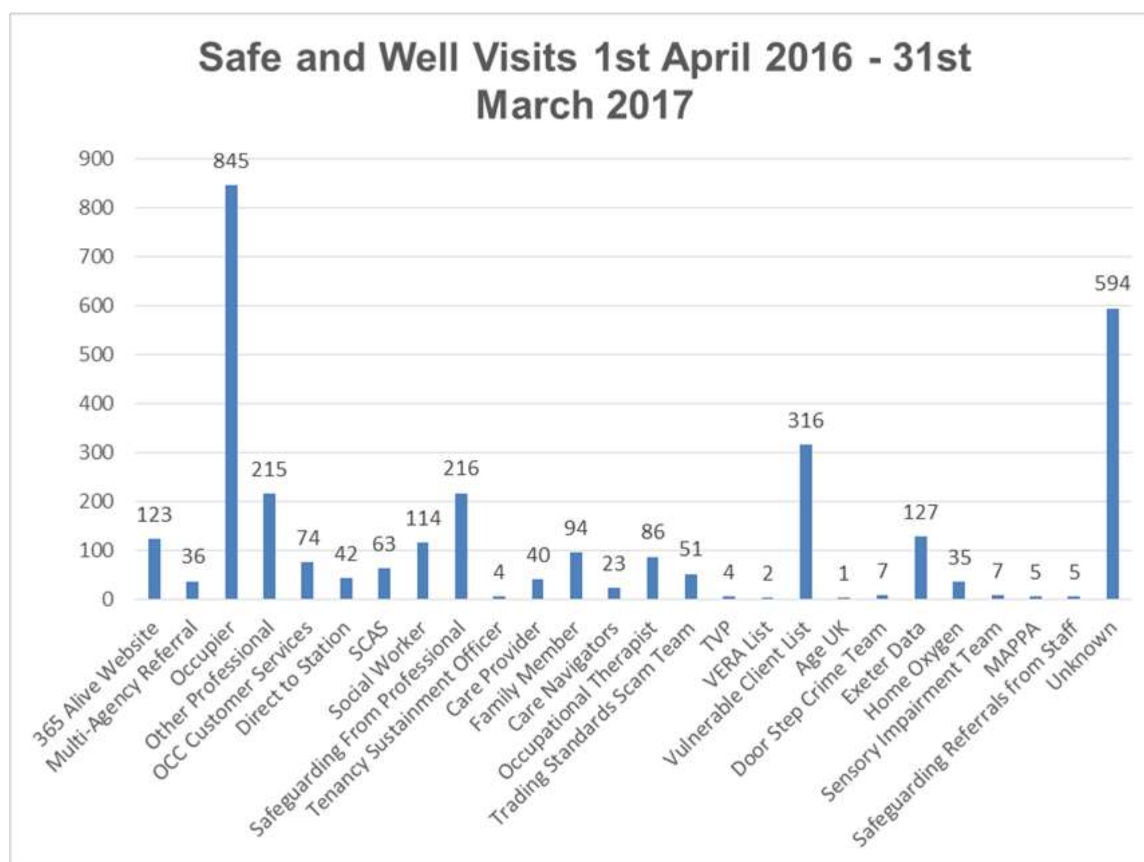


Ward Name	non-care home safeguarding enquiries per 10,000 population over 18s
Blackbird Leys Ward	64
Littlemore Ward	57
Abingdon Caldecott Ward	54
North Leigh Ward	51
Abingdon Abbey Northcourt Ward	50
Barton and Sandhills Ward	46
Rose Hill and Iffley Ward	46
Banbury Grimsbury and Castle Ward	45
Banbury Ruscote Ward	45
Jericho and Osney Ward	45
Iffley Fields Ward	43
Hinksey Park Ward	43

Preventative Work by the Fire and Rescue Service

In 2016-17, 3129 safe and wellbeing checks were undertaken by the Oxfordshire County Council Fire and Rescue Services.

The diagram below shows a breakdown of where the referrals to carry out the safe and wellbeing check originated. It should be noted that support services such as AgeUK work with the occupier to help them make their own referral so would be classed as occupier as the source of the referral.



Deprivation of Liberties Safeguards (DoLS)

There has been a continued increase in referrals following Cheshire West Supreme Court judgment in March 2014. In response to this, Oxfordshire has taken a positive approach to ensuring staff are qualified to complete this increase in applications.

We have an increased number of qualified Best Interests Assessors (60 staff to date).

A key response has been to combine the teams responsible for all Deprivation of Liberty requests, both the statutory DoLS and community Deprivation of Liberty authorisations, to create a high level of expertise.

We have established an Oxfordshire Mental Capacity Act forum continuing to create good working relationships with providers and advocacy services.

Oxfordshire continues to work to meet the necessary demand of the Deprivation of Liberty safeguard (DoLS) applications and has extended its training to target healthcare professionals to share this responsibility with those trained in the local authority.

DOLS Activity 2015-2017	2015-6	2016-7
No. requests received	1433	1739
No. Granted	159	159
No. withdrawn	335	630
No. Not Granted	15	17
Not signed off at year's end	924	933
No. assessments in year	509	806

In March 2017 the Law Commission published its long awaited report on proposals to amend the current Mental Capacity Act and DoLS framework. Significantly, the report proposes to change the name of the scheme to 'Liberty Protection Safeguards' (LPS). At this stage these are proposals only, and the Government's response in awaited.

What is the Safeguarding Adults Board?

The Oxfordshire Safeguarding Adults Board (OSAB) is a group of statutory, private, voluntary, and independent organisations across Oxfordshire who work together to empower and protect some of the most vulnerable members of our community. Our purpose is to raise awareness and promote the welfare of vulnerable adults by the development of an effective co-operative. This group is committed to ensuring that the work done effectively brings about good outcomes for adults so that people live safe and secure lives.

There has been an OSAB in place in Oxfordshire since 2009. However, the Care Act 2014 gave the OSAB a statutory footing for the first time as of 1st April 2015.

The legislation set out three main duties under the Care Act 2014:

- It must publish a strategic plan for each financial year.
- It must publish an annual report detailing what the OSAB has done during the year.
- It must conduct any safeguarding adults review in accordance with Section 44 of the Act.

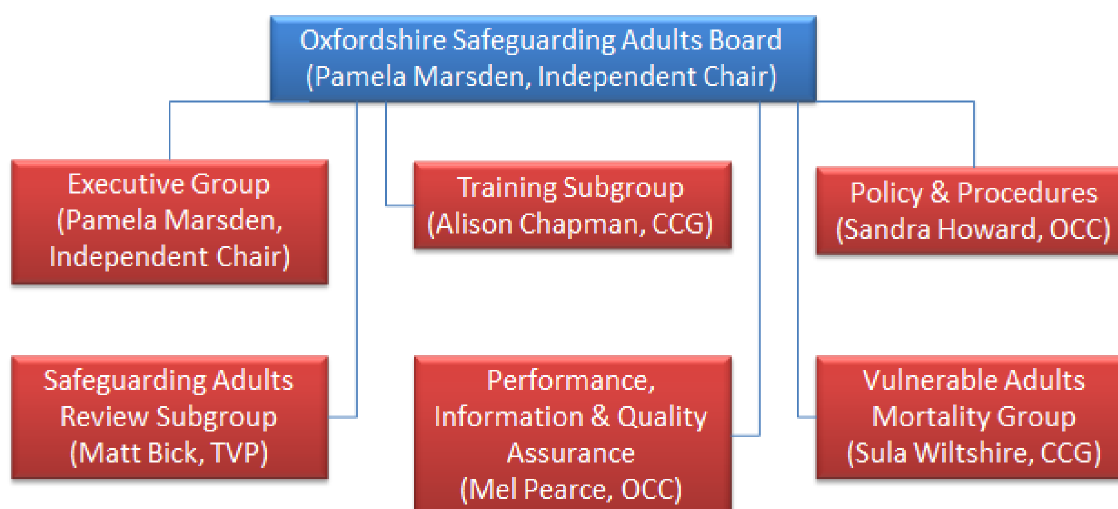
However, the OSAB undertakes many other roles with its partners to ensure individuals in their care are safe and protected.

Governance and Accountability

Board Structure

The Board is supported through the Full Board and six supporting subgroups who drive the work. The subgroups are: the Executive Group; the Training Subgroup (joint with the Oxfordshire Safeguarding Children Board); Policy and Procedures Subgroup; Performance, Information & Quality Assurance (PIQA) Subgroup; Vulnerable Adults Mortality (VAM) Subgroup and the Safeguarding Adults Review (SAR) Subgroup.

The diagram below shows the structure and contains the names of the subgroup Chairs



What have we done

During 2016-17 the Oxfordshire Safeguarding Adults Board undertook significant work to ensure that it fulfilled its statutory responsibilities and has established a firm platform for continuing to do so. This work has been centred around the findings of the 2015 Local Government Association Peer Review.

Safeguarding Board Effectiveness – Peer Review Challenge Session

A peer review was held in 2015 and set a number of recommendations reported in last year's Annual Report (2015-16). In January 2017 the Peer Review team returned to Oxfordshire to see our progress against the actions agreed. The review took place against a background of change for the Oxfordshire Safeguarding Adults Board.

Progress against findings

Progress has been made against all the key findings. Of note were:

- the development and agreement of new Oxfordshire Safeguarding Adults Board (OSAB) joint policies,
- the on-line referral process,
- the greater links between commissioning and contracting, and
- more involvement by all partners sharing leadership roles.

The Peer Review Report Conclusions

"The OSAB should be congratulated for the significant improvements that have been made across all areas of activity in a relatively short time… The Team felt this demonstrated that Oxfordshire has the key building blocks of clear leadership, commitment and energy to make improvements for the benefit of its population."

The actions from the Peer Review Challenge Session have been incorporated into the Strategic Plan for 2017-18, which can be found at the end of this report.

Safeguarding Board Subgroups

Performance, Information and Quality Assurance (PIQA) Subgroup

The Performance, Information and Quality Assurance (PIQA) subgroup has convened quarterly in June, September, December 2016 and March 2017. A new chair was appointed from October 2016.

Performance

- The subgroup has developed an agreed multi-agency draft dataset for agencies of the Board to report on to establish their performance in meeting the needs of vulnerable people, which includes both quantitative and qualitative information.

Action Plans

- It is the role of the subgroup to monitor and track the implementation of action plans from individual safeguarding adult reviews (SAR) and evaluate progress. The subgroup is overseeing two current actions plans following SARs. Further information about the SARs can be found on **page 26**. A draft protocol has been developed, 'Delivering Social Care across Boundaries' following a previous SAR (2016/17) and this will be implemented and reviewed by the PIQA group (2017/18).

Multi-agency Audits

- The subgroup has identified priorities for multi-agency audits, and will then commission the audits and will oversee the implementation of any resulting recommendations and action plans from the audits. There is now a standard template for all audits which has ensured consistency.

Single agency audits

- Following the learning from a Safeguarding Adult Review, Oxford University Hospital Trust and Oxford Health simultaneously shared their annual pressure ulcer reports and action plans to assure the Board of good communication and practice in this area. There is a further audit planned for September 2017.
- There is a further schedule of audits planned throughout 2017/18.

The Vulnerable Adult Mortality (VAM) Subgroup

In 2015, the Mazars Report into deaths within Southern Health Foundation Trust, identified a lack of robust investigation into the deaths of vulnerable adults. Subsequently, in December 2016, Care Quality Commission (CQC) have published a report "Learning, Candour and Accountability", which supported the findings of Mazars, and identified a need to develop more consistent and thorough processes in reviewing deaths.

Since the Mazars Report, Oxfordshire Safeguarding Adults Board has been developing local multi-agency processes for reviewing the deaths of vulnerable adults across its services. In September 2016, it established the Vulnerable Adult Mortality (VAM) subgroup, to provide a forum for reviewing all vulnerable adult deaths in Oxfordshire.

The VAM subgroup review the deaths of all individuals identified with a learning disability, and the death of any vulnerable adult, where concern or suspicion related to the circumstances has been identified. This could include known vulnerabilities affecting access to services, sudden death that was unexpected, and a death which is perceived to be preventable. The purpose of this review is to review the quality of services and learn any lessons, which may inform future care provision. Where any service deficits are identified, these are escalated to the Safeguarding Board for further action.

The outcome of the process is to:

- classify cause of death
- identify modifiable factors
- decide on preventability of death
- consider whether to make recommendations and to whom they should be addressed.

Further information about the process can be found on the Oxfordshire Safeguarding Adults Board website.

The Vulnerable Adult Mortality subgroup is made up of senior staff from strategic partner agencies. Service user representation and small provider representatives are also included where appropriate.

Vulnerable Adult Death Review Process Update

To date 8 cases have been reviewed within the VAM subgroup and all have been considered. At this time there are too few to draw any themes or conclusions about the learning from these reviews, however the discussions have led to improved understanding of service provision within the subgroup.

Joint Training Subgroup (TSG)

The Training subgroup (TSG) continues to provide a strategic overview of interagency training, to promote effective practice to safeguard adults and children, promoting their welfare.

It takes responsibility on behalf of the Oxfordshire Safeguarding Children Board (OSCB) and the Oxfordshire Safeguarding Adults Board (OSAB) to ensure good quality, multidisciplinary training is provided and to support agencies in delivering in-house training, ensuring appropriate use of Safeguarding Board materials. This training will use a mixed learning methodology.

For 2017-18 the partner agencies have agreed an increased contribution to improve upon what we have been able to accomplish to date.

Achievements in 2016-17

- The OSAB Training Strategy for 2016-2018 was agreed.
- Joint training discussions are included in every meeting with OSCB TSG members.
- Training materials for 2 levels (basic awareness and frontline professional) of safeguarding adults training courses finalised. As of 31st March 2017, 5 courses have been run, with a further 16 scheduled over 2017-18.
- The basic awareness course is available online and the frontline professionals course is taught face-to-face.
- Related training areas, such as domestic abuse, radicalisation and Female Genital Mutilation, have all be the focus of joint discussions that have informed both adult and children training courses.
- Work plan priorities from strategy confirmed for 2017-18, including learning events and the annual conference.

Future Plans

- Develop a safeguarding competency framework with training recommendations to meet the requirements of the Oxfordshire workforce.
- Support the development and delivery of multi-agency training related to the expectations and requirements identified in the Mental Capacity Act.
- Develop a pool of experienced practitioners to facilitate multi-agency training on behalf of the Board.
- Promote a learning culture, to support increased joint working through shared learning events.
- Develop a process for quality assuring the training programme.

Policy and Procedures Subgroup

This subgroup is responsible for the development and implementation of local multi-agency policies and procedures for the protection of vulnerable adults from abuse in Oxfordshire that ensure:

- that the abuse of vulnerable adults is identified where it is occurring
- there is a clear reporting pathway
- there is an effective and coordinated response to abuse where it is occurring
- the needs and wishes of the vulnerable adult are central to the adult protection process.

Achievements in 2016-17

Over 2016-17 the Policy and Procedures subgroup has agreed the following policies and procedures which are all available on the Oxfordshire Safeguarding Adults Board website.

- Modern slavery & human trafficking
- Hoarding protocol
- Self-neglect policy
- Complex and organised abuse procedure
- Practice guidance on common safeguarding issues:
    - Trips & falls
    - Incidents between residents in residential settings

Work for 2017-18

1. **Agreement of a multi-agency Allegations Management Policy.** The Care Act 2014 guidance states that a Safeguarding Adults Board should have procedures that include *"a statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by ensuring immediate safety, the processes for initially assessing abuse and neglect and deciding when*

intervention is appropriate, and the arrangements for reporting to the police, urgently when necessary". As of 31st March 2017 the work is nearly completed and is on the agenda for the Summer 2017 Full Board meeting for sign off.

2. **Practice Guidance on Financial Abuse.** This has been an area noted of increasing concern for professionals.
3. **Practice Guidance on Delayed & Missed Visits.** This is an area where a number of concerns are raised that are not safeguarding and so the Board is producing clear guidance for professionals on when to refer.
4. **Review of current procedures.** The subgroups duty is to review the current procedures ensuring that there is a multi-agency approach to improved outcomes for the public.

Safeguarding Adults Review (SAR) Subgroup

The Oxfordshire Safeguarding Adults Board (OSAB) has a statutory duty to conduct a Safeguarding Adults Review (SAR) when a person with a care and support need has died or been seriously harmed as a result of abuse or neglect and there are concerns about how agencies worked together to protect the individual.

Over 2016-17, 12 cases were referred to the Safeguarding Adults Review (SAR) Subgroup for consideration for a Safeguarding Adult Review, 9 involved a death and 3 involved serious harm. In 3 of these cases the adult referred did not have a care and support need as defined in the Care Act 2014. In the cases where the concern centred on the practice of a single agency, the subgroup received the relevant management reports, including action plans to address the findings where appropriate.

Two Safeguarding Adult Reviews (SARs) were completed in 2016-17.

The first SAR was Mrs K, who was admitted to hospital after she had attempted suicide. Before a mental health bed and transport could be arranged Mrs K left the Emergency Assessment Unit and made her way to the railway where she died by suicide.

How did we review the case?

This case used the Appreciative Inquiry[2] model of case reviewing. Feedback from practitioners involved was that they felt engaged and listened to and that the learning from the case had a significant impact.

What did we learn?

- There were governance issues around information sharing, risk assessment and ownership of the patient.
- There was poor communication between professionals, including assumptions of the roles of other professionals working with the person.

[2] Information about the AI model can be found here: www.ripfa.org.uk/blog/blog-appreciative-inquiry-decisions-action-plans-for-change/

- The demand for mental health inpatient beds outstripped the capacity within local provision and finding placements outside of the county was time-consuming.
- A&E staff did not all have a shared understanding of the risks associated with mental health.

What have we done?

- The information sharing protocol has been reviewed.
- Access to electronic records across agencies has been improved in line with Caldecott requirements.
- Issues around responsibilities have been resolved.
- The demand and capacity issues in mental health have been escalated.
- Mental Health training is being rolled out across A&E staff.

The second SAR concerns Mr B, who was a man in his 50s with moderate learning disability. The cause of death was recorded as 'unascertained' due to the extent of decomposition, but was thought to most likely be due to complications from diabetes, alcohol intake or both.

How did we review the case?

This case used the traditional model of Case Reviews with agencies providing formal written reports which were analysed and an overview report produced.

What did we learn?

- The multiple hospital admissions were not thought of as a whole and the pattern was not noted.
- There was no specialist service within the hospital for adults with learning disability.
- There was limited understanding of the Care Programme Approach[3] and use of Hospital Passports[4] across the whole system.
- Mental Capacity was not fully understood.

What have we done?

- The hospital has implemented a system for reviewing cases of multiple admissions.
- The hospital has recruited a specialist nurse for learning disability.
- The Board has requested agencies confirm their levels of staff training on Mental Capacity Act as part of the annual Safeguarding Self-assessment

[3] Information about the Care Programme Approach can be found here: http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx
[4] Information about Hospital Passports can be found here: http://www.nhs.uk/Livewell/Childrenwithalearningdisability/Pages/Going-into-hospital-with-learning-disability.aspx

How partner agencies are safeguarding people

In the next chapter Oxfordshire Safeguarding Adults Board (OSAB) partners set out how they have contributed to the work of the OSAB and to the ongoing improvement of local safeguarding adults arrangements.

Each key partner was asked to frame their contribution in response to the following key questions:

What did you achieve in 2016-17

What planned activity and challenges do you foresee for 2017-18

Also as part of the Safeguarding Self-Assessment, agencies challenged themselves and partner agencies on what they did to ensure adults with care and support needs were protected.

Oxfordshire County Council – Adult Social Services

What we did

Introduction of a dedicated Safeguarding Service

From October 2016 the Council implemented an organisational change, creating a specialist countywide Safeguarding Service, delivering its adult safeguarding duties within the 'Responsible Locality Model'. Their work includes the initial investigations of all incoming safeguarding concerns to ensure those at risk are protected from harm.

This new model has enabled a one team approach, aiming to ensure continuity and a consistent approach to safeguarding new concerns work across the Council. All team members have completed an induction and appropriate training and are linked to areas within the County to develop links with locality teams and local partners and providers.

Consultation Service

The safeguarding team now offers a preventative consultation service for professionals and providers to discuss concerns and seek advice in line with the Care Act 2014. This has been reported as a positive addition to the service and the number of contacts are growing. There is evidence from Providers that this service has helped them make appropriate referrals.

Safeguarding Governance

The Council continues to use its Care Governance Framework. This Framework sets out how the Council monitors services and the organisations that provide these. It outlines what will happen when concerns are identified or raised and how they will be managed and providers are supported to address any areas of change/improvement.

The main aims of introducing a Care Governance framework are to:

- Ensure that standards of quality and safety are maintained.
- Identify any concerns early on and intervene as soon as possible.
- Develop a supportive process aimed at addressing problems.
- Ensure we work in partnership with providers.
- Share information with a view to being open and transparent.
- Make continual improvements to the services being delivered.

Through the use of this framework there has been substantial work over the last year with individual providers in the local market to improve quality and address serious concerns and standards of care.

What we need to do

- Review the progress of the new countywide service.
- Work with our providers to continue to look at developing the provider market and support quality standards.
- Continue to closely monitor the level of concerns and enquiries via the Council's daily reporting mechanism.

Oxfordshire County Council - Community Safety Services

Oxfordshire County Council's Community Safety Services consist of the Fire and Rescue Service, Trading Standards Service, Emergency Planning and Gypsy and Traveller Service. Our priorities include:

- Providing a safety net to reduce risks to the community and particularly the vulnerable.
- Working with partners to provide services that support health, wellbeing and independence.
- Reducing demand on health, social care and criminal justice agencies through our prevention work.

We are actively engaged with the Oxfordshire Safeguarding Adults Board, including through supporting the Training and Policy and Procedures subgroups.

We continue to support partners to safeguard individuals through the sharing of information in our day to day activities, such as Safe and Well visits and following fire related incidents or financial abuse investigations (doorstep crime and scams). Community Safety personnel are actively encouraged to report any concerns they should have regarding the wellbeing and safety of adults.

What we did

Hoarding

We continue to support and facilitate significant joint working to help individuals identified to be at risk due to hoarding and neglect. We supported the development of the new OSAB Multi-Agency Hoarding Guidance and participate in local hoarding partnership meetings to identify and manage individual cases. On an increasing frequency this work requires multiple joint visits to the person concerned (e.g. including Social Workers, Environmental Health, Housing Services, Fire and Rescue, etc.).

Safe and Well

Our Safe and Well visits are designed to reduce the risks to people in their homes and reach over 4000 people each year through more than 3200 visits. The content of Safe and Well visits continues to be enhanced and now includes elements relating to fire risks, slips, trips and falls, alcohol and drug use, financial abuse and health lifestyles. Fire and Rescue personnel undertake joint Safe and Well visits with Trading Standards personnel covering smoke alarms, escape plans, electrical safety, scam mail and cold calling.

Scams and Fraud

We continue to work with the National Trading Standards Scams Project to identify and support victims of financial abuse in the County (telephone scams, fake lotteries and prize draws, etc.). Through our Doorstep Crime Team £238,000 was saved for victims of cold-calling fraud.

Training

Safeguarding training is delivered to all Community Safety staff on a 3-yearly basis and refresher training was delivered in 2016 covering all safeguarding elements relevant to our work. This training has been expanded to include a much broader range of safeguarding concerns, including Child Sexual Exploitation, Female Genital Mutilation, radicalisation, reducing reoffending, modern slavery and hoarding.

Partnerships

To understand the risks to our most vulnerable residents, we have built strong relationships with partners such as Age UK to use their knowledge, experience and local connections to inform our work. We are also developing stronger relationships with health and social care colleagues through supporting the area-based Health & Social Care Locality Group. Team members also attend case management meetings (e.g. MAPPA (Multi Agency Public Protection Assessment) and MARAC (Multi-Agency Risk Assessment Conference) to support safeguarding arrangements in relation to priority offenders or victims of domestic abuse.

Fire Risk Reduction

Last year we developed and implemented a new Fatal Fire Prevention Policy which includes a structured learning process from any fatal fires to reduce chances of similar fire deaths in the future. Fatal Fire Prevention reports are provided to the Coroner for relevant inquests alongside the Fire Investigation report to inform decisions on fire risk reduction.

Prevent

The Director for Community Safety and Chief Fire Officer is the Director responsible for ensuring compliance with the statutory Prevent duty across Oxfordshire County Council. All front line staff from Fire and Rescue, Trading Standards, Emergency Planning and the Gypsy & Traveller Unit have received initial training on Prevent. Further in-depth training

is being rolled out across the County. In addition, the Director of Community Safety and Chief Fire Officer is the Chair of the Channel Panel with the administrative support for this panel being provided by the Fire and Rescue Prevention Manager and Safeguarding Leads.

Key Planned Activity for in 2017-18

- **Chief Fire Officers Association (CFOA) Safe and Well Evaluation** - Oxfordshire County Council Fire and Rescue Service have been selected to take part in the national Chief Fire Officers Association Safe and Well Evaluation. This evaluation will inform future developments of these visits and help us understand their effectiveness and potential.
- **Increasing Demand for Risk Reduction Visits** - through our engagement with new partners we are starting to see an increase in the numbers of requests for visits to individuals at greater risk. These visits can be more complex than a standard Safe and Well visit and lead to repeat visits and requirements for cross-agency input.
- **Home Office Prevent Peer Review** - Oxfordshire recently took part in a Home Office Peer Review on the partnership work on Prevent. A key challenge for the Service will be to respond to the outcomes of the review in association with our partners.
- **Safeguarding Self-Assessment Analysis** – through the Prevent Implementation Group, the Service will analyse the results of the safeguarding self-assessment returns with regard to the question around Prevent. The assessment has asked agencies to show how they are compliant with the Prevent duty particularly in relation to policies and procedures regarding staff training, use of public resources and referring to the Channel Panel.

Oxford University Hospitals (OUH) NHS Foundation Trust

The team is comprised of a Band 7 Lead Nurse, a Band 6 Specialist Nurse, a Learning Disability Liaison Nurse and a full time Administrator who is also a registered mental health nurse. The team is led by the Head of Adult Safeguarding who is an Occupational Therapist.

The team has provided safeguarding advice for 882 situations over the year involving vulnerable adults. This advice and support includes clinical advice, training and education and partnership work with Oxford Health NHS Foundation Trust, General Practitioners (GPs), Thames Valley Police, Families and Southern Health NHS Foundation Trust.

The team attends the key partnership groups of Multi-Agency Risk Assessment Committees (MARAC), Multi-Agency Public Protection Arrangements (MAPPA), Community Safety Partnerships and Channel Panels. These multi-agency groups include the Police, Oxford Health NHS Foundation Trust, Oxfordshire County Council, the

Oxfordshire Clinical Commissioning Group (OCCG), Care Home providers, and Southern Health NHS Foundation Trust. These groups have been established to enable teams across the county to work together with the specific aim of keeping people safe.

The team is a member of the Oxfordshire Safeguarding Adults Board (OSAB) Safeguarding Adult Review (SAR) subgroup, the OUH Serious Incident (SI) forum and the County's multi-agency Problems in Practice. These groups have been established to learn from incidents and to ensure that people are safe.

There have been 56 safeguarding concerns raised about the care patients have received from the Trust. Of these, 25 were unsubstantiated, 28 were substantiated and three investigations are not yet complete.

There have been 153 Deprivation of Liberty Safeguards (DoLS) applications and of these 11 or 9% were unnecessary. There continue to be significant issues relating to DoLS applications because of the large number of applications across the county following the Cheshire West judgment in 2014.

The training compliance for safeguarding adults within the Trust is 87.2%. This is increased considerably over the last year although remains lower than the 90% agreed with the OCCG. The team has delivered the multi-agency Oxfordshire Safeguarding Adults Board training and the Trust's safeguarding leaders training. This three day programme included working with the police, Female Genital Mutilation, Wrap 3, Domestic Abuse, Modern Slavery and Human Trafficking, Mental Capacity Act and DoLS. Oxford Health took several places on this course. Considerable training has been delivered to junior doctors and clinical teams in relation to the Mental Capacity Act and DoLS following the Care Quality Commission (CQC) inspection in October 2016.

Key achievements

- The team has given 882 safeguarding consultations during the year.
- The **'Prevent'** awareness training has been attended by 4059 staff and 105 people have attended the Home Office Workshop to Raise Awareness about PREVENT (WRAP) 3 training.
- The Trust has contributed to the countywide review of the care received by people with learning disabilities if they died between 2010 and 2016. Now everyone with a learning disability who sadly dies in our care is reviewed and presented by the person's clinical team at the Trust's Mortality Group. This is so we can learn to improve our care.
- The Trust has been awarded £200,000 to recruit learning disability liaison nurses to work across all four hospitals.
- The Safeguarding Adults and Children Teams and Human Resources Teams presented the first joint self-assessment to a peer review panel in April 2017. The Trust received some excellent feedback on the safeguarding services in place.

- The Safeguarding Adults and Children Teams have adopted the **'Think Family'** approach. Three questions have been developed to assist clinicians in recognising abuse in families.
    - *In your normal life – at school/college, at home, with friends, do you feel safe?*
    - *Has anyone forced you to do anything you did not want to do, that frightened you?*
    - *In your relationship do you feel safe?*
- The Team reviews all the safeguarding referrals from the Emergency Department every day. These referrals include Domestic Abuse, concerns about people not coping at home, homelessness and mental health problems.
- The Team is collecting data about the types of domestic abuse issues to help us better understand the training we need to help clinicians feel more confident in domestic abuse situations.
- The team makes sure the learning from safeguarding investigations is included in the Trust's key quality improvement groups. These are for Falls, Discharge and pressure ulcers.
- The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) practice was audited and more training offered to clinicians.

Future plans for 2017-18

- Recruit the learning disability liaison nurses.
- Complete the project identifying the health needs of people with learning disabilities in the Oxfordshire.
- Develop and pilot a new 'Friends and Family Test', an annual survey and 'lived experience' events to capture the experience of people with learning disabilities and their families receiving health care.
- Recruit and support **'Think Family'** safeguarding champions across children and adult services.
- Implement the Protection of Liberty Safeguards once Mental Capacity Act (2005) has been amended and the national guidance has been published.

Oxford Health NHS Foundation (OHFT) Trust

Oxford Health Foundation Trust (OHFT) in line with other statutory organisations has been working within the context of rising demand for services and resource constraints. To keep patients safe, OHFT is working within a sound framework of safer recruitment and staff development and monitoring. Effective safeguarding of adults requires a sound partnership approach with other agencies.

Partnership Working

On 23rd February 2016, we hosted an event with the Oxfordshire Clinical Commissioning Group (OCCG) and other organisations (Connection Floating Support, Elmore Community Services, Oxfordshire Mind, Response and Restore, Thames Valley Police and South Central Ambulance Service) to showcase how these partnerships are helping individuals to focus on their personal journey towards recovery by identifying the goals that are important to them.

During 2016/17 the Oxfordshire Safeguarding Adults Board developed and introduced a multi-agency training course for staff working with vulnerable adults in Oxfordshire. The course enables people working in Oxfordshire to develop a common understanding and approach when there are concerns for people's safety. OHFT is providing a trainer to support this training.

For a retrospective understanding of what has happened to people, there is now a system in place to review all deaths that occur within Oxfordshire across all agencies. OHFT is engaged with this work.

Staff Working

From the point of becoming junior managers, OHFT has a training programme in place to ensure all managers are able to implement the safer recruitment process. There is a robust structure in place to ensure the appropriate checks are completed on staff and repeated 3 yearly during their employment.

During 2016 the Care Quality Commission (CQC) published their report following their comprehensive inspection of the Trust. The Trust was rated as 'good' overall and 'good' for 14/15 of its core services. It was identified within this report that staff would feel confident to raise issues if they felt concerned. To support people to do this, the Trust has a Freedom to Speak up Guardian, who offers independent and confidential support to staff who wish to raise concerns that could affect patient safety. The role was created following recommendations made by the Freedom to Speak Up Review conducted by Sir Robert Francis and the aim is to promote a culture where staff feel safe to raise any concerns.

Working with Adults at Risk

Throughout 2016/17, the Trust has demonstrated a robust response to allegations that may have implications for the safety of patients. Where necessary, people are facilitated to contact the police and make their own reports into the system. This helps promote the person's autonomy and empower them to ensure their goals are achieved.

The Trust has designated places of safety for people who may be very vulnerable but have not been subject to any formal mental health assesment. These areas are subject to CCTV monitoring. The CCTV has been effective in monitoring what happens in the interests of both patients and staff.

For day to day issues, all of the ward areas across OHFT have a system to display publicly the issues raised by patients and visitors and the action they have taken to respond to these issues (you said … we did). This process helps ensure that issues are explicitly responded to.

Radicalisation and Exploitation

Radicalisation continues to be a high profile concern nationally. To raise awareness about possible radicalisation amongst those who are vulnerable, the national training programme (WRAP 3) has been implemented in the Trust. The techniques used to influence people susceptible to radicalisation can be similar to those used to exploit people. During 2016/17, Oxford Health supported police lead operations to disrupt gangs who were exploiting people.

Key challenges in relation to safeguarding for 2017-18

In Oxford Health, the key areas of development related to the safeguarding of adults during 2017/18 will be:

1. **Pressure Ulcer management:** Pressure ulcers can be an important indicator of quality of care. Preventing the occurrence of pressure ulcers requires engagement of the patient, carers and any agency working with the person. This can be high challenging for the teams working in the community.
2. **Transition of learning disability services from Southern Health NHS Foundation Trust to OHFT:** It is expected that in 2017/18 OHFT will take over the provision of community and forensic learning disability services in Oxfordshire. With any significant change, there can be disruption of care for service users. There is robust project management in place to reduce this risk. The transition of services will be evaluated.
3. **The Think Family Agenda** is identifying that there can be gaps in people identifying the children of parents who are admitted for mental health treatment. This can delay the effective support of the children. During 2016/17 there will be on-going work with the safeguarding children team to help develop robust systems.

Cherwell District Council (CDC)

Introduction of a dedicated Safeguarding Officer

An independent review of the Cherwell District Council's (CDC) Safeguarding Policy and Procedures in 2015 recommended the appointment of a dedicated Safeguarding Officer. This post was recruited in October 2016 and started in February 2017.

Employee Training

The Designated Safeguarding Officer (DSO) has delivered safeguarding training at the Managers Forum and Staff Briefings during the year to raise awareness amongst staff of their responsibilities in relation to safeguarding. The importance of a good safeguarding culture has also been advocated by the Chief Executive at quarterly all staff briefings and the Designated Safeguarding Officer (DSO) has also conducted training for elected Councillors.

Management are aware of the safeguarding training requirements for them and their teams and resources of the Oxfordshire Safeguarding Children Board/Oxfordshire Safeguarding Adults Board are utilised to fulfil this. At this time, the recording of training is not centrally recorded but a project has been initiated to develop a training register to ensure more accurate recording of training requirements and completions. This will be a key responsibility of the Safeguarding Officer upon commencement of employment.

Safeguarding Governance

Safeguarding Leads have been appointed across CDC who are responsible for the adherence of their service areas (those of greatest exposure to vulnerable groups) to the CDC's Safeguarding Policy and Procedures. These Leads meet on a bi-monthly basis to review safeguarding intelligence (including information to feed into the Section 11 return), discuss best practice (including the use of toolkits), consider legislative change and the impact it may have on CDC, agree strategy, identify areas of concern/weakness and develop/track action plans where necessary.

The corporate service planning process now also requires Heads of Service to provide more detail around how they safeguard children, young people and vulnerable adults during the course of service delivery.

A recent external audit of corporate performance reporting for CDC considered Safeguarding and recommended that the internal escalation process be captured in the process notes that accompany the Safeguarding policy. This will be actioned within the first 2 quarters of 2017/18.

Safeguarding in the Community

Following the decision by Oxfordshire County Council to close/reduce services at a number of Children's Centres across the district, CDC, through its Young People, Play and Wellbeing Partnership, is supporting children's centres in bidding for funding to enable them to continue to provide universal services. The partnership is also working with local voluntary groups to pick up areas that will be lost as a result of the closures. Without such easily accessible resources, vulnerable parents may not be able to get the vital support they need.

Taxi Licensing

The CDC Licensing team has played a key role, as part of the Joint Operating Framework, in implementing mandatory safeguarding training and assessment as a condition for obtaining a taxi licence in Cherwell.

The licensing team have been instrumental in instigating a 'Hotel Watch' initiative in the district which raises awareness of Child Sexual Exploitation (CSE) amongst all businesses offering accommodation and other services during the night time. This includes the conducting of test purchase operations at hotels (i.e. where an older male with a clearly younger female tries to book a room) to verify their application of appropriate safeguarding procedures. 50% of businesses failed the test purchase and were revisited and re-educated.

The licensing team are also working alongside Thames Valley Police (TVP) in implementing and promoting a joint 'Night Time Economy' plan. This involves safety checks of licensed vehicles, test purchases to ensure licensed drivers are aware of the law, visits to licensed premises to ensure compliance with conditions and in December manning a 'Departure Zone' in Banbury to give out advice to customers and help ensure they made it home safely.

Planned activity for 2017-18

- **Development and implementation of a robust training framework during 2017**. This will formalise the training requirements depending on the exposure that each role faces to children, young people and vulnerable adults and the level of responsibilities that each has for their protection. The training relies on the resources of the Oxfordshire Safeguarding Children Board/Oxfordshire Safeguarding Adults Board (online and face to face courses) and we are sourcing the services of external trainers to provide more specialists training where required, i.e. mental capacity act, safer recruitment etc. Regular awareness sessions will be developed and delivered to look at different subject areas, refresh knowledge of internal procedures and will be open to all staff. Our training will also extend to the development and delivery of member engagement sessions to raise awareness of safeguarding amongst our counsellor population. A centralised safeguarding training register will be developed which will accurately document the training requirements of all employees and record completions. It will act as a monitoring tool to track expiration and refresher.
- **Development of a formalised Communication Plan.** To schedule regular awareness raising communications via the all staff newsletter, poster campaigns and introduce an annual safeguarding week to be held early 2018.
- **Formalise the role of the Quarterly Safeguarding Leads Meeting.** Introduce a terms of reference for the group to outline the role and responsibilities of the leads in ensuring adherence of CDC with the Safeguarding Policy and associated procedures.

- **Review the Safeguarding Policy and associated procedures**. This will include the conducting of audits of higher risk service areas (e.g. Housing, Customer Services, Leisure, Revenue and Benefits) to ensure procedures in place are adequate and operating as intended to meet the requirements of the policy. These audits may also extend to our contracting partners (e.g. housing providers and to gain confidence that they are operating in line with expected standards in terms of safeguarding.
- **Develop the in house concern reporting system 'See it; Report it' to provide better reporting and encourage staff to use it.** The current system provides a mechanism for reporting any types of concerns (specifically relating to the safeguarding and protection of vulnerable groups in our communities) that our employees may encounter during their day to day activities. We have a repository for recording these concerns; however, the reporting capabilities are currently limited. Improvements will be made to the reporting form and recording system to ensure greater detail is captured and an improved reporting capability. Intelligence and data can then better inform multi-agency discussions and provide overarching statistics.

Oxford City Council

For Oxford City Council safeguarding and the wellbeing of children and vulnerable adults is a corporate priority and the Council is actively striving towards best practice in this area of work.

Working in Partnership

The Council's external partnership working has continued to strengthen through regular attendance at strategic and operational Boards and Working Groups. These include Oxfordshire Safeguarding Children Board and Oxfordshire Safeguarding Adults Board Working Groups which drive forward the Boards key areas of work on Performance Management, Policy Development and Training.

The Council's Policy and Partnership Manager has also actively participated in a number of operational steering groups on behalf of the districts.

Integration of a safeguarding clause into lease renewals for community centres to ensure that they are aware of their key safeguarding responsibilities and that these are acted upon.

Safeguarding Training Programme

Oxford City Council has a comprehensive safeguarding awareness package. This has been fully reviewed and updated by a working group this year. We have 8 internal trainers to deliver these sessions throughout the year. This training subgroup has met quarterly to support the delivery.

A safeguarding training package has been developed and delivered for elected members through the year. All current members have attended one of these sessions.

The total number of staff that have received safeguarding training between 01/04/16-31/03/17 is 624.

Further to the results of the safeguarding questionnaire from 142 staff, we identified the need to deliver training to our staff on the Mental Capacity Act. We have sourced and commissioned an external trainer to deliver this training. To date over 100 members and staff have completed this training within the last 4 months.

Safeguarding awareness training is tracked and monitored through Itrent (the Council's Human Resources Electronic Record System).

Licensing Standards

Oxford City Council has led the development of the Joint Operating Framework for Taxi Licensing. The aim is to have standard requirements for safeguarding measures for all taxi services across the Oxfordshire local authorities. It includes an agreed level of checks, standard training packages and improved information sharing across agencies. This is now well developed and monitored by Oxfordshire Safeguarding Children Board.

Language Schools

The Community Safety Team have played a key part in the Language School Forum this year, driving forward a set of actions to further develop partnerships with language schools and encourage a consistent safeguarding framework in language schools across the city.

Hotel Watch

Oxford City Hotel Watch was established to build closer relationships with Thames Valley Police, Oxford City Council and the hotel industry. It is aimed at helping to identify offences that take place in hotels and other forms of accommodation and to protect vulnerable people from exploitation.

Safeguarding Coordinator Role

Permanent appointment of a Safeguarding Coordinator. This role has actively supported internal and external partnerships and has taken a lead in the support and progression of the Council's Safeguarding Action Plan 2017/18. This is now complete.

Priorities to focus on 2017/18

Oxford City Council have developed a Safeguarding Action Plan 2017/18.

The key areas of focus include:

- Central recording system - centrally collate concerns raised within teams as well as external referrals/requests for assessment/welfare checks. This would give the Council the ability to recognise pockets across the city that perhaps have high numbers of safeguarding concerns and be able to feed this knowledge into local plans when developing service provision.
- Ensure that our Safeguarding Training Programme continues to meet the needs of staff, is kept up to date and evaluated.
- Ensure that departmental safeguarding policy and procedures align with the corporate policy and procedures and introduction of a central reporting system.
- Developing a Safeguarding Communication Strategy that delivers key safeguarding messages throughout the year (to staff and local residents) and to ensure that relevant information is provided in a child friendly format.
- Ensure that there is effective and integrated working with the Oxford Community Safety Partnership Strategies and Plans.
- Agreeing and prioritising which safeguarding assessment tools are to be used (for example Child Sexual Exploitation and Neglect) and to enable staff to use them effectively.
- Ensuring volunteers are provided with opportunities to have the safeguarding training they require.

Thames Valley Police

Safeguarding remains at the heart of the response by all officers and staff in Thames Valley Police (TVP). We are dedicated to work in partnership to keep people safe and hold perpetrators to account. The police inspectorate, Her Majesty's Inspectorate of Constabulary (HMIC) in the 2016 Effectiveness Inspection judged the force to be good. *"It is good at protecting vulnerable people and provides the right support to them in conjunction with partner organisations. Officers and staff are trained to recognise when a person is vulnerable and there are good systems in place to assess and address risks to vulnerable people. Frontline officers display a good knowledge about how to identify a vulnerable person. An enhanced training course, known as safeguarding, vulnerability and exploitation (SaVE), has ensured that their knowledge of vulnerability has increased. SaVE training also encourages front line staff to place a vulnerable person's needs at the centre of all police work."*

Building on this TVP have introduced the SaVE 2 training to further explore our identification of and response to vulnerability and safeguarding for the front line uniformed staff. There has also been SaVE specialist training for the detectives and SaVE training for our senior leaders.

Domestic abuse remains a core area of business for TVP and our priorities include increasing prosecutions and reducing the repeat victimisation of people in our communities. We have specific teams to deal with high risk cases, and there is significant multi-agency work that is completed to help protect the victims of Domestic Abuse, but less so to tackle the perpetrators. TVP have been active in forming the joint strategy for domestic abuse across the partnership in Oxfordshire. This will be an exciting challenge for us over the next year and we believe the new strategy will significantly contribute to safeguarding more victims and their children who are at risk of harm from domestic abuse. TVP are putting more focus on the perpetrators and hope to have a perpetrator programme available to divert people towards. The TVP offender managers will also be available to focus on these types of perpetrators to reduce the harm they pose.

Honour Based Abuse continues to be an area of concern for Thames Valley Police and during the last 12 months we have trained specialist officers investigating honor-based abuse to ensure we maintain and improve our effectiveness in this area as we work to protect people from harm.

The Domestic Abuse Unit have been actively engaging with the Care Quality Commission (CQC) as part of our responsibilities to jointly investigate care home deaths and share expertise to better safeguard vulnerable adults in receipt of care. In order to more effectively implement this, we have taken part in joint training and liaison and have worked jointly to investigate a number of incidents and continue to develop a closer and more efficient working relationship where we can both learn and develop each other to better provide a quality service.

As a service we continue to work with new legislation dealing with coercive control and stalking offences in a Domestic Abuse setting and this presents a challenge for investigators and support agencies. In Oxfordshire we have had recent success in gaining charges for Coercive Control and stalking and continue to work with the Crown Prosecution Service to bring those perpetrators to justice and protect the victims using this new legislation.

Exploitation of vulnerable adults is an emerging issue for Thames Valley Police . Vulnerable adults are also being targeted where drug dealing takes place in their homes, and they are being exploited in numerous ways by county line drug dealers. The police are responding to bring perpetrators to justice and disrupt their activities and safeguarding pathways need to be defined.

During 2016/17 we have developed a monthly partnership meeting (Vulnerable Adults Meeting) where we are able to identify those adults we believe are at risk of exploitation/are being exploited. We have then been able to work with partners such as Turning Point, Salvation Army, Adult Social Care and Housing to get these individuals reengaged with the support that is available. We have also been able to use this as an opportunity to share information and gather intelligence to support our enforcement work and disrupt those offenders who are preying on vulnerable people. We have worked with Housing officers to safeguard vulnerable adults through the use of Closure Orders. We

have persuaded Registered Social Landlords to work with us and not seek eviction when we seek a closure order. (An order is mandatory grounds for possession). The orders help those vulnerable adults who are not able to police their own front door by providing powers of arrest for anyone found in breach of an order. Officers will regularly check addresses subject to an order and in many cases the vulnerable adults have provided statements saying they support the order as it prevents them being exploited by drug lines looking to use their premises. We have used 15 closure orders in this way across the local police area since January 2017. In March 2017 we had Operation Reacher in Banbury. This was an operation which saw 7 warrants executed at addresses of vulnerable adults in order to disrupt county drug lines. Seven arrests were made in connection with the supply of controlled drugs a quantity of class A drugs seized and seven closure orders granted on these addresses in one day. One vulnerable adult was referred to the National Referral Mechanism due to a disclosure in relation to modern slavery. We have continued to work with our partners to safeguard vulnerable adults in this way and it has proved to be an effective tactic.

Changes to the Bail Act came into force in April 2017 and this has presented challenges when safeguarding victims from both a police and partner perspective where bail with conditions was not achievable. This necessitated a review of the measures available to protect victims and involved many joint agency conversations and an increased use of Domestic Violence Protection Orders to successfully protect victims.

Key challenges for the coming year include the need to develop a perpetrator programme to address the behaviour of serial perpetrators with a proven programme to educate and prevent on-going abuse. There is also a need to train more officers in the use of preventative powers or protection orders to protect victims and improve their confidence in obtaining these orders.

Oxfordshire Clinical Commissioning Group (OCCG)

An Assurance Audit of GP Safeguarding Practice in Oxfordshire

The Oxfordshire Clinical Commissioning Group (OCCG) safeguarding team undertook an audit in July 2016 of GP's safeguarding practice for adults and children. The audit, based on section 11 of the Children Act and the Care Act 2014 requirements, was designed by a team of Named GPs in the Thames Valley Safeguarding Network, supported by NHS England. It was circulated to safeguarding leads and practice managers in Oxfordshire primary care practices. The practices were asked to assess themselves and rate their practice under the standards statements as red, amber or green (RAG rating). They were asked to identify evidence demonstrating compliance and areas for development with a time scheme for achieving this. A thematic analysis identified areas in which practices needed continued support and improved resources.

Results

Responses were received from 61/75 practices (81% return). Overall all practices were able to present evidence of compliance with good practice. Within the sub sections there were areas for improved and further development, discussed below.

Themes from the analysis

Training needs

In general, practice self-assessment of training levels was good in core safeguarding knowledge. Areas for development were focused on requiring further training in specific areas of safeguarding knowledge (Prevent Strategy, child sexual exploitation, female genital mutilation, Mental Capacity Act, and Deprivation of Liberty Safeguards). These are emerging areas of knowledge development required because of local and national drivers.

Policy development

Safeguarding leads highlighted the need for more rigorous practice policies in some areas, particularly adult safeguarding, and GP's contribution to case conferences. Several practices identified documenting feedback from children and young people, as not generally embedded in GP practice culture and requested help with this. Some practices felt they required more understanding of escalation policies.

Record keeping

Other areas raised related to the complexity of record keeping in safeguarding situations, for example how to minute all safeguarding discussions and case reviews, and a need for clearer guidance around record keeping and information sharing in split families.

Discussion

This self-assessment exercise identified a wide variation in safeguarding need across practices in the county. Developing local networks in 2016 has enabled the sharing of good practice and supporting the improvement of safeguarding across the county.

Actions

Improvements to the safeguarding website such as increasing the easy access via links to key safeguarding documents.

- Draft policy templates sent to practices for local adaptation.
- Focused adult safeguarding training sessions provided to address identified knowledge deficits such as Prevent, Mental Capacity Act and Deprivation of Liberties Safeguards and learning from partnership reviews.
- Opportunities for primary care to join multi-agency training and learning events included in the General Practitioner (GP) newsletter and at regular safeguarding leads meetings.

- Support to practices for training by providing information and resources.
- The audit tool used was subsequently adapted for use across small contracts within joint commissioning and public health. It will be added to the annual audit cycle

Provider Contract 2017-19 update

Safeguarding reporting requirements for providers have been standardised. The Oxfordshire Clinical Commissioning Group (OCCG) Quality Team has established regular safeguarding support and monitoring meetings with providers, providing opportunities to share good safeguarding practice across the health teams and services. A new dataset to identify safeguarding activity will provide assurance and identify concerns as they arise with performance. The dataset is included in the updated contract for 2017-19. The smaller independent providers will submit a safeguarding audit annually and will continue to be assessed against national standards.

Annual Safeguarding Self-Assessment

The Oxfordshire Clinical Commissioning Group's safeguarding self-assessment to the Oxfordshire Safeguarding Boards provided evidence of compliance for all the standards.

The return included an assessment of staff knowledge from within organisations. Questionnaires were returned from 25% of staff across the directorates. Within the OCCG staff knowledge was found to be of a good standard, commensurate with their roles, with everyone aware of how to access procedures and advice when required. 76% of staff felt they would be confident to ask providers about safeguarding issues. Those identifying a lack of confidence would not normally contact providers directly. 96% of staff were clear about how to manage allegations about a staff member and 100% were able to name the organisational safeguarding leads.

Oxfordshire's Focus on Mortality Review Processes

Following the publication of the Mazars review, OCCG has undertaken a retrospective review of all deaths of Oxfordshire people with learning disabilities in the period of the review (1/4/2011 – 31/3/2015). 106 patients were reviewed. Wherever possible the next of kin has been identified, contacted and asked how they would like to be involved. Of the 106, 60 were closed with the decision being made that we had sufficient evidence to conclude that there were no significant deficits in their care and that we had sufficient information to close. For 6 there were existing investigations. For the remaining 40 we took the decision that we needed to seek out further information.

For these 40 cases, the agencies involved in their care were requested to undertake a case audit. There was a focus on the areas identified by Mazars as requiring further scrutiny (delays in referral treatment, dysphagia assessments and nutrition). We then held two multi-agency events where multidisciplinary groups were asked to review the cases. The results of these events are currently being prepared.

On 13th December 2016 the Care Quality Commission (CQC) published *'Learning, Candour and Accountability'.* The report was the result of a year-long investigation of how deaths are reported and investigated and how families are engaged with. The report recommendations have all been considered as part of the wider development of a multi-agency review process.

Health care providers commissioned by the Oxfordshire Clinical Commissioning Group (OCCG) have all reviewed and updated their process for reviewing deaths within their services. All undertake mortality reviews. OCCG has also led on the establishment of a subgroup of the Oxfordshire Adult Safeguarding Board to review the deaths of people with learning disabilities and other vulnerable adults. The Vulnerable Adults Mortality subgroup will be informed by the mortality reviews being undertaken in provider services and provides a structure for sharing issue and learning across the partnership. The group has agreed a process similar to the well-established Child Death Overview Process.

West Oxfordshire District Council

Achievements 2016/2017

- During the year West Oxfordshire District Council undertook a comprehensive review of policies and procedures. These were revised so that they now cover children, young people and vulnerable adults in the same document thus giving a single reference point for staff.
- The Safeguarding Leads have undertaken additional training in respect of vulnerable adults.
- West Oxfordshire District Council has been fully involved in the Prevent initiative and the Channel Panel and ensure that key staff are familiar with the requirements of the Counter Terrorism & Security Act (February, 2015). Training is also in place for staff.
- The Safeguarding Leads met with the Chair of Oxfordshire Safeguarding Adults Board (OSAB) to discuss issues and future relationship with the board.

Planned Activity/Challenges 2017/2018

- To review the training requirements of staff. As a District Council we tend to have as much interaction with vulnerable adults as other groups. Therefore, it has been identified that frontline staff need to be properly trained. Specific areas such as housing, revenues and benefits and parking have been identified as key target areas for training and awareness.

- The Lead Safeguarding Officers also plan to engage more with elected members on issues associated with vulnerable adults. The Cabinet portfolio holder is already 'on board' and it is planned to have awareness sessions/briefings with councillors.
- On a corporate basis the continuing budget issues will be a challenge for the council.
- The council is moving to a new management model later in the year and it is a target to ensure that safeguarding is fully considered and covered in any new structures to ensure that all requirements are met.
- The council aims to strengthen its relationship with OSAB and ensure that we are fully participating.

Safeguarding Self-Assessment 2016-17

In 2016, the Oxfordshire Safeguarding Children Board and the Oxfordshire Safeguarding Adults Board worked together to produce a joint safeguarding self-assessment for agencies to complete.

In summary the returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel.

Five agencies state that they meet all points and can 'evidence best practice' for the majority of the standards (six or more).

Strengths were:

- Senior management commitment is strong (1A)
- Information sharing is effective (2C)
- Safer Recruitment and Vetting procedures are in place and working (3B)
- The Effectiveness of the Safeguarding Boards is deemed sufficient (1C)

The main area for improvement across all agencies was:

- Involvement of Service Users in Service Development (2A) where the responses were not as robust as other areas

Based on the main area of improvement, the following action has been added to the OSAB Business Plan for 2017-18:

Empowerment - Gaining feedback from users of safeguarding services and involving them in the strategic development of safeguarding and at OSAB meetings.

This will be achieved through audits of User-defined Outcomes information recorded by Social Care. Healthwatch will also be approached to facilitate safeguarding service user engagement to better understand the journey of someone experiencing a safeguarding issue.

Oxfordshire Safeguarding Adults Board in 2017-18

OSAB Strategic Plan – 2017-2018

This document outlines the vision, strategy and business plan for Safeguarding Adults in Oxfordshire. The Oxfordshire Safeguarding Adults Board is a partnership committed to working together to ensure local safeguarding services are effective. Its remit is to lead the strategic development of adult safeguarding and to hold agencies to account for their safeguarding work.

Our Vision for Oxfordshire

"Oxfordshire is a place where safeguarding is everyone's responsibility, where the OSAB partners work together to recognise and prevent abuse so that adults at risk from harm feel safe and empowered to make their own life decisions."

Principles and Values

The Principles and Values of the OSAB are as follows:

Prevention*: All organisations will have the necessary culture and structures in place to work to prevent abuse from occurring; which takes all concerns seriously, working transparently and enabling swift proportionate interventions at an early stage. There is active engagement with all sections of the local community so that everyone is well informed about safeguarding and related issues.*

Proportionality*: All staff and volunteers in whatever the setting have a key role in working towards preventing abuse or neglect from occurring and in taking prompt, proportionate action when concerns arise. All staff and volunteers will have the appropriate level of skills, knowledge and training to safeguard adults from abuse.*

Empowerment*: Any intervention and support provided is person centred and focused on the outcomes identified by the individual. People must be supported with dignity and respect and be in control of decision making as much as possible; enabling individuals to safeguard themselves from harm and to be able to report any concerns that they have.*

Governance: *There is a robust outcome focused process and performance framework so that everyone undergoing safeguarding procedures will receive a consistently high quality service which is underpinned by multi-agency cooperation and continuous learning. The Board and its partners are accountable for what agencies do and learn from local experience and national policy.*

Our Priorities for 2017-18

Following the principles and values above, the Board has agreed the following priorities for 2017-18.

Prevention - It is better to take action before harm occurs.

- Developing a prevention and early intervention strategy

Proportionality - Proportionate and least intrusive response.

- Championing the multi-agency approach to safeguarding

Empowerment - Presumption of person led decisions and informed consent.

- Running Stakeholder events (public, service users, grass roots organisations and staff)
- Gaining feedback from users of safeguarding services and involving them in the strategic development of safeguarding and at OSAB meetings.

Governance - Ensuring the Board is fit for purpose and working effectively

- Ensuring Making Safeguarding Personal is fully implemented across the partnership. (R2.1)
- Ensuring the data collected by the Full Board provides a full picture of safeguarding activities and issues. (R2.2)
- Ensuring that all partners are encouraged and enabled to take on a leadership role (R2.3.1)
- Reducing the paperwork associated with the Board (R2.4)
- Reviewing the operational changes within Oxfordshire County Council's (OCC) safeguarding service. (R2.5)

Joint Working – working together with the Oxfordshire Safeguarding Children Board to ensure people are protected from birth until end of life.

- Ensuring the work done with children transitioning to adult life is exemplary and offers them the best possible life chances, optimising opportunities.
- Ensuring domestic abuse services within Oxfordshire are fit for purpose and support victims and their dependents while ensuring high levels of prosecution of perpetrators
- Ensuring the workforce within Oxfordshire undertake high quality safeguarding training that meets the needs of staff and volunteers, giving them the skills to work with safeguarding issues.

OSAB Business Plan 2017-18

The OSAB Business Plan is designed to address the priorities agreed in the strategic plan, detailed above.

No.	Theme	Action Required	Subgroup	How	Success Measure
1	**Prevention** It is better to take action before harm occurs.	Developing a prevention and early intervention strategy	Executive Group	Task & finish group to develop guidance	People at risk are identified at an early stage and offered appropriate advice and support before a crisis develops
2	**Proportionality** Proportionate and least intrusive response appropriate to the risk presented.	Championing the multi-agency approach to safeguarding	All Board Members	Clear statement in all agency safeguarding policies regarding multi-agency working	Staff across all agencies are clear on their safeguarding responsibilities and those of other partners and involve partners appropriately in safeguarding work
3	**Empowerment** Presumption of person led decisions and informed consent.	Ensuring Stakeholder events (public, service users, grass roots organisations and staff).	Executive Group	Healthwatch to be approached to facilitate a service user engagement subgroup/panel	Increased numbers of service users involved in safeguarding adults work. People at risk have a voice and are able to influence change
4		Gaining feedback from users of safeguarding services and involving them in the strategic development of safeguarding and at OSAB meetings. (R2.3.2)	PIQA	Audits of Outcomes information recorded by Social Care. Healthwatch to be approached to facilitate a service user engagement subgroup/panel	Increased numbers of service users involved in safeguarding adults work. People at risk have a voice and are able to influence change
5	**Governance** *[picks up peer review and*	Ensuring Making Safeguarding Personal is fully implemented across the partnership	Executive Group	Conduct temperature check, reporting	All agencies are compliant with the requirements of Making Safeguarding

No.	Theme	Action Required	Subgroup	How	Success Measure
	annual report action plans]	through use of the **MSP** Temperature Check Tool for Local Authorities.		to Autumn Full Board	Personal and can demonstrate this.
6		Ensuring the data collected by the Full Board provides a full picture of safeguarding activities and issues, to enable the OSAB to identify priorities and help evaluate the effectiveness of its collective endeavours.	PIQA	Dataset to come to Full Board for challenge and scrutiny	All Members are satisfied the dataset from the Board gives and accurate and informative picture of safeguarding and is used to focus the work of the Board on those areas of need.
7		Ensuring that all partners are encouraged and enabled to take on a leadership role, such as chairing subgroups.	Executive Group	Review current Chairs and make recommendations for Summer 2017 Full Board	All Members are in agreement that leadership roles within the Board are appropriately shared across the partnership.
8		Reducing the paperwork associated with the Board to ensure Members have clarity in regards to the Board, its role and purpose.	Executive Group	Streamlined documentation to be created and brought to Summer Full Board for sign off	Documentation is reduced to a minimum, that it uses plain English and that it has a clear summary if over 10 pages (excl Report Cover Sheet and appendices).
9		Reviewing the operational changes within **OCC**'s safeguarding service to understand impact these arrangements have had on partners, how capacity and demand	Full Board	Report to be provided for the Autumn Full Board	All members are assured that **OCC**, who have responsibility for safeguarding, are sufficiently resourced and working effectively and that partners are fulfilling their role in supporting

No.	Theme	Action Required	Subgroup	How	Success Measure
		is managed, whether there has been an increase in handovers, and how skills within the locality hubs is maintained.			safeguarding investigative work.
10	**Joint working** *[Joint working initiatives the **OSAB and OSCB** have agreed]*	The Safeguarding Boards to work together to agree three top priorities and work jointly on these over the year. For 2017-18 these have been agreed as: • Transitions • Domestic Abuse • Training	Full Board	Twice yearly report to both Boards on progress against this (March & Sept).	Professionals across Oxfordshire are assured that these areas of joint working are approached with a truly "think family" approach, considering the needs of all individuals concerned.