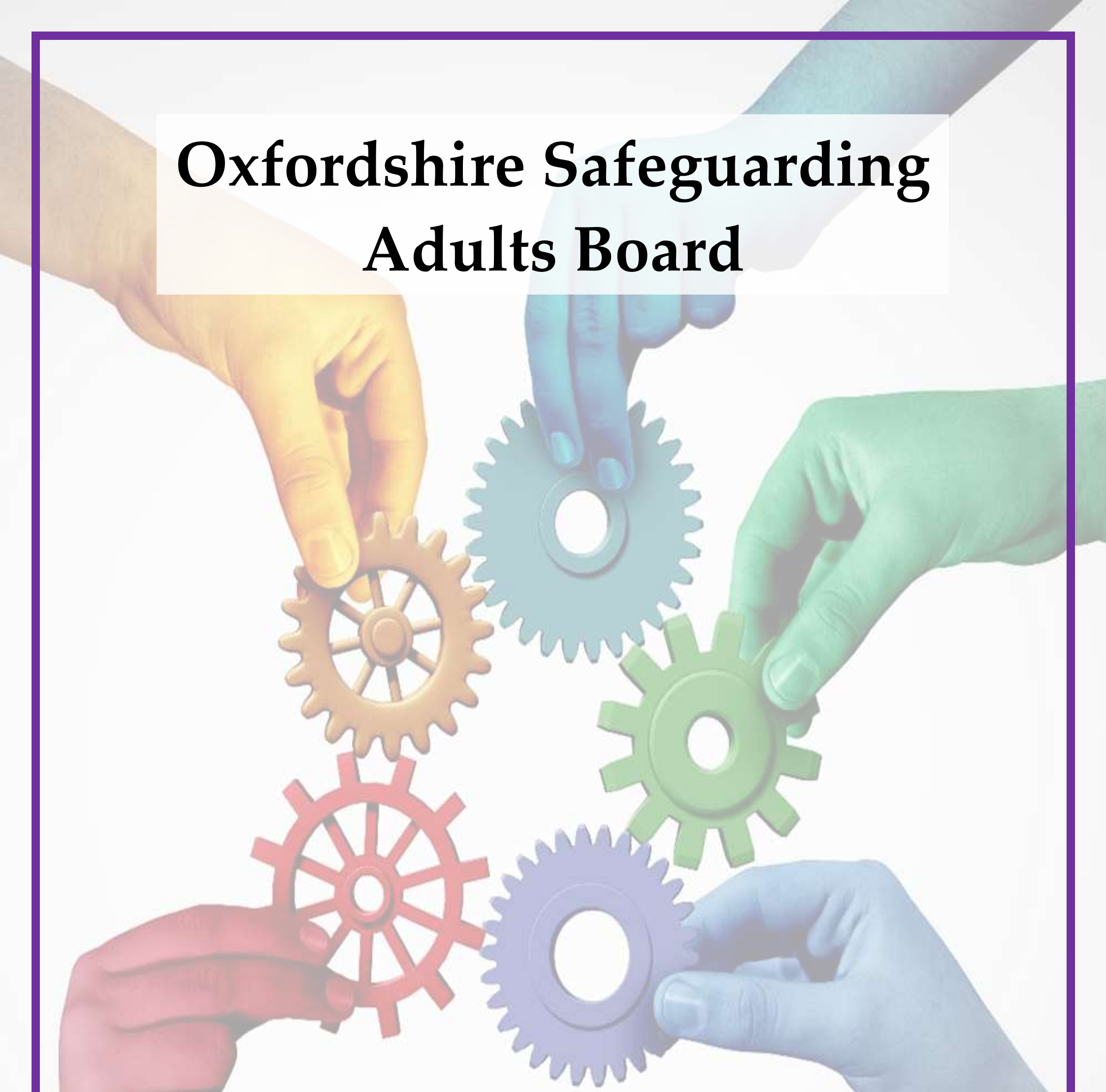
Oxfordshire Safeguarding Adults Board



Annual Report 2021-22

Foreword

“This report covers a year which has raised the profile of adult social care and the importance of Adult Safeguarding to a new level. Whilst COVID has affected all communities, it has had a significant impact on our more vulnerable, including individuals with a learning disability and our older generations, many of whom receive care and support, often in residential and nursing homes, or within their own homes.

I would like to pay tribute to all those who have been working tirelessly to keep adults with care and support needs safe. The safeguarding of some our most vulnerable members of the community remains a key priority for the Board and all its partners.

I have witnessed some great examples of partnership working in Oxfordshire, in which the voluntary and community sectors have played a key role. This puts us in a good place to respond to the ongoing impact of the pandemic that will have a strong influence on the work of the partners well into 2022 and beyond.

As the new Independent Chair, I would like to extend my thanks and appreciation to my Board Strategic Partnerships Manager, the Board and members of our various subgroups, for their continued support and commitment to developing and promoting the work of protecting adults with care and support needs, especially during these unprecedented times.

I would also like to acknowledge the work and commitment of our front-line practitioners, as safeguarding adults at risk would not happen without the dedication and professionalism of our front-line staff.”

Dr Jayne Chidgey-Clark
Independent Chair, Oxfordshire Safeguarding Adults Board

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Introduction

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

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

The SAB has 3 core duties:

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

Each SAB should:

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

Who are we Safeguarding? ***Demographic Information***

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

The Census 2021 reports the population of Oxfordshire as 725,300. This is an increase of just over 71,000 since the 2011 Census. Currently there is a limited release of the 2021 Census figures, more commentary on the demographic data will be released when more Census data is released in October 2022.

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

In the population, nearly 91% are white, 2% of mixed ethnicity, 5% Asian, 1.5% Black and 0.5% other groups (from the 2011 census). Within safeguarding this year, it appears all other ethnicities are represented within safeguarding proportionate to their representation in the general public, other than within those identified as Asian where this is a 2% difference (3% in safeguarding). However, reviewing the percentages of concerns that go on to become enquiries, all ethnicities have a conversion rate around 58%, which suggests there is no bias in formal safeguarding processes once safeguarding are notified.

This data will continue to be scrutinised in 2022-23, along with ethnicity data of service users. The census data for 2021 should be available in late 2022 and will mean we have more accurate figures for comparison. The Board has also recruited a Board Officer for Equalities and Inclusion to focus on the data and what it is telling us, as well as doing primary research with communities to establish what barriers exist to accessing safeguarding services, if any.

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

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

The Board is facilitated by an Independent Chair and supported by a small team. In November 2021 a new Independent Chair joined the Board. Thanks to a funding increase by Oxfordshire County Council, the Board has been able to create four new posts to support the work of the Board. These are Board Officers with specific responsibilities around safeguarding and homelessness, learning disability, multi-agency risk management and the equalities and inclusion project.

The partnership is made up of:

Completing the membership of the Board is a Lay Member, who provides another level of scrutiny and challenge to the work of the Board partners. As someone outside of the organisations represented at the Board, they offer another independent view on how services work together and help to ensure that our work is as accessible as possible to the broadest audience. This dovetails with the role of Healthwatch at the Board, who provide additional scrutiny and ensure the voices of service users are heard at the Board.

Structure of the Safeguarding Board

The structure of the Safeguarding Adults Board is outlined in the table below. The subgroups report to the Full Board when it meets quarterly. The subgroups have each defined their meeting frequency, ranging from monthly (Safeguarding Adults Review Group) to meeting four-monthly (Homeless Mortality Review Group).

<table>
<tr><td colspan="2">Full Board
Multi-agency partnership group, bringing together senior leaders from member agencies to agree on strategic safeguarding work and hold each other accountable for safeguarding practice
Provides direction to all subgroups</td></tr>
<tr><td>Executive Group
Drives the work of the Full Board between meetings
Discusses urgent and emerging issues, problem solving as required to provide a clear direction and offer leadership support.</td><td>Safeguarding Adults Review Group
Considers incidents and situations that require a multi-agency review called a Safeguarding Adults Review
Manages the reviews once they are commissioned</td></tr>
<tr><td>Vulnerable Adults Mortality Group
Oversees the Learning Disabilities Mortality Review (LeDeR) process
Leads on sharing the lessons from LeDeR</td><td>Training Group
Shared with the Children’s Board
Oversees the safeguarding training for the Board
Provides multi-agency training and supports training for non-Board partners, such as community and volunteer groups</td></tr>
<tr><td>Procedures Group
Oversees the multi-agency procedures
Offers advice & guidance on single agency procedures</td><td>Engagement Group
Oversees how the Board interacts with the wider community of people working with adults
Inputs on Board publications</td></tr>
<tr><td>Performance, Information & Quality Assurance Group
Scrutinises performance information from across the partnership, identifying emerging issues and concerns for the board within services
Manages the quality assurance processes, such as the annual Safeguarding Self-assessment and Supportive Learning Visits
Leads on sharing the lessons from reviews</td><td>Homeless Mortality Review Group
Reviews the deaths of all people identified as homeless or in homeless accommodation at the time of their death.
Provides lessons from these deaths to partnership groups, particularly the safeguarding board and the Countywide Homelessness Steering Group</td></tr>
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Priorities for the last year (2020-21)

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

The three priorities set last year were:

1. **Leadership in Homelessness** – During the year, the organisations represented at the Board have come together, with the support of the Board's Business Unit, to form the Homelessness Directors' Group. This group of executive-level representatives from the organisations in Oxfordshire meet with the sole purpose of ensuring that the Countywide Homelessness & Rough Sleeping Strategy 2021-2026 work is progressing and to act as a forum for any 'stuck' issues with this work to be escalated to and resolved.
2. **Working with complexity** – Also during the year, the Board set up the Multi-Agency Risk Management (MARM) process, designed to bring together organisations for multi-agency discussion of individuals who were at risk but who were not already involved with either statutory social care or safeguarding processes. This came out of the work conducted in the previous year for the thematic SAR into homelessness that noted organisations outside of the key statutory partners had no process for or experience of leading on multi-agency work.
3. **Refreshing the links between strategic partnerships** – The Chairs of the Safeguarding Children's Board and the Safeguarding Adults Board have set up monthly meetings to ensure that the two groups are working in alignment. This has also led to discussions around setting some joint priorities for the Boards, which we aim to agree in 2022-23. The Safer Oxfordshire Partnership coordination group brings together the Managers of the two safeguarding boards and relevant information from that group is fed back into the safeguarding board work. There is also a review of all strategic partnership groups underway being led by the Local Authority. The Board is actively involved and will act on any findings.

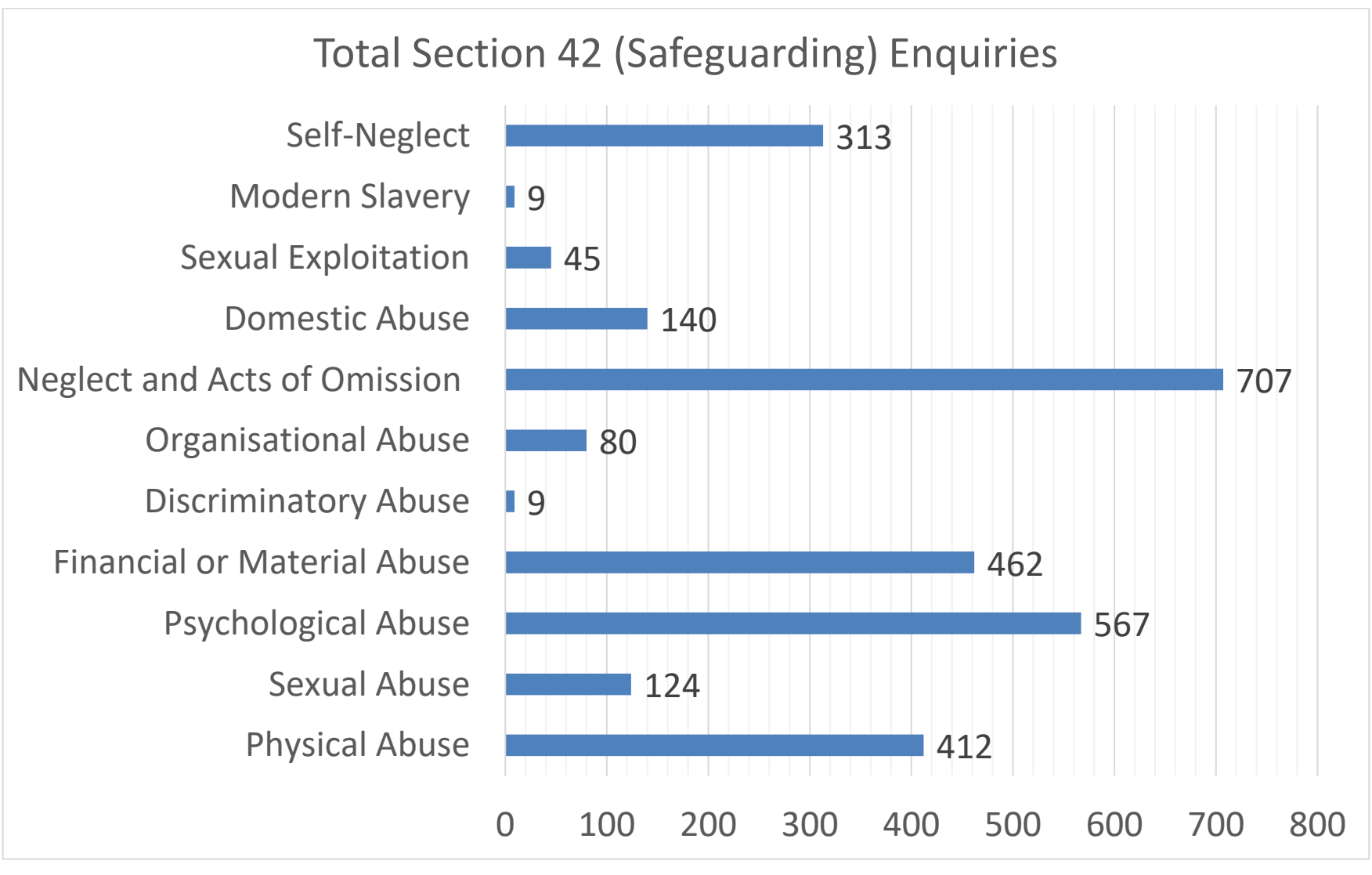
The Effectiveness of Safeguarding Arrangements

Safeguarding data

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

In Oxfordshire, there were **5,934 safeguarding concerns** raised in 2021-22. This is a **21% increase** from the previous year (4,941). Of these concerns, 1,738 went on to be safeguarding enquiries, down from 2,254 in the previous year. (33% decrease). The conversion rate from concern to enquiry has seen significant change in the last year as compared to the previous year (29% in 2021-22 down from 46% in 2020-21, which was up from 26% in 2019-20). However, the conversion rate for concerns raised by the person themselves, family or friends has remained high (72%). As there was a significant increase in the level of safeguarding concerns, the Adult Safeguarding team were required to work flexibly to ensure that concerns were managed and completed earlier which resulted in less cases requiring formal enquires.

The majority of safeguarding issues still occur in the person's own home or in the community (69% of all enquiries). This is an increase on the previous year from 55%. The reasons for this need further exploration but it is suggested some of this may be due to COVID and people remaining in their own homes rather than enter care homes. There was also a drop in the number of concerns coming from care homes as compared to the previous year, so these two factors combined may explain the change. The chart below breaks down the enquiries by the types of abuse. The total here (2,868) exceeds the number of Safeguarding Enquiries quoted above (1,738) as an enquiry may have multiple types of abuse e.g. a person may experience domestic abuse, emotional abuse and physical abuse.



Making Safeguarding Personal data

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

- 96% of adults who were involved in a safeguarding enquiry defined the outcome they wanted
- 98% of those adults reported that they were satisfied with the outcome of the safeguarding enquiry
- 92.5% of safeguarding enquiries resulted in the risks being removed or reduced

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

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

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

Annual Safeguarding Self-assessment

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

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

Summary of Red, Amber, Green (RAG) ratings

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

Overview of Red, Amber, Green (RAG) ratings

Section	Question Total				%	%	%
1 Leadership, Strategy & Working Together	11	0	15	165	0	8	92
2 Service Delivery, Development & Effective Practice	9	0	20	127	0	14	86
3 Commissioning Arrangements	5	0	18	52	0	26	74
4 Safe Recruitment, Staff Development & Effective Learning	9	0	12	135	0	8	92
5 People's Experience of Safeguarding	5	1	10	72	1	12	87

Peer Review

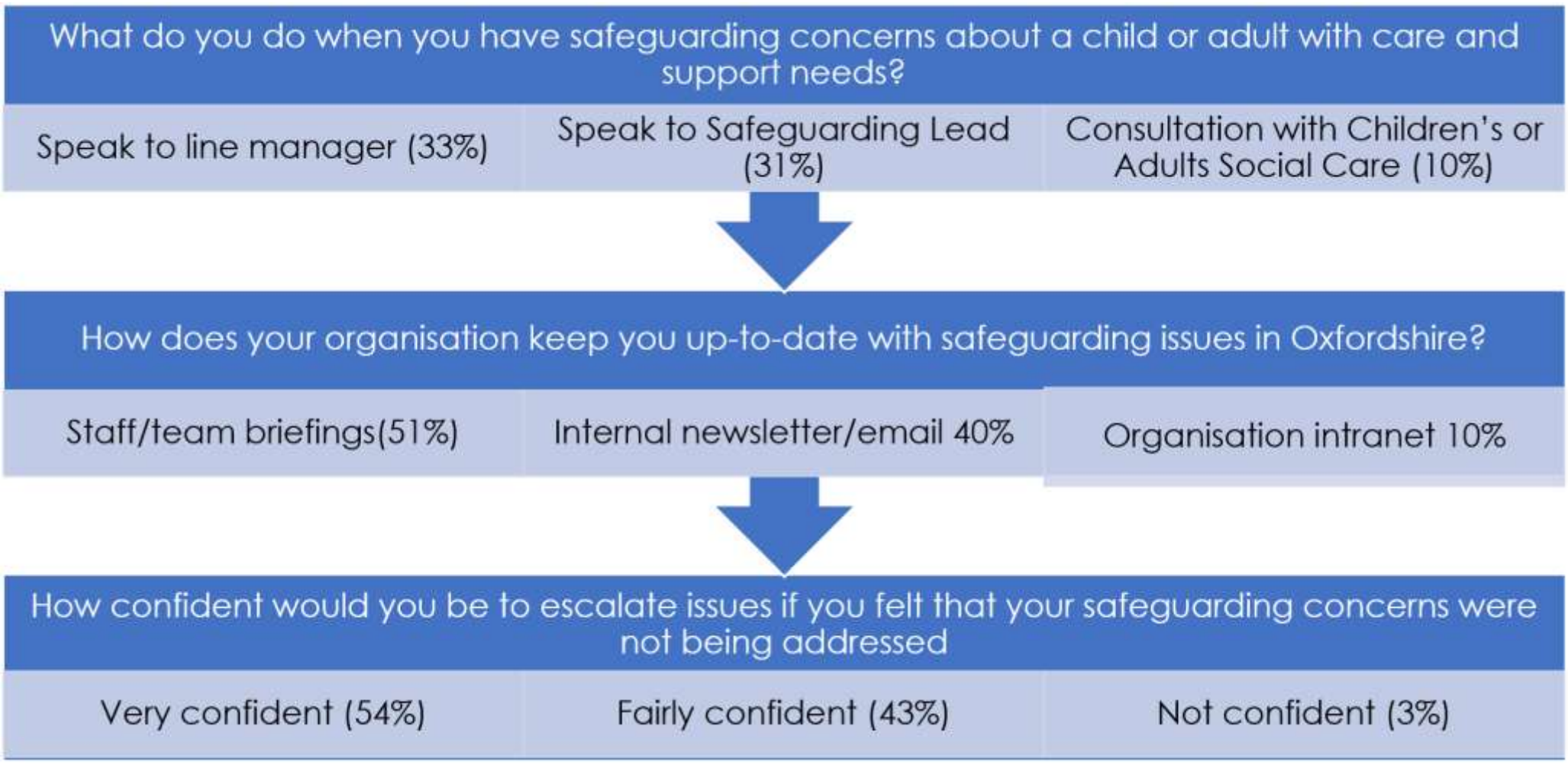
The Peer Review event is held each year for organisations to explain their return responses to a small group of their peers and to receive constructive challenge from them on how they could improve and to provide some moderation to the self-assessment ratings. For 2021, the peer review meeting took a different approach to that of previous years. Board Members were divided into small groups of three or four organisations. Each organisation was given the complete Peer Review response for the others in their small working group in advance of the peer review day. This meant that members were able to ask questions spanning the entirety of the returns of their fellow participants rather than the scrutiny being on standards decided by the Board Business Units.

The event was held virtually, due to the coronavirus pandemic, and there was good discussion in groups, both to provide scrutiny of evidence submitted in relation to ratings given, and in higlighting examples of good practice. There was also some discussion around the challenges and opportunities resulting from the pandemic, examples of how organisations and practitioners have worked creatively to provide support to vulnerable children and adults, and the high level of commitment shown to safeguarding in challenging circumstances.

Summary of findings from practitioner questionnaire

A questionnaire about safeguarding was sent to all Board Members for them to share with their frontline workers and we received 760 responses. These came from a broader range of organisations than previous years and provided a useful snapshot of the views of frontline workers about how safeguarding works within Oxfordshire. Agencies cited the demand on frontline staff during the COVID-19 crisis as a reason for not chasing responses to the same level as the previous year.

Some of the key learning for the Safeguarding Boards came from the practitioner questionnaire:



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

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

In 2022 the Board is challenging itself by opening up the practitioner questionnaire to non-Board member practitioners to see how embedded safeguarding is outside of those that sit at the Board.

Summary of findings from the Impact Assessment

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

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

1. **Increasingly complex individuals**
2. **Increasing volume of demand on services**
3. **Keeping people safe in their own homes (neglect, self-neglect, hoarding, access to services, etc)**
4. **Staffing issues – recruitment, retention and resilience**
5. **Domestic abuse and violence against women and girls**
6. **All forms of Exploitation**

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

Overall Conclusions of the Self-assessment

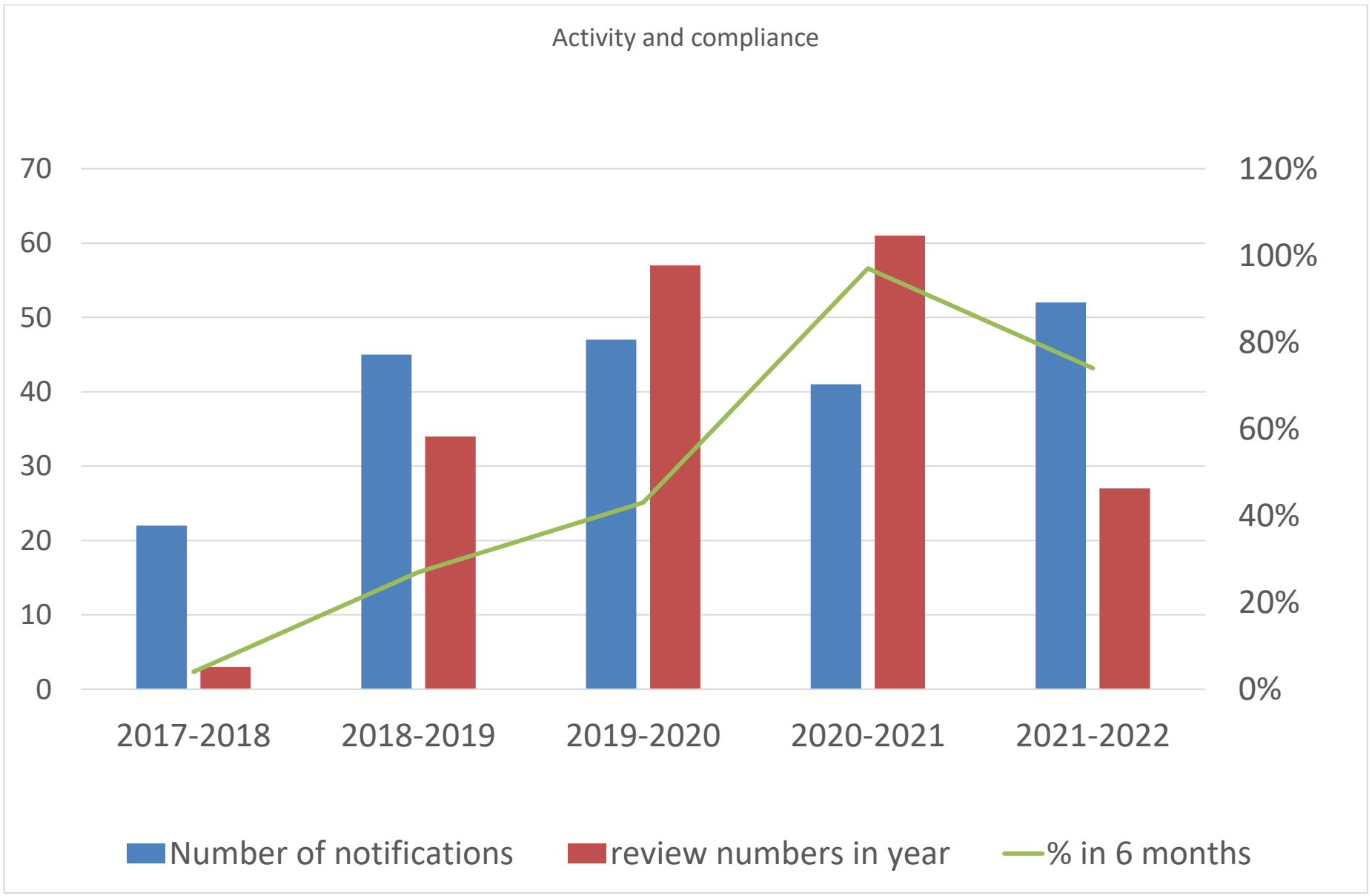
Overall, the peer review groups felt that returns showed a strong level of critical self-analysis. There were some excellent examples of good practice and a very high level of evidence submitted for review. The following were most commonly highlighted areas for actions to improve practice within agency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

- **Training -** Nearly all agencies highlighted a training need for their staff, although there was no common theme to these needs.
- **Multi-agency Procedures and Tools -** As in previous years, a number of agencies recorded an action to improve knowledge of or use of the multi-agency tools.
- **Monitoring Arrangements -** A number of organisations noted actions to monitor current arrangements to ensure they are fit for purpose and high levels of safeguarding and other service delivery can be maintained.

Vulnerable Adults Mortality Group work

Performance:
The new NHS England Learning from Deaths Review (LeDeR) platform went live in June 2021 The new review process and policy has incorporated into working practice. This has causes some delay in completion.

- 52 notifications in the year 1 April 21 - 31 March 22.
- 27 reviews completed this year (including some cases from previous years). (University of Bristol platform closed to review access 1 March, NHS Digital platform opened in June 2021).
- 74% of the reviews were completed within six months of notification. This reduction is largely due to the gap in access to records as the platform was transferred, and changes in review processes that resulted.



Local reviewer arrangements

- The Oxfordshire Clinical Commissioning group (OCCG) Safeguarding team coordinates the review process.
- Provider teams and support organisations all contribute records and information, which is centrally collated and written up ready for the reviewer.
- The reviewer is responsible for contacting the family and carers, ensuring their contribution is integrated with the review documentation, undertaking the analysis and identification of learning points.
- In 2021-22, 100% of reviews were completed by OCCG reviewers, all from within the Quality Directorate Safeguarding team.
- The reviewer profile includes frontline staff and these in the past have been found to contribute effectively, offering real time learning. This year they have been focused on supporting care provision.

Learning from the reviews:

- There is evidence of some excellent multiagency working crossing acute and community services.
- Prompt relocation to appropriate care facility when care needs changed were seen. It is recommended that the health and care system needs to consider how this was achieved within the timeframe to model a protocol on this approach.
- There needs to be a proactive process for specialist practitioners to seek support and follow up actions from GPs to prevent time delays especially when there are changes in care or treatment needs.
- To ensure a safe and effective discharge, a solid discharge planning procedure to be put in place that involves next of kin and other allied health providers. The process needs to include ensuring that checks on caregivers' physical health abilities, competency in planned discharge care updates for family, and mutual agreement on discharge arrangements have been completed.
- Conversations about death and dying are never easy, but where they have been proactive there is evidence of much greater levels of understanding. There have also been more opportunities to represent views and wishes of an individual more effectively in times of crisis and sadness.
- Developing anticipatory end of life plans proactively has been recognised as good practice, valued by those who are mourning a loved family member or friend.

Homeless Mortality Review Group work

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

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

The Mortality Review panel was set up in December 2020. The group initially met monthly, which moved to meeting every four months to reflect the decrease in deaths from the previous year. There were 11 deaths of homeless people identified between April 2021 and March 2022. This is slightly above the pre-COVID figure of 10 per year but significantly below the figure reported last year (2020-21) of 27 deaths.

Emerging Findings

There are some key findings outlined below:

- All those who died were male.
- 1 of the 11 were street homeless at the time of their death. The others were in homeless accommodation.
- 2 of the 11 were Eastern European. The other 9 were British.
- 50% were under 45 when they died. The youngest was 33, the eldest was 68.
- COVID-19 was not noted as contributing to any of the deaths.

The themes from the cases were as follows:

- Alcohol addiction was a feature for the majority of people and in some cases was a very long-term issue.
- Efforts to work with the person were often hampered by threats of and/or acts of violence while inebriated and some services that could offer help are not available to people while they are intoxicated.
- While a majority of these people attended the Emergency department with varying levels of frequency, the follow-up with the services outside of the hospital, such as addiction services, could be improved.

The mortality review process is only in its second year and requires significant commitment from all agencies involved, both in leading reviews but also in providing information to the lead reviewers.

In 2022-23 a new Officer will be joining the Board to oversee the Homeless Mortality Review (HMR) process, conduct the reviews and support the work of the HMR Group. This will provide a greater level of consistency to the reviews, which are currently carried out on a voluntary basis by someone who sits on the HMR group.

Learning from Safeguarding Adult Reviews

There were four Safeguarding Adult Reviews active during 2021-22, three of which were published and are summarised below, the fourth is still in development. This is the same number of reviews as the previous year.

SAR 1 - Adult V

The following SAR was reported on in last year's annual report but had not been completed. As it has now been completed it is being shared again. It has been established from the details contained within the multi-agency chronology that V was a gentleman who had periods of time in his life when he struggled to maintain his health and well-being and was offered support on several occasions to achieve this.

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

V stated to a professional on one occasion that he found it hard to keep "on top of things" and in October 2014 a referral to Adult Social Care highlighted areas of serious concern relating to self-neglect, which included his personal hygiene, his lack of food consumption and extremely poor living conditions. There were occasions when V had to be prompted to pay his rent and the chronology verified that he was evicted on one occasion due to the condition of the property.

The period from 2014 to April 2020 highlights the general ongoing theme of professional concern for V regarding his general wellbeing which included his ability to attend to his basic needs, his health, and his ability to sustain a tenancy. The aim of the Appreciative Inquiry was to look at where, how and why events took place and use professional hindsight and wisdom to design practice improvements.

The method of an Appreciative Inquiry uses a systemic methodology which refers to focussing on the interactions and relationships between professionals to help them address any interactions and to move on. It gives those involved with the process the chance to explore the circumstances and say what they think in a safe, non-judgmental environment. Professionals at the workshop came to a consensus regarding the learning points to be endorsed by the Oxfordshire Safeguarding Adult Board for all agencies involved with Adult V. Board members to ensure that frontline professionals are mindful of the following learning points from this review:

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

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

SAR 2 - Adult "Ian"

Ian died in April 2020 at just 36 years of age. The Coroner was satisfied that his death was due to natural causes. Prior to his death, Ian had been in receipt of multiple health, social and homelessness services in regard to his mental health, addiction and self-neglect issues. The day after Ian was evicted from his supported housing onto the street, he had a heart attack and collapsed; he never regained consciousness and died three weeks later. This was during the first national lockdown caused by the 'covid-19' pandemic. In May 2020, the Oxfordshire Safeguarding Adults Board (OSAB) decided to conduct a Safeguarding Adult Review (SAR) to explore how agencies had worked together to safeguard Ian and to learn lessons for the future.

The authors identified and analysed 8 key issues:

i. **Multi-agency care coordination and risk management**: though in receipt of services from nine different organisations, and despite increasing concern for Ian's safety and wellbeing, he had no comprehensive support plan, or risk assessment and management plan.

ii. **A whole family approach**: Ian's parents were heavily involved in supporting him but were never offered carers assessments for their own support. Ian maintained frequent contact with his daughters even when homeless and described how much those relationships meant to him.

iii. **Mental Capacity**: It was clear that not all agencies understood that there is an expectation placed upon them to assess mental capacity. Outside of mental health and hospital services, the authors encountered many practitioners who did not see it as their role to assess capacity nor as something their organisation expected them to do, even when asking a person to give consent, provide a signature, make a decision, or agree with a suggested course of action important to the person's care.

iv. **Self-neglect, trauma and frequent attendance at the hospital Emergency Department:** Towards the end of his life, Ian showed extreme self-neglect, unable to manage the most basic self-care (nutrition, hygiene etc). It is not always possible to establish a root cause for self-neglecting behaviours and there are numerous possible influences, including addictions, brain injury and traumatic life events.

v. **A psychological approach:** Ian was known to have an alcohol problem by his early 20s (possibly earlier) and also abused various illegal drugs for over ten years. In his final year and a half, Ian harmed himself through extreme self-neglect and attempted suicide several times. Ian accessed substance misuse treatment for just a few months, and only in the last year of his life. His GP and

others (including some family members) connected his alcohol use to anxiety. Ian was advised by mental health services to seek treatment for anxiety once he was abstinent from alcohol and drugs.

vi. **The eviction:** The report closely examines events leading up to Ian's eviction from supported housing. Opportunities to prevent Ian's homelessness were not used to the full and the report explores why that might have been, concluding that housing providers need reassurance that in accommodating complex and challenging individuals, they will not be left alone to manage a crisis. Equally, Commissioners need reassurance that housing providers will use all available channels and multi-agency forums to seek support when crises occur, and indeed to prevent them.

vii. **Coronavirus**: The report notes the context in which decisions were taken by agencies about Ian in the final few weeks of his life: the emerging 'covid-19' pandemic. By March 2020, pressure was building on public services at all levels, and decision-making happened in the context of high uncertainty and huge apprehension about what was coming. Oxford's "Everyone-In" initiative to provide self-contained accommodation for all homeless people was impressive, and would have increased Ian's (short-term) housing options, had he not collapsed and been hospitalised.

viii. **Wellbeing and Safeguarding Principles**: Finally, the report comments on the persistence of the idea that safeguarding a person means referring them to a specific safeguarding team at the local authority, rather than working with a client, and collaboratively with other agencies, to understand: what does 'safe' look like for you? What does 'well' look like for you?' The authors describe this as a 'process-led approach" rather than the 'principle-led' approach introduced by the Care Act 2014. Some ideas about how safeguarding principles could have been applied more widely are given in an appendix.

Conclusion

Overall, the review recommends better coordination of care and support, addressing the needs of the whole family, with clear identification of who leads cases and what is expected of each contributing agency. Where there are safeguarding concerns, oversight and guidance to the response by agencies must be provided by the local authority. There needs to be greater integration of mental health, substance misuse and homeless services, with at least one agency having the resources and responsibility to try to find out what has happened to a person that leads them to neglect themselves so seriously, and to formulate robust care and risk management plans. The Care Act (2014) and Mental Capacity Act (2005) provide the framework for effective care coordination but these Acts are not widely understood at the operational level and there is a system-wide issue of Care Act compliance.

Summary of Recommendations

New Learning

Based on the authors' understanding of the thematic review and resulting action plan, they suggest that the following issues have not previously been highlighted, and should be prioritised by the Board.

1. The Local Authority oversees a review of procedures to ensure that it retains oversight of safeguarding and vulnerable adult concerns passed to the mental health trust.

2. OSAB ensures action is taken by all its partners to create greater awareness of carers assessments and support for carers of people with addiction issues, complex mental health needs etc.
3. OSAB partners to consider where the ambulance service can take a person who does not need further medical attention but who is highly distressed and under the influence of alcohol or illicit drugs.
4. OSAB should find a way to hold partner agencies accountable for the support they offer to agencies in the Homeless Alliance to manage homeless people with complex care and support needs.
5. OSAB to reduce the barriers to accessing mental health treatment for people who misuse alcohol or illicit drugs, through greater integration of services and services to support clients to bridge the remaining gaps; this would likely include reviewing the provision of assertive outreach support and pre-contemplative work with chaotic drug and alcohol users who are not yet ready to attend appointments.
6. The use of 'excluded licence agreements' in supported housing should be reviewed, with a view to providing some security to residents, and clearer information about breaches.

There were also several learning points that reinforced the learning from the Thematic SAR of Homelessness. These have been made into an audit of the learning from the Thematic SAR

SAR 3 - Rhonda

Rhonda had been relatively well most of her life but had been declining in the short months leading up to her admission to Hospital and her eventual death a month later.

There were a number of concerns relating to her care whilst at Banbury Heights care home raised by her sister, which were subject to a Section 42 enquiry. As an adult with a learning disability, Rhonda's death was also subject to a review under the Learning Disability Deaths Review (LeDeR) process.

The Safeguarding Adults Review (SAR) subgroup of the Board agreed to conduct a discretionary review of what happened during Rhonda's care. This review brings together the findings of the Section 42 enquiry conducted by Oxfordshire County Council and the LeDeR review process carried out by the Clinical Commissioning Group.

Rhonda's Background

Rhonda was born partially sighted and with a mild learning disability after her mother contracted German measles during pregnancy. Although partially sighted, Rhonda had learnt to read and write. Rhonda's family felt that Rhonda could express her needs eloquently and was described as a bubbly, lovely lady who loved ballroom dancing.

Later in life, she moved into sheltered housing flat with support from her family. She then met a gentleman who although 20 years older than her was a lovely caring gentleman. She would visit him most days but return to her flat at night.

About 7 years ago she started becoming forgetful and she was eventually diagnosed with dementia in 2017. She also developed arthritis in her hips which caused her a lot of pain.

Rhonda moved into her partner's house in March 2020 temporarily after discussion between him, his daughter and her sister (and care provider) to ensure that during lockdown she received more companionship and meals. This worked well but tragically her boyfriend, who was in his 80s and had multiple health issues, succumbed to COVID in early April and died in the Horton Hospital. Rhonda really struggled with this, especially as there wasn't a funeral.

After discussions with his daughter, it was agreed that Rhonda and her partner's daughter would both benefit from the company they could offer each other at this sad time and Rhonda also still required help. Rhonda's family paid for Rhonda's living expenses while she was with the partner's daughter.

By prior arrangement and after setting up care visits at her flat, Rhonda returned home on the 6th June 2020. Her health was declining both mentally and physically, prompting the move back into her own flat with four visits a day arranged by social care and agreed by her Doctor

Within 48 hours Rhonda was found wandering in the communal hallway by other tenants, and she was then taken into hospital that night by the paramedics, where she was found to have a UTI. From there she was transferred two days later into a Hospital Hub Bed at Banbury Heights Care Home, under the joint care of Banbury Heights Care Home and the Hospital Hub Unit. At no point was Rhonda's sister advised another MRI had been carried out while Rhonda was in Hospital and the decline that it has shown; this was revealed at a meeting held much later. As Rhonda's legal guardian this should have been shared with Rhonda's sister at the time of the event, which would have helped her understand why the mental health decline was so obvious.

While at Banbury Heights there were a number of issues, which are explored further in this report. These included a lack of clarity about responsibilities for a patient in a hub bed, an overshadowing of perceived behaviours, failure to maintain regular recording and a lack of action in response to concerns raised by Rhonda's sister.

Findings
There are four key areas that need addressing.

There was a clear **failure to monitor and identify a deteriorating patient**. There were no pain charts, observations were irregular, there was no use of recognised warning tool and no evidence of use of the bowel charts.

The **perceived behaviour and known minor illnesses** potentially contributed to a failure to identify a deteriorating patient. This perception based on past behaviour and known medical conditions is referred to as clinical overshadowing.

Patients in hub beds should receive the same level of nursing care and monitoring as in a hospital bed (e.g. daily observations which were in Rhonda's care plan). Nursing staff caring for patients in hub beds have a duty of care to ensure their patients are safe and that appropriate tools and guidance is used at all times (eg Restore2, pain charts, bowels charts).

Nursing home need to change practice for patients in hub beds to ensure there is regular monitoring of patients to ensure timely management of issues and prompt identification of a deteriorating patient. The health system to organise a series of learning sessions on the use of Restore2 tool.

There was a **lack of clarity between teams about who was responsible** for what and how to escalate concerns. Staff need clearer documented information about who is following up on which issues and that explicit processes are in place for sharing concerns, whether or not they are deemed valid or not. Oxford University Hospitals (OUH) should develop guidance for care homes and the MDT re responsibilities for patients in hub beds. Clarity to be sought from commissioners regarding expectations of care and clinical oversight of patients in hub beds.

Rhonda's sister did not feel her **concerns were being heard and valued** and **did not know how to escalate** these when nursing home staff did not value them. Family members & carers have invaluable knowledge of an individual and not considering these is short-sighted of organisations and potentially could lead to important information or opportunities being missed. All organisations involved need to ensure that staff are listening to and valuing a family member's concerns. OUH need to develop a leaflet for individuals and their families about how to escalate concerns when the person is in a hub bed. The Vulnerable Adults Mortality Steering group should consider if this is needed for other settings.

Conclusion

Rhonda's final days were spent in unnecessary pain due to the issues outlined in this report. While professionals can never know the severity of that suffering, this must be taken as an opportunity for organisations to learn the lessons highlighted in this report to bring about positive change, ensuring all reasonable steps are taken to prevent this happening again to another person.

Learning & Action Plan

Nursing home's should:

- ensure there is regular monitoring of patients **as per care plan** to ensure timely management of issues and prompt identification of a deteriorating patient
- ensure that appropriate tools and guidance is used at all times (eg Restore2, pain charts, bowels charts)
- ensure that nursing and care staff have up to date training to be able to spot a deteriorating patient
- All individuals should have personalised care plans
- Staff should be trained in caring for individuals with Learning disabilities
- Staff should consider the interplay between existing known health and emotional conditions and new emerging risks

There must be clarity for staff, patients and family members about who is responsible for which areas of care and how and who to escalate concerns to. Learning for all settings:

- Settings must develop a personalised care plan for every individual in their care
- Settings must work in partnership with family members

As with all Safeguarding Adult Reviews, the action plans are monitored by the PIQA subgroup and then audited for impact once completed.

OSAB Training Programme

During COVID-19, all training was moved to e-learning. This allowed professionals to continue to maintain high levels of training adherence without the risks associated with bringing large groups of people together. It also improved the accessibility to training as it could be done at the pace and time of the delegate rather than attending a face-to-face training session. The training figures have risen from 2,144 delegates to 2,521 delegates. This is likely to rise again in 2022-23 as the Learning & Engagement Officer expands the OSAB's training offer. The Board is also offering a series of interactive sessions on trauma and the impact of trauma.

Satisfaction rates with the training have not decreased despite the move to only providing training in an e-learning format (96% approval rating for the reporting year as well as the previous reporting year). The training has remained free for everyone to remove as many barriers as possible for accessing the training. This is due to the funding from the partner agencies to support the multi-agency training offer.

Conclusion

The Board Member partnership knows:

- The local safeguarding partnership has continued to maintain a high standard of work during a second year of COVID that has affected all partner organisations. There has been an increase in safeguarding concerns across all types of abuse and neglect. There is no obvious reason behind this increase in concerns or the drop in the number of enquiries during the year, but year to date figures (April 2022 to June 2022) indicate this trend is already reversing.
- The Making Safeguarding Personal approach has been championed throughout the year and there has been an improvement in the number of people who have defined what they wanted to happen as a result of the safeguarding work and who were satisfied with the work that was undertaken. This is excellent progress during a difficult year and demonstrates professionals are continuing to keep the person at the centre of their work with them, empowering them to make the decisions that are important to them and honouring that as much as they are able to whilst seeking to protect them.
- The annual Practitioner survey of Frontline workers has indicated that the majority of workers have maintained a high level of safeguarding training despite challenging conditions. There is still work to do to improve practitioner confidence with escalating concerns when there is a difference of opinion.
- Organisations continue to experience issues around recruitment, retention and resilience, which have been included in the impact assessment consistently since it was introduced. As in previous years, Organisations are reporting an increase in demand on their services as well as an increasingly complex individuals seeking our help and support.
- Despite challenging financial and workforce pressures and the against a backdrop of COVID, there is a narrowing gap between the life expectancy for people with a learning disability and the general population. The leading cause of death (cancer) is now the same as for the general population, COVID deaths were no greater for adults with LD than the rest of the population, and the clear line of sight between Commissioners and people in out of county placements. This demonstrates that we can still improve support to the most vulnerable people in our society when we set our minds to it.

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

- **Refreshing the links between strategic partnerships** – during COVID-19 the focus of organisations has rightly been diverted to ensuring those most vulnerable in our society are protected as much possible. This had the effect of reducing the focus on strategic partnership work during this period. The relationship between the strategic partnership groups within Oxfordshire (Children's Board, Health & Wellbeing Board and the Safer Oxfordshire Partnership) needs to be reviewed and refreshed.
- **Improving Engagement** – there is an extensive plan of work being undertaken by the Engagement Subgroup to better understand the views of the people of Oxfordshire about safeguarding as well as agreeing routes for their views being fed into the work of the Board to influence our work and hopefully improving our impact on adults with care and support needs.
- **Improving how we manage risk on a multi-agency basis –** out of the work around homelessness, the Board developed the MARM process to address multi-agency risk and how it is managed. The work is new and throughout 2022-23 the Board will work to improve this process and will be formally reviewed at the end of the year.