Divisions Affected -

People Overview and Scrutiny Committee

9 November 2023

OXFORDSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2022-23

Report by KAREN FULLER

RECOMMENDATION

1. **The Cabinet is RECOMMENDED to** note the contents of the report and its conclusions.

Executive Summary

2. The report summarises the work of the Oxfordshire Safeguarding Adults Board (OSAB) and its partners over the course of the year 2022-23. It is a requirement set out in the Care Act 2014 statutory guidance that the Local Authority receive a copy of the report and that they "will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the Board" (Chapter 14, para 161).

3. The Report is not produced as a document but as a webpage. It is accessible via this link: Safeguarding Adults Board Reports - Oxfordshire Safeguarding Adults Board (osab.co.uk).

Background

4. Safeguarding Boards are required to share their annual reports with all statutory partners and those partners are expected to consider the report and its contents to decide how they can improve their contribution to both safeguarding throughout their own organisation and to the joint work of the Board *(S14.161, Care and Support Statutory Guidance).*

5. This report and the work of the Board will take on additional significance in light of the new Care Quality Commission Inspection regime, which will see the Local Authority inspected for the first time since Safeguarding Boards became a statutory requirement. Based on feedback received from the inspection pilot areas, the Board will be asked for its view on the Local

Authority and how they discharge their safeguarding function under The Care Act 2014.

Key Findings

Board work during 2022-23

6. Organisations have continued to see safeguarding as everybody's business and as a priority through many challenges (e.g. funding, recruitment, retention, sickness, reorganisations, industrial action, etc).

7. There has been an increase in safeguarding concerns across all types of abuse and neglect. This increase in concerns is replicated in other Local Authority areas across the country. There is no obvious reason behind this increase in concerns, but there is also a corresponding increase in the number of safeguarding (Section 42) enquiries that have taken place.

8. Despite challenging financial and workforce pressures and the against the continued 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 remains the same as for the general population.

9. 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.

10. The Board's annual frontline practitioner survey has indicated that there is still work to do to improve practitioner confidence with escalating concerns when there is a difference of opinion.

11. The Board's annual safeguarding self-assessment indicates that organisations continue to experience issues around recruitment, retention and resilience, which have been included in the impact assessment consistently since it was introduced.

12. As in previous years, Organisations also reported an increase in demand on their services. More people are presenting with multiple needs requiring the coordinated input of several organisations, which can be challenging for services.

13. There has been significant progress in the work of the Multi-Agency Risk Management (MARM) process, managed by the OSAB, since a dedicated Officer has been taken on to chair the meetings. Feedback from adults who are being discussed at the meeting has been positive, with some very positive

examples of adults changing the direction of their lives thanks to the hard work of those involved in the process.

14. Some of these have not been because of huge pieces of work carried out by individual organisations but from professionals attending the meetings, contributing to finding practical solutions (sometimes small things like sorting out a bus pass or helping complete application forms) that improve the persons' everyday lives and demonstrating their commitment to putting the person first.

15. Further information on the MARM process and the full summary report of its first year can be found here: Multi-Agency Risk Management (MARM) Framework - Oxfordshire Safeguarding Adults Board (osab.co.uk)

Board priorities for 2022-23 from the annual report (and mid-year current position)

16. The Board's Strategic Plan sets out its objectives for the next five years. This is reviewed annually to ensure that the priorities remain relevant and that new or emerging themes are incorporated, where necessary. Examples of key priorities are included below, but the full plan is available to read elsewhere on the Board's website OSAB Strategic Plan + Action Plan – 2023-27**.**

Ambition One: Working in Partnership

17. The Board is only effective if the partners around the table are working together to safeguard adults with care and support needs at risk of abuse and neglect. The Board will build upon the close working arrangements already in place to achieve the following:

1. The Board Members will work together as a partnership at all levels, looking to strengthen that relationship, empowering those working within our systems.
2. The Board and its partners will look for greater integration across the Adult and Children's Board, either at Full Board or at subgroup level. This does not have to mean combining the groups but reviewing Board processes and aligning the group agenda it may streamline some of the discussions.
3. All work will be done with the "so what?" question in mind. If work does not actively improve practice outcomes and is not linked to clear outcomes in the purpose of the work then it will not be taken forward.
4. The Board will work to improve the understanding of the roles and responsibilities of the organisations working with adults across Oxfordshire, what they offer, what are the thresholds for those services and what to do when there are professional differences of opinion about accessing services.

Ambition Two: Preventing Harm Occurring

18. It is always better to prevent harm occurring rather than responding once harm occurs. The Board will build upon the work that is already in place to achieve the following:

1. Improve the use of the Multi-Agency Risk Meeting (MARM) to assist providers who have cases that are not progressing, such as cases where there are lots of agency involvement but not necessarily a key lead, so that ideas and actions can be shared to improve outcomes. This requires a senior leadership ownership and active engagement to promote the process and hold their own and other organisations to account for its effectiveness.
2. Develop an overarching practice framework for the whole partnership, which includes restorative practice and trauma-informed working and clearly defines what these mean.
3. Develop an overarching commitment and strategy to tacking inequality and anti-discriminatory practice within safeguarding, and actively assess and respond to any identified issues.
4. Improve awareness of the safeguarding support available, the pathways and mechanisms e.g. how to trigger a statutory response before serious harm has occurred, amongst people most at risk and those supporting and working with them (perhaps using the Engagement Subgroup to do this?)

Ambition Three: Responding Swiftly when Harm Occurs

19. When organisations are alerted to abuse occurring, we are responsible as a system for responding swiftly and intervening as early as possible. The Board will build upon what is already in place to achieve the following:

1. Initiate a system-wide discussion on how we share information and intelligence in a way that reduces requests from information between partners (i.e. proactive information sharing), improving our intelligence and therefore the support we offer in an effort to reduce or remove the risks people are facing, where possible.
2. Adopting a collaborative problem-solving approach in the face of learning from MARMs, SARs, SI's and difficult or complex safeguarding events. This must come with an acknowledgement that decisions can be extremely complex with no clear right/wrong answer and we will not be able to protect everyone as well as we would want to.
3. Reviewing the Board's dataset to ensure that the Board is assured when an issue occurs that the system responds in a timely fashion and in line with Making Safeguarding Personal principles.

Ambition Four: Engaging Effectively with People at Risk

20. The Safeguarding Board and its partners should be engaging with those who are using services or have experience of the safeguarding process to better inform our work and improve how we react to incidents of safeguarding. The Board will work to achieve the following:

1. Hearing the voice of the adult at every meeting, whether it is a success story, a concern or just the experience of someone on the receiving end of our services
2. Consider an expert by experience at the Board or its subgroups or link into existing expert by experience panels run by partner agencies

3. Work closely with Advocacy organisations/providers to include the voice of those they work with are also heard at Board level
4. Review the strategic plan for 2024 onwards to co-create with people using our services the safeguarding priorities for the partnership

Financial Implications

21. N/A – The Local Authority is not being asked to commit any further financial resources towards the Board beyond what is currently committed.

Comments checked by: **James Thomas, Finance Business Partner**

Legal Implications

The Care Act 2014 requires Oxfordshire Safeguarding Adults Board (OSAB) to ensure that vulnerable adults are safe, and that agencies work together to promote their welfare. The Act sets out a legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect. The Board has a statutory duty to prepare an annual report on its findings of safeguarding arrangements in its area. There are no direct legal implications arising from the publication of the report.

Comments checked by: Anita Bradley Director of Law and Governance

Staff Implications

22. N/A – There are no additional staff resources being requested by way of this report for the work outlined in the Annual Report.

Equality & Inclusion Implications

23. N/A – there are no additional equality & inclusion implications.

Sustainability Implications

24. The Board have moved the majority of its work to a virtual environment, reducing travel congestion, and no longer prints any materials for Board meetings or training sessions, instead making these available electronically. It has also reduced printing & design costs by making more things, such as this annual report, plain text on the OSAB website.

Risk Management

25. The Board is made up of the partners who attend the meetings, supported by a small team in the Board Business Unit. If organisations do not continue to

provide the level of engagement with the work of the Board it is likely it would fail to meet its duties laid out in statute and its accompanying guidance. As the Local Authority is the organisation charged under The Care Act 2014 to ensure the Board is established and running well, this would represent a reputational risk. It is also likely any such failings would be highlighted under the new CQC inspection framework and in their resulting published report.

NAME	Karen Fuller, Corporate Director of Adult and Housing
Annex:	Annex 1 – One Page summary of the Report Full Report: Safeguarding Adults Board Reports - Oxfordshire Safeguarding Adults Board (osab.co.uk)
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[October 2023]

Annex 1 – one page summary of the report

Oxfordshire Safeguarding Adults Board Annual Report – 2022-23

6 Key Messages

1. Organisations have continued to see safeguarding as everybody's business and as a priority through many challenges (e.g. funding, recruitment, retention, sickness, reorganisations, industrial action, etc)
2. Safeguarding concerns have continued to rise (14% increase on 2021-22) as they have since 2018-19 (a 39% increase between these periods). This trend is in line with national and regional increases in concerns.
3. Safeguarding enquiries (those incidents deemed to meet the Care Act 2014 criteria for safeguarding) have also risen at a similar rate to last year and again in line with regional & national trends.
4. A person's own home remains the most likely place for them to experience abuse, with neglect remaining the most common type
5. Only 1% of people were unsatisfied with the outcome of the safeguarding work done to protect them
6. 80% of people deemed to lack capacity had an advocate (family, friend or impartial advocate)

5 Key Themes

1. Professional curiosity about a person's background or the veracity of self-reported information could be improved
2. Risk Assessments are often done in isolation without input from other agencies
3. Discussions about a person (e.g. in supervision) and the outcome/actions are not routinely recorded on the person's file
4. There is a lack of flexibility in our ways of working with people who professionals find complex or difficult to engage
5. Multi-agency/joint work is often seen as a last resort than an option for earlier intervention

4 Key Priorities for the Future

Working in Partnership

- Reviewing practical operational relationships with the OSCB and Safer Oxfordshire Partnership
- Improving understanding of the roles & responsibilities across organisations & the system

Preventing Harm Occurring

- Improve the knowledge and use of the MARM process to intervene early
- Develop overarching practice framework, including what trauma-informed work looks like

Responding Swiftly

- Adopt a collaborative problem-solving approach to learning from incidents
- Review the Board's dataset to ensure a swifter systemic response to issues

Engaging Effectively

- Bring Advocacy & 3rd Sector organisations into the Board's work to gather voices not currently heard at Board
- Involve experts by experience/service user voices in the work of the Board.