Divisions Affected - All

PEOPLE OVERVIEW AND SCRUTINY COMMITTEE
19th September 2024

Oxfordshire Safeguarding Adults Board Annual Report

Report by Karen Fuller, Director of Adult Social Services

RECOMMENDATION

1. **The Cabinet is RECOMMENDED to**

    - Note the annual report of the Oxfordshire Safeguarding Adults Board (OSAB).

Executive Summary

2. The report summarises the work of the OSAB and its partners over the course of the year 2023-24. 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).

Body of the Report

3. 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).*

4. 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 2023-24

5. The local safeguarding partnership has continued to maintain a high standard of safeguarding.

6. There has been a slight decrease in safeguarding concerns across all types of abuse and neglect, which is in line with the yearly fluctuations in the number of concerns. Comparative data is published later in 2024-25 so until that point we cannot know whether this pattern is replicated in other Authorities.

7. Despite challenging financial and workforce pressures, the partnership has continued to undertake a large amount of work against the four key strategic priorities of the Board and the details of this work is detailed within the report itself.

8. The proportion of concerns that led to enquiries decreased from 28.8% in 22/23 to 22.25% in 23/24, with care providers (including care homes) remaining the highest source of referrals in 23/24 accounting for 29% of all referrals. To understand this further audit work has been commenced to review decision making at the triage stage of concern. 10% of care home concerns were audited for Q3 and found that decision making by the safeguarding team was correct and in line with statutory guidance. This is indicative that further training and support with care providers would be beneficial in reducing the number of inappropriate referrals.

9. The number of completed safeguarding enquiries also decreased by 22% in 23/24. A number of factors have contributed to this figure. It is noted that where detailed information is gathered when a concern is received this is not being recorded as an enquiry. To address this, the pathways in the Liquid Logic Care records system have been redesigned to ensure that work undertaken by the team is rightly captured as enquiry activity and thus we would expect to see an increase in the number of completed enquiries in 24/25 once this is live in Q3.

10. Throughout the last 12 months, there has been a robust focus on improving safeguarding performance. This included the closure of inappropriate or historic cases throughout 22/23 still open. This has been a significant achievement for the team illustrated by the fact that in July 2023 there were 527 open enquiries with 268 of these open over 12 weeks. As of July 2024, there are 183 open enquires with only 13 over 12 weeks. Historically there have been waits for an allocated officer to complete an enquiry. To overcome this, allocations were made across adult social care teams where the person was already known to a social worker which provided rapid resolution of longstanding cases and positively ensured continuity of worker. This not only improved the experience for the person but ensured that safeguarding is everybody's business and that all teams participate in the safeguarding duty. This targeted work also identified, that enquiries would often remain open beyond the remit of the safeguarding intervention where a complex case management approach would be more appropriate from one of the locality teams. Therefore, closure to more

appropriate intervention has also contributed to the overall reduction in enquiry numbers. This will need careful consideration throughout the coming year, in view of the data indicating 1107 people who have had a concern raised in both years. Audit focus on decision making will focus specifically on whether the person has had a previous concern and whether safeguarding duty can and should add a more robust approach to the persons situation as opposed to a case management approach.

11. To ensure robust decision making further detailed audits are also planned to review reductions in the number of concerns that do not progress to enquiries specifically in the areas of referrals from Police, Ambulance and those raised by friends or family, This will be an area for Performance Information and Quality Assurance subgroup to scrutinise over the coming year.

12. A number of workshops have been completed in relation to Making Safeguarding Personal (MSP) across the service. Whilst MSP scores remain strong at the closure of an enquiry, the team identified that outcomes were not always robustly sought at the very beginning of the enquiry process. Regular "dip audits" now show that the introduction of the enquiry pod and the focus on MSP means that people's views are now being sought at the very beginning of the safeguarding episode.

13. Overall, the County Council Safeguarding Team's performance has improved significantly but will require close monitoring to ensure that enquiry rates remain proportionate to individual circumstances and that data continues to inform areas requiring qualitative exploration.

14. 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. This is backed up by findings with case review and multi-agency work undertaken by the Board.

15. The Board's annual safeguarding self-assessment indicates that organisations continue to experience issues around recruitment, retention and workforce resilience, which have been consistently included in the assessment since it was introduced. The budgetary constraints on services are outside the scope of the Board but have been discussed at national networks where they impact on safeguarding work, such as the availability of mental health beds.

16. 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.

17. 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.

Board priorities for 2023-24 from the annual report

18. A significant amount of local and national work in regard to adult safeguarding has been undertaken. In acknowledgement of the demands on services to act on learning, the Board is reviewing its strategy and workplan to have a greater focus on acting on learning and measuring impact of learning activity. Sources of learning include:
    (a) Local Safeguarding Adults Reviews and Homeless Mortality Reviews due to be completed and published in 2024-25
    (b) The findings from the 2nd SAR national analysis, reviewing 652 Safeguarding Adult Reviews (there is a dedicated briefing on this for Elected Members produced by the Local Government Association: Briefing for elected members: Second national analysis of Safeguarding Adult Reviews)
    (c) The safeguarding dataset used by the Board

19. Linked to this, the Board will reconsider its strategy overall, ensuring the priorities are informed by the learning mentioned above and framing the priorities against the impact they are expected to have on the people of Oxfordshire.

Financial Implications

20. 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:

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Legal Implications

21. There are no specific legal implications for the Local Authority arising from this report. The committee is reminded that the requirements of the Care Act 2014 are that the Safeguarding Adults Board must produce an annual report setting out
    - what it has done during that year to achieve its objective,
    - what it has done during that year to implement its strategy,
    - what each member has done during that year to implement the strategy,
    - the findings of the safeguarding adults reviews (SARs) arranged by it which have concluded in that year, details of any SARs which are ongoing at the end of that year, what it has done during that year to implement the findings of its SARs, and, where it decides not to implement a finding of its SARs, the reasons for its decision.

And a copy of that report is to be sent to each of the statutory partners.

Comments checked by: Janice White

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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, Director of Adult Social Care
Annex:	N/A
Background papers:	Nil
[Other Documents:]	N/A

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