Oxfordshire Safeguarding Adults Board Annual Report 2013-2014

Safeguarding is everybody's business…

Agencies working together to ensure a coherent policy and a consistent and effective response for the protection of vulnerable adults at risk of abuse






Contents

Foreword

Welcome to the Oxfordshire's Safeguarding Adults Board Annual Report for 2013/14. As Independent Chair I would like to take the opportunity to comment on how I believe The Board is contributing to reducing the risks of abuse, neglect or exploitation of vulnerable adults in Oxfordshire. It must be emphasised that a Safeguarding Board does not directly protect the vulnerable. What it does do however, is to coordinate the efforts of those professionals from many disciplines who work to keep people safe. It develops the best practices and policies, it quality assures service delivery and it investigates when things go wrong in an effort to learn and improve. Equally importantly, it challenges and holds to account both its own constituent agencies and other partnerships.

Safeguarding vulnerable adults continues to be at the centre of media attention nationally, and one cannot help but be concerned at the findings of the Francis Report and more latterly the Keogh Report, both of which highlight the quality of care in hospitals. Though abuse in hospitals and care home settings are an obvious focus for our Safeguarding Board, the fact remains that the majority of abuse and neglect does occurs in a person's own home.

This illustrates the complexity of the issue and the need for agencies to strive for optimum response to abuse of all types and in all settings. Complexity is further compounded by scale and the main body of the report indicates that the number of safeguarding concerns received by Oxfordshire County Council rose by 49% in 2013/14 compared to the previous year. Such a rise in demand for services would be challenging in the best of times, but is particularly formidable in light of the current public sector budget reductions. It is to the credit of the partnership that it has remained strong and committed to working together throughout the year. It is my responsibility to request that such commitment continues despite the challenges from competing demands and reduced resources.

On the continued subject of support to the safeguarding adults agenda, the Care Bill 2014 can do much to strengthen both involvement in, and delivery of, safeguarding services. New proposed powers in respect of duty to report, right to access and the creation of a specific offence of neglecting or ill- treating an adult at risk of abuse, will provide a degree of legislative muscle hitherto quite sadly lacking. The standing item on the Board's agenda to be informed of capacity issues and organisational change has provided clear information about the continuing rise in the demand for safeguarding services which impact on all agencies.

The data provided by Adult Social Care is consistent with agency reports of greater activity which has been challenging for all agencies to respond to. The Board is now receiving more cases to be considered as case reviews and this demonstrates a greater awareness of the Board, and greater understanding of the Board's role in considering situations for potential case review.

A critical issue that emerged at the end of the year was the 'Cheshire West' judgment in respect of deprivation of liberty. The Board recognised the implications of this judgment and has put in place governance systems to be able to understand the challenging issues of capacity to meet the new threshold established within the judgment.

All of the above is of little consequence if we are unable to answer two simple Questions; are vulnerable adults in Oxfordshire safe and how do we know that they are? The answering of these questions should be the sole focus of the Safeguarding Board as it moves from a process of inward looking self-development, which has made it fit for purpose, to a position of positive influence to drive up standards of service delivery and identify and protect those in need of our help.

Finally, I would like to thank all of those agencies that continue to support the Board's important work, but most importantly our frontline practitioners who continue to work hard in protecting vulnerable people, often in difficult circumstances.

Donald McPhail
Independent Chair
Oxfordshire Safeguarding Adults Board

Introduction

High quality adult safeguarding systems are in place in Oxfordshire. Under the stewardship of the Oxfordshire Safeguarding Adults Board, these systems and services continue to protect adults at risk from abuse and harm and to support community safety.

The term 'safeguarding' is used to mean both specialist services that intervene, investigate and support the person where harm or abuse has, or is suspected to have, occurred, and any other activity designed to promote the wellbeing and safeguard the rights of adults. In its broadest sense, safeguarding is everybody's business: the public, volunteers and professionals. It covers a wide range of activities and actions taken by a large number of people, not least by people in the community.

This annual report describes the current arrangements for ensuring the safety of "adults at risk" in the county and provides an assessment of the key developments in local multi-agency adult safeguarding systems in 2013/2014 along with a statistical analysis of the casework activity, outcomes and reports from individual agencies.

The Board has followed current government guidance in considering an adult at risk to be someone aged 18 years or over "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (DOH, No Secrets, 2000). The Board notes however that implementing the Care Bill (see below) may have an impact on the numbers of people for whom safeguarding enquiries will be necessary. This will be analysed in next year's annual report.

Developments in National and Local Policy in 2013/14

Mental Capacity Act 2005: House of Lords post-legislative scrutiny report

In March 2014 the House of Lords Select Committee on the Mental Capacity Act published its post-legislative scrutiny report. The Committee concluded that so far the potential of the Act to bring about real change in the support and protection of people who struggle to make their own decisions had not been realised.

The main findings of the Report are as follows:

- The ethos of the Mental Capacity Act is widely welcomed but it has not been adequately implemented due to lack of "ownership" by a dedicated independent oversight body;
- Too much decision-making in health and social care is still motivated by paternalism and risk-aversion rather than the principles of the Act;
- There is a lack of adequate information for all stakeholders – individuals, family members, professionals – leading to confusion over rights, roles, and responsibilities;
- The Deprivation of Liberty Safeguards are not working and need to be replaced;
- The Court of Protection needs more resources and should place more emphasis on mediation prior to court action.

In its response to the report the Government acknowledged many of the concerns raised by the House of Lords. The Government has set up a Mental Capacity Advisory Board and will seek to work with partners such as NHS England, Association Directors of Adults Social Services (ADASS) and Care Quality Commission (CQC) to implement the Act more effectively. The Government has also asked the Law Commission to review the operation of the Deprivation of Liberty Safeguards (see below) and will provide more resources to the Court of Protection.

Oxfordshire Adult Safeguarding Board remains committed to undertaking its duties in seeking assurances that the application and implementation of the Mental Capacity Act is robust and has the vulnerable adult at the centre of the process.

Deprivation of Liberty – the "Cheshire West" Supreme Court Decision

In March 2014, a Supreme Court judgement known as the "Cheshire West" decision changed the criteria for assessing whether a person lacking mental capacity is being "deprived of their liberty" in a care home, hospital or other care setting. The judgment overturned a number of previous rulings from the Court of Appeal which had progressively restricted the application of the Deprivation of Liberty Safeguards (DoLS).

The judgement will lead to a significant increase in the number of capacity assessments for people with cognitive impairments who are held to require formal authorisation of "deprivation of liberty", either under a) the deprivation of liberty safeguards (DoLS) (for hospital patients and care home residents), or b) through the Court of Protection (for people in supported living schemes

The judgement introduced an “acid test” to identify deprivation of liberty in cases where a person is deemed to lack the capacity to give valid consent to their care arrangements. There are two key questions in the test; (1) is the person subject to continuous supervision and control, and (2) is the person free to leave?

If the answer to both questions is “yes”, then the person would now be considered to be deprived of his/her liberty and in need of the protection of an appropriate legal framework. Under previous case law deprivation of liberty was deemed to occur only when there were aggravating factors such as the person or their family objecting, high levels of restraint etc.

This means that more people in care homes, hospitals, independent supported living schemes, mental health hospitals and institutions require assessments in order to consider whether they are being “deprived of liberty” and whether this is in their best interests. This has already seen significant financial and operational implications for the local authority overseeing the process and for service providers.

The “Cheshire West” judgment was handed down at the very end of the year and had had an initial impact on the numbers of referrals for a DoLS in Oxfordshire in 2013-2014. It is already clear that the situation for 2014-2015 will mean increased rates of activity for the service and will need the Oxfordshire Safeguarding Adult Board oversight.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a sector-led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the ‘No Secrets’ consultation and other engagement with Councils and their partners. It aims to develop outcomes-focused, person-centred adult safeguarding practice and a range of responses to support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people. This is in keeping with the focus on individual wellbeing promoted by the Care Bill.

Oxfordshire is committed to implementing Making Safeguarding Personal. The authorities’ work to implement the Care Bill will draw on the principles and resources of the MSP programme to ensure that staff have the skills and expertise to engage with service users and support them to achieve their preferred outcomes wherever possible.

Changes in the Care Quality Commission (CQC)

In the past year, the CQC have made significant changes to the way they inspect and regulate health and social care services to make sure services provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements.

CQC's Strategy for 2013-16 outlines the changes that apply to many services regulated by the Commission. During 2013–14, national teams have been introduced to inspect NHS hospitals and mental Health Trusts.

Response to Winterbourne View

In December 2012, the Department of Health published *Transforming Care: A National Response to Winterbourne View Hospital* Final Report. This report made a number of recommendations aimed at strengthening accountability and corporate responsibility for the quality of care and defined actions for the Department of Health, CQC, secure services (including prisons), the police, LGA, Healthwatch, as well as health and social care services.

The Department of Health Report was followed by the launch of the "Winterbourne View Concordat and the Interagency Programme of Action".

Oxfordshire Safeguarding Adults Board has been proactive in seeking assurances through robust monitoring that the needs of individuals with Learning Disability have been met and that agencies and commissioners have worked together to ensure the welfare and dignity of those who are provided with services are safe.

The Care Bill 2014

The Care Bill is due to receive Royal Assent in early 2014/15. The Act will set out the statutory framework for adult safeguarding and will place Adult Safeguarding Boards on a statutory footing. Once enacted, the Safeguarding Adults Board will need to review the responsibilities and duties placed on the Board and its partners, developing an action plan for its own compliance and a clear mechanism for monitoring partners' compliance.

Safeguarding arrangements in Oxfordshire

What is the Oxfordshire Safeguarding Adults Board?

The Oxfordshire Safeguarding Adults Board (OSAB) is a non-statutory multiagency partnership that has a remit to protect adults-at-risk from abuse, neglect and significant harm. The Board seeks to bring about positive outcomes for adults-at-risk who live within Oxfordshire.

Governance arrangements

- Provide assurance and act as a multi-agency partnership board of lead officers and key representatives that takes strategic decisions aimed at safeguarding adults at risk of abuse/harm.
- Co-ordinate the work of each partner agency to minimise the risk of abuse/harm in community and service settings.
- Promote the safeguarding interests of adults to enable their well-being and safety.
- Promote inter-agency co-operation, to encourage and help develop effective working relationships between different services and agencies.
- Develop inter-agency safeguarding adult procedures to ensure an effective and consistent response to instances of abuse/harm.
- Monitor the effectiveness of what is done to safeguard and promote the welfare of adults, reviewing performance on safeguarding adults and making recommendations about changes within partner agencies.

The board meets bi-monthly and reports directly to the Oxfordshire Health and Wellbeing Partnership Board, with members having responsibility to report to their respective executive boards.

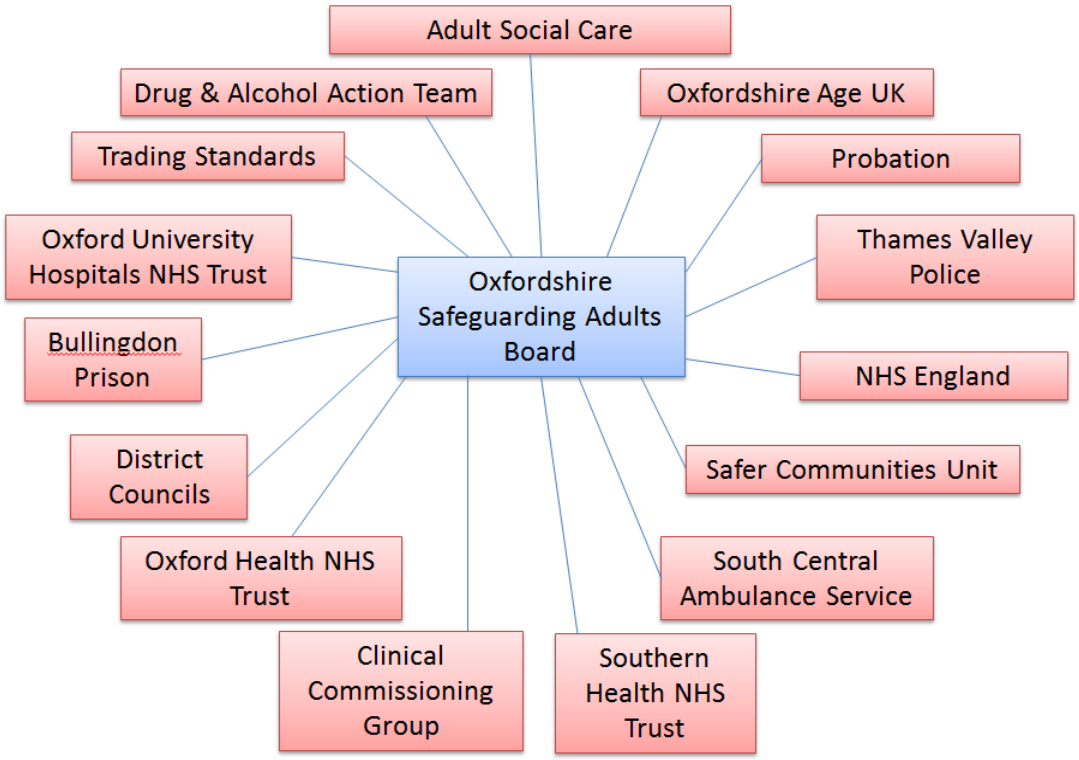
The board's structure ensures that effective interfaces and robust governance arrangements are in place to promote the safeguarding of vulnerable adults and ensure accountability for performance.

The board's multi-agency approach ensures that effective collaborative leadership is in place to drive forward the government's principles to safeguard adults from the risk of abuse or neglect which are:

- **Empowerment** - Presumption of person-led decisions and informed consent
- **Prevention** - It is better to take action before harm occurs
- **Proportionality** - Proportionate and least intrusive response appropriate to the 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.

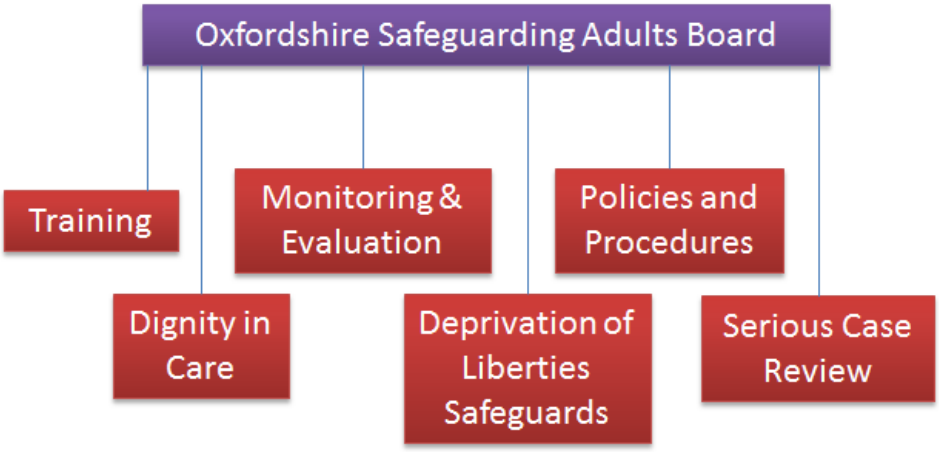
Who are the members?

The Board has membership from a wide-range of partners including:



What is the structure?

The board is supported in its work by a variety of subgroups. The structure is outlined in the diagram below.



How Safeguarding works in Oxfordshire

The Social & Health Care Team acts as the single point of entry for all safeguarding concerns. The Team determines whether the adult at risk is known to social services or health services and asks the appropriate department to investigate. Each investigation is led by a trained Safeguarding Adults Manager.

The Safeguarding Adults Manager identifies all those who can help to protect the adult at risk or help with the investigation. These may be family members, service providers, health professionals, the police or Oxfordshire Client Financial Affairs Team.

An initial risk assessment is completed to determine what response is needed. If further action is required then a strategy meeting will take place chaired by the Safeguarding Adults Manager.

This will confirm the protection plan for the adult at risk and identify who will carry out the investigation. Further meetings will be arranged to confirm the outcome of the investigation and to review the protection plan. The person and their carer/family will be supported to be involved as much as possible.

Sometimes the person causing harm is also an adult at risk of abuse. In such cases the safeguarding process will consider whether they need their own protection plan to help them avoid facing any allegations in the future.

The desired outcome from review of the post-safeguarding interviews is to feel safer and have a better quality of life. If the person cannot make their own decisions about their care then they may need to be protected in their best interests.

Types of protection include:

- Increased monitoring – e.g. more frequent reviews, more contacts with staff
- Enabling the adult at risk to stay away from the person causing harm
- Better management of the finances of the adult at risk
- Application to the Court of Protection (a court that makes decisions based on best interests where there are disputes over serious decisions regarding a person's welfare)

Whenever possible the person causing harm should be held to account. This can be done through criminal and /or civil law, or by the employer.

The Work of the Board 2013/14

Neighbourhood Return Scheme

The Board was informed of the scheme that has been introduced in Oxfordshire to assist in raising the profile of those living with dementia and to assist them in leading a more active life in the community. The scheme is currently funded from Lottery Funding and is being delivered in conjunction with Oxford University.

Volunteers are recruited to support vulnerable adults who have become confused to find their way back home.

The neighbourhood scheme is being advertised across the county to all practitioners across all agencies to widen both an understanding and take up of the Scheme. The Project Manager of the Scheme will engage directly with the agencies of the Board.

The Board was assured that there was already good engagement with community safety groups, and in particular Oxford City Council.

Hospital Safeguarding Reviews

The Mid-Staffordshire Review examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report makes 290 recommendations, including:

- openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers,
- improved support for compassionate caring and committed care and stronger healthcare leadership.

The Board received a presentation on the main factors identified in the review. It was recognised that the report found that there a number of managerial issues that needed to be addressed, but that as important, were issues of attitude and respect, and support to staff to be able to provide good quality services.

As a result of this presentation, the Board decided to:

- include whistle-blowing in the Board's Quality Assurance Tool,
- recommend that value-based interviewing techniques are employed,
- request all agencies present annually to the Board on the key issues from their complaints processes.

Governance arrangements and progress in respect of this review will be overseen by the Clinical Commissioning Group and the County Council contract monitoring team.

Giving Victims a Voice

In the aftermath of revelations about Jimmy Saville, the Board received a presentation on an overview report 'Giving Victims a Voice', outlining concerns about the key issues for hospitals to strengthen the safeguarding of vulnerable adults.

The key issues identified were:

- Vulnerable adults were specifically targeted
- Staff and volunteers need to speak out and whistle blow when necessary
- There is a need to ensure that there are safe recruitment and supervision processes for fundraisers and volunteers
- Policy and practice have developed in the course of the decades that the report covered

Actions taken by Board members include:

- Revised their policy on the use of volunteers, and recruitment checks are in place.
- A review of the use of volunteers and the CQC template for action is in place.

On-going assurances regarding agreed board actions will be presented by agencies on their submissions to the CQC.

Development of Safeguarding Board Audit Tool

It was agreed that an audit tool would be developed to enable organisations and the Board to be assured that their framework for providing safeguarding services was robust. This tool should take account of the section 11 tool used by the Safeguarding Children Board and should address the requirements set out in the ADASS document.

Hate Crime Update

The Board representative from the Community Safety Partnership informed the Board of action being taken by the Community Safety Partnership to address Hate Crime across Oxfordshire. The Board requested that links be made with advocacy groups and with anti-social behaviour teams across the County. It was confirmed that these links were being established.

There is an evaluation of Stop Hate UK, and it was agreed that the Board would link with the Community Safety Partnership to establish the extent to which vulnerable adults were targeted in Hate Crime.

Crown Prosecution and Safeguarding Adults

The Crown Prosecution Service has been active in developing links with the Safeguarding Adults Board and invited the Board to attend a conference on how the Crown Prosecution Service manages children and vulnerable adults in Court processes. The Business Co-ordinator of the Board attended the conference and fed back to the Board on the arrangements being made for vulnerable adults when they are required to appear in Court.

It was agreed that the Crown Prosecution service would be invited to the Board annually to ensure that the Board remained up to date with an understanding of the support needs of vulnerable adults when they appear in Court.

Suicide Reduction Strategy

Following a joint approach by the Oxfordshire Safeguarding Adults' and Children's Boards the Health and Wellbeing Board commissioned development work on a Suicide Reduction Strategy. The Board received a presentation from Public Health on the development work on the suicide reduction. The Board will be further consulted before the strategy is finalised.

Link between Serious Case Review Policy and Domestic Homicide Reviews

The Board's serious case review policy was amended to incorporate links with domestic homicide reviews to ensure that the parallel processes could be managed efficiently.

Review of service provision for homeless people

A review had been undertaken because of a peak in the number of deaths amongst hostel residents.

The review undertaken by Safeguarding Services concluded that there was no systematic or individual neglect in the service. It was noted in the report that deaths fitted the demographic norms.

The review did identify how policy and practice could be strengthened, and it was recommended that:

- there was more pro-active work with residents
- a health and safety protocol should be revised
- that staff should engage in multi-agency training
- that there should be a review of the alcohol policy, and
- there should be improved recording

An action plan was developed and implemented and work is currently underway to address the issues.

Link with Safeguarding Children's Board E-Safety Strategy

Although mainly focusing on children this strategy does also link to the abuse of vulnerable adults. A representative from the Safeguarding Children's Board presented the strategy and the Board was able to agree it in relation to vulnerable adults.

Communication Strategy

As part of the learning and improvement strategy, a communication strategy for the Board was agreed. This provides the framework for the Board to achieve communications across agencies and within agencies to ensure that key policies are implemented and that practice improvements are communicated effectively

Section 136 Detentions under the Mental Health Act

The Board considered the position of vulnerable adults who were being held by the Police under section 136 of the Mental Health Act pending a formal assessment by mental health professionals. There was concern by the Police that the interests of some vulnerable people were not being serviced by a delay in finding a suitable environment for the vulnerable adult pending the formal assessment. Too frequently the vulnerable adult was being held in a Police station awaiting the assessment.

At a subsequent meeting of the Board it was reported that that the response to vulnerable adult could be improved by increasing the capacity within the health service to provide suitable holding accommodation and that the earlier involvement of a mental health professional to provide a triage service could help to reduce the number of vulnerable adults who required to be held under section 136.

The Board was assured that there were plans to 1) increase capacity and 2) to pilot a triage service.

Human Trafficking and Slavery

The Human Exploitation Coordinator from Oxford City Council who provides a lead across the County on Human Exploitation informed the Board of an increased national awareness of the human trafficking and slavery of adults. They also outlined current work being done across Oxfordshire to develop an awareness of the problems and the strategy to respond. The main lead has been Safer Communities and it was agreed that the Board needed to remain informed of further developments.

Making Safeguarding Personal

Making Safeguarding Personal is a sector-led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the 'No Secrets' consultation and other engagement with councils and their partners. It aims to develop an outcomes focus to adult safeguarding work and a range of responses to

support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people.

The Training Manager of the Board up-dated the Board on the Oxfordshire pilot of the national programme of Making Safeguarding Personal. This programme aims to provide structure to the way of working to ensure that the focus remains driven by the service user, and in particular seeks to establish the service user's view of how well agencies have met their needs.

It was reported that the pilot in Oxfordshire was well received and service users rated their being at the centre of their service provision highly.

The Board supported the wider implementation of Making Safeguarding Personal. It was recognised that the lead for the pilot was leaving the Council and a new lead would be required to be identified to ensure this is embedded in practice across all agencies. .

Making Safeguarding Personal Case Studies

Sarah

Sarah is a 19-year-old young woman with a physical disability who was living at home with her parents and younger brother when she alleged to her teacher that she had been sexually abused on a number of occasions by her father.

The school immediately reported this to adult social care. Her social worker met with her and with her agreement her allegation was reported to the police. An immediate strategy meeting was held at which it was agreed that Sarah wanted to move out of the family home at which point a criminal investigation would commence. A shared lives placement was identified and Sarah moved the next day.

Using MSP guidelines adopted by Oxfordshire the social worker met with Sarah to identify what was important to her and what outcomes she wanted. Sarah was able to identify 3 outcomes that she wanted:

1. To continue attending school
2. To continue going to her riding lessons
3. To go to university

Whilst supporting Sarah with her placement and the criminal investigation, the social worker was able to focus on working with the school and arranging transport to ensure that Sarah was able to continue at school.

The criminal investigation was unable to proceed due to lack of evidence. However, Sarah achieved her goal and is now at university studying computer design.

Miss J

Miss J has a severe physical disability and communication difficulties and lives at home with support being provided by a care agency four times a day. The safeguarding team received a high number of alerts about bruises and other injuries sustain by Miss J apparently as a result of poor moving and handling. The care agency seemed unable to address these concerns.

The team approached Miss J's social worker asking him to review the care package with a view to identifying an alternative agency to support her.

The social worker met with Miss J to discuss with her what Miss J wanted to happen. Instead of saying she wanted to change the agency Miss J said that she liked most of the carers and wanted to keep them. Instead, she wanted to be assured that she could have a group of regular carers to support her and that she wanted to be directly involved in the training they had.

The social worker worked with Miss J and the agency manager was able assure a regular group of carers and that training was much more personalised to Miss J's needs in the way that Miss J had wished for. No further concerns were raised.

Multi-agency Safeguarding Hub

The Board was informed of the plan for adult services to be included in the future development of the Multi-agency Safeguarding Hub (MASH).

The Oxfordshire MASH was initially set up to manage referrals relating to children but it has been agreed that this will be extended to include safeguarding alerts in relation to adults due to its success and the benefits and outcomes for vulnerable adults.

What is a MASH?

The Multi Agency Safeguarding Hub (MASH) will provide triage and multi-agency assessment of safeguarding concerns in respect of vulnerable adults. It brings together professionals from a range of agencies into an integrated multi-agency team. The MASH team makes assessments and decisions depending on the referral information and is able to sign post to other services if the safeguarding threshold is not met.

The MASH team shares information from every agency to decide the most appropriate intervention in response to the person's identified needs. This ensures that vulnerable adults are responded to quickly and efficiently by the most appropriate professional.

Outcomes of the MASH

- A faster, more co-ordinated and consistent response to safeguarding concerns about vulnerable adults.
- An improved 'journey' for the adult, with greater emphasis on early help and better informed services delivering intervention at the right time.
- A clearer process for the professional or member of the public raising a concern about a vulnerable adult.
- Closer partnership working, clear accountability and improved multi-agency communications.
- A reduction in the number of inappropriate referrals and re-referrals.

Benefits to agencies of the MASH model

- Safeguarding of vulnerable adults is a collective priority.
- Efficiency savings – financial savings through economies of scale and avoiding duplication of work.
- Efficiencies through centralisation of business support/back office, accommodation and utilities.
- Quicker response times with a better co-ordinated approach to resources meaning each agency works more effectively and efficiently in their own field of expertise.
- A better understanding and appreciation of each other's roles and responsibilities, leading to effective multi-agency working.
- Development of flexible working patterns and providing enhanced customer service.

Establishing a Monitoring and Evaluation Sub-Committee of the Board

A Monitoring and Evaluation sub-committee was established. The terms of reference were agreed as:

- To agree a data set for agencies of the Board to report on to establish their performance in meeting the needs of vulnerable adults.
- To receive the audit programme of Board agencies, to identify audits which provide information on services to vulnerable adults, and to have these reported to the Sub-committee.
- With the Board, to identify priorities for multi-agency audits.
- To commission multi-agency audits and have these reported to the sub-committee.
- To maximise the potential for audits to incorporate the views of vulnerable adults and their carers.
- To oversee the implementation of actions plans from audits.
- To inform the Board of quantitative and qualitative information that indicates the effectiveness of agencies in meeting the safeguarding needs of vulnerable adults.
- To prepare an annual report on the work of the sub-committee to the Board.
- To propose a multi-agency audit programme to the Business Planning day of the Board.

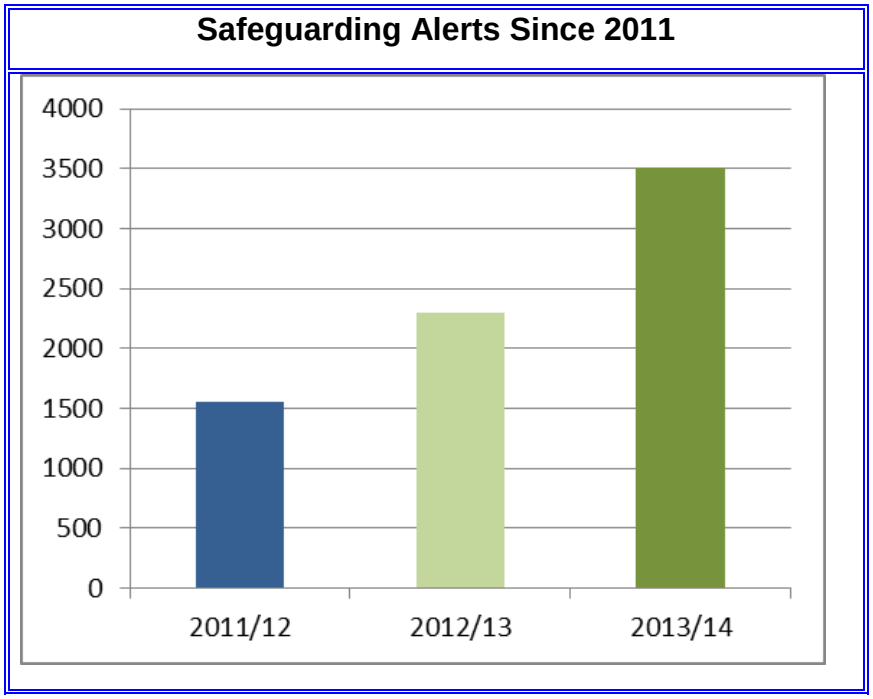
The group will report annually to the OSAB Full Board to inform the OSAB Annual Report and to provide robust information that helps to inform the business planning process.

Safeguarding Adults Activity in Oxfordshire 2013-2014

Overview of Safeguarding Alerts

When concerns about possible abuse or neglect are reported into the multi-agency safeguarding process, this is now called a Safeguarding Alert.

During 2013-14 there have been 3515 safeguarding alerts raised. The graph below shows the total number of alerts over the last three years broken down by year



During 2013/14 there have been 1135 more safeguarding alerts than in the previous 12 months, an increase of 49%. This is an indication of increasing awareness of safeguarding adults.

Whilst initial enquiries are made in relation to all alerts and records of all alerts are retained and reviewed, not all will require a formal strategy discussion or investigation in accordance with adult safeguarding procedures as there may be more appropriate ways of responding to the concern, e.g.:

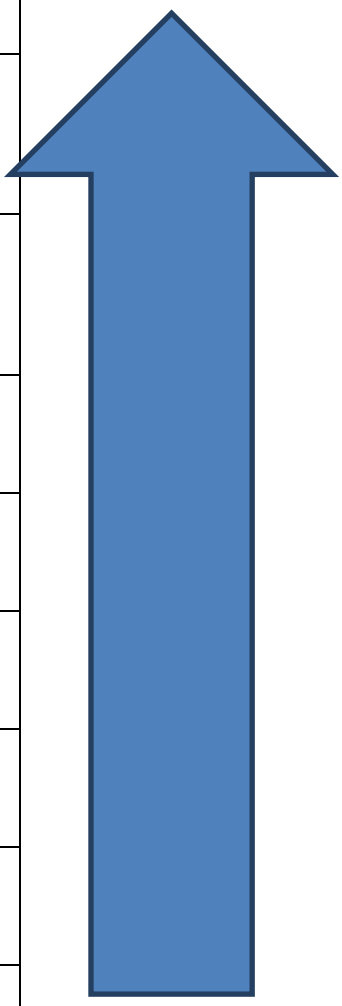
- Signposting or the provision of information or other forms of help
- Other forms of assessment e.g. a carer's assessment

Where further action is require the alert is progressed to a referral and a strategy discussion or investigation is held.

Oxfordshire Safeguarding activity	2013/14
Alerts made	3515
Alerts progressed to Referrals	1540
Conversion rate	44%

Source of Safeguarding Alerts

	2012/13	2013/14	Trend
Care Quality Commission	12	20	
Education/training or employment	6	8	
Family, friend or neighbour	266	343	
Health	557	740	
Housing	31	48	
Other	238	342	
Police	162	260	
Self	52	70	
Social care	1097	1623	



This table shows where these alerts have come from over the last 2 years. There has been an increase in the proportion of safeguarding alerts made by different groups has remained very similar meaning that awareness has grown at the same level across all group.

Overview of Safeguarding Enquiries

Safeguarding by Clients Group

This table sets out the groups of people who are affected by the safeguarding concerns raised.

	2012/13	2013/14	Trend
Learning Disability	519	691	
Mental Health	305	334	
Other	155	106	
Physical Disability/Sensory Impairment	1346	2121	
Substance Misuse	20	18	
Unpaid carer	36	26	

Safeguarding by Age

This table details the proportion of people who are affected by the safeguarding concerns raised by both gender and age.

	2012/13	2013/14	Trend
Age 18-64	893	1136	
Age 65-74	264	386	
Age 75-84	553	811	
Age 85+	658	1115	

The majority of safeguarding investigations concern females (63%). Considering that 57% of safeguarding investigations concern people aged 75+, this is most likely explained by differences in mortality rates and the resulting differences in population size.

Safeguarding Investigations by Type of Alleged Abuse

This table outlines the type of abuse reported.

	2011/12	2012/13	2013/14	Trend
Emotional/Psychological	13%	12%	11%	
Financial	16%	14%	13%	
Neglect % acts of omission	28%	35%	45%	
Physical	38%	34%	27%	
Sexual	5%	5%	4%	

There has been a decline in the proportion of safeguarding enquiries involving physical abuse (-7%). Alongside this, neglect and acts of omission, has increased by 10%.

Safeguarding by ethnicity

This table outlines the ethnicity of those people affected by the safeguarding concerns raised, where there ethnicity is known.

	White	Mixed/ Multiple Groups	Asian/Asian British	Black or Black British	Chinese	Other Ethnic Group
2012/13	96.15%	0.53%	1.06%	1.44%	0.38%	0.43%
2013/14	96.25%	0.50%	1.21%	1.55%	0.15%	0.34%

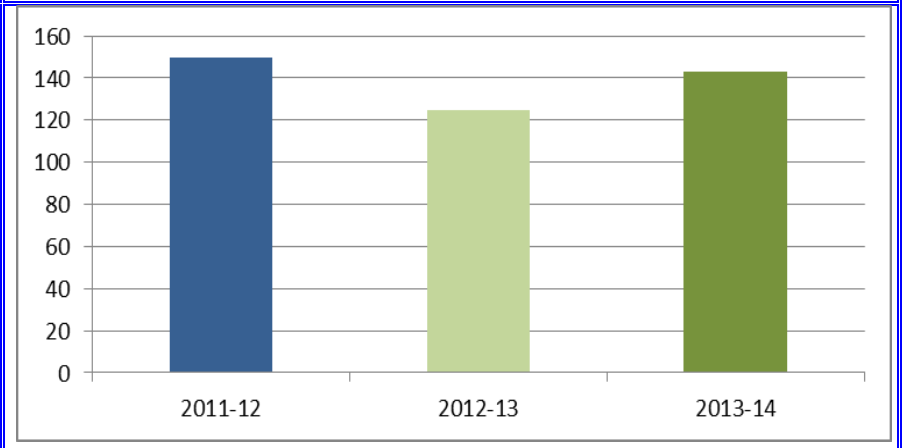
During 2013/14, 3.75% of people supported within the safeguarding adults procedures were from minority ethnic communities. According to the 2011 Census, **9.15%** of Oxfordshire's residents come from non-white backgrounds. This discrepancy is largely explained by the difference between age groups. Whereas the proportion of adults under 65 from non-white backgrounds is **9.44%** the proportion of adults over 65 from non-white backgrounds is **2.25%.**

Mental Capacity Act Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 provides a statutory framework to protect people who lack capacity to makes decisions for themselves. It sets out who can make decisions, in which situations they should do so, and how they should go about this. The House of Lords Select Committee's report on the implementation of the Mental Capacity Act 2005 highlighted that this piece of legislation was not working well. It was reported that this was because people do not know about the Act and where they do they do not understand it.

We will continue to commission and deliver a comprehensive training programme in relation to the Mental Capacity Act and DoLS The implementation of the Act is a priority for the board and a safeguarding adults sub-group has been set up to monitor the governance of the Act during 2015-2016.

DoLS Authorisations

During 2013/14	Over the last 3 years
143 **DoLS Authorisations**	

The DOLS service is working to raise awareness of the change in the definition of deprivation of liberty and is increasing the number of trained Best Interests Assessors in Oxfordshire so more assessments can be completed in as timely way as possible.

Looking forward

The board's priorities for 2014-2015 were:

- **Priority 1**: Improve information sharing between partner agencies to strengthen joint working to safeguard adults from abuse/harm.
- **Priority 2:** Develop methods for engaging service users and carers to capture their views and experience.
- **Priority 3**: Ensure there is a strong multi-agency approach to prevent adult abuse/harm.
- **Priority 4**: Ensure there are robust processes and procedures in place to respond to national and local safeguarding developments by risk assessing the impact of developments and risk assess response.

The financial pressures on care and support services, whether provided or commissioned by health or social care, have not eased. The demographic pressures that are generating increased demand for care and support services have yet to peak. These pressures apply to all the statutory services and to the independent, voluntary and community sector agencies that are commissioned to provide services.

OSAB and the Chair's role is in holding members to account for their activity as it effects the wellbeing and safety of the adults at risk in Oxfordshire, both as individual agencies but also a partnership working together. The OSAB is committed to developing, owning and implementing its Business Plan and strategic vision.

The OSAB's vision is that all vulnerable adults live and work or are cared for and supported in an environment free from abuse and neglect. This will continue to be the Board's priority going forward.

The Care Bill 2014 will establish Safeguarding Adults Boards on a statutory footing, bringing it in line with the well-established statutory Local Safeguarding Children's Boards. This will be an incredibly positive step and the OSAB will strive to meet the challenge of raising its profile to match that of the Children's Board. The increased duties and responsibilities contained in the Care Bill have yet to be fully identified.