OSAB

Oxfordshire Safeguarding Adults Board

2017-18
Annual Report

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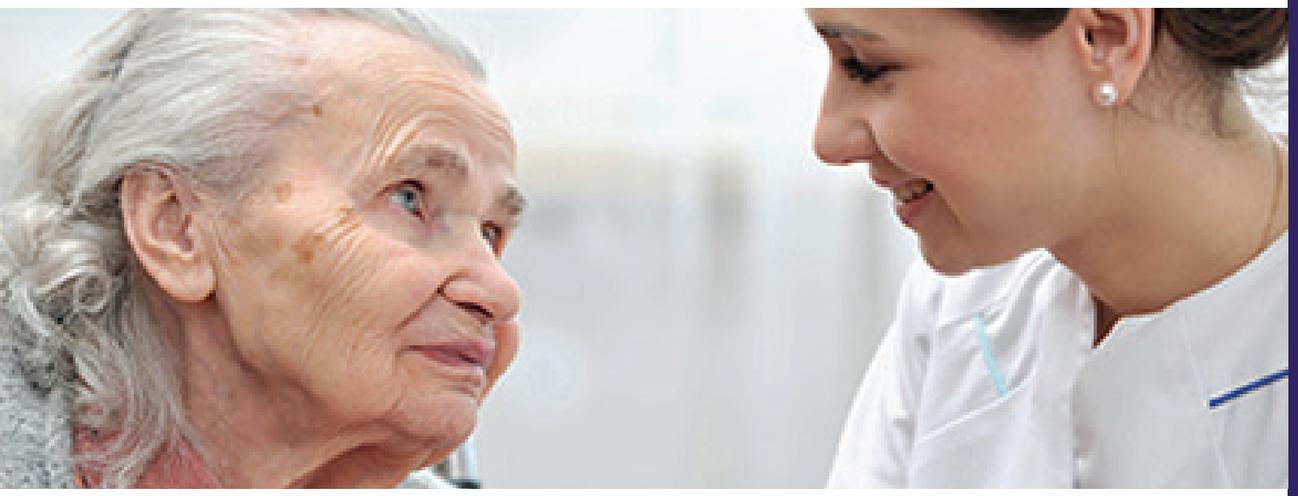

FOREWORD

I am pleased to present the fifth annual report of the Oxfordshire Safeguarding Adults Board. This report outlines the role, function and purpose of the Board as prescribed by the Care Act 2014 and lists the organisations represented. It highlights the risks faced by the most vulnerable and most importantly what local agencies both statutory and voluntary are doing to safeguard them.

The report contains examples of the collaborative work undertaken by partners to show through case studies the effectiveness of our work to empower and protect the most vulnerable adults in our community. I am however mindful of the risk of complacency, as for many the arrangements for their care are made either through their own or their family's private arrangements and the volume of other settings stretches the capacity of organisations such as CQC to effectively monitor all of these arrangements.

We have been looking at the patterns in safeguarding activity to inform our priorities for improvement going forward. We are particularly proud of our data around Making Safeguarding Personal, which has improved throughout the year and demonstrates our joint commitment to ensuring the person is at the centre of all decision-making and safeguarding activity. The statistics also include contextual data showing the size of the eligible adult population and the estimated number of those adults who have care and support needs as well as the overall numbers of concerns and enquiries, giving an idea of the activity across the partnership relating to safeguarding work.

Work will also continue on increasing practitioners' confidence in applying the Mental Capacity Act 2005 to decision-making. Other themes are to ensure that prevention and early intervention work is better understood across the partnership; that the key issues identified by partners (mental ill-health, domestic abuse, substance abuse, exploitation, and housing) are monitored and progress is challenged where appropriate, and that service users and community groups are better engaged with the work of the Board and its partners.

The Board continues to work closely with the Oxfordshire Safeguarding Children's Board to ensure that we all "Think Family', make progress on our joint priorities and importantly we learn together and from each other.

Through discussions and reports received at the Board and through our annual impact assessment, I am very mindful of the pressures on partners in terms of their contribution of people, funds and other resources. I continue to be very grateful to all partners for their contributions and the considerable time and effort they put into the Board. The partnership has continued to grow and develop, as reflected in this annual report.

Pamela Marsden
Independent Chair of the Oxfordshire Safeguarding Adults Board

WHAT IS THE OXFORDSHIRE SAFEGUARDING ADULTS BOARD?

The Care Act 2014 says that Local Authorities must have a Safeguarding Adults Board in place from 1st April 2015.

The Oxfordshire Safeguarding Adults Board has provided leadership for adult safeguarding across the county since 2009. The Board is a partnership of organisations working together to promote the right to live in safety, free from abuse or neglect.

Its purpose is to both prevent abuse and neglect, and where someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Care Act says key members of the Board must be the Local Authority; the Clinical Commissioning Groups; and the Chief Officer of Police.

The three key members on the Oxfordshire Safeguarding Adults Board are:

- The Director of Adult Social Care, Oxfordshire County Council
- The Director of Quality, Oxfordshire Clinical Commissioning Group
- The Detective Chief Inspector, Protecting Vulnerable People, Thames Valley Police

The Care Act says these key members must appoint a chairperson who has the required skills and experience. Pamela Marsden is the Independent Chair of the Oxfordshire Safeguarding Adults Board. She has many years' experience as a Director within Adult Social Services and has held the Chair position since November 2016.

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience.

There are senior representatives on the Board, from the following organisations:

Oxford University Hospitals NHS Foundation Trust

Oxford Health NHS Foundation Trust

South Central Ambulance Service NHS Foundation Trust

NHS England

Public Health England

Community Protection Services (Fire & Rescue, Trading Standards & Community Safety)

National Probation Service

Abingdon & Witney College

OCHA Oxford Citizens Housing Association

healthwatch Oxfordshire

Oxfordshire age UK

Oxfordshire Association of Care Providers

HM PRISON SERVICE

CareQuality Commission

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Board Members are the senior people in each of the organisations with responsibility for safeguarding. Their role on the Board is to bring their organisations adult safeguarding issues to the attention of the Board, promote the agreed priorities and work to embed learning throughout their own organisation.

The Board meets four times each year and alternate meetings include a joint meeting with the OSCB (Oxfordshire Safeguarding Children's Board) where our joint priorities can be progressed.

THE ADULT SAFEGUARDING STRATEGY 2017-18

In March 2017, the Board consulted with organisations working with people who have care and support needs, to develop the Board's strategic plan. From what organisations told us was important to the people they work with, we created the OSAB Strategic Plan 2017-18 and vision.

Our Vision for Oxfordshire

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

Principles and Values

PREVENTION

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

PROPORTIONALITY

All staff and volunteers in whatever setting have a key role in preventing abuse or neglect occurring and in taking prompt, proportional action when concerns arise. All staff and volunteers also have the appropriate level of skills, knowledge and training to safeguard adults from abuse.

EMPOWERMENT

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

GOVERNANCE

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

WHAT HAS THE BOARD BEEN DOING?

Prevention

"It is better to take action before harm occurs"

The Executive Group

The group has overseen the development of a strategy around prevention. As the Board members have again highlighted prevention and early intervention as priorities for 2018-19, the strategy will be reviewed and how it works in practice will be monitored.

The group has also improved its engagement with other local organisations, particularly the University of Oxford, through joint working on case reviews.

Policy & Procedures Group

The group have developed and reviewed a number of strategies contributing towards preventative work. These include:

- Working with people who don't engage
- Hoarding & Self-neglect
- Modern Slavery/Exploitation
- Thresholds for accessing safeguarding services

The group has also reviewed the multi-agency safeguarding policy, working closely with colleagues in the Buckinghamshire Safeguarding Adults Board to produce a policy covering both counties.

Training

2017-18 was the first full year of the Board running Frontline Worker training. This has led to over 600 delegates receiving face-to-face training from the Safeguarding Board, delivered by a Safeguarding Social Worker and a Health professional. Feedback on the training has been excellent, with a 98.5% satisfaction rating.

We have also started delivering Safeguarding Training for Managers/ Leaders, delivering our first course in February 2018.

Vulnerable Adults Mortality Group

The group is in the process of producing its first annual report, highlighting themes and trends across the cases that have been reviewed this year and cascading this learning through the Board Members to partner agencies and via the OSAB training to ensure practitioners are alerted to the specific issues for this cohort of service users.

Performance, Information & Quality Assurance Group

The group receives a wide range of data, which is placed under themes, including prevention. Each theme contains data relevant to that area, so as an example, prevention includes data from the Fire & Rescue service on fire safety (safe and well) checks carried out. For adults with mobility issues this is a vital piece of preventative work, with over 2,000 visits being conducted in 2017-18.

Proportionality

"Proportionate and least intrusive response"

Policy & Procedures Group

The group has increased its membership from care providers, both at the group and at its temporary working groups that complete specific tasks. This has led to policy and procedures being much more user-friendly from the perspective of care providers and other professionals.

The best example of this is the review of the thresholds document, which was significantly rewritten as a result of the feedback from frontline professionals.

Safeguarding Adult Review Group

The group have reviewed 7 cases in 2017-18 from a variety of partner agencies. One met the criteria for a Safeguarding Adults Review and the findings are outlined later on.

The other cases were subject to internal serious incident processes, the outcomes of which were reported to the group to ensure any learning could be shared across the partnership.

Training Group

The training overseen by the group has been well received, with over 600 delegates across 60 agencies having attended either the level 2 course for frontline workers or the level 3 course for managers and team leaders. Feedback has given a 98.5% satisfaction rating for the training. The training promotes the person-centred approach to work, ensuring the adult with care and support needs is empowered to protect themselves where they have declined a response from partner agencies. It also aims to improve professional understanding of the roles and responsibilities of partners, informally through networking at the sessions and directly through content of the course.

Empowerment

"Presumption of person led decisions and informed consent"

Full Board
During 2017-18, the Board commissioned Healthwatch to meet with those who had been through a safeguarding process to establish their views on the service they had experienced. All service users are asked at the point the safeguarding enquiry is concluded whether they would be willing to share their views on the experience with a third party.

The project began in January 2018 so its findings have yet to come to the Board for discussion. This work will be completed in 2018-19.

Vulnerable Adults Mortality Group
This group has a lay member who comes from a local community group supporting adults with learning disabilities. The Board is rolling out this good practice to other meetings, including the Full Board to ensure the voice of those with care and support needs is heard at Board meetings.

Performance, Information & Quality Assurance Group
The Making Safeguarding Personal data forms part of the performance dataset and has seen significant improvements in 2017-18. The proportion of adults who define the outcomes they want from a safeguarding enquiry has risen from 90% in quarter 1 to 96% in quarter 4. The proportion of people who have gone through a safeguarding enquiry and who are satisfied with the outcomes has increased from 45% in quarter 1 to 73% in quarter 4, which is a significant increase and shows the partners are working hard to keep the adult at the centre of all decision-making. The rates of both figures have continued to improve throughout the year, demonstrating that professionals are following the principles of Making Safeguarding Personal throughout their work with adults with care and support needs.

Governance

"Ensuring the Board is fit for purpose and working effectively"

Full Board
All subgroups of the Board have reviewed their Terms of Reference and the Full Board has developed a series of questions each subgroup in required to report against for each Full Board meeting.

As part of the Peer Review carried out in January 2017, the Board requested a report from Oxfordshire County Council, requesting they provide an assurance report on the changes made to the Safeguarding Service, which went live in October 2016. The report was received in Autumn 2017 and provided both qualitative and quantitative assurance that the creation of a central team had produced a positive impact on the safeguarding work undertaken by the County Council.

Executive Group
The Executive continues to review the membership and the chairing arrangements for all of the sub-groups to ensure they reflect the partnership and are as fully representative as possible. During the year it was agreed that the police would take over chairing the Safeguarding Adults Review subgroup.

The Executive also oversaw the review of Board documents, simplifying a number of documents and combining others, such as the self-assessment and impact assessment, to reduce the paperwork associated with the Board. There is now a requirement that all documents over 10 pages have an executive summary to improve accessibility.

Vulnerable Adults Mortality Group
This group was created as part of the Board' responsibilities for ensuring the deaths of those with a learning disability are reviewed and given appropriate scrutiny. The group was one of the first in the country and has provided a forum for frank discussions on the deaths of those with a learning disability within Oxfordshire. The first annual report of the group is due to be considered by the Full Board in June 2018.

Performance, Information & Quality Assurance Group
To ensure the Board is fully aware of the current safeguarding issues and is working effectively, the PIQA group have developed and improved its dataset throughout the year, resulting in a performance dashboard that partners agree shows the breadth of safeguarding work underway across partner agencies throughout Oxfordshire.

Joint Working

"working together to ensure people are safe from birth until end of life"

Transitions

Work is continuing with the co-production group 'Moving into Adulthood: Working Together', which fully involves people affected by the issues and using services, to refine proposals for a new approach to supporting young people with social care needs through transition. Conversations are being held with focus groups to test the emerging proposals with a wider group of young people, and to discuss emerging ideas with key groups of staff. The proposals, which include moving to a dedicated social care team which spans transition (from around 14 to 25), improving information, focusing on promoting independence, and following a case work model with a named social worker, are being well-received. Finer detail as to exactly which cohorts and age groups should be included in this team are still under discussion, but the intention is to focus on those with life-long disabilities and to ensure that the service is aligned well with services for other young people which extend up to 25 (care leavers, young carers and Special Educational Needs and Disabilities). The group will present its final recommendations to Directors of Adult and Children's Services in July.

The Joint Commissioning Team has recently re-aligned, bringing together commissioning for children and adults of working age into a single team. This provides a step-change in thinking about transition and the way services are planned and commissioned, providing opportunities to improve continuity between children's and adult services. The Strategic Commissioning Group is also in the process of radically reviewing the decision-making structures that relate to young people and adults with disabilities, with a view to bringing together decisions which have traditionally been fragmented into a cohesive life-time model.

Housing

A successful workshop was held in June 2017 for housing providers led by the two safeguarding boards for the following purpose.

- To create a better understanding of safeguarding challenges in the housing sector and identify what could be done to help promote effectiveness
- To share learning from Serious Case Reviews relevant to the housing sector
- To provide information on the new locality structures in children's services and adult social care
- To consider how we can strengthen working together in the new structures

The workshop recognised that a number of actions would need a more strategic response and would be complex and challenging to address on a multi-agency basis. These include concerns about the overall gap in support between front line housing services and statutory provision since the services provided through the Supporting People Programme are no longer available, and issues relating to supply of housing not meeting demand. The first two actions below would enable those more strategic safeguarding issues to be addressed. The other actions are practical responses to operational concerns raised.

There is now have a housing representative on each safeguarding board, from Sovereign Housing (Adults Board) and Response (Children's Board).

The new adults' protocol on 'Working with people who do not engage with services/ or are deemed ineligible to receive services' has been launched across housing providers and to test out how it works in practice.

A network for Housing Provider Safeguarding Leads is being established to improve communication about issues such as :

- referral routes;
- ensuring all housing providers keep up to date with best practice in safeguarding;
- raising awareness of key issues on a two-way basis;
- promoting safeguarding training opportunities.

Domestic Abuse

The Domestic Abuse Operational Board is now working effectively, meeting quarterly, with good participation from a broad range of relevant local services. There is now also service user attendance on the Board and this is being developed to enable service users to have a voice at the Strategic Board. The Operational Board works on a thematic basis and most recently has developed the Young People's Pathway Action Plan which follows on from the recently completed YP DA Safeguarding Pathway Audit. The Pathway has been revised and due to be relaunched in June 2018.

The Strategic Domestic Abuse Board is overseeing the delivery of the co-commissioned domestic abuse services. The commissioning process identified a winning bidder to deliver the new domestic abuse service model and we had been working towards implementation from 4 June for the new service -. Unfortunately, at the beginning of May the preferred bidder withdrew due to unforeseen implications from the transfer of undertakings regulations which meant they felt unable to continue. We have now awarded the contract to the second highest bidder and are working with them to deliver the new service model with a revised timetable for some aspects of the service.

A sub-group of the Strategic Board is working on a training strategy, developing a framework for a range of multi-agency and single agency training which sets expectations for specific organisation types, in terms of the types of training their staff should have. This framework is likely to include Champions training, Designated Multi Agency Risk Assessment Conference (MARAC) Officer Training, Basic multi-agency domestic abuse training, Risk Assessing, and Young People and Domestic Abuse, and other training with specialist focus. The sub-group is also considering the funding options for such training.

SAFEGUARDING ADULT REVIEWS

In 2017-18 one Safeguarding Adults Review was completed.

Adult C

Adult C was a man in his 40s living alone in Oxford. He had no partner or children. He had historic unspecified mental health issues. While living in Oxford, Adult C was involved in a number of disputes with a neighbour about noise, and was arrested on several occasions for aggressive and threatening behaviour.

In February 2017, Police were called to his home as there were concerns about his behaviour and mental health. A Mental Health Act assessment was convened, but Adult C had calmed down and the outcome was that he did not require admission to hospital. Community follow-up was arranged with the Step-Up Team, and Adult C had face-to-face and telephone contact with staff over the next two days.

Less than a week later, there was an explosion at the block of flats where Adult C lived, resulting in a large fire and total demolition of the two-storey structure. The body of Adult C was later found in the rubble. There were no other casualties. An Inquest concluded that "the explosion is likely to be accidental in nature but he was heard to say he was going to cause an explosion about five days before and it cannot be ruled out that it was caused deliberately."

Overall Conclusion

The Safeguarding Review Report concludes, having examined all of the information and spoken to a range of professionals, that if the fire was accidental then it could not have been reasonably predicted or prevented. It also concluded that if the fire was deliberate, then there was still no clear evidence that it was predictable or preventable. The Review found that the mental health services were of good professional standard, and the system for convening and undertaking an emergency Mental Health Act assessment worked well in this case. Police Officers attended the address within a few minutes of the initial calls, and restrained Adult C before calling an Ambulance. The assessment appears to have been thorough and to have resulted in a unanimous and reasonable conclusion based on the evidence available.

While the Review found that the death of Adult C was neither predictable nor preventable, there is always something for agencies to learn from the detailed analysis of incidents like this, as shown below:

Recommendations

The NHS 'Root Cause' investigation report makes the following recommendations:

- A full review of the inputting and removal of information onto the Step-Up FACT board
- Any change to a pre-existing Step-Up plan must be documented

The Thames Valley Police (TVP) report makes the following recommendations:

- To review current practices and agree a standardised Safeguarding Referral process with Fire and Rescue Services across the TVP area and communicate this to staff and officers. This should include referrals being made both ways.
- The Contact Management Call handling Procedure should be updated to reflect the importance of attaching the correct address to a URN (i.e. the address for officers to attend). Contact management staff should be advised of the change to the policy.

A2Dominion (the housing provider) have identified the following actions:

- All residents who live in homes who are on the cautionary contact list (CCL) will be visited and each of them assessed to understand their circumstances and individual needs, involving relevant agencies where necessary.
- Where there is a known Anti-Social Behaviour case involving a resident on the CCL, A2Dominion will visit the alleged victim & perpetrator in their own homes rather than calling them to the office.

HOW WE KNOW WE ARE MAKING A DIFFERENCE

Here are five examples of how the work of the Safeguarding Adults Board is making a difference to the residents of Oxfordshire.

CALL BLOCKERS PROJECT

As part of partnership work to tackle the harm caused by nuisance and scam telephone calls, the Trading Standards Service provides call blockers to people who may be vulnerable to telephone scams.

Call-blockers are devices that are fitted to telephones to restrict unwanted calls. They can be set to block all calls except those from pre-programmed numbers or to block calls from specific numbers.

Cold-calls can be harmful in many ways. A cold-call is often the start of a fraud, whereby vulnerable people are identified and systematically targeted with different misleading phone calls to elicit payments for non-existent goods or services. For some they are the start of systematic financial abuse. For people with mobility problems they can also lead to higher risk of falls as they repeatedly answer the phone at all hours of day or night.

Working from referrals about vulnerable people from the Police, Fire Service, Social Care or the National Trading Standards Scams team, Oxfordshire Trading Standards will offer to fit call blockers where a person may be vulnerable to telephone scams. Since May 2015, they have installed 69 call-blocking units, free of charge.

In total, by the end of February 2018 these units had blocked 40,235 nuisance calls. On average those using the equipment had been receiving 50 nuisance calls per month (the average across the UK is 18 per month). One household had been receiving 448 nuisance calls per month.

Research commissioned on the effectiveness of call-blockers concluded that the call-blockers fitted in Oxfordshire in 2017 alone blocked 4,196 scam calls, prevented 23 scams being committed and provided total savings to the individuals affected as well as to the health and social care services of over £59,000.

IDENTIFYING RISK AND ENGAGEMENT FOR A BETTER OUTCOME

Mrs Brown*

Mrs Brown, aged 59 and living alone, was known to have alcohol problems. Concerns regarding her wellbeing were raised by Thames Valley Police following a small fire in the area around a chair she used in her kitchen. In response to this safeguarding concern, Oxfordshire Fire and Rescue services arranged a joint visit to meet with Mrs Brown with colleagues from Environmental Health, Adult Social Care and the Police..

At the joint visit, the kitchen area was heavily cluttered with combustible material, rotten food and alcohol bottles, some of which were broken, leaving shards of glass across the floor. On inspection of the fire debris, it appeared that material possibly from clothing or a tea towel had become ignited, spreading to some food packaging and the bottom of a curtain. There was evidence of careless disposal of cigarette ends around her chair, around the settee in the living room and around her broken bed in her bedroom.

All present agreed a multi-agency approach was required to ensure the safety of Mrs Brown and her neighbours.

At the time of the joint visit two temporary smoke alarms were fitted to the kitchen area and the living room area near to her settee.

A GOOD OUTCOME

With Mrs Brown's consent, arrangements were made for the District Nurse to visit her as she did not want to attend the surgery and there were concerns for her health. A mental health assessment was also carried out. Environmental Health arranged with Mrs Brown for a blitz clean in the property to make the home environment less of a health risk. Food deliveries were arranged and a Care Agency was also employed. The Fire & Rescue Service had managed to build a positive relationship with Mrs Brown and so they continued to visit her.

Mrs Brown subsequently agreed for Extreme Heat Sensors, a Falls Alarm and a Key Safe to be installed and her care has been increased to support her with maintenance of the home.

*all names have been changed to protect to identity of those involved

ESCAPING A COERCIVE RELATIONSHIP

Mrs Vine*
Mrs Vine was living with her husband in their family home along with another woman who was said to be Mr Vine's girlfriend. A safeguarding concern was raised as it was suspected that Mrs Vine's husband had slowly isolated her and was preventing her from attending the day centre and even health appointments. There was previous evidence that Mrs Vine had been living in an abusive and controlling relationship for a long time.

A Social Worker and an Occupational Therapist visited Mrs Vine and tried to encourage her to discuss her home situation but she would not speak openly.

Mrs Vine was admitted to hospital shortly after this meeting, so the Social Worker and the Occupational Therapist took the opportunity to address again the concerns that had been so difficult to discuss candidly whilst in the family home. Mrs Vine disclosed that she did not want to go home and that she was not happy with her home life.

A GOOD OUTCOME

Working together to support Mrs Vine led to a proposal for her to move from her family home to an Extra Care housing facility locally at her request.

To facilitate this sensitively involved a lot of close joint working with other agencies: colleagues from Adult Social care, the Safeguarding service, the housing and care providers, and the acute hospital staff.

Mrs Vine was supported emotionally and practically as there needed to be conversations with her husband about the move. There were complexities with her tenancy and starting a new one in her own name, as well as finances/benefits to sort. Mrs Vine required furniture and adaptations for her new property and the care agency staff needed special training to support Mrs Vine's health care needs.

Several months on Mrs Vine is settled in her new home and she is reportedly much happier.

PROVIDING PROTECTION FOR VULNERABLE ADULTS

Mr Benn*
At the time the Housing officer referred Mr Benn to the safeguarding team, he was an extremely vulnerable man. He had suffered a stroke a few months before and needed regular hospital appointments.. When Mr Benn was at a previous address his grandson brought lots of unwanted visitors involved in drugs and drug dealing to his home . The situation had gotten so bad that the Housing provider had had to move Mr Benn to another property for his own safety.

More recently, following a term in prison Mr Benn agreed for his grandson to live with him and for Mr Benn's home to be his grandson's bail address. The situation rapidly deteriorated, his grandson's visitors causing problems as before and bailiffs coming to take Mr Benn's goods due to his grandson's debts and unpaid fines. Mr Benn was also forced by his grandson to give him money and to hand over his bank card.

There was a risk that if his grandson caused any more trouble at the property, Mr Benn could lose his home and tenancy.

A GOOD OUTCOME

The Housing officer carried out regular welfare visits to Mr Benn jointly with the Police. Mr Benn told the Housing officer he did not want his grandson living with him any more.

Mr Benn's grandson was again remanded in custody and a multi-disciplinary meeting was held to discuss the risks posed to Mr Benn should his grandson be released and bailed back to his address.

Through this joint working the decision was confirmed by the Probation service that they would not approve the release from prison to Mr Benn's address. Notification was shared on the planned date of release so that any additional security measures needed could be arranged. Sadly, Mr Benn passed away during this time.

*all names have been changed to protect to identity of those involved

WORKING TOGETHER TO PROVIDE MATERNITY CARE AND PLANNING FOR THE FUTURE

Miss Kay*
Miss Kay is rehabilitating and is expecting her third child, her oldest children live at home.

Miss Kay has the mental capacity to consent to care and treatment, and surrounding the birth of her baby however the team were concerned that she doesn't have capacity surrounding her rehabilitation and discharge home, this prompted a safeguarding concern to be raised.

WORKING TOWARDS A GOOD OUTCOME

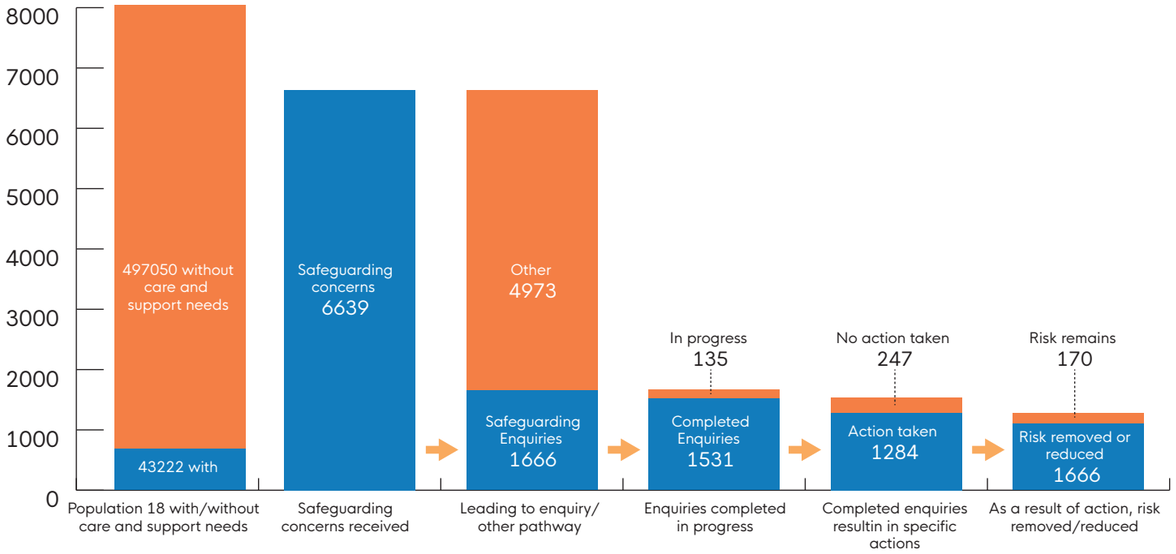
The teams involved with Miss Kay are the children's and adults health and social care safeguarding teams.

Miss Kay now has an advocate to enable her 'voice' to be heard whilst pregnant and planning for the baby's care once born; and plans are in place between her clinical team and the maternity services for the safe delivery of her baby.

*all names have been changed to protect to identity of those involved

WHAT ARE THE NUMBERS TELLING US

The safeguarding journey - from raising of safeguarding concern to outcome of safeguarding enquiry 2017-18



RAISING OF SAFEGUARDING CONCERNS

- Safeguarding includes a whole range of activities that are designed to "protect an adult's right to live in safety, free from abuse and neglect". First and foremost, it is about prevention – stopping abuse and neglect before it happens.
- However, when abuse does occur Oxfordshire has robust procedures to ensure that people receive the support they want to live a safer life.
- Safeguarding procedures support people who are at greatest risk, those of us who rely on others (staff, family and neighbours) for their care and support.
- In Oxfordshire this is about 43,222 people.
- Most people in Oxfordshire say their needs are well met and they feel safe
- Anybody can notify the county council if they have concerns about someone with care and support needs – but if you can talk to the person you're worried about first and ask them what they want, that's better.
- In 2017-18, Oxfordshire County Council were contacted 6639 times about concerns that a person with care and support needs was experiencing abuse or neglect.

RESULTING SAFEGUARDING ENQUIRY PROCESS

- A quarter of the concerns received last year were assessed as requiring further enquiries
- This is because the people involved were:
  (a) Experiencing, or being at risk of, harm or abuse; and
  (b) Having care and support needs which prevented them from protecting themselves
- Those concerns (4973) which did not result in a safeguarding enquiry were followed up in other ways:
  - Providing information or advice
  - Referring on to other agencies: trading standards; domestic abuse support agencies; the police or other health or social care services

OUTCOME OF ENQUIRY PROCESS

- Of the safeguarding enquires which were completed in 2017-18, 1284 or 84% resulted in action being taken to reduce the level of risk to the person.
- Where no action is taken it is usually because the person themselves doesn't want anything to change, or at the end of the enquiry it is evident that abuse or neglect have not occurred.
- Even in these cases we are often able to support people in other ways to live safer lives.
- In a small number of cases (170), despite actions being taken, the risk to the person was judged to have remained or the outcome was unknown (we have amended our processes to ensure that the outcome is now known in all cases)
- This may occur where the actions taken are intended to protect others but the person themselves doesn't want anything to change in their own lives.
- However, in most cases, 88%, the risk of harm or abuse to the person was removed or reduced as a result of the support of all the people involved in their care and support.

WHAT WILL THE BOARD WORK ON IN 2018-19?

A business planning meeting of the OSAB in May 2018 agreed the following interim strategic priorities, which will be finalised after consultation with service users, carers, community groups and other stakeholders. The priorities detailed below are based on feedback from Board Members on those matters which are of most concern to the range of agencies working within Oxfordshire. They also include feedback from front line practitioners.

In 2018-19 the OSAB will continue to build upon its good joint working work with the OSCB, holding bi-annual joint meetings and sharing a number of priorities identified as affecting both children and adults with care and support needs.

Service User and Community Engagement

1. Establish an Engagement & Communications Group to:
   - Oversee a series of meetings with services users, carers, community groups and other stakeholders.
   - Investigate the development of a Phone App and a shared multi-agency safeguarding website.
   - Produce flyers/posters/promotional material/briefings to share with existing communication networks.
   - Raise awareness of safeguarding issues amongst the general public.
   - Co-ordinate a community awareness week.
2. Recruit at least one lay member to the Full Board

Early Help Strategies & Initiatives

1. Refine the annual self-assessment to understand more about the challenges around Prevention & Early Intervention
2. Monitor the enquiries made to the safeguarding consultation services operating across all partner organisations to establish the themes and range of issues.

Improving Multi-agency Working

1. Develop further multi-agency awareness of Mental Capacity Act best practice, including the issues raised by the concept of Executive Capacity.
2. Review current Making Safeguarding Personal (MSP) training sessions. Consider models of delivery in order to maximise practitioners knowledge and confidence.
3. Define and develop a multi-agency risk assessment tool.
4. Review the membership of sub-groups and the roles of vice-chair to ensure they reflect the wide range of partner organisations.
5. Review work-plans of subgroups to ensure all actions are matched to the four priorities

Monitoring Key Issues

1. Continue to monitor the thematic priorities identified by Board Members that remain at the forefront of safeguarding work:
   - Prevention and early intervention work
   - Mental health service provision
   - Domestic abuse
   - Alcohol and drug abuse
   - Exploitation
   - Housing

Specific work is already underway to address these key issues. The governance of them falls to other strategic groups to manage so our role is to scrutinise and challenge these arrangements to ensure that safeguarding is kept at the forefront of any new developments.

With regards to domestic abuse, the development of a Multi-Agency Tasking and Coordination (MATAC) strategy is currently being trialled in Oxford City with a view to expanding this to address needs across the county.

Public Health are already reviewing pathways for children to access Children and Young People Services, especially for drug and alcohol abuse, as some who are eligible are not accessing this support.

Further development of the 'Think Family' approach to address inter-related safeguarding issues, including domestic abuse and exploitation, is also welcomed.

Prevention has become a focus for the Health Improvement Board and Housing is now a joint priority for both safeguarding boards.

GLOSSARY OF TERMS

Safeguarding
Safeguarding means protecting our right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and reduce the risk of abuse and neglect. When people have experienced abuse or neglect, safeguarding is about taking actions that are informed by the person's views, wishes, feelings and beliefs.

Making Safeguarding Personal
Making Safeguarding Personal starts with the principle that we are experts in our own life. Things other than safety may be as, or more, important to us; for example, our relationship with our family, or our decisions about how we manage our money. So, our staff are being encouraged to always ask 'What is important to you?' and 'What would you like to happen next?'

An Outcome
An Outcome is what you hope to get out of the conversations we have, and the work we do with you. Measuring outcomes helps the Board to answer the question "what difference did we make?" rather than "what did we do?"

Deprivation of Liberty Safeguards (DoLS)
Deprivation of Liberty Safeguards apply when a person in a care, or nursing home, or hospital, is subject to continuous supervision and control from staff, and is not free to leave; under the Supreme Court judgement known as 'Cheshire West', they are deprived of their liberty. Once identified, a deprivation of liberty must be authorised either by the Court of Protection order; or under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005; or under the Mental Health Act 1983. If it is not authorised, under the law, it is an illegal detention.

Self-neglect
Self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health, or surroundings, and behaviour such as hoarding. The term itself can be a barrier as some people do not identify with this term or description of their situation. It is important that practitioners find common ground and understand the person's own description of their lifestyle rather than making assumptions about how it can be defined.

Hoarding
Hoarding behaviour was previously seen as a symptom of Obsessive Compulsive Disorder but it has now received a separate clinical definition of 'hoarding disorder' and is defined as: 'A psychiatric disorder characterised by persistent difficulty discarding or parting with possessions, regardless of their actual value resulting in significant clutter that obstructs the person's living environment and produces considerable functional impairment.' (Greater Manchester Fire and Rescue Service: Hoarding, Prevention, and Protection).

Clutter Image Rating
Clutter Image Rating a series of pictures of rooms in various stages of clutter – from completely clutter-free to very severely cluttered. People can just pick out the picture in each sequence comes closest to the clutter in their own living room, kitchen, and bedroom. When clutter reaches the level of picture number four, or higher it begins to impact on people's lives and we would encourage the person to get help for their hoarding problem.

Safeguarding Adult Review
A Safeguarding Adults Review must be conducted where an adult with care and support needs has died as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult.

A Safeguarding Adults Review should also be conducted where an adult with care and support needs has experienced serious abuse or neglect as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

Boards can also choose to arrange a review into any other case of an adult in its area with care and support needs.