Oxfordshire Safeguarding Adults Board

Annual Report 2023-24

Report on a Page

During 2023-24, there has been a significant amount of work completed across the partnership (p9-32) contributing to making the people of Oxfordshire safer.

There was a small decrease in the number of safeguarding concerns received by the Local Authority (p33) which is in line with previous yearly fluctuations we see in the numbers of concern.

Self-neglect and neglect remain the main cause for concern about someone, which is in line with previous years locally and nationally.

There was a bigger decrease in the number of safeguarding enquiries conducted by the Local Authority (p36). This means the number of concerns received that were felt to meet the statutory criteria for a safeguarding enquiry under The Care Act 2014 were fewer. Auditing to understand this appears to offer two contributory factors:

1. *Of 10% of cases audited, the decision-making to not escalate the concern into an enquiry was agreed with in nearly all cases. This may indicate a need for some organisations to improve their training offer to staff to help them better understand what is a safeguarding concern. The Board is highlighting this to relevant organisations and commissioners of services.*
2. *Further auditing also points towards the safeguarding social workers are doing work that would usually constitute a safeguarding enquiry at the safeguarding concerns stage. The Local Authority is doing internal work with the team on this matter.*

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.

Future Plans for the Board Partnership

1. *Learning and development are to have a higher focus in 2024-25 as there are a number of workstreams identifying learning. Therefore there will be a greater focus on embedding the learning and measuring its impact.*
2. *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.*

Content

FOREWORD

INTRODUCTION

THE SAFEGUARDING BOARD

- Why it exists
- What our priorities were for 2023-24
- How the Board worked towards those
- What our partners did to achieve these
- What data is telling us
- What case reviews are telling us

PRIORITIES FOR 2024-25

Chair’s Foreword

Welcome to Oxfordshire Safeguarding Boards’ 2023/2024 Annual Report. Since I joined the Board in 2021 I have seen a number of positive changes in Oxfordshire and I have remained impressed at the dedication organisations have shown to improving care for adults with care and support needs under ongoing challenging circumstances including staffing and funding. Oxfordshire still has many areas to improve but I think it is a real demonstration of the maturity of the Board that members have been open and honest about their services and the improvement journey they are on, both individually and as a system.

During this last year Board and its subgroups met to address safeguarding matters and implement the learning from the different reviews we commission and those that are published nationally. We continue to seek assurance that the adult safeguarding duties within the Care Act 2014 are at the heart of the work of the statutory, voluntary and community services that work together to prevent and/or protect individuals from abuse and neglect in Oxfordshire.

A key part of our role is to scrutinise our data regarding adult safeguarding concerns to examine trends and seek assurance alongside commissioning reviews to learn from where care has not gone as well as it could. This past year we have commissioned seven Safeguarding Adults Reviews and will be publishing further reviews completed this year, the learning points of which can be found on this report. A key focus must be learning from reviews and ensuring we have evidence that recommendations are put into practice and practice is improving across all our frontline services.

This year we have reviewed the team supporting the Board and have amended our structures to maximise the support we can give to the work of the Board and partners. I welcome the appointment of an Independent Scrutineer, Dr Dawne Garrett to support the ongoing work.

Dr Jayne Chidgey-Clark

Why the Safeguarding Board exists

- The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area.
- The SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect.
- These will include the safety of patients in its local health services, quality of local care and support services, effectiveness of prisons and approved premises in safeguarding offenders and awareness and responsiveness of further education services.
- It is important that the SAB has effective links with other key partnerships in the locality and share relevant information and work plans. They should consciously cooperate to reduce any duplication and maximise any efficiency, particularly as objectives and membership is likely to overlap.

How the Board operates

Oxfordshire Safeguarding Adults Board – Full Board					
Learning, Development & Training Subgroup	Safeguarding Adults Review Subgroup	Performance, Information & Quality Assurance Subgroup	Engagement Subgroup	Policy, Procedures & Practice Subgroup	Board Chairs Meeting
Joint with the Children's Partnership Oversees the training offered by OSAB Oversees the multi-agency training strategy	Oversees the case review functions • Safeguarding Adults Reviews • Homeless Mortality Reviews Oversees implementation of learning from actions from these reviews	Scrutinises the dataset of safeguarding activity Oversees multi-agency audit work Oversees the annual safeguarding self-assessment (joint with Children's Board)	Brings together organisations to agree how to cascade messages from the Board to the frontline and the general public as well as how to escalate messages to Board from the frontline	Oversees the multi-agency policies and procedures of the Board Discusses practice changes (locally or nationally dictated) for impact on the safeguarding system	Brings together the subgroup chairs with the Board Chair to discuss cross-subgroup issues, share learning between groups, agree ownership of work raised at the Full Board and share other national news relevant to safeguarding.

Where the Board fits in the partnership geography

Safer Oxfordshire Partnership (SOP)

The Partnership is a thematic group that brings together community safety partners to work together to deliver on joint priorities and emerging themes. The partnership is part of a strategic framework that community safety partners are expected to put in place to improve outcomes for local people. Includes regular reporting on DHR's, Modern Slavery, Prevent & Violent Crime

Safeguarding Adults Board (OSAB)

Its main duty defined in statutory guidance is to assure itself that local arrangements and partners act to help and protect adults with care and support needs in its area. This includes conducting Safeguarding Adult Reviews (SARs)

Safeguarding Childrens Board (OSCB)

The OSCB is there to oversee how organisations work together to safeguarding and promote the welfare of children, known as the Multi-Agency Safeguarding Arrangements (MASA) under Working Together 2023

Health & Wellbeing Board (HWBB)

HWBBs are charged with promoting greater integration and partnership between the NHS, public health and the Council. They must produce a Joint Strategic Needs Assessment and a joint Health and Wellbeing Strategy for their local population.

Integrated Care Board (ICB)

The ICB's role is to join up health and care services, improve people's health and wellbeing, and to make sure everyone has the same access to services and gets the same outcomes from treatment. They also make sure health services work well and are of high quality.

What our priorities were for 2023-24

The Safeguarding Board agreed a five-year plan covering four themes

Working in Partnership

Preventing Harm Occurring

Responding Swiftly When Harm Occurs and

Engaging Effectively with People at Risk.

*"it must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and **what each member has done to implement the strategy**" Care Act Guidance*

What the Board did to towards the priorities

Working in Partnership

- The Chair of the Safeguarding Adults Board has a monthly meeting with the Chair of the Safeguarding Children's Board to ensure that safeguarding matters are being appropriately addressed. A schedule of meetings is being set up to include the Chair of the Safer Oxfordshire Partnership (that brings together the Community Safety Partnerships). This will strengthen the relationships between the partnerships as well as improving strategic oversight of the issues that are impacting on the safety of the residents of Oxfordshire.

- The Subgroups of the Board have been reviewed to ensure they include a wider membership of organisations. Of particular success in this matter has been the Engagement Subgroup, which is now mainly made up of organisations not represented at the full board and how have extensive experience of listening to the people they are working with.

What the Board Partners did to towards the priorities

Working in Partnership

Oxfordshire County Council

In the last year OCC has forged closer relationships with SCAS, Childrens services and TVP amongst others. We have set up regular meetings with each agency to understand the pressures, priorities and perspectives that each agency has and how the safeguarding can respond.

The Safeguarding Service Manager recently met with Benedict Clarke TVP to talk about some of the challenges we have with our timescales. As a way forward we agreed that TVP sharing named Safer Neighbourhood contact details would support OCC to make timelier decisions.

BOB ICB

BOB ICB has introduced a BOB ICS All Age Safeguarding committee; established during 2023, this continues to evolve to facilitate system wide safeguarding oversight, assurance and drive system improvements.

BOB ICB has connected with the Board in terms of assurance in several areas: Working Together 2023 - changes around reporting deaths in the adult care leaver population, Patient Safety Incident Response Framework (PSIRF), migrant populations, modern slavery, Martha's Rule and the Thirlwall Enquiry.

Thames Valley Police

TVP has begun to implement Right Care, Right Person principles in terms of responding to adult safeguarding needs in Oxfordshire. This currently relates to concerns for welfare calls, walk-outs from hospital settings and those reported absent without leave from psychiatric care units. Taking learning from the initial announcement, a multi-agency operational group has been set up to monitor impact and issues.

The TVP custody 2025 project is ongoing with 2024 being the second phase of the project which seeks to reduce reoffending by working with partners and 3rd sector agencies through early intervention in the custody environment. The project is working with NHS and external organisations to signpost referrals for specific at-risk groups including ex-service personnel, women offenders and substance misusers.

Thames Valley Together is an innovative data sharing approach across the region, but including partners in Oxfordshire, where partnership information will be shared across agencies in order to allow data to be used more effectively to understand safeguarding risks and allow for mitigation. The project is ongoing, with the initial strategic-level product being rolled out imminently.

What the Board Partners did to towards the priorities

Working in Partnership

Oxford Health NHS Foundation Trust

We have a dedicated mental health social worker to work collaboratively with homeless services to support people with mental illness out of homeless services. We also work closely with our MH housing pathway and general needs housing partners so that we can respond quickly to concerns, to assess, investigate and implement protection plans. The mental health social care service manager works in partnership with the operations manager of the local authority safeguarding adults' team as well as the local authority principle social worker to identify themes, trends and concerns and to share learning.

The mental health social care service manager has set up a monthly meeting with the Trust safeguarding adults' team to share data on safeguarding adult concerns/enquires and OHFT MCA lead is meeting weekly with Oxfordshire DOLS team to review requests and make sure resources are prioritised effectively.

Co-chair multi-agency Right Care Right Person local implementation meeting and have recently joined a MH and Substance Misuse sub-group of the Combatting Drugs Partnership. OHFT are currently working in partnership with OMHP and wider system partners to review all elements of the current MH contract in Oxon as part of the new contract which will come into place in Apr 2025.

AgeUK

Chairing the Board's Engagement Subgroup and proactively strengthening partnership by widening the membership to include new VCS agencies including advocacy.

What the Board Partners did to towards the priorities

Working in Partnership

Cherwell District Council

As a Board Partnership member, we have an understanding of our accountability as the appropriate representative for Cherwell in each forum.

Good practice is evidenced through the joint district safeguarding partnership group, whereby Cherwell district council works with the other districts on responses changing themes and concerns.

Some themes have relevance across a number of partnerships and in these cases the Boards/Partnerships will work together and take a pragmatic approach to achieve the best outcomes for people and ensure that there is no duplication of effort.

In practice this means that each Board/Partnership has the opportunity to input into an area of work where it carries a responsibility and/or has relevant knowledge, expertise and experience.

Oxford City Council

From April 2023-March 2024, 12 ASMART and 85 ASMARAC meetings have been held under Oxfordshire's Adult Exploitation pathway with 41 different partners involved. As a result of these multi-agency meetings, more victims were supported out of exploitation and disruption plans put in place to tackle the exploiters, which also included 15 multi-agency visits. The partnership approach ensures that the victim is safeguarded and supported in all areas of need for them to exit exploitation and prevent re-victimisation through referrals to relevant agencies or supporting those workers already involved with the individual.

The Safeguarding Coordinator has requested to attend Board subgroup meetings in addition to one district representative, in order to strengthen and maintain partnership working

Contact with statutory agencies has enabled effective internal learning reviews

West Oxfordshire District Council

WODC staff have a key role in attendance at joint agency meetings including, but not exclusively: OSCB; OSAB; Oxfordshire Domestic Abuse Partnership; Prevent Implementation Group; Safer Oxfordshire Partnership Group; Police and Crime Panel; JTAC; PAQA; PIQA; Neglect Strategy Group and Community Safety Partnership.

A Joint Safeguarding Partnership Group has been formed with representatives from each of Oxfordshire’s Local Authorities, funded for a countywide Representative to attend Neglect; PIQA; PAQA meetings and others where relevant. To lead, chair and take minutes at this Sub-Group. The Group has introduced a ‘Purpose and Aims’ document along with ‘Commitment Statements. The Partnership Group enables common themes and policies to be reviewed and implemented, best practice to be undertaken, a common themed dashboard for reporting of issues of concern has been implemented and Districts have a shared Neglect Strategy and Action Plan.

What the Board Partners did to towards the priorities

Working in Partnership

Probation Service

Oxfordshire Probation Delivery Unit (PDU) has had a Partnership Manager in role for a year, working to improve relationships and partnership working between Probation and other organisations.

We rolled out a commissioned Autism Service for People on Probation. Oxfordshire teams make the most referrals the region and client satisfaction with the service is high.

Through Multi Agency Public Protection Arrangements, Oxfordshire Probation and Adult Social Care have better links at senior management level leading to better partnership working.

Oxfordshire PDU has been focusing work on the most complex and vulnerable service users, who also pose significant harm to communities. Staff working with this cohort have been given additional training and resources and work these cases in partnership with Police to best effect.

Oxfordshire PDU has a close working relationship with Turning Point, delivering services, co-locating workers, and co-producing training.
In April MIND gave a presentation to all Probation Staff to increase understanding of their services,

The Head of Oxfordshire PDU chairs the Combatting Drugs Partnership Criminal Justice subgroup.

Fire & Rescue Service

OFRS collaborate with other agencies to better protect vulnerable individuals. This includes working closely with health and social care partners, local authorities. By leveraging the expertise and experience of fire and rescue services, health and social care providers can enhance their prevention efforts and adapt engagement strategies for those most at risk.

What the Board Partners did to towards the priorities

Working in Partnership

Domestic Abuse Strategic Board

The Oxfordshire Domestic Abuse Strategic Board is a statutory partnership board which continues to deliver on the Oxfordshire Domestic Abuse Strategy. It has a strong focus on safe accommodation for victim survivors of domestic abuse. The board has multi agency partnership engagement. It brings together system wide leaders to deliver the strategic action plan, focusing on four key areas; Prevention, Provision, Pursuing and Partnership.

Multi-Agency Group Suicide Prevention

Public Health chair the Oxfordshire Suicide Prevention Multi-Agency group which brings together key partners across the system to promote mental wellbeing and reduce suicide and self-harm in children, young people and adults. There are over 20 organisations who are members of the group.

The local action plan focuses on building resilient communities to make suicide prevention everyone's business

Combatting Drugs Partnership

In line with the 10 year national drug strategy From Harm to Hope, Public Health lead the Oxfordshire Combatting Drugs Partnership. This multi agency group brings together key partners across the system to address the harms from drug and alcohol use. This results in safeguarding people not only against health harms but also criminal activity related to drug use.

Over the last year this has become an established group. The group are now in delivery phase of a targeted strategic action plan to deliver on the aims set out in the national strategy at a local level.

What the Board Partners did to towards the priorities

Working in Partnership

Sexual Health Action Partnership (SHAP)

The Health and Social Care Act 2012 gave health protection duties to Oxfordshire County Council as well as a general function to maintain the public's health.

The SHAP helps raise awareness about issues that help or hinder achieving better sexual health for Oxfordshire. Its main purpose is to build relationships with key partners in order to provide a safe and supportive environment to share good practice and discuss barriers to achieve good sexual health. E.g sharing good practice on prevention of unwanted pregnancies, safeguarding children from sexual exploitation, preventing sexually transmitted diseases and promoting better sexual health, etc.

South & Vale District Councils

South Oxfordshire and Vale of White Horse District Councils work closely with partners and agencies to support vulnerable individuals. Through our monthly Community Safety Joint Tasking meetings and case conferences we help provide solutions for vulnerable people who may not meet the threshold of need or refuse engagement with services.

We work with our district and city colleagues to share good practice and address emerging themes through our joint district safeguarding partnership group.

We have supported the Anti-Slavery Multi Response Conferences and Teams, where victims of modern slavery and Exploitation have been identified to help develop and coordinate disruption plans.

Oxford University Hospitals NHS Foundation Trust

OUH attend OSAB board and sub group meetings to actively support partnership working. Attendance at multiagency case review meetings, SAR's, DHRs, HMRs, MARAC, MARAC and strategy meetings as requested.

There is a health wide BOB ICS meeting to provide assurance and identify area for escalation, areas of good practice and quality improvements.

What the Board did to towards the priorities

Preventing Harm Occurring

- The **Multi-Agency Risk Management (MARM)** process brings together organisations working with a person who is showing an increased level of risk but who does not current fit within the criteria of a statutory safeguarding duty under Section 42 of The Care Act 2014. There are several very positive examples of multi-agency working that has been undertaken via the MARM process and the Safeguarding Board has received a presentation from a support worker involved in the MARM process to share the positive impact the process has had on the person they were working with.
- A **7-minute briefing** has been produced on the MARM and its use to help inform frontline workers of when it is best to call a meeting under the MARM process or when there are other alternative pathways that can be utilised.
- The Board has also offered specialised training in relation to trauma; **trauma, stigma & belonging**, **trauma and language**, and **trauma-informed coproduction**.

What the Board Partners did to towards the priorities

Preventing Harm Occurring

BOB ICB

BOB ICB work in partnership with primary care (GP, Pharmacy, Optometry & Dentistry) and other key health partners to ensure learning from statutory reviews is identified and embed within frontline practice.

We have committed to and delivered several recent training sessions to Primary care staff; closer connections for primary care & maternity services, understanding the health needs of the homeless population and, carer suicide & homicide. In addition, we have provided additional domestic abuse training to primary care to support disclosures.

Oxfordshire County Council

In the last year we have prevented harm occurring in care settings by working closely with our quality improvement team and care homes to prevent harm to individuals and the wider care community experiencing the risk of harm by having frequent, meetings, discussions and developing action plans. We are completing a care home specific audit to ensure that when cases are closed that wider considerations have been made not only for the individual but to other residents.

Thames Valley Police

TVP has received an uplift in funding for neighbourhood policing roles and this includes Oxfordshire, where neighbourhood teams will be brought up to strength and there will be an increase in dedicated neighbourhood officers. One of their core functions will the identification and mitigation of risks around safeguarding, taking preventative activity where needed – including early referrals.

Oxfordshire LCU will be rolling out a monthly partnership tasking meeting process – which has been trialled to good effect in Oxford City LPA – allowing police and partners to ensure that effective activity is joined up across the community safety agencies. Early assessment of data from RCRP indicates that the implementation has, thus far, not had a significant effect on the numbers of adults being identified at risk of abuse or neglect. Demand has historically been seasonal, and this demand trend has continued without much change following implementation.

What the Board Partners did to towards the priorities

Preventing Harm Occurring

OUH

The OUH works in partnership to identify harm and ensure care and support needs are met.

Safeguarding incidents are reported and reviewed by the safeguarding team to identify learning. This informs the Harm Free assurance process in place that identifies any areas for improvement and an open learning culture is in place and in line with our Patient Safety Incident Response Framework PSIRF framework.

Mental Capacity Act training is supported across the Trust to ensure the safety of our patients. Safeguarding training compliance monitored closely and meeting the levels required.

AgeUK

Worked to increase public awareness through our Marketing and Comms team actively participating in Safeguarding Adults Awareness Week.

Oxford Health

The s.75 establishment have a 6 weekly meeting called the Safeguarding Prevention Meeting which is a multi-agency meeting to ensure that people in the mental health housing pathway are protected from abuse and neglect. We use the 6 principles of safeguarding to ensure that we take a rights-based approach.

All mental health social workers use leadership skills to ensure that discussion about abuse and neglect is at the centre of MDT working.

OHFT have worked closely with police supporting Drive meetings.

Employed an MCA lead to support staff and improve practice.

We use the MCA as a key concept of safeguarding and intervene to make decisions on people's behalf when they are unable to protect themselves due to lack of decision-making capacity.

Refresh of the DOLS recording in community hospitals with a focus on making sure any restrictions are proportionate and to prevent risk of harm.

What the Board Partners did to towards the priorities

Preventing Harm Occurring

Cherwell District Council

Recruited new domestic coordinator to post supporting victims of domestic abuse alongside our housing team. Increased number of staff training offered on domestic abuse pathways and referrals.

Identifying trends across Cherwell locally or nationally ,reviewing and updating training when needed. Bespoke training form external parties when needed. Districts meeting reviewing themes that can be highlighting concerns across the county or rural locations.

Awareness campaign and signposting to service are best practice through Cherwell's services, internal and external media platforms used to communicate to staff and community.

Oxford City Council

Oxford City's commitment to DAHA accreditation is improving responses to domestic abuse, by equipping staff with the skills, knowledge, and the tools that serve to build their confidence to work more effectively with their most vulnerable tenants. As a housing provider we are best placed to identify and respond to domestic abuse early.

Promotion of Early Help and MARM process to identify and respond to concerns before harm occurs

Training levels have increased over the last year, particularly the last six months

Recorded safeguarding concerns have increased within the last year, demonstrating awareness and effective training

West Oxfordshire District Council

All staff must complete a Mandatory Level 2 Adults Safeguarding online course provided through the council's training provider iHASCO. Level 2 Childrens Safeguarding module is being rolled out to all.

Due to concerns around the rising trend in instacnes of threat to self-harm from residents in our community a Suicide Prevention Guidance document has been implemented and is available for all staff with links to NHS training. Safe Talk Suicide Prevention face to face training is being undertaken by front line teams.

What the Board Partners did to towards the priorities

Preventing Harm Occurring

Probation Service

Within our collaboration with Turning Point we have ensured all staff are trained in administering naloxone and this is available in all our sites. Turning Point work from our buildings and offer brief interventions to lower-level drug and alcohol users to prevent further harm occurring.

We have facilitated Hepatitis C and Liver Scanning in our buildings.

We have rolled out Mental Health Treatment Requirements and ensured high levels of Drug and Alcohol Rehabilitation Requirements as robust alternatives to custody.

Our commissioned services include a specialist women's services, as well as personal well-being services specialising in issues affecting men.

All staff have been required to attend Preventing Suicide Training. Training completion (child safeguarding, adult safeguarding and prevent) is linked to our annual salary increase. This has led to nearly 100% of required training being completed.

We are engaged with all the MARACs across the county and in May 24 we rolled out domestic abuse tags for perpetrators coming out of custody on licence to strengthen our risk management and oversight of these cases.

In 23/24 we doubled the numbers of home visits from the previous year, which means more oversight of home circumstances and any risk or vulnerabilities.

Domestic Abuse Strategic Board

The domestic abuse board owns a strategic action plan, around four priorities – prevention , provision, pursuing and partnership. The prevention work has included co-producing strategic delivery with victim-survivors of domestic abuse, communications campaigns to raise awareness of domestic abuse and how to seek help, and developing an updated domestic abuse policy for employees of OCC.

South & Vale District Councils

South Oxfordshire and Vale of White Horse District Councils have appointed a Domestic Abuse Support Officer who works closely with our housing needs officers to support the completion of Domestic Abuse Stalking Harassment and Honor Based Violence (DASH) risk assessments, agree a level of priority for housing needs and signpost victims to relevant support organisations.

We have promoted two domestic abuse campaigns across the districts to raise awareness of how to spot the signs and support available.

Domestic abuse training has been delivered to councillors and staff.

We have promoted OSCB/AB pathways and tools kits to staff to prevent harm from occurring.

What the Board Partners did to towards the priorities

Preventing Harm Occurring

Combatting Drugs Partnership

Partners are working together to reduce harm caused by drug and alcohol use. This has included a focus on increasing Naloxone distribution (a drug which blocks the life-threatening effects of opiate overdose)

Multi-Agency Group Suicide Prevention

Oxfordshire has a number of initiatives focusing on promoting wellbeing and this is led by the Mental Health Prevention Concordat Partnership. We have also recently launched mental wellbeing and suicide awareness training for local communities and are providing grants to community initiatives for key groups at risk of poorer wellbeing.

Sexual Health Action Partnership (SHAP)

Our sexual health providers work with children and young people in various schools and collages in order to improve their knowledge, attitude and behaviour /skills on sexual health and healthy relationships. Topics include: Consent, preventing sexually transmitted infections, healthy relationships, HIV awareness, contraception, intimate photo sharing, media and porn literacy etc

Fire & Rescue Service

In 2024, we will be implementing Risk Profiling across Oxfordshire. This approach enables operational crews to take charge of the appropriate prevention activities, knowing that the safety messages will make a difference in improving people's safety and to deliver reliable and relevant safety messaging to our communities.

What the Board did to towards the priorities

Responding Swiftly When Harm Occurs

- This priority has been the one that has had the least work done at present as the work within it is mainly reliant on work from other priorities being completed first.

- The Performance, Information & Quality Assurance (PIQA) subgroup of the Board have reviewed and updated the dataset that they scrutinise. There is still work to do on making this scrutiny as effective as it can be so that patterns are identified earlier so they can be acted upon before they develop into a significant issue.

What the Board Partners did to towards the priorities

Responding Swiftly When Harm Occurs

Oxfordshire County Council

In the last year we have worked hard to reduce the response times when the team receives safeguarding concerns. We are doing this working towards adhering to the local authorities' timescales increasing the number of concerns answered between 1-2 days. Since the end of January 2024 we have introduced a weekly meaningful measures meeting to review the timeliness of all cases across the service

BOB ICB

BOB ICB works alongside health provider organisations to manage cases which require escalation to NHSE to engage regional support and guidance.

BOB ICB supports health providers identified under section 42 of the Care Act, together with cases that reach both the adult social care strategy stage and the Multi-Agency Risk Management (MARM) process.

Thames Valley Police

Robotic process automation is now used in the triage of all adult protection (AP) and domestic abuse (DA) incidents involving adults in order to allow for swift assessment of threat, harm and risk. Secondary research also takes place to determine whether there are linked persons to the subject who may be at risk – including children and other potentially vulnerable adults. A multi-agency working group to monitor progress and implementation is in place.

A new AP governance board has been instigated to ensure that any risks and themes are identified early – this board is internal but is chaired by a local policing lead and feeds into the TVP vulnerabilities strategic group. Similarly, the DA and RASSO governance boards also identify similar risks and feed into the same strategic group to ensure join-up. TVP MASH have received an uplift in funding to allow recruitment of 10.5 additional staff at various bands. Op Yearn, which began in August 2023 has also allowed for the temporary flex of officers into the MASH to reduce AP and DA queues – reducing outstanding numbers from around 1700 each to 200. The triage process (see above) now means high and medium risk AP/DA incidents are triaged and shared with partners within 24 hours of identification.

What the Board Partners did to towards the priorities

Responding Swiftly When Harm Occurs

Oxford Health

All s.42 safeguarding concerns are triaged daily by a senior social worker and actioned within 48 hours. The s.75 establishment continue to achieve 100% in managing safeguarding enquiries within 12 weeks (as set by the local authority).

Engagement in Homeless mortality review process.

Introduction of Patient Safety Incident Response Framework (PSIRF) which include learning huddles to identify learning quickly.

OUH

The OUH identifies cases of harm on a day to day basis through staff, incident reporting and referrals directly to the team. This ensures a timely referrals and escalations to partner agencies as required.

Response is timely for section 42 enquiries, and request for information request. Any learning from reviews are disseminated across the Trust.

Cherwell District Council

Internal safeguarding reports are monitored, reviewed and patterns or themes are identified and discussed with relevant services, OSCB/OSCB/ DSL/ DA partnership/ Neglect Panel.

Any concerns are discussed in the contract monitoring meetings, we also ensured that the provider was involved in the Cherwell Operations Group meetings.

Where they are connected to the multi-agency discussions about concerns and could report into this forum, their interactions with the clients they meet during the outreach .

All front-line staff have completed compulsory safeguarding training and additional bespoke training such as handling suicidal calls.

AgeUK

Redesigned our staff and volunteer training programme to improve recognition of harm and quality of response.

What the Board Partners did to towards the priorities

Responding Swiftly When Harm Occurs

Oxford City Council

Increased referrals to ambulance service for mental health assessments following Right Care, Right Person policy

Exceptional Circumstances Panel utilised in cases of high risk DA. One such case resulted in a two bedroom property away from the City was offered within days and target hardening was arranged at the new property.

Internal learning reviews conducted to explore potential learning opportunities

Whole-council approach to ensure all concerns are identified and responded to, using appropriate information sharing

South & Vale District Councils

South Oxfordshire and Vale of White Horse District Councils provide support for vulnerable people for example, rough sleepers and victims of ASB through our Joint Tasking Meetings, exceptional case conferences.

We respond promptly to any concerns raised, managing processes such as Domestic Homicide Reviews and engaging in Child Safeguarding Practice Reviews.

Learning is shared internally to support staff and prevent harm reoccurring.

All safeguarding concerns are reviewed, monitored and escalated as appropriate. Where these do not meet the threshold of matrix the cases are managed through internal processes to ensure the individual is kept safe and supported.

West Oxfordshire District Council

An online system for raising issues of concern has been implemented that immediately sends alerts to the safeguarding team there is an issue to triage and support appropriately. There has been an active ongoing case of concern relating Modern Slavery with a Care Service provider which involved immediate attention from the Council's HMO Licensing Team.

There have been instances where an escalation of a concern has been required resulting in a MARM with active engagement across our service teams. The safeguarding team conducts monthly supervision on cases and follow up on outcomes where possible to ensure cases are escalated and progress through the correct channels.

What the Board Partners did to towards the priorities

Responding Swiftly When Harm Occurs

Probation Service

Probation Staff use recall back to prison, variation of licence conditions, GPS tagging, Polygraph, Probation hostels and a range of other measures to manage emerging or escalating risk.

We have made links with links with Oxford University Hospitals to rapidly share information on individuals who may pose a risk of harm in emergency departments or other medical settings.

We commission Serious Further Offence enquiries in the event that someone under our supervision commits a serious offence and we share learning across our staffing group.

We respond promptly and engage with other enquiries, such as the SAR process for homeless deaths and share learning across our staffing group.

Combatting Drugs Partnership

Public health lead on the Local Drug Intelligence System which provides rapid alerts to contaminated batches of drugs, reducing the potential harm by reducing the use of these drugs.

Fire & Rescue Service

OFRS plays a crucial role in making our communities safer. Whether it's preventing and protecting people from fire and other risks or responding swiftly and effectively when incidents occur, the work is vital for public safety. Fire crews are also well trained to identify concerns and manage safeguarding referrals.

Multi-agency Group Suicide Prevention

Oxfordshire has a real time surveillance system to ensure that bereaved families and friends are provided with immediate supportive signposting and support. We are also able to monitor emerging methods, clusters and high-risk groups to provide support. As a partnership we have worked in local communities to provide targeted support when required. This has included working with district councils, parish councils, workplaces. We also work closely with the coroners to ensure there is sensitive media reporting on suicides to minimise the impact on communities.

What the Board did to towards the priorities

Engaging Effectively with People at Risk

- The Engagement Subgroup has grown and now welcomes a wide range of organisations. The majority of those who are in attendance are not represented at the Board but work extensively with adults with care and support needs in Oxfordshire. The advocacy organisation in Oxfordshire (VoiceAbility) are also a member, replacing the former advocacy organisation.

- There is still more work to be done against this priority, particularly ensuring that this work is done in a way that is respectful of the experience of people at risk.

- The presentations of cases at the Full Board (mentioned earlier in this report) is another step towards ensuring that the voice of people at risk is heard at this senior level.

What the Board Partners did to towards the priorities

Engaging Effectively with People at Risk

Oxfordshire County Council

An audit in summer 2023 indicted that Making Safeguarding Personal outcomes whilst well reported at the end of an enquiry were not always sought at the initial information gathering stage. In the last year we have undertaken MSP audits and established a duty enquiries pod. A recent sample audit of closed cases indicates significant improvement in duty enquiries where the persons views and wishes are recorded or an identified plan as to which appropriate partner will make contact with the person is in place.

BOB ICB

BOB ICB commissions All Age Continuing Health care services and supports risk assessing placements and flexing if the needs of the client are not met. BOB ICB works in collaboration with all health systems, police and social care partners as part of both statutory and non-statutory review work, by triangulating information, including urgent escalations and embedding system learning.

TVP

TVP Oxfordshire will be moving to a new policing model in 2024, whereby the existing 3 local policing areas (LPAs) will merge to create one county-wide local command unit (LCU). This unit will, as part of its remit, focus on those individuals (children and adult) most at risk of harm and allow effective engagement with them and partners to reduce identified risks. This structure will allow consistency and clarity around engagement. Additionally, neighbourhoods teams will also feed into the adult safeguarding processes, ensuring ongoing engagement to mitigate against longer term problems/issues.

Officers and staff across Oxfordshire have had refreshed inputs around ensuring capturing concerns correctly, with a view to improving the quality of information provided by officers attending incidents into the MASH process. Within the custody environment as part of the Custody 2025 project, TVP has changed its approach to information sharing – moving to a presumption of data-sharing to proactively offer support to those at risk. TVP is the first force to collaborate with charities to proactively offer details of those at risk rather than seek permission. Pilots have taken place across the force, but in Oxfordshire this is running in Abingdon custody in partnership with the Maslow Foundation, to ensure a proactive offer of support is made to every female detainee. Work is ongoing to expand this process with other agencies to allow focus onto other risk groups.

What the Board Partners did to towards the priorities

Engaging Effectively with People at Risk

Oxford Health

The s.75 establishment use Making Safeguarding Personal and the six principles of safeguarding to ensure that people at risk of abuse and neglect are at the centre of safeguarding meetings and plans. Our safeguarding investigations and plans attest to this.

Working as part of a Thames Valley Crisis Project to implement Mental Health Response Vehicles (MHRVs) across the Thames Valley – and will be a mobile health-based blue light response to MH crisis.

Working with system partners to continue to build and adapt the out-of-hospital care team model (homelessness from inpatient care) which has been receiving national recognition and being held up as exemplar service.

Introduction of Keystone Mental Health and Well-being Hubs which are a one stop shop to support mental health and wellbeing and include Primary Care Mental Health Team.

OUH

The OUH works in collaboration with partner agencies to ensure identification and effective risk management of any concerns raised.

Weekly triangulation of incidents, complaints, claims, safeguarding and inquests takes place to provide assurance and follow up as required.

AgeUK

Supported the refresh of the Board’s Engagement Subgroup and the development of the action plan to improve engagement.

What the Board Partners did to towards the priorities

Engaging Effectively with People at Risk

Cherwell District Council

Cherwell district council frontline service have safeguarding champions who can triage concerns at point of contact. Informed experienced designated safeguarding leads in place, with continued improvement and training plans implemented across the teams.

People of risk often present in various ways however, the majority of these can by phone call to housing & customer service. There is a percentage of these who will present as homeless, all staff are trained on dealing with making referrals and signposting to services for people at risk or in crisis.

Food poverty has been recognised as a risk in Cherwell and there are various programs and mechanisms to support those most in need.

Oxford City Council

The ASBIT case manager does not have a live ASB case but remains in weekly contact with a tenant who has enduring mental ill health. The tenant is under the care of the Warneford Hospital. They call the ASBIT case manager every week. The phone call is for someone to talk to but also to provide reassurance that they will not lose their social tenancy with Oxford City Council.

The ASBIT case manager speaks to a male tenant every week to support him with his engagement with Turning Point and Hospital. He is constantly causing anti-social behaviour which has led to him receiving a Notice of Seeking Possession (NOSP). The ASBIT case manager does not want him to lose his tenancy so actively engages with him every week to encourage and support him to get the right support to change his behaviour which will enable him to remain housed.

A female tenant spoke to the ASBIT Case Manager and learned she had cut her wrist. The case manager was able to find her CPN on the Aspen Team. The case manager explained the situation so the CPN could get the female urgent support. The Police had raised also raised an adult protection. The female told the case manager she was in crisis and the Aspen Team are working with her for a meds review. The female did received the appropriate response and support. The case manager then made a referral to the Tenancy Sustainment Team so the female could have additional support to maintain her tenancy. Project developed to identify and respond to vulnerable females at risk, part of this project focuses on engagement with the females

What the Board Partners did to towards the priorities

Engaging Effectively with People at Risk

South & Vale District Councils

South Oxfordshire and Vale of White Horse District Councils' Wellbeing and Housing Teams support 'Homes for Ukraine', Afghan families and residents struggling with the cost of living or struggling with day-to-day life to access local services and appropriate support.

Our Community Safety Team resolve issues of ASB, providing mediation and coordinating action to prevent issues from escalating.

Our Senior Management Team are committed to staff wellbeing to ensure any concerns raised in either their work or personal life is managed, and they receive the support they need.

West Oxfordshire District Council

The Community Wellbeing and International Migration Teams are engaged in many activities within the local community and share knowledge and experience with other service areas such as Housing, Disabled Facilities Grants and Client Support to help residents to receive access to appropriate support agencies and professionals.

The Safeguarding Team and Service Managers ensure that risks to staff are mitigated and that their wellbeing is supported when they are involved with an issue of concern or personally.

Fire & Rescue Service

As a service we treat every visit/call as individual and tailor our response accordingly. Examples of this are our Threat of Arson visits, Fire Setter Interventions, Joint agency visits with health and social care.

Our roll out of the Risk Profiling will further develop our engagement with those most at risk in our community.

What the Board Partners did to towards the priorities

Engaging Effectively with People at Risk

Sexual Health Action Partnership (SHAP)

In addition to working with children and young people as mentioned above, our sexual health providers directly engage with various at-risk- groups providing outreach services in order to promote good health and prevent harm . e.g of population covered: MSM, commercial sex workers, BAME communities, asylum seekers in temporary accommodations, homeless population, substance users etc.

Multi-agency Group Suicide Prevention

Samaritans have worked closely with the rail network locally to train staff to talk with passengers they are concerned about. The Men's Health Partnership are providing health and wellbeing events across the county. There are also organisations in place that provide 1:1 support for people at risk such as The Cornermen Project and Safe Haven.

Probation Service

Our Probation Victim Liaison Unit work closely with victims ensuring they are aware of developments and can have a voice in plans to keep them safe.

We are represented at all MARAC meetings across Oxfordshire.

We routinely refer people on probation who themselves may be at risk from others to MARMM, MARAC, ASC,

We work closely with the Anti-Slavery Coordinator with respect to specific cases presenting vulnerabilities to exploitation.

We have a specific women's team with women only reporting times, specific training to ensure effective engagement and management of this vulnerable group.

We have a designated manager who liaises with youth justice teams to ensure smooth transition to adult probation services

We have developed better collaboration with Adult Social Care at MAPPA meetings at all levels to better understand issues and find solutions to the most complex and urgent cases in the community.

Data Headlines

The key figures of the number of safeguarding concerns and safeguarding enquiries carried out in Oxfordshire during 2023-24

MEASURE	2024	2023
Safeguarding Concerns	6581	6770
Section 42 Safeguarding Enquiries	1484	1921
Conversion Rate Number of Section 42 Enquiries / Number of Concerns	23%	28%
Average enquiries per individual Number of Section 42 Enquiries / Total number of individuals involved in Section 42 Enquiries or Other Enquiries	1.14	1.11

Data Headlines

Detail of the changes we have seen in safeguarding concerns and enquiries – Top and Bottom five

Service	Concern change	Service	S42 Enquiry Change
Police	-69 (drop of 11.9%)	Ambulance	-105 (drop of 46.5%)
Ambulance	-60 (drop of 6.6%)	Family	-52 (drop of 28.2%)
Housing	-60 (drop of 18.9%)	Care Home	-42 (drop of 44.2%)
Other Local Authority	-60 (drop of 45.8%)	Police	-33 (drop of 24.6%)
Family	-46 (drop of 10.2%)	Friend/Neighbour	-28 (drop of 58.3%)
Children’s Social Care	+10 (increase of 142.9%)	Informal Carer	-3 (drop of 42.9%)
Health – Hospital	+23 (increase of 7.3%)	Children’s Services – Education	-1 (drop of 33.3%)
Health – Other	+31 (increase of 8%)	Children’s Services – Other	+1 (increase of 200%)
Adult Social Care	+47 (increase of 22.2%)	Children’s Services – OCC	+1 (increase of 100%)
Provider Agency	+204 (increase of 18.8%)	Adult Social Care	+10 (increase of 10%)

“analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operational arrangements” Care Act Guidance

Data Headlines

- The location of risk has seen no significant change
- There has been no significant change in the demographics of those with an enquiry.
- The risk outcomes have shifted from risk reduced to risk removed (risk removed now 30% from 24%). The percentage of enquiries where risk remained increased slightly from 5% to 6%.
- The percentage of people who lacked capacity and were supported by an advocate fell from 80% to 74%
- The source of risk 'unknown to individual' increased from 19% to 31%, with a reduction in both service provider and known to individual.

What the data is telling us

The total number of safeguarding concerns received in **23/24 was 6581**, a slight decrease from **6670 in 22/23**. These concerns involved **4700 people**, of whom **1107 had concerns raised in both years**.

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.

The number of **completed 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.

What the data is telling us

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.

What the data is telling us

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.

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.

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.

What case reviews are telling us

During 2023-24, the Safeguarding Adults Board did not sign off any **Safeguarding Adult Reviews**. However, this does not mean the Board has not been completing reviews or learning from serious incidents.

There were **7 referrals** for cases to consider during the year, of which **2** have gone on to be Safeguarding Adult Reviews.

Additionally, there were **3 reviews** already open.

Finally, 9 deaths were reviewed under the **Homeless Mortality Review** process. These are reviews conducted under the discretionary Safeguarding Adults Review framework where the person was experiencing homelessness at the time of their death and where the circumstances do not meet the mandatory Safeguarding Adults Review criteria.

The following pages contain the learning from these currently unpublished reviews.

What case reviews are telling us

Adult L: this discretionary Safeguarding Adults Review (SAR) was initiated following a referral from Adult Social Care. Adult L and Adult M were a private couple who sought to live out their days without the intervention or interference of services, which was clearly documented across agency records. Friends and neighbours were raising concerns about the couple and this continued when Adult L was living alone. There were a number of agencies actively working with Adult L around the time of his death and his needs appear to be well documented. In his last two weeks, Adult L did finally accept that he was not managing well and accepted the offer to find him a care placement, which was being arranged at the time of his death.

Learning Points:

1. There appeared to be a reliance on informal sharing when formal sharing (e.g. a Safeguarding Concern) may have been more appropriate.
2. In adopting a strengths-based approach, it may be that Adult L's limitations to care for himself were not fully appreciated.
3. There appeared to be a lot of activity by professionals but the evidence of this having a positive impact is limited. It may be that a coordinated multi-agency response, bringing together the professionals involved could have offered some alternative options for working with Adult L.
4. Capacity assessments are not clearly documented when references were made to Adult L lacking capacity.

One Reflective Thought for Workers: Impact and Consequence – what is the likely impact of my decision/action? Is this likely to affect anyone else in the family/household? What can I or other agencies, singularly or together, do to mitigate any negative impact?

One Key Lesson for Organisations: Supporting the Frontline - How are we supporting frontline workers who are working with complexity? Are we offering enough time to reflect on practice and enough constructive challenge to ensure we are doing all we can within our resources and have considered the possibilities of multi-agency options?

What case reviews are telling us

Adult K: this discretionary Safeguarding Adults Review (SAR) was initiated following a referral from the Church of England following a review into the death of Adult K. Adult K took his own life on the day he was due to appear in court in regard to historic child abuse allegations made against him. The question was asked in the report of whether Adult K's death should've been referred for a SAR at the time it happened.

On the basis of the information shared for purposes of this SAR, it does not appear that there are significant concerns about how organisations worked together to safeguard Adult K and there are no systemic issues that can be identified from the information provided. There is ample evidence that the agencies interacting with Adult K were working in line with expected practice of the time. There are many examples of good practice in regard to timely referrals between agencies. The regular engagement and thorough work done by the GP Practice is of particular note. Some agencies were unable to provide a complete account of their work due to recording issues and the accessibility of historic information. However, when the information provided from all agencies is reviewed as a whole, there are no indicators that the content that was unavailable is of significance to this review.

One Reflective Thought for Workers: Risk Management - does this information/observation/interaction indicate the person is at an increased risk of harm? If so, how am I mitigating the risk? Who else am I sharing this information with to help mitigate the risk?

One Key Lesson for Organisations: scanning and uploading documents to electronic recording systems is only helpful if the documents are legible afterwards so a check should be done to ensure this is the case before destroying the original document.

What case reviews are telling us

Adult M: this discretionary Safeguarding Adults Review (SAR) was initiated following a referral from Adult Social Care. It concerns a historic death (occurred in 2017) that was revisited after a recent court case concerning neglect by the carers of Adult M leading to his death.

Given the amount of time that had passed since Adult M's death, the Author was asked to review the information assembled for the court case, pull out any learning points based on the practice in the information and then use these to lead a practitioner workshop to assess how a similar case would be approached today, highlighting any areas that still required development.

Findings:

1. The Board should assure itself that how Professional Curiosity and Self-neglect are explained in guidance (internal and multi-agency) and how organisations ensure this is embedded in practice is clear
2. Organisations should consider ways of gathering information about the person's history beyond the presenting issue to help frontline workers identify changes over time that might require further exploration, e.g. by developing a pen portrait of the person.
3. Those involved in this process fed back that it felt valuable and constructive and would recommend further reviews producing shorter reports that were more accessible.

One Reflective Thought for Workers: Risk Management - does this information/observation/interaction indicate the person is at an increased risk of harm? If so, how am I mitigating the risk? Who else am I sharing this information with to help mitigate the risk?

One Key Lesson for Organisations: scanning and uploading documents to electronic recording systems is only helpful if the documents are legible afterwards so a check should be done to ensure this is the case before destroying the original document.

What case reviews are telling us

Steffeny: this homeless mortality review (a discretionary safeguarding adults review) was initiated following her death in 2022. She had a degree in psychology and worked for a time in Childrens Services. She struggled with her mental wellbeing from a young age, attempting to take her own life twice (once at 17 and again in her 20s). On the first occasion she was hospitalised briefly. The second attempt occurred while under a Section, where she attempted to hang herself. The time without Oxygen caused a trauma to her brain, leaving her needing to re-learn how to walk, talk, write & remember. She moved to Oxford to marry her partner around 2016. In 2022 she was sectioned again following a domestic abuse incident. She was discharged from hospital a month later and placed into temporary accommodation. In early December 2022, her husband advised her that he was proceeding with a divorce. Steffeny didn't share this information but continued to engage with support, including spending time in mid-December making Christmas decorations with staff and other residents. She had plans to meet with the Adult Mental Health Team and with the Housing Team at Oxford City Council the following week. Before this happened, Steffeny took her own life by hanging.

Findings:

- The agency supporting Steffeny in this accommodation were not aware of any previous attempts of suicide. This information was not provided on the referral form or on any additional documentation.
- Organisations supporting people in shared, temporary accommodation, with a 'No Visitor' policy should ensure a robust, person-centred plan is in place, to look at how to combat loneliness for residents.

If you do one thing: 'Think about Risk' Assess incoming referrals thoroughly and confirm with referring organisations, that they have shared all risk information with you. This is not to avoid working with people who present with risks, but to understand the best way to support and work with them. Be open with the individual about concerns and involve them in the risk/safety planning. Collaborate with the other relevant agencies who are involved with the person, to ensure you all have a full understanding of the plan.

What case reviews are telling us

"Adam": this homeless mortality review (a discretionary safeguarding adults review) was initiated following his death in 2023. He was well known amongst the community and remembered as a very happy-go-lucky person, even when drinking and never aggressive towards staff. Adam had a history with criminal justice services, being first convicted in 1996, last convicted in 2016. Between 2005 and 2016 he was in and out of prison for domestic violence offences. His health needs were significant and complex. He lost the use of his right hand after an accident that caused damage to his shoulder. He struggled to access health support around this & was at risk of losing his hand. He was alcohol dependent and had korsakoff syndrome. He also had a diagnosis of spinal haematoma. He also had a historic diagnosis of schizophrenia and experienced low mood, depression and anxiety. It was noted that Adam focused on access to pain relief medication, rather than attending follow-up appointments to address the underlying issues (such as medical appointments and physiotherapy).

Findings:

- Outreach work with rough sleepers – some areas make the outreach worker's role more challenging. While it was noted that the anti-social behaviour team at Oxford City Council do an excellent job to support them, there are only two Officers.
- Professional Curiosity & Trauma Informed Approaches – There was potential for better outcomes in some instances if staff were a little more curious and followed through with calls to agencies to better understand the person, their background and needs.
- Involving Family - Adam's mother said that during the times Adam would return home, she felt very alone and unsure how best to help and support him. She realised he would be ill if he did not drink, but it felt wrong to be handing him a bottle of alcohol. She did not fully understand his needs or what the signs of danger were for him if the drinking continued.

If you do one thing: 'Think Multi-agency working' When there is more than one agency working with a person, then all the agencies will benefit from a clear understanding of each other's roles and a joint plan, on how best to support the person with whom they are working. This would avoid duplication of work and support a joined-up approach, with the sharing of risk and help avoid confusion of roles for the service user.

What case reviews are telling us

“Ben”: this homeless mortality review (a discretionary safeguarding adults review) was initiated following his death in 2023. Ben trained in Italy to be a Chef and upon returning to the UK worked in bars and restaurants as a Chef. It was at this point he started using drugs. Following the death of a friend, he entered rehab and moved away from the area to Oxford, where he worked in an Oxford College as a Chef. Ben developed mobility issues and required aids to mobilise himself. He was admitted to hospital after a fall. It became apparent he was being financially exploited by his Landlord and was living in a poor condition. He was accepted as homeless after this and moved to homeless support accommodation outside the city. He was found dead in his accommodation and the cause of death noted as multi-drug toxicity.

Findings:

- It appears that some organisations were unclear of each other’s roles and more precisely what they were not able to do or provide.
- It was noted that the embedded housing workers (from oxford city and from the out of hospital care team) perform a vital role and work hard, but they have a limited capacity.
- It was stated that getting medication for people when they are in temporary accommodation is difficult. Trying to get ‘Ben’s prescriptions to a local pharmacy, considering his location and his need to change GP practice etc, caused extra work for the substance misuse service.

If you do one thing: ‘Think planning’ When planning to place people into any accommodation, especially temporary accommodation (that does not have cooking facilities), agencies must fully understand, what it will be like for every individual. Consideration should be given to its location and their support needs, abilities, mobility, access to funds, medication and transport.

What case reviews are telling us

"Carol": this Homeless Mortality Review (a discretionary Safeguarding Adults Review) was initiated following her death in mid-2023. Carol had a number of health issues and a history of alcohol dependency. She had also experienced a lot of trauma, including domestic abuse and multiple miscarriages. The miscarriages, which were contributed to by liver cirrhosis, Diabetes and a congenital kidney disease, were often a trigger for returning to drink dependency. Due to Carol being a very private person, not all organisations were aware of who else was supporting her, which also meant that relevant information/knowledge was not shared across these services.

Findings:

- Communication – find out the best way to communicate with the individual you are working with (according to their likes, needs and ability).
- Health needs – what are they? How can you support them? Are there signs and symptoms you should be aware of? Do you have consent to discuss with medical personnel, should the person want that?
- Understanding trauma - use the information you have and consider the triggers people experience that can lead them into negative coping strategies (such as alcohol use).

If you do one thing: 'ask more questions' - in order to help you to understand how you can work with people, to suit their needs, remember your '6 best friends'…who, what, where, when, how & why? Maximise your time with them and get their consent to work with the other agencies who they are linked to, as a team.

Other Work Partners are Bringing to the Board

Modern Slavery case presentation

South Central Ambulance Service

LGA Peer Review & outcome

Oxfordshire County Council

Homelessness Strategy & Action Plan Update

Prevention of Homelessness Director's Group

Patient Safety in the NHS (PSIRF Framework)

BOB Integrated Care Board

Right Care, Right Person

Thames Valley Police

Carer's Strategy

Oxfordshire County Council

Safeguarding Adults Collection (SAC) national data return

Oxfordshire County Council

An overview of Public Health: what we do and how we do it

Public Health

The Future of Learning Disability Death (LeDeR) Reviews

BOB Integrated Care Board

PRIORITIES FOR 2024-25

1. *Learning and development to have a higher focus in 2024-25 as there are a number of workstreams identifying learning so more focus on embedding the learning and measuring its impact. Sources of learning include:*
    1. ***The number of our own reviews being published***
    2. ***The findings from the 2nd SAR national analysis***
    3. ***The dataset from PIQA, which gives clear indications of what areas are either being under-reported or are poorly understood***
2. *The Board reconsiders the strategy overall, framing the priorities against the impact they are expected to have on the people of Oxfordshire*
    1. ***For example, theme two might become "The Prevention of Abuse and Neglect" with a desired outcome of "Adults at risk are identified early and have their needs met promptly and effectively."***