PEOPLE OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 19 September 2024 commencing at 10.00 am and finishing at 11.40 am

Present:

Voting Members:	Councillor Kieron Mallon - in the Chair
	Councillor Imade Edosomwan - Deputy Chair Councillor Trish Elphinstone Councillor Jenny Hannaby Councillor Alison Rooke Councillor Nigel Simpson
Other Members in Attendance:	Councillor Tim Bearder, Cabinet Member of Adult Social Services Councillor Dan Levy, Cabinet Member for Finance
Officers:	Dr Jayne Chidgey-Clark, the Independent Chair of the Oxfordshire Safeguarding Adults Board Karen Fuller, Director of Adult Social Care Victoria Baran, Deputy Director of Adult Social Care Lorraine Henry, Safeguarding Mental Health Service Manager Richard Doney, Scrutiny Officer

The Council considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and decided as set out below. Except insofar as otherwise specified, the reasons for the decisions are contained in the agenda and reports, copies of which are attached to the signed Minutes.

17/23 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Cllr Waine sent his apologies, with Cllr Simpson substituting. There were also apologies from Cllrs Graham and Leverton.

Cllr Dan Levy also attended online.

18/23 DECLARATION OF INTERESTS

(Agenda No. 2)

There were none.

19/23 MINUTES

(Agenda No. 3)

The minutes of the meeting on 9 July 2024 were **AGREED** as a true and accurate record.

20/23 PETITIONS AND PUBLIC ADDRESS

(Agenda No. 4)

There were none.

21/23 OXFORDSHIRE SAFEGUARDING ADULTS BOARD ANNUAL SAFEGUARDING REPORT

(Agenda No. 5)

Dr Jayne Chidgey-Clark, the Independent Chair of the Oxfordshire Safeguarding Adults Board (OSAB), Cllr Tim Bearder, Cabinet Member of Adult Social Services, Karen Fuller, Director of Adult Social care, Victoria Baran, Deputy Director of Adult Social Care, and Lorraine Henry, Safeguarding Mental Health Service Manager, were invited to present the OSAB Annual Safeguarding Report and answer the Committee's questions.

The presentation was led by the Independent Chair, who stressed that safeguarding was a collective responsibility, regardless of any staff shortages and budget limitations. A decrease in safeguarding enquiries was also observed. The importance of quicker and more effective learning from reviews to prevent future incidents was highlighted, pointing out recurring issues such as insufficient professional curiosity and poor multi-agency risk assessment. The Independent Chair identified three key priorities for OSAB, derived from over 200 recommendations: understanding barriers to learning, embedding acquired knowledge, and monitoring effectiveness.

The Cabinet Member stressed that professional curiosity was crucial, particularly when staff were overworked and underpaid, and that it was important to grasp the broader context of challenges faced by frontline workers, such as staff shortages and more complex cases.

Members of the Committee made the following observations, and raised a number of questions and concerns, including:

- What strategies were in place to ensure adequate time was provided for individuals at risk?

  The Director of Adult Social Care emphasised that care was individualised, with no fixed time allocated per person. This flexibility ensured that care was tailored to the unique requirements of each person.

- Members observed that a substantial number of concerns surfaced in both 2022/23 and 2023/24, prompting curiosity about the underlying reasons.

The team had begun to conduct an in-depth review of these cases to understand the nature of the concerns, assess any similarities or differences between the years, and determine whether the issues were resolved or continued. Following this analysis, steps would be taken to address the concerns, prioritising the identification of barriers to resolution and enhancing the safeguarding process for the affected individuals.

- The objectives and interplay of the Multi-Agency Risk Management (MARM) process and the Multi-Agency Safeguarding Hub (MASH) was explored with the MASH described as a central point where all referrals for adults and children, including those from the police, were received. It served as a coordinating hub for safeguarding concerns whereas MARM was a process intended for individuals who may not have had traditional care and support needs but still presented recurring risks. It involved multi-agency teams discussing the most effective pathway to safeguard the person involved.

  These processes formed part of a comprehensive safeguarding framework, ensuring that at-risk individuals were identified and supported through coordinated efforts from multiple agencies. Additionally, it was noted that the Oxfordshire MARM process had been commended by other local authorities due to its significant positive outcomes, highlighting interest in how the process operated.

- Members noted the significant reduction of the number of open enquiries, compared to the previous year, especially the number of enquiries open for over 12 weeks.

  Despite the substantial decrease in cases and the implementation of new measures to identify, measure, and monitor them, a major reason for this reduction was the enhanced process for recording inquiries and streamlining how information was reported and documented.

  It was acknowledged that effective safeguarding processes naturally involved several ongoing inquiries. Efforts had been made, and would continue, to enhance the team's overall performance to ensure that cases were resolved both swiftly and efficiently.

- Members questioned whether effective whistleblower schemes were in place for staff to communicate issues up and down the chain.

  The County Council had whistleblower policies allowing staff to report concerns anonymously if they felt unable to escalate them through regular channels. These policies enabled anonymous safeguarding referrals, ensuring that concerns about care or service provision could be investigated and addressed.

  The discussion emphasised that anonymous safeguarding referrals were taken seriously and thoroughly investigated to address any issues. This process was part of the wider safeguarding framework, ensuring that individuals at risk were identified and supported through coordinated efforts from various agencies.

- The Independent Chair stressed, in response to a question about proposed changes to the Integrated Care Board's operating model which the Committee was mindful that the Oxfordshire Joint Health Overview and Scrutiny Committee had strong concerns about, that it would be important to carefully monitor and understand the effects of the proposed service resign.

- Members concluded the discussion, seeking advice for members of the public concerned about an individual in their community.

  The Independent Chair highlighted the need for public awareness on reporting safeguarding concerns and noted efforts to increase awareness, especially during Safeguarding Awareness Week, using the telephone or online. The Independent Chair stressed that anyone, including families and friends, could report any concern, no matter how small, to help protect vulnerable individuals.

The Committee requested the following **ACTIONS**:

- Update of social worker pay, and compare to national rates of social worker pay, including:
  - A summary of the recent recruitment process, what is being done to recruit local and train new staff
- Data of staff vs people in care
- Once the National Adult Safeguarding Data has been reported in April 2025, the data and Oxfordshire comparisons will be fed back to committee.

22/23 DEPRIVATION OF LIBERTY SAFEGUARDS

(Agenda No. 6)

Karen Fuller, Director of Adult Social Care, Victoria Baran, Deputy Director of Adult Social Care, and Lorraine Henry, Safeguarding Mental Health Service Manager, were invited to present a report on the Deprivation of Liberty Safeguards (DoLS) and to answer the Committee's questions.

The Deputy Director of Adult Social Care provided a summary of the state of the DoLS service, explaining that DoLS was created to protect people in care homes or hospitals who could not consent to their care, allowing them to challenge their situation. A 2014 Supreme Court ruling expanded the definition of deprivation of liberty, increasing those under DoLS. The DoLS service required a complex assessment process, needing both a doctor and a qualified social worker or occupational therapist. While acknowledging that the completion rate for DoLS assessments was below the national standard, efforts were being made to improve through additional staffing and external agency support.

Following the presentation, members raised a numbering of comments and queries, including the following:

- Measures taken to enhance the quality of the services provided.

  NHS Digital supplied data on the number of DoLS assessments carried out by various local authorities, which helped to analyse trends and compare

performance. This identified areas needing improvement and offered a national benchmark for Oxfordshire. To tackle the backlog, an external agency was hired to handle 500 of the oldest pending best interest assessments. Efforts to boost efficiency included using shorter documents, which still complied with the legal requirements, to raise the number of completed assessments.

Members asked about the assessment procedure for those who enter care unexpectedly. It was explained that the assessment was only appropriate where someone was already under continuous supervision and could not consent to their care. The Council used a tool to manage the risk, ensuring high-priority cases were quickly assessed. A best interest assessor and a section 12 doctor handled urgent cases within seven days of referral.

In the case of continuing care circumstances, the DoLS assessment was conducted annually, even when there was little likelihood of change.

- It was noted that rescheduled DoLS referrals had increased 22% nationally, over the last two years, whilst the rate in Oxfordshire was 43%. Members sought clarity on why this was so much higher in Oxfordshire.

  The increase was linked to factors like the impact of COVID-19, which altered care home admissions and care provision, affecting DoLS referrals. Many postponed entering care homes until after the pandemic by opting for private care. Additionally, better understanding and awareness among social workers about the DoLS process led to more accurate and timely referrals. Training for care home staff and social workers also enhanced the DoLS assessment identification and referral process.

23/23 COMMITTEE FORWARD WORK PLAN
(Agenda No. 7)

The Committee **AGREED** that the following items should be included in the forward plan:

- A DoLS update,
- Inequalities,
- Prevention,
- CQC Assurance,
- Recruitment and Retention.

24/23 COMMITTEE ACTION AND RECOMMENDATION TRACKER
(Agenda No. 8)

The action and recommendation tracker was **NOTED**.

25/23 RESPONSES TO SCRUTINY RECOMMENDATIONS
(Agenda No. 9)

The Committee **NOTED** the Cabinet to the report on Adult Social Care Assurance Update, which was agreed by Cabinet on 17 September 2024.

..... in the Chair

Date of signing .....