Subject:	Response to the Ombudsman Public Interest Report
Reason for briefing note:	To provide an update to the Adults, Children and Health Overview and Scrutiny Panel on the actions the Royal Borough and Optalis has taken following the Ombudsman's recommendations, and progress against them.
Responsible officer(s):	Michael Murphy, Director of Statutory Services Optalis and Deputy DASS
Senior leader sponsor:	Hilary Hall, Director of Adults, Health and Commissioning
Date:	30 September 2020

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Royal Borough of Windsor & Maidenhead

SUMMARY

This report provides information on the public interest report issued by the Local Government and Social Care Ombudsman on 3 September 2020 and details the response of the Royal Borough and Optalis to the recommendations and the actions taken to date. The Royal Borough and Optalis accept in full the recommendations of the Ombudsman and is committed to learning from what has happened and ensuring sustainable improvements to its processes.

1 BACKGROUND

1.1 The actions of the Royal Borough and Optalis were the subject of a public interest report by the Local Government and Social Care Ombudsman (Ombudsman) on 3 September 2020, see appendix 1. The report is summarised by the Ombudsman as follows. '*Mr X complains on behalf of his late parents. He says the council did not properly consider the risks of separating them after 59 years of marriage or of Mr Y (his father) living on his own. He complains about the quality of care the council provided to them both and says it did not deal adequately with his concerns and complaints. He also complained that the safeguarding process was flawed, and the Council would not give him a copy of Mr Y's assessment*.'

1.2 The outcome was that the Ombudsman found fault causing injustice and recommendations were made. The Ombudsman stated that he had completed his investigation and upheld Mr X's complaints that the council:

- *did not properly consider the risks in supporting Mr Y to remain at home on his own;*
- *did not properly consider the impact of separation after 59 years on Mr Y and his wife, Mrs Y;*
- *did not provide Mr X with a copy of Mr Y's assessment;*
- *did not provide an adequate quality of care to Mr Y;*
- *did not deal adequately with Mr X's concerns and complaints.*

1.3 The Ombudsman did not uphold Mr X's complaint that the Council carried out a flawed safeguarding process.

1.4 One of the requirements placed upon the Royal Borough was that the report be considered in a public council meeting. The Overview and Scrutiny Panel is, therefore, asked to consider the report and the council's response and to make any recommendations to Cabinet.

2 KEY IMPLICATIONS

2.1 The report was published on 3 September 2020, and the Ombudsman identified the following recommendations to remedy the injustice identified:

- *apologise to Mr X and Ms Z (his sister) setting out the faults identified in this report and the actions the council will take or is taken to put this right*
- *pay Mr X and Ms Z £750 each in recognition of the distress caused in failing to properly consider the risks of separating Mr and Mrs Y.*
- *pay Mr a further £500 for the time and trouble and distress he was caused in bringing his complaint*
- *review any cases where couples are separated by their care needs to ensure the risks and human rights will fully considered for both parties also, that adequate contact is included in care and support plans.*
- *review assessment practice across the council to ensure it is consistent and Care Act compliant. It should do this using the quality measures and reporting processes it has implemented since these events*
- *ensure that it has an effective mechanism for following up where complaints about poor practice have been received and to check improvements are made and sustained*
- *put in measures to ensure complaints about several agencies receive a coordinated response and review its commissioning practice when services are rated 'requires improvement' to ensure it considers any increased risk to people.*

2.2 In addition to public scrutiny of the report, the Ombudsman also requires the Royal Borough to report to him within three months on the measures taken to address the recommendations in the report.

3 DETAILS

3.1 The Royal Borough and Optalis accept in full the recommendations of the Ombudsman and is committed to learning from what has happened to ensure sustainable improvements to its processes. Actions taken in response to the issues identified in the Ombudsman report are as follows:

1. We have written letters of apology to Mr X and Ms Z providing an update on actions taken so far and including the relevant offer of financial recompense.

2. We have reviewed our assessment and care management processes to ensure that all practitioners are absolutely clear on what they are required to do and to ensure that any issues are identified at the earliest opportunity. This review was undertaken in late 2018 and the various stages of the process refined so that they reflected the Care Act nomenclature as well as the Each Step Together process that was adopted within the Royal Borough in 2016 in response to the implementation of the Care Act 2014. The initial presentation to Overview and Scrutiny in 2016 on Each Step Together is attached as appendix 2.

3. As part of the routine management of the contract with Optalis by the Royal Borough, the number of assessments that are completed within six weeks is reported each month. This indicator measures that assessments are being completed within reasonable timescale and identifies any outliers for specific attention. Current performance in this area indicates that 68% of all assessments were completed within

timescale in August 2020. This is outside the target of 80% but performance has been impacted by Covid and people taking annual leave in August. Performance is anticipated to be back on track by October.

The performance monitoring process indicated a lack of clarity around monitoring requirements and expectations. Guidance has been issued, see appendix 3, which requires managers and senior practitioners to have full oversight of performance. The operation of this guidance is monitored via supervision.

4. The clear need to improve practice has been taken forward through a quality circle approach which involved two meetings on 21 November 2019 and 14 July 2020, see appendix 4 for a note of the meetings. As a result, we amended our Quality Assurance Panel process to ensure that staff identify and record where couples are likely to be affected and the actions that we are taking to safeguard relationships. The Quality Assurance Panel forms require the worker and their manager to answer the following questions
   - *Is there a significant person that lives with the service user? (examples- Husband, Wife, Partner, Sister, Brother, Friend).*
   - *Has the impact of the panel application been considered for the significant person and how the potential impact can be minimised? Provide details.*

   The Quality Assurance Panel is chaired by the Director of Statutory Services or the Head of Older Persons Services and approves packages of care or directs mitigating actions for representation. Following a review of the Panel's operation, further mandatory practice guidance was issued in September 2020 which required senior social workers to ensure that key standards were met where couples were at risk, see appendix 5.

5. In addition, we are in the process of identifying all people whose care needs, and arrangements, are related and for whom there is a risk of separation and loss of contact. We have identified 27 cases so far where this is the case and have thoroughly reviewed 22, with the remainder to be completed by the end of September 2020. These reviews will ensure that people's needs, and wishes are followed in respect of loss of contact, in accordance with the Human Rights Act. The Director of Statutory Services has reviewed the current case file recording in these cases and has identified that in most cases the appropriate steps were being taken and that there were several examples of good practice in these cases. This exercise will be routinely undertaken as part of the ongoing quality assurance and audit work across the service.

6. As part of the wider adult social care transformation programme, we identified that our public information needs to be significantly updated to ensure that residents and their families are fully aware of the processes that we use to ensure that people's needs are met in the most appropriate manner. This work is now underway and we will be inviting residents and their families to review the information and the way it is presented.

7. We have implemented an action log process for ensuring that any quality improvement actions arising from complaints are embedded in routine procedures. Progressing these actions is seen as a critical component of quality assurance within Optalis and is reported to the Optalis Board on a regular basis.

8. We have reviewed our complaints process to ensure that a co-ordinated response is provided in cases where complaints are made against several agencies. All complaints are notified to the relevant senior manager who oversees the process to ensure a co-ordinated response and each response is quality assured by the Director of Statutory Services before it is issued.

9. Both the Royal Borough and Optalis work with providers of care to improve quality. The council has employed a dedicated commissioning officer to monitor domiciliary care providers and to work with the care quality team in Optalis to ensure improvements. Within Optalis, the care quality assurance team operates a robust care governance process which regularly monitors the quality of domiciliary care and care homes within a well-established multiagency framework. The monitoring framework is attached as appendix 6.

10. Four out of five of the council's domiciliary care providers are rated good with the Care Quality Commission with one remaining as "requires improvement", the brokerage team within Optalis prioritises the providers that are rated good. The Royal Borough is committed to working only with providers that are rated good or outstanding and on that basis is seeking to terminate contracts with other providers as early as possible.

11. Whilst the Ombudsman did not uphold the complaint that the safeguarding process was flawed, we are, however, midway through a fundamental review of our safeguarding processes. This will include the issue of effective communication with families and other parties.

4 NEXT STEPS

4.1 The view of the Adults, Children and Health Overview and Scrutiny Panel on the actions taken by the Royal Borough and Optalis in response to the Ombudsman's report are invited, including any further recommendations to Cabinet.

4.2 The outcome of the scrutiny and a further report will be sent to the Ombudsman in three months' time updating on progress.

4.3 Quarterly updates on progress against the actions will be presented to the Adults, Children and Health Overview and Scrutiny Panel.