Subject:	Update on the response to the Ombudsman Public Interest Report
Reason for briefing note:	To provide a further 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:	12 January 2021

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Royal Borough of Windsor & Maidenhead

SUMMARY

This report provides an update on the actions taken following the public interest report issued by the Local Government and Social Care Ombudsman on 3 September 2020. It confirms that the Ombudsman has reviewed the response and confirmed that he is satisfied with the council's response.

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. 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.

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.*
- *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 required 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 In November 2020, following the Panel's consideration and that of Cabinet, an update was sent to the Ombudsman on the actions taken in respect of the recommendations set out in point 2.1. In response, on 25 November 2020, the Ombudsman wrote to the council saying:

"We welcome the action your Council has taken following the report on Mr X's complaint and are pleased to see how seriously it has taken this. This letter is therefore to tell you formally we are satisfied with the Council's response in accordance with section 31(2) of the Local Government Act 1974.

We have recorded a compliance outcome of ***Remedy complete and satisfied.***"

3.2 An update on the actions taken by the council and Optalis is provided at Appendix 1.

3.3 In addition, at the Panel's request, the Lead Member and Director of Adults, Health and Commissioning wrote to the Chief Inspector of the Care Quality Commission to ask if they would come out to re-inspect Carewatch. All standard inspections have been suspended during the Covid period. The response from the Commission was that during the pandemic , they were taking a risk based approach and did not feel that Carewatch were currently at risk.

Appendix 1

Remedy	Update
Apologise to Mr X and Ms Z setting out the faults identified in this report and the action the Council will take, or has taken, to put this right;	A letter of apology was sent to Mr X and Ms Z on 2 September 2020 by recorded delivery. Both have acknowledged receipt of the letter.
Pay Mr X and Ms Z £750 each to recognise the distress it caused in failing to properly consider the risks of separating Mr and Mrs Y;	In the letter, bank details from both Mr X and Ms Y were requested in order to make the agreed payments. To date, this information has not been received and it is the council's understanding that both parties are seeking solicitors' advice.
Pay Mr X a further £500 for the time and trouble and distress he was caused in bringing his complaint;	As above.
Review any cases where couples are separated by their care needs, to ensure the risks and human rights were fully considered for both parties. Also, that adequate contact is included on the care and support plans;	27 cases involving couples were identified and all 27 have now been reviewed by the Director of Statutory Services in Optalis. Appropriate steps were being taken in all cases and there were several examples of good practice. This exercise of review has been included within the routine quality assurance arrangements going forward.
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;	The council has reviewed its 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 Quality Assurance Panel process has been amended to ensure that staff

Remedy	Update
	identify and record where couples are likely to be affected and the actions that are being taken 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. 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
Ensure it has an effective mechanism for following up where complaints about poor practice have been received and to check that improvements are made and sustained;	Optalis has implemented an action log process for ensuring that any quality improvement actions arising from complaints are embedded in routine procedures. Progressing these actions is a critical component of quality assurance within Optalis and is reported to the Optalis Board on a regular basis.
Put in measures to ensure complaints about several agencies receive a coordinated response; and	Optalis has reviewed the 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.
Review its commissioning practice when services are rated “Requires improvement”	Both the Royal Borough and Optalis work with providers of care to improve

Remedy	Update
to ensure it considers any increased risk to people.	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. 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 Care Quality Commission has not been able to carry out any formal inspections during the Covid period; however, the nominated inspectors remain in close contact with providers as does the care quality assurance team in Optalis. The Royal Borough remains committed to working only with providers that are rated good or outstanding.