READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE AND MONITORING OFFICER

TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES & EDUCATION COMMITTEE**		
DATE:	**4 APRIL 2019**	**AGENDA ITEM:**	
TITLE:	**OMBUDSMAN INVESTIGATION**		
LEAD COUNCILLOR:	**CLLR TONY JONES**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**DIRECTORATE OF CARE AND HEALTH SERVICES**	**WARDS:**	**BOROUGHWIDE**
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1. PURPOSE AND SUMMARY OF REPORT

1.1 This report gives notice of a completed investigation by the Local Government and Social Care Ombudsman into a complaint about the quality of home care provided by the Council's contractor to the complainant's late mother-in-law (the subject), in particular that the carers failed to call 999 when the subject was ill. The Ombudsman found that injustice had been caused by faults on the part of both the care provider and the Council. The Ombudsman's report has been made available for public inspection at the Civic Officers and in the Central Library, and circulated separately to Committee members. It is also published on the Local Ombudsman's website, at https://www.lgo.org.uk/search?q=reading&d=webpages

1.2 The home care was commissioned by Adult Social Care and provided by Radis Group under contract to the Council. The Ombudsman investigation found that Radis care workers were late getting medical attention for a vulnerable woman, with faults in the following specific areas:

- The carers did not encourage the subject to move around or use her inhaler
- The carers did not visit the subject at lunchtime on the day before she died, or deal properly with the morning carer's concerns about her health
- The carers failed to call 999 on the evening of the same day, or to follow Radis's own emergency procedures
- The recording of the carers' discussions with the subject with Radis management was not flawed and incomplete
- The investigation of the subsequent complaints was flawed in procedural and safeguarding terms, failed to establish that the provider had not followed their own emergency procedures, and the outcome was not reported back to the complainant by the Council

1.3 This report sets out the response of both the Council and Radis to the Ombudsman's investigation, and his proposed remedy, which we fully accept. The action taken by Adult Social Care to implement the Local Ombudsman's recommendations, and remedy the faults to the complainant and his family, are described in para. 4.5 below.

1.4 This report, and any specific comments made by the Committee, will be shared with the Local Ombudsman following your meeting.

2. RECOMMENDED ACTION

2.1 That the Ombudsman's finding of faults (maladministration) by both the Council and the Council's home care provider, Radis, be noted;

2.2 That the action being taken to remedy the injustice experienced by the subject's family as a result of these faults, as recommended by the Local Ombudsman, be endorsed, as follows:

1) the Council has:
- **apologised to the complainant for the distress caused by the faults identified**
- **is discussing with him whether he wishes the Council to provide a lasting tribute (such as planting a tree) in memory of the subject**
- **paid £100 to the complainant acknowledge the time and trouble he had in pursuing this complaint;**

2) Within three months of the Local Ombudsman's final report, the Council will have:
- **ensured the care provider has:**
  - **trained all staff on the use of its emergency procedures and the procedures to follow when a service user is ill**

- **trained all carers on accurate and complete record keeping**
- **reviewed its adult social care complaints procedure to clarify how it deals with complaints against commissioned care providers, and how it will ensure independent investigation of serious complaints**
- **reminded staff involved in adult safeguarding enquiries of the importance of ensuring enquiry reports are factual and accurate**
- **provided the Ombudsman with evidence it has taken these actions**

3. POLICY CONTEXT

3.1 The Local Ombudsman summarised the relevant law and guidance relating to adult social care as follows:

3.2 Fundamental standards for care providers:
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the fundamental standards those registered to provide care services must achieve. The Care Quality Commission (CQC) has issued guidance on how to meet the standards. The fundamental standards include:

- Safe care and treatment ***(Regulation 12(2)(b)***: The provider must have arrangements to take appropriate action if there is a clinical or medical emergency.
- Good governance ***(Regulation 17(2)(c))***: The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user.

3.3 Emergency procedures
Radis, the care provider in this case, has a procedure for emergency situations. This says, in relation to service users "who are in a deteriorated state of health, but appear not to require urgent medical assistance and are quite responsive":

"In clearly non-emergency situations the Care/Support Worker should contact the duty manager/supervisor to take advice and record their actions clearly in the diary record book. They should also remain with the Service User if they are instructed to do so.

The duty manager/supervisor MUST follow the procedure below:
• The relevant social worker, Duty team or commissioner should be contacted immediately to report the problem. Any instructions that are given should be recorded and followed exactly.

• The Service User's GP should be contacted to obtain advice and a home visit if necessary. Any instructions given by the GP should be followed exactly.
• A decision made whether to ask the Care/Support Worker to remain with the Service User based upon instructions given by the GP.
• Notification to other Service Users that the Care/Support Worker has become delayed and alternative staff deployed if this delay is excessive.
• A full record made of the event and actions taken in the Service Users notes.

It should be recognised that some Service Users may not wish to receive medical attention and may refuse any assistance. In these circumstances the above procedure should still be followed, as the Service User will still be able to refuse assistance if the GP attends. This policy is part of our duty of care for all Service Users and is balanced against the Service User's right to have choice and control."

3.4 Safeguarding adults

A council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk ***(Section 42, Care Act 2014)***.

There should be a multi-agency strategy discussion to decide whether the criteria are met for a formal Section 42 safeguarding enquiry. When a safeguarding case is closed, individuals should be told how matters will be followed up. The Safeguarding Procedures say enquiry reports "need to be concise, factual and accurate".

3.5 Complaints about social care

Councils should have clear procedures for dealing with social care complaints. Regulations and guidance say they should investigate a complaint in a way which will resolve it speedily and efficiently.

The complaints regulations say if a complaint is about the actions of a care provider, councils must send the complaint to the provider as soon as reasonably practicable.

The complaints guidance says for some serious complaints, it may be necessary to ask an independent investigator to look into the case. But most complaints will be investigated by someone from within the organisation, who should be appropriately trained and independent of the part of the service that is being complained about.

The Council's complaints procedures say if the complaint involves one of its partner services it may arrange a joint investigation.

4. THE COMPLAINT

4.1 Complaint History

4.1.1 The complainant made a formal complaint to the Council in July 2017, following the subject's death. Adult Social Care opened a safeguarding concern, which was progressed to an enquiry to Radis to undertake an internal investigation, and Radis replied directly to the complainant. Adult Social Care did not respond directly to the complainant.

4.1.2 The complainant was dissatisfied with the Radis response, and complained to the Local Government and Social Care Ombudsman in June 2018. The Local Ombudsman referred it to the Council for comment on 2 July 2018. The Head of Legal Services responded to the Local Ombudsman on 24 August 2018, in conjunction with the Director of Adult Social Care. This response also incorporated feedback on the complaint from Radis.

4.1.3 The Ombudsman did not initiate a formal investigation into this complaint. However, in the light of the Council's comments on the complaint, he advised the Council in October 2018 that the Ombudsman felt that he should issue his findings on the complaint as a public report.

4.1.4 The Ombudsman issued his final report and findings on 10 January 2019, and published the report on the website on 21 February 2019.

4.2 Local Government & Social Care Ombudsman – Conclusions

4.2.1 The Ombudsman's commentary on their website detailed the findings as followed:

> **"Reading care workers late getting medical attention for vulnerable woman"**
>
> Care workers in Reading did not follow emergency procedures to ensure a vulnerable woman received the correct medical attention, the Local Government and Social Care Ombudsman has found.
>
> The woman, who was being cared for by Reading Borough Council's care provider, the Radis Group, was elderly and had health conditions including lung disease.
>
> She lived alone, and received three calls a day from care workers. However, when she fell ill in July 2017, care workers failed to follow the provider's procedures and alert her GP in a timely manner.
>
> The woman was eventually admitted to hospital but died the next day.

Michael King, Local Government and Social Care Ombudsman, said:
"The woman in this case was clearly unwell when care workers made their visits. We cannot say whether earlier medical intervention might have resulted in a better outcome for her, but the family has been left not knowing whether their mother and grandmother might have survived had care workers acted differently.

"Councils can outsource care but they cannot outsource responsibility for that care, which is why we are finding the council at fault for the actions of the care provider.
"I'm pleased the council has accepted its responsibilities, and welcome its readiness to make the procedural changes we have recommended to try to avoid the issue reoccurring."

The woman's son complained to the Ombudsman when they were unhappy with the council's investigation into his complaint.

The Ombudsman's investigation found faults with the care provider's actions, including that it did not follow its own emergency procedures, that workers missed a lunchtime visit, that care logs were incomplete or there were questions about their accuracy, and information was not passed on between workers.

The investigation also found the council's safeguarding investigation was not robust enough in identifying the faults.

The Local Government and Social Care Ombudsman's role is to remedy injustice and share learning from investigations to help improve public, and adult social care, services. In this case the council has agreed to apologise to the man and discuss with him whether he wishes the council to provide a lasting tribute in memory of his mother.

The council will also pay him £100 to acknowledge the time and trouble he has had in bringing his complaint.

The Ombudsman has the power to make recommendations to improve a council or care provider's processes for the wider public. In this case the council has agreed to ensure the care provider has trained all staff on its emergency procedures, and the procedures to follow when a service user is ill. They will also be trained on accurate and complete record keeping.

The council will also review its adult social care complaints procedure to clarify how it deals with complaints against commissioned care providers, and how it will ensure serious complaints are independently investigated.

It will also remind staff involved in adult safeguarding enquiries the importance of ensuring enquiry reports are factual and accurate."

4.3 Actions Taken to Remedy

4.3.1 The Acting Head of Adult Social Care produced an action plan to implement the Local Ombudsman's findings, including the actions described below, on 31 December 2018, and this will be part of the evidence presented to the Local Ombudsman.

4.3.2 The Director of Adult Care and Health Services wrote to the complainant on 31 January 2019, recognising and apologising for the distress caused to him and his family, and making a £100 'time-and-trouble' payment.

4.3.3 The Director of Adult Care and Health Services has been in direct contact with the complainant, and is discussing with him the provision of a lasting tribute to his late mother-in-law.

4.3.4 The Director of Adult Care and Health Services and Acting Head of Adult Social Care have reviewed the Ombudsman's findings with Radis Group, and required Radis to provide current information on their staff training on emergency procedures, the procedures to follow when a service user is ill, and accurate and complete record keeping; including evidence that staff have been trained, and that records are accurate and complete, including those kept by carers in individual homes. The commissioning team completed a Quality and Monitoring visit on 14 February 2019 to review this, and will visit again by the end of May 2019 to ensure this has been embedded.

4.3.5 The Acting Head of Adult Social Care and Customer Relations Manager are reviewing the complaints procedure for Adult Social Care, including how complaints about commissioned care are assigned to providers; how responses are quality assured; the criteria for undertaking a joint or independent investigation of serious complaints concerning the actions of a care provider; and ensuring that safeguarding procedures are followed. The following specific actions are being pursued:

- Ensuring a clear process is in place for providers to send the complaint response to Adult Social Care as the commissioner of care;
- Reviewing the criteria and thresholds for undertaking a joint or independent investigation, to ensure staff are clear on the complaints process and safeguarding procedure and who the decision maker will be;
- Undertaking an initial safeguarding enquiry into every complaint to establish whether there are any safeguarding matters;
- Ensuring that the complaints process is not compromised once the safeguarding enquiry has concluded;

- When it is a safeguarding matter a strategy discussion/meeting will take place, and when the safeguarding has completed a further strategy discussion/meeting will be held to finalise outcomes.

4.3.6 The Acting Head of Adult Social Care has directed all operational teams that strategy discussions and meetings on individual cases need to take place promptly and that enquiry reports must be factual and accurate. In this respect:

- Staff are to check and ensure that commissioned services are implementing their procedures as part of all complaint and safeguarding investigations
- The Director of Adult Care and Health Services has issued a practice note to all staff on 14 March 2019, which has been discussed in team meetings, dealing with:
    - Authorisations and closures of S42 enquiries
    - Strategy meetings / discussions
- The note also sets out a more detailed process for dealing with complaints, including undertaking the initial safeguarding enquiry, the complaint investigation to follow the safeguarding investigation, and to be independent of both the commissioning service and the service provider if there are safeguarding issues;
- A bite-sized learning session is to be held to cover and reinforce the practice note.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The complaint is relevant to the strategic aim of protecting and enhancing the lives of vulnerable adults and children.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Following the receipt of the Ombudsman's final report, I placed a public notice in the Reading Chronicle, Reading Midweek and on the Council's website in the week commencing 25 February 2019 to draw attention to the report, which was made available for public inspection for three weeks, from 25 February 2019, at the Civic Offices.

7. LEGAL IMPLICATIONS

7.1 The legal and administrative situation as summarised in the Ombudsman's report is set out under Policy Context above.

7.2 The Local Government & Social Care Ombudsman – officially known as the Commission for Local Administration - operates under the provisions of Part III of the Local Government Act 1974. Under Section 26 of the Act, the Ombudsman may investigate complaints of maladministration or service

failure causing injustice to the complainant. Under Section 30, the Local Ombudsman may issue a public report on the results of her investigation. Where he does this, Section 30 also requires the Council to place public notices about the Local Ombudsman's report and findings in more than one newspaper or website within two weeks of the report being published; and to make copies of the report available free of charge at one or more of its offices.

7.3 Under Section 31(2) of the Act the authority must formally consider the Local Ombudsman's report and its finding of maladministration causing injustice, within three months, either at full Council or a Committee, and then send a formal written response to the Local Ombudsman explaining what steps it has taken or will take to comply with the recommendations in the report.

8. FINANCIAL IMPLICATIONS

8.1 The Ombudsman has recommended that the Council makes a £100 "time and trouble" compensatory payment to the parent, and also to discuss with the complainant whether he wishes the Council to provide a lasting tribute, such as planting a tree, in memory of the subject.

9. BACKGROUND PAPERS

9.1 Ombudsman report on an Investigation into Complaint 18/001/676 against Reading Borough Council