SURREY COUNTY COUNCIL

CABINET

DATE:	**01 JUNE 2021**
REPORT OF CABINET MEMBER:	**MRS SINEAD MOONEY, CABINET MEMBER FOR ADULT SOCIAL CARE, PUBLIC HEALTH AND DOMESTIC ABUSE**
LEAD OFFICER:	**SIMON WHITE, EXECUTIVE DIRECTOR, ADULT SOCIAL CARE**
SUBJECT:	**LOCAL GOVERNMENT AND SOCIAL CARE OMBUDSMAN PUBLIC REPORT REGARDING THE END OF LIFE CARE PROVIDED BY A COMMISSIONED CARE HOME**
ORGANISATION STRATEGY PRIORITY AREA:	**TACKLING HEALTH INEQUALITY/EMPOWERING COMMUNITIES**

Purpose of the Report:

This report concerns the findings of the Local Government and Social Care Ombudsman (the Ombudsman) in response to a complaint concerning a Surrey funded care home and the end of life care received by the complainant Mrs X's late mother, Mrs Y. The identity of the family in question is not made publicly available and the Ombudsman refers to the daughter as Mrs X and her late mother as Mrs Y.

The Council remains responsible for its commissioned services and the actions of those services. Any fault identified as a result of the actions of the commissioned service is fault by the Council.

The Ombudsman's investigation has found fault with the quality of care and service provided by the care home which resulted in injustice and avoidable distress to Mrs X and Mrs Y.

As the Ombudsman has found maladministration causing injustice has occurred under Section 31 (2) of the Local Government Act 1974, the report must be laid before the authority concerned.

The Council has accepted the recommendations of the Ombudsman. The Council has made a payment of £500 to Mrs X for the distress caused. It has also apologised to Mrs X for the fault identified and for her avoidable distress.

Recommendations:

It is recommended that Cabinet:

1. Consider the Ombudsman's Report and the steps that have been taken by the Service to address the findings, and

2. Consider whether any other action should be taken.

3. Ensure the implementation of all actions listed under 'What Happens Next'.

4. Note that the Monitoring Officer will be bringing his report to the attention of all Councillors.

Reason for Recommendations:

There is a statutory requirement for the Monitoring Officer to bring to Members' attention any public report issued by the Ombudsman about the Council which identifies it is at fault and has caused injustice as a result.

Executive Summary:

1. The Local Government and Social Care Ombudsman has investigated a complaint made by Mrs X in respect of her late mother, Mrs Y's care by a commissioned care home on the day she died. A report into the investigation was published by the Ombudsman on 23 March 2021.

2. Mrs X complained about Mrs Y's care on the day she died. Surrey County Council arranged and funded Mrs Y's care. Mrs X said that Puttenham Hill Care Home, owned by Bupa, delayed in calling the emergency services, did not have appropriate staff, did not protect Mrs Y's dignity when she was dying or provide appropriate care and did not communicate with the family adequately. This caused Mrs X avoidable distress.

3. The care provider investigated a complaint by Mrs X in March 2020 and apologised for the nurse's conduct and advised that the nurse would no longer be used by the Home and had appropriate arrangements for nurse staffing.

4. The Ombudsman makes clear that when a Council commissions another organisation to provide services on its behalf, it remains responsible for those services and for the actions of the organisation that provides them. The care provider acted on behalf of the Council when providing services to Mrs Y so any fault that Mrs Y received in the care of the provider is fault by the Council.

5. The Ombudsman's findings were that there was fault as Mrs Y was alone in her final moments of life with no support from care staff or the nurse, potentially suffering avoidable distress. Mrs X also suffered avoidable distress because she was left in the waiting area and missed the opportunity to be with Mrs Y before she died.

6. The Council has accepted the Ombudsman's recommendations. The Council has apologised to Mrs X for the fault and for her avoidable distress and has made a payment of £500 to her. The Council's Quality Assurance Team continues to regularly monitor the Care Home to ensure adequate staffing is in place and appropriate training is being delivered to the staff in line with the recommendations.

7. In accordance with section 30 Local Government Act 1974, which requires the Council to place two notices in local newspapers, the Council placed public notices about the Ombudsman's public report in local newspapers (The Surrey Mirror and Surrey Comet) on 13 May 2021.

Consultation:

8. The Chief Executive and S151 Officer have been consulted on this report in accordance with the statutory requirements.

Risk Management and Implications:

9. The Ombudsman findings highlight failures with the care provider that caused injustice to the service user, Mrs Y. The Council is working closely with the care provider to ensure it reviews its staffing arrangements and provides appropriate training to all its care staff.

Financial and Value for Money Implications:

10. The Council made a payment of £500 to Mrs X, as recommended by the Ombudsman.

Section 151 Officer Commentary:

11. Although significant progress has been made over the last twelve months to improve the Council's financial position, the medium-term financial outlook is uncertain. The public health crisis has resulted in increased costs which may not be fully funded in the current year. With uncertainty about the ongoing impact of this and no clarity on the extent to which both central and local funding sources might be affected from next year onward, our working assumption is that financial resources will continue to be constrained, as they have been for the majority of the past decade. This places an onus on the Council to continue to consider issues of financial sustainability as a priority in order to ensure stable provision of services in the medium term.

12. Although the financial implications specifically relating to the resolution of this dispute are not material for the Council's budget, the Section 151 Officer recognises the importance of taking the issues highlighted by this case into account in reviewing the Council's Adult Social Care commissioning and quality assurance practices. The Section 151 Officer confirms that if any material financial implications were to arise from this review then these will be factored into the Council's Medium-Term Financial Strategy.

Legal Implications – Monitoring Officer:

13. The Ombudsman has made a finding of fault (described in law as maladministration) causing injustice. The Local Government and Housing Act 1989 places a duty on the Monitoring Officer to report these findings to the Cabinet and draw his report to the attention of each Member of the Council.

14. Ombudsman's recommendations are not legally enforceable although it is extremely unusual for any authority not to accept them. In this instance, Officers have accepted all the findings of the Ombudsman's report.

Equalities and Diversity:

15. As a vulnerable older person, Mrs Y was protected under the Equality Act 2010. Adult Social Care services have completed the Ombudsman's recommendations detailed in this report. As learning, the services are working closely to support our Commissioned providers to ensure their policies and practices are safe, fair and effective for adult care users, including the older people they support.

Other Implications:

16. The potential implications for the following council priorities and policy areas have been considered. Where the impact is potentially significant a summary of the issues is set out in detail below.

Area assessed:	**Direct Implications:**
Corporate Parenting/Looked After Children	None
Safeguarding responsibilities for vulnerable children and adults	As part of our commitment to continuous improvement, Adult Social Care are working closely to support our commissioned providers

	to ensure that their procedures, policies, and practices are safe, well led, caring and effective.
Environmental sustainability	None
Public Health	None

What Happens Next:

- An apology letter was sent to Mrs X on 3 March 2021 and the recommended financial redress has been paid.

- The Council's Quality Assurance team is working closely with the care provider through regular quality monitoring visits, to ensure the care home is regularly assessing staff capacity and requirements so there are enough appropriately qualified staff at the care home and all its care staff receives training in communication skills around bereavement.

- The Council has established a more systematic and strategically robust approach to commissioning social care services through the creation of a centralised commissioning, contract management and quality assurance function within Adult Social Care.

- The Council continues to develop and embed new approaches to the commissioning of care services for adults, in collaboration with colleagues in health.

- Going forward, the Council will build on these changes through implementing more robust methods for the contracting of care services. This will include improved mechanisms for monitoring quality and using a new provider database and dashboard. Having better information, including staffing levels and agency use in individual care homes, will allow for more proactive approaches and for providers to be supported before concerns arise.

- A report of the Cabinet's response to the Ombudsman recommendations will be produced and sent to all Members and to the Ombudsman.

Report Author:

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Consulted:

See paragraph 8 above.

Annexes:

Annex 1 - Report of the Local Government Ombudsman – Reference Number 19 020 69

Sources/background papers:

None