Local Government Ombudsman public report into Oxfordshire County Council and Caring Homes Healthcare Group

1. Purpose

1.1 The Local Government Ombudsman has issued a public report on response to an investigation into complaints against Oxfordshire County Council's Safeguarding Adults Team and Huntercombe Hall Care Home. The complaint relates to events that took place in 2014. The public report can be accessed here OXON - ASC - SAFEGUARDING

1.2 This briefing describes the action taken by the Council and the Ombudsman's response. The Ombudsman concluded that there is a public interest in how the complaint and the care of the complainant's wife were mismanaged and how further residents may have been at risk.

2. KEY POINTS

2.1 The report describes poor quality care provided by Huntercombe Hall Care Home. It criticises the Care Home and expects them to take certain actions in response. The complaint directed to the Care Home is about the quality of care received by the complainant's wife during a one week private respite placement in March 2014. The Council does not run this care home and has not directly managed any care home since 2001. Shortly after the respite placement the complainant's wife was admitted to hospital with dehydration. The hospital social work team raised a safeguarding alert on 7th April 2014. The complainant's wife died nine days after discharge on 9 May 2014. Section 5 of this report provides information on what we have done to monitor the quality of care at the Care Home.

2.2 However, the report also criticises the County Council. In essence, the complaint against the Council is about the safeguarding process not being fully followed in this case.

2.3 The Council accepted the Ombudsman's finding of fault and are satisfied that this incident is not reflective of the consistently high standards shown by the Safeguarding Team.

2.4 I have provided a full written apology to the complainant which set out actions taken as a result of the investigation. This information has been shared with the Ombudsman and is reflected in the comments in her report. In her press release on the publication, the Ombudsman says “I welcome the significant steps Oxfordshire council has already taken to improve its policies, procedures and staff training in this area and am pleased it has agreed to my further recommendations.”

3. PROCESS OF THE PUBLIC REPORT

3.1 The report has been made public by the Ombudsman by issuing a press release to the media and by publishing it on their website. The Council must consider the report within three months from the date of the report together with any findings in it. The report is therefore an agenda item for the next County Council meeting on 12th July. A formal written response will then be sent to the Ombudsman explaining what steps the Council have taken or will take to comply with the recommendations in the report.

3.2 Within two weeks after the public report is received, the Council should make a public notice in more than one newspaper and that copies of the report will be available for a period of three weeks. During this time, the report should be available for inspection, and for copying, by the public. The Ombudsman will promote the public report in the media along with a press

release. The names of individual members of staff involved in the complaint and the name of the complainant and their family will remain confidential.

4. THE COMPLAINT and Local Government Ombudsman Findings

4.1 The complaint was first received by the Council in November 2015 from the Ombudsman. Whilst the Safeguarding Team did respond promptly to the initial safeguarding alert raised on 7th April, there were significant delays following up with the Home when they failed to produce the necessary paperwork and a failure to contact the family directly about the investigation. On 1st September the case was concluded and a letter sent to the complainant informing them of the outcome of *'neglect - partially substantiated'.*

4.2 The Complaint to the Home was about standards of care around fluid intake. The Council were not involved in the complaint as it concerned a private respite arrangement. The complainant believed that the Home were not aware that his wife was dehydrated and that her condition was deteriorating. It took the home nine months to respond to the complaint before the LGO became involved.

4.3 The Ombudsman found the home at fault for failing to provide adequate care which has been found to amount to partial neglect and for failing to respond adequately to the complaint. The Ombudsman recommended that the home provide a full written apology and waive the fee for the stay in the care home.

4.4 The Ombudsman has found the Council at fault for failing to adhere to statutory safeguarding guidance, failing to follow policy and procedure, failure to inform the monitoring department and the Care Quality Commission of the finding of partial neglect, and failure to engage with the complainant which caused a significant injustice. As the Council have already implemented a robust improvement plan and full apology, the Ombudsman has recommended the Council pay the complainant £750 for their time and trouble pursuing the complaint and for the distress caused. I support this recommendation.

5. COUNCIL RESPONSE

5.1 The council has implemented robust and extensive improvements to policies and procedures, as acknowledged by the Local Government Ombudsman, and the Council does not hesitate to publicly apologise to the complainants. Our actions in this case did not meet requirements or our usual high standards.

5.2. Our high standards are clearly demonstrated by the fact that in 2015/16 there were 5162 referrals of people where there was a safeguarding concern with only two of these resulting in any formal complaint

5.3 The Local Government Ombudsman's Annual Report 2014-15 stated that Oxfordshire County Council has one of the lowest numbers of referrals to the Ombudsman and one of the lowest numbers of complaints upheld by the Ombudsman. That year the Local Government Ombudsman undertook six investigations about adult social care. Minor fault was only found in two cases. This is the first time that Oxfordshire County Council has been subject to a public report.

5.4 Members will be aware that the Council commissions a broad range of services both within and outside of Oxfordshire; many of the services are complex in nature. To ensure that they receive an appropriate and proportionate management response and to allocate staff resources appropriately we adopt a risk based approach to our quality assurance work.

5.5 In doing so we have a structured approach to our care governance work across the care sector through intelligence gathering to establish performance and weaknesses in the care sector. This includes the receipt on a weekly basis of published inspection reports from the regulator which are reviewed to determine follow up action.

5.6 It also includes close liaison with the Care Quality Commission, Oxfordshire Clinical Commissioning Group and Oxford Health's Continuing Care Team and a clear framework and a structured approached to Standards of Care and Serious Concerns.

5.7 Oversight of the above is through meetings of a multi-agency Care Governance Board that is chaired by a Deputy Director. Attendees include senior representatives from Adult Social care, the Care Quality Commission, Oxfordshire Clinical Commissioning Group and Oxford Health's Continuing Care Team.

5.8 The Council undertook a Quality Monitoring Visit to Huntercombe hall Care Home in July 2014. This was a positive visit which at that time we did not identify areas for concern regarding the quality and safety of the service in the home.

5.9 For the remainder of 2015 the Council maintained its standard overview of the service provided at Huntercombe Hall through normal intelligence gathering that included information from social work staff, the safeguarding team, and communication with the Care Quality Commission. At that time the Council did not have concerns about the quality of care within the home.

5.10 However, in October 2015 the Care Quality Commission undertook an inspection at Huntercombe Hall using its new inspection procedure as part of a much more rigorous inspection regime. It published an inspection report in December 2015 showing that the home 'Requires Improvement' in four of the five areas assessed. Ratings that can be applied are Outstanding (rarely used); Good; Requires Improvement; Inadequate. Initially many care homes received Requires Improvement ratings in Oxfordshire. The performance has since improved as care homes have learnt from the new inspection regime to improve standards.

5.11 In response to this the Council included Huntercombe Hall in its Standards of Care procedures and carried out a monitoring visit in February 2016. The purpose of this visit was to review the general quality and safety of the service.

5.12 At this visit, some weaknesses were identified with incident reporting processes in the home, particularly in relation to safeguarding and health & safety. Council staff have provided guidance and information for the home to support the necessary improvements and this work is continuing; it will be reviewed through the Council's quality monitoring processes over the coming weeks and months to ensure that the required standards are met.

5.13 Significant learning has been put in place as a result of this complaint. This includes implementing new best practice safeguarding procedures, training / briefing staff to ensure they fully understand expectations and new procedures, clearer standards around response and completion times for safeguarding enquiries and the introduction of serious concerns/standards of care framework to be monitored on a monthly basis. The Safeguarding Team have an action plan in response to this issue. All of the key actions were implemented by December 2015; one month after the complaint was received. The outstanding action is for the Complaints Service to deliver a workshop to the Safeguarding Team on the importance of good complaints handling. This will take place in September 2016.

6. **Summary**

6.1 The actions of the Safeguarding Team on this occasion did not meet our usual high standards. However the wider context is that this was very much an exception and an isolated case. It is not indicative of wider practice – practice which has now been strengthened further.

6.2 The report from the Ombudsman has made a series of recommendations in relation to the care home's actions and the Council's actions. The Council has responded fully and the Ombudsman has acknowledged that "During this investigation the Council has voluntarily implemented robust and extensive improvements to its policies and procedures". The Ombudsman has no ongoing concerns about the Safeguarding Team.

6.3 I have also written to the complainant to provide him with a full written apology for its failings and set out the action it has taken as a result. The Council also publicly apologises for the failings.

6.4 The Council will pay the complainant £750 for the injustice and distress caused.

John Jackson
Director of Adult Social Services
Oxfordshire County Council
30th June 2016