STANDARDS COMMITTEE – 27TH JANUARY 2020

SUBJECT: **COMPLAINT MADE TO THE PUBLIC SERVICES OMBUDSMAN FOR WALES**

REPORT BY: **HEAD OF DEMOCRATIC SERVICES AND DEPUTY MONITORING OFFICER**

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1. PURPOSE OF REPORT

1.1 To note the contents of the report from the Public Services Ombudsman for Wales on a complaint against Caerphilly County Borough Council.

1.2 To receive an update on the progress made to date in respect of the recommendations contained in the Ombudsman's report.

1.3 To consider whether the matter would benefit from further consideration by the appropriate Scrutiny Committee. If Committee considers this course of action is appropriate a report setting out the reason for referral will be presented to the relevant Scrutiny Committee along with the report from the Ombudsman. The Chair of Standards Committee (or a nominee) will be invited to attend the respective Scrutiny Committee when the report is presented.

2. SUMMARY

2.1 To note the Ombudsman's Report and to consider whether or not to refer the matter to the appropriate Scrutiny Committee.

2.2 To receive an update on the actions taken in respect of the recommendations contained in the Ombudsman's report.

3. RECOMMENDATIONS

3.1 That the Committee notes the contents of the report of the Public Services Ombudsman for Wales and the progress made in respect of the recommendations contained therein.

3.2 To consider whether the matter should be referred to the appropriate Scrutiny Committee, the grounds for referral are where in the opinion of the Standards Committee there has been a serious failure in service delivery that would benefit from further consideration by the appropriate Scrutiny Committee. If Committee considers this course of action is appropriate a report setting out the reason for referral will be presented to the relevant Scrutiny Committee along with the report from the Ombudsman. The Chair of Standards Committee (or a nominee) will be invited to attend the respective Scrutiny Committee when the report is presented.

4. REASONS FOR THE RECOMMENDATIONS

4.1 To satisfy the Council's statutory duties under the Public Services Ombudsman (Wales) Act 2005.

5. THE REPORT

5.1 The report by the Public Services Ombudsman for Wales has been issued under Section 21 of the Public Services Ombudsman for Wales Act 2005. There are two forms of report under the 2005 Act - Section 16, which is the form of report, which needs to be formally considered by the Authority and Section 21 where the Ombudsman feels that a public report is not required and the matter has been satisfactorily resolved.

5.2 The report dated 4th November 2019 is attached at Appendix 1B for members' consideration. However as the detail in the report contains information which is likely to reveal the identity of the complainant and/or relative, members are asked to consider the Public Interest Test in appendix 1A as to whether this information contained in Appendix 1B should be considered and discussed in exempt session.

5.3 Notwithstanding the position regarding the full report, a summary of the complaint is outlined as follows and for completeness includes details of the complaint and outcome in respect of both the Council and the Health Board.

5.4 Mr A complained to the Ombudsman about the way in which the Council and the Health Board handled his late mother (Mrs A's) care. He had many concerns.

5.5 As against the Council, Mr A complained about the manner in which it managed Mrs A's admission to a Council owned and managed care home, and complained that it had failed to undertake appropriate capacity assessments or assessments under Deprivation of Liberty Safeguarding (DoLS) arrangements (procedures for those who lack capacity). Mr A was concerned that the professionals involved in his mother's care had not had adequate access to Mrs A's records to enable them to make the correct decisions and assessments.

5.6 As against the Health Board, he complained that it had failed to assess Mrs A's declining dementia appropriately and had failed to respond appropriately to a possible stroke identified by her GP. Mr A also considered that the Health Board failed to undertake appropriate assessments for NHS Funded Continuing Healthcare ("CHC funding") and about the way a POVA1 referral was handled following Mrs A's admission to hospital. Mr A claimed that wet sores on Mrs A's body and how they had been allowed to develop had not been investigated under the POVA process. He further questioned the arrangements for Mrs A's transfer to a different hospital shortly before her death. Mr A also complained about the manner the Council and the Health Board had dealt with his complaints about Mrs A's care.

5.7 The Ombudsman concluded that the Council's care home was an appropriate setting for Mrs A when she was placed there and **did not uphold** this complaint. He also determined that the decision not to convene a formal POVA meeting was appropriate in the overall circumstances of Mrs A's case and so **did not uphold** this element of Mrs A's complaint. Further, the Ombudsman found that Mrs A's care was not compromised at the Council's care home by the lack of full access to Mrs A's records as complained about.

5.8 The Ombudsman concluded that the Health Board's investigation, diagnosis and management of Mrs A's dementia was appropriate. He **did not uphold** this element of the complaint or the complaint about the delay in assessing Mrs A's eligibility for CHC funding. He considered the delay appropriate in order to allow for Mrs A's condition to stabilise. The Ombudsman also found it was necessary to transfer Mrs A to a specialist setting for those dealing with dementia shortly before her death as she was medically fit for discharge and required dementia assessment.

5.9 The Ombudsman found that the assessments, services and treatments provided to Mrs A by the Council and the Health Board, following the diagnosis of a probable stroke by her GP, were inadequate. This element of the complaint against both public bodies was **upheld**. Similarly, the Ombudsman also **upheld**, as against both bodies, Mr A's complaint about the failure to assess Mrs A's mental capacity with sufficient promptness, or to assess her appropriately under DoLS processes. Finally, the Ombudsman found shortcomings in how both the Council and the Health Board had handled Mr A's complaints. He found there had been inappropriate delays in responding to Mr A and so upheld this complaint.

5.10 The Ombudsman recommended that the Council and the Health Board apologise to Mr A for the failings identified. He also recommended that the Council amend its procedures (and training related to such) to ensure staff involved in arranging admissions to care homes were aware of the need to consider the capacity of the individual concerned to agree to the admission. Otherwise, staff should be aware of the need to ensure DoLS processes were followed for those persons lacking capacity.

5.11 In relation to the Health Board the Ombudsman recommended that it review its current approach to assessing suitability of care home placements to ensure that complex care needs are adequately assessed and that care plans are developed collaboratively with multi-disciplinary teams where required. He also recommended a review of its current practice in primary and community care services in relation to capacity assessment for those diagnosed with dementia.

5.12 The full recommendations in respect of the actions to be taken by the Council were as follows:-

5.12.1 Within one month of the date of the final version of this report both the Council and the Health Board apologise to Mr A for their respective shortcomings identified in this report.

5.12.2 In relation to the Council, I also recommend, if it has not done so already, that it implements the following recommendations within three months of the issuing of the final version of this report:

a) To amend its training and procedures to ensure that all staff (including residential home managers and social workers) involved in admissions to residential or nursing care (whether long-term, short-term or respite) are aware of the need to consider the capacity of the person concerned to agree to the admission and then to act in accordance with the Mental Capacity Act 2005 if the person lacks capacity.

b) To amend its training and procedures to ensure that all staff (including residential home managers and social workers) involved in admissions to residential or nursing care (whether long-term, short-term or respite) are aware of the need to consider the potential need for DoLS authorisation, both before and during any admission to a home, in accordance with the Mental Capacity Act 2005.

5.13 Members are advised that the Council wrote to Mr A on 23rd December 2019, there was a slight delay in complying with this recommendation due to work pressures.

5.14 With regard to training and procedures, this information was provided to the Ombudsman on 2nd July 2019 which was prior to the final report being issued

5.15 **Conclusion**

Members will note the information provided in respect of compliance with the recommendations.

6. ASSUMPTIONS

6.1 No assumptions are necessary in respect of the content of this report.

7. LINKS TO RELEVANT COUNCIL POLICIES

7.1 The Authority is under a statutory duty to consider reports from the Ombudsman and to give effect to their recommendations. They duty to oversee this is within the terms of reference of this Committee.

7.2 Monitoring of the Council's corporate complaints, including referrals to the Ombudsman contributes to the following Well-Being goals within the Well-being of Future Generations Act (Wales) 2015 as it supports the provision of higher quality and more effective services to the public across all service areas. Compliance with recommendations made by the Ombudsman enables departments to focus on areas of concern, to improve services and to monitor performance, ensure that any issues raised are identified and dealt with so as to be avoided in the future.

- A prosperous Wales
- A resilient Wales
- A healthier Wales
- A more equal Wales
- A Wales of cohesive communities and thriving Welsh language
- A globally responsible Wales

8. WELL-BEING OF FUTURE GENERATIONS

8.1 This report contributes to the Well-being goals as set out in above. It is consistent with the five ways of working as defined within the sustainable development principle in the Act in that the Monitoring of the Council's corporate complaints including referrals to the Ombudsman contributes and supports the provision of higher quality and more effective services to the public across all service areas. Compliance with recommendations made by the Ombudsman enables departments to focus on areas of concern, to improve services and to monitor performance, ensure that any issues raised are identified and dealt with so as to be avoided in the future.

9. EQUALITIES IMPLICATIONS

9.1 There are no equalities implications arising from this report.

10. FINANCIAL IMPLICATIONS

10.1 There are no financial implications arising from this report

11. PERSONNEL IMPLICATIONS

11.1 There are no personnel implications arising from this report.

12. CONSULTATIONS

12.1 This report reflects the contents of the Ombudsman's Report and therefore there has been no formal consultation on the format of this report. A copy of this report and appendix has been

provided to the consultees listed below.

13. STATUTORY POWER

13.1 Public Services Ombudsman (Wales) Act 2019, Local Government Act 1972.

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Appendices:
Appendix 1A Public Interest Test
Appendix 1B **EXEMPT** Report of Public Services Ombudsman for Wales 4th November 2019