Croydon Council

REPORT TO:	**CABINET** **January 2023**
SUBJECT:	**Local Government & Social Care Ombudsman Report** **Finding of Fault with Maladministration and Injustice and** **Report by the Monitoring Officer under section 5A of the Local Government and Housing Act 1989**
LEAD OFFICER:	**Annette McPartland, Corporate Director of Adult Services,** **Simon Robson, Director, Adults Services, and** **Stephen Lawrence-Orumwence Director of Legal Services and Monitoring Officer**
CABINET MEMBER:	**Councillor Yvette Hopley**
WARDS:	**All**
CORPORATE PRIORITY/POLICY CONTEXT/AMBITIOUS FOR CROYDON: The recommendations and actions from the Local Government & Social Care Ombudsman (LGSCO) will be carried out by the responsible service manager in the Adults Social Care Team.	
FINANCIAL IMPACT: £7,450 by way of compensation;	

1. **RECOMMENDATIONS**

The Executive Mayor in Cabinet is asked to:

1.1 Consider the public interest report dated 16 June 2022 and the recommendations made by the Local Government & Social Care Ombudsman (LGSCO) in relation to Croydon Council set out in Appendix 1;

1.2 Adopt the report as the Executive's formal response as required by section 5A of the Local Government and Housing Act 1989 for distribution to all members and the Monitoring Officer;

1.3 Adopt the report as the Council's formal response under section 31 of the Local Government Act 1974 to be communicated to the Ombudsman;

1.4 Accept the findings and agree the recommendations set out in the public interest report;

1.5 Endorse the actions taken by the Council and note the steps, progress and timeline to implement the recommendations set out in section 7 of this report; and,

1.6 Note the chronology, that substantive concerns for the LGO were in the main for the period 2017 to 2020.

2. EXECUTIVE SUMMARY

2.1 On 8th February 2022, the LGSCO wrote to the Chief Executive Katherine Kerswell to confirm that after consideration of a complaint they had received, they decided to issue their findings as a public interest report.

2.2 The LGSCO consider six criteria when deciding whether to issue a public interest report, these are:

- Recurrent faults (for example, the organisation keeps making similar mistakes)
- Significant fault, injustice or remedy (by scale or the number of people affected)
- Non-compliance with an Ombudsman's recommendation (it has not agreed or has not carried out their recommendations)
- A high volume of complaints about on subject
- A significant topical issue
- Systemic problems and/or wider lessons (for example, problems with how the organisation does things that if not put right are likely to affect others, and this is an opportunity for others to learn).

2.3 In this case the reasons for issuing the report are:

- Significant Fault, Injustice or Remedy
- Significant topical issue
- Systemic problems and/or wider lessons

2.4 The LGSCO issued a joint report in respect of failings identified by the Council, South London and Maudsley NHS Foundation Trust (SLAM) and Croydon NHS Integrated Care Board (ICB).

3. BACKGROUND

3.1 The complainants who we refer to as Mr and Mrs X complained about faults by the Council, Trust and ICB relating to health and social care services for their daughter, Miss X. This includes:

• failing to refer Miss X for supported living accommodation and to place important documents on her files;

• flawed planning and provision of aftercare under section 117 of the Mental Health Act 1983;

• failing to provide relevant information; and

• inadequate support for Mr and Mrs X as Miss X's carers.

3.2.1 The LGSCO report confirmed that the following failings by the Council had been identified:

• the Council failed to act on the Trust's referrals of April and May 2018;

• the Council and Trust collectively failed to provide accurate advice during 2018 and 2019

• the Council did not offer Mr X a carer's assessment in 2017 and this was fault;

• the Council has not kept adequate records of what happened after Mr and Mrs X requested carers' assessments in 2018

• the Council has not offered further carers' assessments in 2019 and 2020

• flawed planning and provision of aftercare under section 117 of the Mental Health Act 1983

• poor record keeping;

• failing to hold CPA reviews at least annually;

• failing to refer Miss X for supported living accommodation and to place important documents on her files;

• failure to provide relevant information and share important documents;

• inadequate action in response to a possible risk of harm to Mr and Mrs X; and

• inadequate support for Mr and Mrs X as Miss X's carers.

4 CHRONOLOGY OF THE COMPLAINT

The substantive concerns for the LGO were in the main for the period 2017 to 2020.

What follows is a brief chronology of the complaint. It does not contain the information reviewed during the investigation.

4.1 Miss X was taken into care aged five and had a series of placements until Mr and Mrs X adopted her as an older child. She is now a young adult. Just before he 18th birthday Ms X was transferred by the Trust from their Child and Adolescent Mental Health (CAMH) Service to an adult ward

4.2 Mr and Mrs X had made previous complaints to the Council and Ombudsman in respect of the support provided to them and to Miss X from 2017 through to 2019.

4.3 The Ombudsman notified the Council on 31 March 2021 that they were

investigating a further complaint. This complaint did not complete the Council's own complaint's process as Mr and Mrs X approached the Ombudsman directly, who accepted the complaint as a follow on to the previous complaint.

4.4 The Ombudsman wrote to Katherine Kerswell on 8 February 2022 to notify of their intention to publish a public report. The report was to be a joint report across the three organisations complained of.

4.5 The Ombudsman issued their final report on 16 June 2022.

4.6 Details of the full scope and investigation of the complaint can be found in the Ombudsman report in Appendix 1.

5 CONCLUSIONS

What follows is a summary of the Ombudsman conclusions from the Final Decision report:

5.1 Identified flawed planning and provision of aftercare under section 117 of the Mental Health Act 1983. As a result nobody knows what services Miss X should be getting as section 117 aftercare. This is despite Miss X being entitled to this for nearly five years and her parents raising concerns regularly

5.2 A failure to ensure Personal Health Budgets (PHBs) and information about them are available to people eligible for section 117 aftercare, despite this being a legal requirement since 2019

5.3 Poor record keeping

5.4 Failing to hold Care Programme Approach (CPA) reviews at least annually

5.5 Failure to refer Miss X for supported living accommodation and to place important documents on her files

5.6 Failure to provide relevant information and share important documents

5.7 Inadequate action in response to a possible risk of harm to Mr and Mrs X

5.8 Inadequate support for Mr and Mrs X as Miss X's carers.

5.9 Having identified fault, we must consider if there has been injustice in this case. We are satisfied that Miss X and her parents have suffered significant and prolonged frustration, distress, inconvenience and uncertainty because of the faults we have identified. It is concerning that, despite repeated efforts by Miss X's parents and the Ombudsmen's involvement, Miss X still does not appear to have an up to date care plan setting out in detail what her section 117 aftercare entitlement is.

5.10 Miss X is an extremely vulnerable young adult who has been exposed to significant trauma in her early and teenage years. We consider this intensifies the impact of these faults on her. We are deeply concerned that others who rely on the Council, Trust and ICB for section 117 aftercare and PHBs may have been

affected by similar problems. We therefore consider it in the public interest to issue this report.

6 RECOMMENDATIONS

To remedy the injustice caused, the Ombudsman has made the following Recommendations:

6.1 Offer meaningful apologies for the faults identified in this report and their impact on the complainants.

6.2 Pay the following symbolic sums to the complainants within a month of our decision:

- £2,250 to Miss X in recognition of the avoidable distress, frustration, uncertainty, loss of legal entitlements, increased risk of harm, lost opportunities

- £850 each to Mr and Mrs X in recognition of the injustice we have identified.

6.3 The Council and ICB will pay her £7,000 equally shared between the two organisations (£3,500 each), in recognition of the PIP she missed out on between June 2018 and May 2019.

6.4 Ensure Mr and Mrs X receive carers' assessments if they still want these.

6.5 Council, Trust and ICB will ensure Miss X has a CPA care plan that clearly sets out her section 117 aftercare and an explanation of how she can request a personal health budget.

6.6 Review its process for ensuring carers can have their needs assessed in accordance with the Care Act 2014 and associated guidance.

6.7 Ensure relevant staff properly understand the law and any joint processes relating to supported accommodation referrals, and can offer suitable advice.

6.8 Review the processes and record keeping around section 117 aftercare are in line with the relevant law and guidance, especially the Mental Health Act 1983 and associated Code of Practice, and the CPA Guidelines; and

6.9 Ensure everyone to whom the Council and ICB owe a section 117 aftercare duty has a care plan setting out their section 117 aftercare and when this will be reviewed.

7 ACTIONS TAKEN BY CROYDON COUNCIL

7.1 Local Authority has apologised to Mr and Mrs X and Miss X for the failings identified in this report

7.2 The Local Authority have made the compensatory payments recommended by the Ombudsman to Mr and Mrs X and Miss X

7.3 A Carers assessment has been offered to Mr and Mrs X.

7.4 A reassessment of Miss X's support needs and advice on personal health budget has taken place.

7.5 A review of the carers assessment process has been completed

7.6 A training masterclass workshop has been held with Adult Social Care staff with a focus on supported accommodation referrals and key contacts

7.7 The Head of Mental Health Services is working jointly with the ICB and Trust to conduct a full review of the processes and record keeping in relation to Section 117 aftercare.

7.8 Although, Miss X has a complex mental health presentation and risk profile, she has made significant progress in her health and wellbeing and is currently undertaking a course in Animal Studies in a higher education institution in the County of Hampshire.

8. LESSONS LEARNT, IMPROVEMENT AND PREVENTION

8.1 Croydon Adult Mental Health Service is an integrated service under a Section 75 Agreement with Health (South London and Maudsley NHS Foundation Trust). The service provides both Local Authority and NHS statutory functions and duties as set out in various legislations. The s75 Agreement has been in place since 2003 with a review carried out in 2015 following the commence-ment and implementation of the Care Act 2014.

8.2 The purpose of the review in 2015 was solely to make the existing s75 agreement Care Act Compliant. However, this review and its recommendations were neither adopted nor implemented. Prior to the LGSCO report, the Adult Mental Health Service has started the review of the s75 with the view to address some of these challenges.

8.3 Nonetheless, the concerns and/or faults identified in the case of Ms X appeared to engage a number of integrated duties and functions delivered by the Croydon Adult Mental Health Services as an integrated service and calls for a review of its operational model to better fulfill the integrated roles.

8.4 The LGSCO recommendations also identified areas of improvement in the joint working processes between different internal departments in Croydon Council e.g. Housing that provides access to a range of accommodation options; Contracted Voluntary Sector services that deliver statutory duties e.g. Carers Centre; and other Adult Social Care e.g. Disability, Transition and Older Adults who may have individuals eligible to S117 aftercare within their care and support.

8.5 The recommendations seek to address the gaps where individuals/residents who may be eligible for S117 aftercare but do not have an established framework outside various funding panels can expect a clear oversight and accountability (e.g. via a real-time and live updated S117 register); robust processes to ensure that such individuals have a S117 aftercare plan (from relevant Care Programme Approach process and intervention (CPA – a health based assessment and

review framework); to an alignment of the above to the Care Act processes and intervention; and provides a risk framework that addresses both the Local Authority and Health statutory responsibilities.

8.6 As a result of the above, there is ongoing work via a number of workstreams within Adult Mental Health Service focused on various areas e.g. a review of how the Health and Local Authority Information management systems can best serve to meet the needs of this cohort of residents; a review of various processes in place in identifying, assessing, reviewing and meeting the needs and addressing any potential risks to the S117 cohorts of residents; and finally, provide a platform that links into various multiagency funding panels across the Local Authority, Integrated Care Board (ICB) and the Integrated Adult Mental Health Service.

8.7 There are already quick gains and improvement actions in these areas which include a four borough social care leads meetings (Croydon, Lewisham, Lambeth and Southwark) which have worked with the Director of Social Care (SLAM) to update and ratify a S117 policy; revised and improved S117 assessment and review documentation; provide a S117 register from Health Systems that tracks individuals within the four boroughs who may be eligible for S117 aftercare; working to make changes to the Health Systems for better documentation and recording; provide a training platform for front line practitioners; and provide multiborough systems leadership to managing any barriers or challenges from the processes.

8.8 The above work also links into the concern identified by the LGSCO on the statutory duty of ICB to provide personal health budgets to individuals who are eligible to S117 aftercare. A place-based multisystem leadership team is working to deliver the processes and frameworks on Personal Health Budget (PHB). The first stage of this intervention led to the commissioning of MIND in Croydon to deliver a wraparound service under PHB to individuals eligible for S117 aftercare at the point of discharge from hospital for up to 12 weeks of personal support. There are further actions to ensuring that information around PHBs are accessible to Croydon residents in the community; that relevant trainings are delivered to frontline practitioners; and that the PHB offer from ICB link closely with the Local Authority Personal Budget through various funding panels across system partners.

8.9 The LGSCO investigation and recommendations serve as a reminder to the importance of regular training and workshops to front line practitioners on the Health and Local Authority statutory functions and duties to improve practice. As a result of the above, an Adult Masterclass Workshop Sessions have been introduced with participants from various departments within the Local Authority to share ideas, identify concerns, provide relevant updates and processes and further remind practitioners and managers of their roles and responsibilities in the identified areas.

8.10 As already highlighted in this report, the LGSCO recommendation around carers and carers' interventions, assessments and offers has led to a review of the carers' provision via the Carers Centre and the recommendations will contribute to the re-commissioning of the carers' provision and services contracts, which is ongoing.

9. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

9.1 The financial recommendations made by the LGSCO were:

£7,450 in respect of compensation.

In addition to the financial costs, the LGSCO's recommendations, have a reputational impact on the Council's Adult's Services.

9.2 Section 8 - Lessons Learnt, Improvement and Prevention will help mitigate future financial risks of this type.

Approved by: Matthew Davis, Interim Director of Finance

10. LEGAL CONSIDERATIONS

10.1 Under the Local Government Act 1974 (the Act), the LGSCO has the power to investigate the complaint and to issue a report where there has been maladministration causing injustice; a failure in a service that it was the Council's function to provide; and a total failure to provide such service. The LGSCO has the power to make recommendations to the Council on how to improve its services and to put things right for the complainant. However, these recommendations are not mandatory and the Council does not have to accept or follow them.

10.2 Within 2 weeks of receiving the LGSCO's report, the Council is required to give public notice by advertisements in newspapers stating that copies of the report will be available to inspect by the public at the Council's offices for a period of three weeks (s.30 of the Government Act 1974).

10.3 The Act provides that the report shall be laid before the "authority" for consideration. In the case of a local authority operating executive arrangements, "the authority" includes the executive which under current governance arrangements means the Directly Elected Mayor and Cabinet (s.25 (4) and (4ZA) Local Government Act 1974).

10.4 Where a finding of 'maladministration' is made the Council's Monitoring Officer is obliged to prepare a report for the Executive following the LGSCO findings and to consult with the Head of Paid Service and Chief Finance Officer for this purpose. This report must also be sent to each member of the Council and the Executive must meet within 21 days thereafter. The implementation of the proposal or decision must be suspended until after the report has been considered by the Executive (s.5A Local Government and Housing Act 1989). The Executive is required to consider this Monitoring Officer report on the findings of and response to the LGSCO's report.

10.5 Where the Executive considers a LGSCO's report and it is considered that a payment should be made or other benefit given to a person who has suffered injustice, such expenditure may be incurred as appears appropriate (s.31(3) Local Government Act 1974)

10.6 Within 3 months of receiving the LGSCO's report or such longer period as may be agreed in writing with the LGSCO, the Council must notify the LGSCO of the action which the Council have taken or propose to take (s.31(2) Local Government Act 1974). If the LGSCO is not satisfied with the action which the Council has taken or propose to take, the LGSCO shall make a further report.

The LGSCO can also require the Council to make a public statement in any two editions of a newspaper circulating the area within a fortnight (s.31(2A) and (2D) Local Government Act 1974).

10. 7 An Ombudsman's report should not normally name or identify any person (s.30 Local Government Act 1974). Therefore, the complainant should be referred to as 'Mr X' and officers are not identified.

Approved by: Mark Turnbull, Corporate Solicitor

11. HUMAN RESOURCES IMPACT

11.1 The recommendations in this report do not have any direct human resources implications. Following the completion of recommendations, the learning from the case will be fed back to practitioners and managers through existing learning and development activities within the department.

Approved by: Debbie Calliste, Head of HR for Adult Social Care & Health, on behalf of the Chief People Officer

12. EQUALITIES IMPACT

12.1 The Council has a statutory duty to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must therefore have due regard to :

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b)advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c)foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

12.2 Due consideration should be given to residents who may need to be treated even more favourably under the Equality Act 2010. These include disabled residents, parents/carers of disabled people and others who do not have English as a first language. This action does not constitute discrimination under Equality Act 2010.

Approved by: Denise McCausland Equality Programme Manager

13. ENVIRONMENTAL IMPACT

13.1 There are no environmental impacts arising from this report

Approved by:

14. CRIME AND DISORDER REDUCTION IMPACT

14.1 I can confirm there are no community safety / crime and disorder comments needed for this report.

Approved by: Kristian Aspinall, Director of Culture and Community Safety

15. DATA PROTECTION IMPLICATIONS

15.1 WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?

NO

15.2 HAS A DATA PROTECTION IMPACT ASSESSMENT (DPIA) BEEN COMPLETED?

NO

To comply with data protection requirements all personal details have been removed from the published report.

16. Corporate Management Team

16.1 The above report was presented to the Corporate Management Team on the 06th December 2022 with the following comments;

a. Strengthen the report in respect of the current wellbeing of the person concerned – See 7.8 as amended

b. Assurance regarding the transition of children and young people known to Children and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services.

Approved by:

CONTACT OFFICER: Simon Robson, Director of Adult's Social Care

APPENDICES TO THIS REPORT: Appendix 1 – Full LGSCO Report

Final report for publication).pdf

BACKGROUND DOCUMENTS: None