DECISION-MAKER:		Governance Committee		
SUBJECT:		LGSCO (Ombudsman) Complaint Outcome: Kentish Road		
DATE OF DECISION:		14th May 2019		
REPORT OF:		Service Lead: Legal Partnership (LGSCO Link Officer) / Service Director: Adults, Housing & Communities		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY				
N/A				
BRIEF SUMMARY				

This report updates Members on the outcome of 8 grouped complaints relating to 9 individuals affected by the transfer of service users from the full time respite provision offered at Kentish Road to revised respite services at other locations and / or the reduced hours of service provided at Kentish Road following a review of the closure decision taken by the Council.

All complaints were upheld as maladministration (fault) resulting in injustice to the complainants. Although the fault in each case differs slightly, the nature and thematic approach taken by the Local Government and Social care Ombudsman (LGSCO) and the outcomes found merit reporting to Governance Committee as a stand-alone item rather than waiting for the annual complaints report later this year.

The LGSCO has three options available to them in reaching a finding on a formal investigation:

- Not uphold the complaint (no fault)
- Uphold the complaint (fault and injustice) but not proceed to statutory report
- Uphold the complaint (fault and injustice) and proceed to full statutory report requiring a statutory publication process in the press and consideration at the highest levels of the Council.

The LGSCO has opted not to exercise their power to proceed to statutory report on any of the complaints on this occasion.

This report also updates Governance Committee on the internal review undertaken by the Council, the 'Lessons Learned' Report, commissioned from an external independent third party on the overall governance of the project from inception to decision making and outcomes which was received by the Council in May 2018 together with progress on the delivery of the resultant action plan and the changes that have been introduced as a result of learning from this report. The report is presented to Governance Committee as part of the overall learning from the complaints investigated by the LGSCO as the report was heavily relied upon by both

the Council, in setting its service recovery plans for the last year, and by the LGSCO in reaching their decision not to investigate the wider governance arrangements in place within the Council already addressed by the report and action plan but focus instead on the impact on individual complaints. The Lessons Learned Report sets the complaint outcomes in context in terms of the substantial improvements made to the Council's service delivery in project management and adult social care following the events in 2014-17 and from which the individual complaints arise.		
RECOMMENDATIONS:		
	(i)	To note the subject matter of the investigations, the faults identified by the LGSCO and the settlements offered by the Council and accepted by the LGSCO to remedy these complaints.
	(ii)	To offer advice, guidance and assistance to the wider Council and Adult Social Care Services in particular on any learning from the complaints that can be further considered in terms of the overall governance of the Council.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To ensure that Members are engaged with the outcome of these complaints given the serious nature of the investigation and the outcomes.	
2.	To assist the Council in any further learning from these complaints that may assist in improving the Council's governance arrangements and service improvements within Adult Social Care in particular.	
3.	To set the complaints in context against the Lesson learned Report and Action Plan and the development and improvement of the Adult care services and project management functions within the Council since the events that gave rise to the complaints.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
4.	N/A	
DETAIL (Including consultation carried out)		
5.	The LGSCO has been investigating 8 complaints from individual carers (and their 9 dependants) since May 2018. The original complaints related both to the closure process pursued in relation to Kentish Road and how that was subsequently implemented in relation to each of these cases. The complaints were originally received while the Council was still conducting its own independent review of the service provision in May 2018 as 'premature enquiries'. Considerable work was undertaken with the LGSCO triage team to identify the group of complaints and ensure that, at the instigation of a formal investigation, these could be taken forward together in a single timeline and by a single investigator. The formal investigation process was started between 21st and 26th June 2018 over which period the 8 complaints were individually sent to the Council for a co-ordinated response. The LGSCO recognised the significant amount of work required in order to respond and amended their normal timescale for response to allow the Council time to pull together full bundles of supporting information for each	

	complainant, together with a detailed submission on the events complained of. The Council's response was submitted to the LGSCO on 26th July 2018.
6.	Further, detailed enquiries were received over the course of August 2018, which the Council formally responded to on 21st August 2018. The matter has been with the LGSCO for consideration since that date. The LGSCO has periodically updated the Council on the progress of their enquiries, which has included substantial discussion and correspondence with the complainants in each case.
7.	The LGSCO has since indicated it will not pursue its investigation into the original closure decision as it feels that is adequately addressed by the independent review undertaken by the Council and the 'Lessons Learned Report' and Action Plan , which was supplied to the LGSCO in confidence to assist them with their consideration.
8.	The LGSCO process is broadly as follows: • Complainant completes Council's complaints process and refers matter to the LGSCO • LGSCO makes some initial inquiries for information that the LGSCO Link Officer (Service Lead: Legal Partnership) responds to with information provided by the service area and complaints team. • Formal Investigation letter for each complaint received from LGSCO. • LGSCO Link Officer considers / makes an initial assessment of fault and outcomes, undertakes and evidence gap analysis and requests further information and evidence pack from service areas / meets with service areas as needed to clarify requests and evidence gaps in Council's position. At this stage if the Link Officer considers there is a fault in the way the Council acts we also discuss potential remedy offers with the service area based on the LGSCO guidance on remedies. • LGSCO link officer drafts and prepares a formal response on behalf of the Council including any remedy offer where appropriate (within the delegated powers of that officer). • LGSCO may submit a request for further inquiries which are responded to by Link Officer • LGSCO considers evidence and response. Usually takes around a month – in this case the outcome was under consideration for six and a half months. • LGSCO issues draft decision to Council and complainants and invite comments (only factual corrections can generally be made at this stage). Link Officer consults service area and responds. • LGSCO issues final decision. The decision by the LGSCO can be: • Not upheld (with or without comments and guidance) • Upheld – fault but no injustice (no statutory report) • Upheld –fault and injustice (remedies required- no statutory report) • Upheld – fault and injustice (remedies required AND statutory report) (this requires report to full Council, newspaper adverts etc.)

	All LGSCO decisions, regardless of outcome, are now public and published on the LGSCO website once finalised. All Complainants names are legally required to be replaced and anonymised. Complainants cannot be named on reports (or in Council reports) and the complaint between the complainant and the Council, including the full details of the complaint, are private and confidential outside of the details otherwise published by the LGSCO.
9.	The seriousness of the findings arising from these 8 complaints should not be understated. This is the most significant multi party LGSCO complaint, resource intensive and expensive (in terms of remedies agreed) outcome the council has had for over 20 years and the closest the Council has come to finding with a statutory report since 1998. The total cost in compensation payments for the proposed financial remedies will be £40,375.
10.	The remedies agreed with the LGSCO as part of the settlement package the Council offered to resolve this matter are set out below. The LGSCO has indicated the remedies offered by the Council are satisfactory to resolve the fault they have found in each case and are wholly in line with what they would have recommended in this case / the best they could hope to achieve for the complainants short of going to statutory report. The LGSCO is clear that had the Council not undertaken the independent review and agreed to action its findings and offer the remedies set out below, it WOULD have issued a statutory report.
11.	The Council has agreed with the LGSCO that all of the recommended remedies will be completed within two months of the final decisions.
12.	**REMEDIES AGREED:**
	(Complainant 1) • Carry out a review of Ms E's needs as a carer, agree a carer's support plan and personal budget. This will include a review of the number of nights of respite care needed to maintain her wellbeing and continue in her caring role; • To carry out an assessment of Mr F's mental capacity to decide on respite care options; • To appoint an independent advocate for Mr F if he wants one; • To carry out a review of Mr F's care and support plan; • To pay Ms E £500 for her avoidable time and trouble in complaining and £8250 to recognise the Council's failures. This is the cost of the respite care she was entitled to and did not receive (33 nights at £250 a night) when Kentish Road was closed; and • To apologise. **(Complainant 2)** • Carry out a fresh assessment of Ms A's needs as a carer and agree a carer's support plan and personal budget to meet identified needs, including a review of the number of nights of respite care required; • Review Mr B's care and support plan;

	• Appoint an independent advocate for Mr B; • Carry out an assessment of Mr B's mental capacity to choose between respite options' • To make a payment of £4000 to Ms A to reflect the 16 nights respite Mr B did not receive (at £250 a night) plus £500 to reflect her avoidable time and trouble • To apologise. **(Complainant 3)** • Carry out a review of Ms K's needs as a carer, agree a carer's support plan and personal budget. This will include a review of the number of nights of respite care needed to maintain her wellbeing and continue in her caring role • To carry out an assessment of Ms L's mental capacity to decide on respite care options; • To appoint an independent advocate for Ms L; • To carry out a review of Ms L's care and support plan • To pay Ms K £500 for her avoidable time and trouble in complaining and £6250 to recognise the Council's failures. This is the cost of the respite care she was entitled to and did not receive (23 nights at £250 a night) when Kentish Road was closed; • To apologise.
	(Complainant 4) • Carry out a fresh assessment of Ms M's needs as a carer and agree a carer's support plan and personal budget to meet identified needs, including a review of the number of nights of respite care required; • Review Mr N and Mr O's care and support plans; • Appoint an independent advocate for Mr N and Mr O; • Carry out an assessment of their mental capacity to choose between respite options; • To make a payment of £8,000 to Ms A to reflect the 16 nights respite Mr N and Mr O did not receive (at £250 a night) plus £500 to reflect her avoidable time and trouble; • To apologise. **(Complainant 5)** • Appoint an advocate for Ms D; • Carry out a full review of Ms C and Ms D's needs, including a review of the number of respite nights needed; • Carry out a mental capacity assessment for Ms D on her capacity to choose respite care; • To carry on paying the current carers payment of £34 a month; • To pay Ms C £5000 based on the cost of 20 nights of respite care she missed out on and £500 for her avoidable time and trouble. • To apologise. **(Complainant 6)** • Carry out a fresh assessment of Mrs P's needs as a carer and agree a carer's support plan and personal budget to meet identified needs, including a review of the number of nights of respite care required; • Review Ms Q's care and support plan • Appoint an independent advocate for Ms Q

	• Carry out an assessment of Ms Q's mental capacity to choose between respite options • To make a payment of £4,000 to Mrs P to reflect the 16 nights respite Ms Q did not receive (at £250 a night) plus £500 to reflect her avoidable time and trouble • To apologise
	(Complainant 7) • Carry out a review of Ms G's needs as a carer and agree a carer's support plan and personal budget to meet identified needs, including a review of the number of nights of respite care required; • Review Mr H's care and support plan, ensuring it seeks an advice from an occupational therapist and other health professionals taking into account Mr H's mobility needs; • Appoint an independent advocate for Mr H; • Carry out an assessment of Mr H's mental capacity to choose between respite options' • To make a payment of £250 to Ms G to reflect her avoidable distress due to the fault identified; • To apologise. **(Complainant 8)** • Carry out a full review of Ms I's needs as a carer, review the number of nights of respite needed to enable her to maintain her wellbeing and support her other child and confirm the outcome promptly; • Review Mr J's care and support plan and confirm the outcome promptly; • Carry out a mental capacity assessment for Mr I regarding respite care and appoint an advocate to help him take part in assessments and decisions about his care and support; • Pay Ms I £1125 representing the 6 nights of respite care she should have had and did not take as outreach support, plus £500 for her avoidable time and trouble in complaining. • Apologise
13.	**NO FAULT FINDING COMMON TO ALL:**
	The decision to close Kentish Road meant the Council was required, under the Care Act, Mental Capacity Act and Care and Support Statutory Guidance to: • Review individual care and support plan as there was a change in circumstances; • Take reasonable steps to agree any proposals to change services to meet eligible needs, having due regard to individuals and their carer's wishes as a starting point; • Revise the care and support plans because of a change affecting the plan; • Carry out an assessment of individual's mental capacity where appropriate to decide about proposed respite care arrangements. If the outcome was a

	complainant lacked mental capacity, make decisions about respite care in their best interests; • Arrange an advocate if the Council considered a complainant / service user had significant difficulties taking part in the review, but only if there was no suitable person to assist them. The Council carried out reviews of individuals' care and support needs in September 2017; this was undertaken three months before Kentish Road closed and the LGSCO consider this was in good time. These reviews recorded carers concerns about changes to respite, in particular about individuals navigating a new environment and the impact of change on them. The LGSCO was satisfied the reviews noted individual and carer views and was in line with paragraph 13.32 of Care and Support Statutory Guidance and there is no fault in this regard. The LGSCO found the Council had due regard to the carer's views in line with the Davey case [R on the application of Luke Davey v Oxfordshire County Council and the Equality & Human Rights Commission and Inclusion London 2016 – in which significant cuts to service packages were ruled lawful provided proper process, including consulting affected users, had been followed], and had no grounds to criticise officers' view that with some additional support, Weston Court could have met the client's needs. The Council was required to appoint an advocate for the clients who had significant communication difficulties, if it did not consider there was an appropriate person to represent their views. In all cases their carer was an appropriate person to represent the client and so the LGSCO did not regard the failure to involve an advocate to be fault. They recognise the Council has offered an advocate in all cases in any event and as part of the agreed remedies, the council will arrange for independent advocates to be appointed for eight of the nine individuals. The purpose of the advocate in these cases will be to ensure that the individual is involved as fully as possible in their assessments and to establish what is important to them while they are receiving replacement care (to give respite to their carers).
14.	**FAULT FINDINGS COMMON TO THE MAJORITY OF CASES:**
	A delay of a month in opening Weston Court meant there was no opportunity for an overnight visit to transition to the new service before Kentish Road closed, which the Council has already recognised as a fault. The Council has recognised it should have carried out a formal assessment of the clients' mental capacity to make decisions about respite care. The failure to do so is not in line with the Mental Capacity Act 2005 and is fault. It is not possible to say whether the outcome would have been any different had a capacity assessment taken place in each case. There should also have been a carers assessment review in each case as there was a change in circumstances and the carer should have had a carer's

	support plan that set out their respite care needs. The lack of a carer's support plan was fault and not in line with Care and Support Statutory Guidance. However, the LGSCO did not conclude that any injustice arose because the clients' care and support plans contained their respite entitlement and the approach of providing a service of benefit to the carer, directly to the adult is permitted, although the law required the Council to provide a carer's support plan as well.
15.	**INDIVIDUAL FINDINGS ADDITIONAL TO THE ABOVE:**
	(Complainant 1) The review carried out by the Council recorded Ms E's concerns about changes to respite, in particular about Mr F navigating a new environment. The LGSCO was satisfied the review noted Ms E's views and was in line with paragraph 13.32 of Care and Support Statutory Guidance and there was no fault. The draft care and support plan, which Ms E received in September, explained any future respite provision would need to be organised so Mr F had support to familiarise himself with a new environment. This addressed Ms E's concerns about the specific impact of Mr F's disability on any change to his care arrangements. While the Council had due regard to Ms E's views the draft care and support plan was faulty because it did not set out revisions needed to Mr F's care arrangements: there was no alternative named respite provision for Mr F set out on the plan although Kentish Road was not going to be available from December. The plan should have set out Mr F's future respite provision and the failure to do so meant the plan was not in line with section 27 of the Care Act 2014. Recognising this, the Council prepared a final care and support plan in November, naming Weston Court. The Council accepts it never sent Ms E a copy of the final plan. While it was appropriate for officers to respect Mr F and Ms E's wish not to be intruded upon when they were dealing with the aftermath of his serious injury, the Council should still have sent them the final care and support plan by post before Kentish Road closed and the failure to do so was fault. The chief executive advised Ms E in an email that officers considered Weston Court was a suitable respite placement. This did not absolve the Council of its responsibility to ensure Ms E had a copy of the final care and support plan which set out the future respite arrangements. The Council has recognised that its communication about future respite arrangements for Mr F was not timely and this was fault which caused Ms E and Mr F avoidable uncertainty and confusion. The records of the placement team's attempts to find an appropriate residential care home willing to take Mr F as a respite client are numerous. However, there is no evidence that the placement team identified a home with a vacancy that was willing to take Mr F. The records indicate that any potential placements fell through or were not pursued for various reasons. But there is no evidence that this was due to Ms E unreasonably declining suitable placements that were willing to take Mr F. Delays in opening Weston Court meant there was no opportunity for any visits to transition to the new service before Kentish Road closed, which the Council has already recognised as a fault.

	The Council was required to appoint an advocate for Mr F, who has some communication difficulties, if it did not consider there was an appropriate person to represent his views. Ms E was an appropriate person to represent Mr F and so the LGSCO do not regard the failure to involve an advocate to be fault. They recognise the Council has offered an advocate in any event. It is up to Mr F to decide whether he wants an advocate and he cannot be forced to have one if he does not so wish. The Council should also have carried out a further formal review of the care and support plan in November 2017 when Mr F's injury became known as this was a significant change in his condition. The review would have determined whether Mr F's eligible needs had changed such that a revision to the care and support plan was needed, including revisions to respite arrangements. The failure to carry out a prompt review was fault. The LGSCO notes the social worker tried to make urgent alternative care arrangements and liaised with NHS staff to provide additional support and advice, but there should still have been a formal care and support plan review in November. The LGSCO recognise the Council did carry out a fresh assessment of need in April 2018, but this was not timely as it was five months after Mr F's injury. The delay was fault. The LGSCO further notes the family said in November 2017 they wanted the search for respite care to cease. But the evidence indicates that they meant 'for the time being' because they were in shock. Later emails from Ms E are clear that she wanted the Council to resume sourcing respite care. The Council also cancelled the Kentish Road booking for September at late notice due to staffing problems. The LGSCO did not conclude this was fault though as there is not enough evidence to suggest the staffing problems were foreseeable or within the Council's control. They took into account that the social worker offered to arrange live-in carers as an alternative and accept the family did not like this idea, but it would have provided an urgent solution and enabled Ms E to go on her trip. Ms E also had to cancel a work trip in November because of the lack of respite care. The LGSCO found this caused her avoidable inconvenience because she was not at the time aware that the Council's formal offer of respite care was Weston Court because she had not received a copy of the final care and support plan. The LGSCO report also notes Ms E arranged informal care to cover a second work trip in April 2018. The social worker offered Ms E a direct payment to pay the informal carers. She declined. The LGSCO commented that they understand her reasons, but had no grounds to criticise the Council as the payment would have been a means of meeting Mr F's respite needs, albeit not the family's preferred way. There should also have been a review of Ms E's carer's assessment as there was a change in circumstances and she should have had a carer's support plan that set out her respite care needs. The Council's records suggest Ms E did not pursue this issue in 2015, but given her caring and work commitments, the LGSCO consider it unreasonable of the Council not to have checked with her about what she wanted to do. And the lack of a carer's support plan was fault and not in line with Care and Support Statutory Guidance. However, the LGSCO report notes they cannot conclude that any injustice arose because Mr F's care and support plan contained his respite entitlement and the approach of providing a service of benefit to the carer, directly to the adult is

	permitted, although the law required the Council to provide a carer's support plan as well.
	(Complainant 2) As with complainant 1above, the Council issued a revised draft care and support plan in September 2017 setting out the agreed respite offer of an identified care home for some of the client's respite entitlement. It sent a further care and support plan in November naming Weston Court as a second option because that care home could not provide all of the client's agreed respite nights. The LGSCO recognised the carer did not share the Council's view that Weston Court was suitable, but considered the records evidenced the Council considered her concerns and addressed those concerns in respect of size and social isolation. Furthermore, officers met with her to discuss the concerns and offered a further option of converting some of the respite nights into home care support. The LGSCO noted agreement could not be reached about the suitability of Weston Court but considered the Council had due regard to the carer's wishes in line with the Davey case and there are no grounds for the LGSCO to criticise the view that Weston Court could have met the client's needs. The LGSCO consider the Council acted in line with the Care Act and Care and Support Statutory Guidance through a carer's assessment and carer's support plan in January 2018 setting out respite entitlement. Although this should have taken place at the same time as the clients care and support plan review (so in anticipation of the closure of Kentish Road and not after the event), the LGSCO do not consider this caused any injustice as the respite entitlement was set out in the client's care and support plan. The LGSCO found no fault in the way the Council dealt with the review of the client's care and support plan. There was delay in completing a carer's assessment and carer's support plan but there is no injustice to her as the client's respite entitlement was set out on his plan. There was some fault in the failure to have in place arrangements for the client to transition to Weston Court. The Council accepted this and the LGSCO considered this caused avoidable uncertainty and distress. The Council has proposed actions and payments which the LGSCO consider remedy the injustice.
	(Complainant 3) The LGSCO noted the complainants view was Weston Court was unsuitable, but the notes suggest neither she nor the client visited the scheme before it opened and so it would not seem this view was based on experience, more a concern about change. The LGSCO considered the Council took reasonable steps to reach agreement on the proposed changes by offering visits and also offering other alternatives like additional outreach support, instead of overnight respite. Accordingly the LGSCO found the Council had due regard to the carer's views in line with the Davey case, and had no grounds to criticise officers' view that, Weston Court could have met the client's needs.

	The Council issued a revised care and support plan in November 2017. This was in line with section 27 of the Care Act. However, it was very close to the date when Kentish Road was due to close and should have been issued at the same time as the review so that the carer and client were informed in good time about the proposed changes to care. The delay created avoidable uncertainty for both about future respite. The Council should have reviewed the complainant's carer's assessment. The LGSCO noted this appears to have been offered and refused because the clients care and support plan said she did not want another carer's assessment. There should have also been a carer's support plan on file for the carer. The lack of a carer's support plan was fault and not in line with Care and Support Statutory Guidance. However, the LGSCO cannot conclude that any injustice arose because the client's care and support plan contained her respite entitlement and the approach of providing a service of benefit to the carer, directly to the adult is permitted, although the law required the Council to provide a carer's support plan as well. The Council's failure to send a copy of the client's revised care and support plan in good time and the failure to have in place timely transition arrangements to the new service caused the complainant avoidable distress and uncertainty about future respite care.
	(Complainant 4) The review noted the complainant's concerns about changes to respite care and sought an opinion from a specialist physiotherapist who confirmed Weston Court was suitable. The LGSCO was satisfied the review was in line with paragraph 13.32 of the Care and Support Statutory Guidance and there is no fault. Again, the LGSCO recognised the complainant's view was Weston Court was unsuitable, but considered the Council took reasonable steps to reach agreement on the proposed changes by discussing her concerns and involving a physiotherapist who confirmed the layout of Weston Court could be made suitable for the client. Accordingly they found the Council had due regard to the complainant's views in line with the Davey case, and saw no grounds to criticise officers' view that, Weston Court could have met the client's needs. The Council issued a revised care and support plan in November 2017 in line with section 27 of the Care Act. However, it was very close to the date when Kentish Road was due to close and should have been issued at the same time as the review so the parties were informed in good time about the proposed changes to respite care. The delay created avoidable uncertainty for the clients about future respite.

	The Council should have offered the complainant an updated carer's assessment when it was reviewing the clients care and support plans. It has now offered a carer's assessment and the records evidence the complainant declined this. There should also have been a carer's support plan for the complainant. The lack of a carer's support plan was not in line with statutory guidance and so is fault. However, the LGSCO could not conclude that any injustice arose because the clients care and support plan contained her respite entitlement and the approach of providing a service of benefit to the carer, directly to the adult is permitted, although the law required the Council to provide a carer's support plan as well.
	(Complainant 5) Again, the LGSCO commented that the complainant's view was Weston Court was unsuitable, but the notes suggest this was a concern about any change in the social arrangements at respite care for her daughter. There is no requirement on a council to preserve respite arrangements permanently. They consider the Council took reasonable steps to reach agreement on the proposed changes by offering visits and also exploring other alternatives like additional outreach support, instead of overnight respite and accordingly found the Council had due regard to the complainant's views in line with the Davey case, and had no grounds to criticise officers' view that, Weston Court could have met the client's needs. The Council issued a revised care and support plan in November 2017. This was in line with section 27 of the Care Act. However, it was very close to the date when Kentish Road was due to close and should have been issued at the same time as the review so that the complainants were informed in good time about the proposed changes to care. The delay created avoidable uncertainty for them about future respite. The Council carried out a carer's assessment for the complainant and a carer's support plan in September 2017 set out her personal budget. This is in line with section 10 of the Care Act 2014 and statutory guidance and there is no fault. The Council has acknowledged it should have reviewed the number of nights of respite the carer was entitled to when she asked for more nights. Also, it should have set out her respite entitlement in the carer's support plan and the failure to do this was not in line with statutory guidance and is a further fault.
	(Complainant 6) As with all of the cases, the LGSCO recognised the complainant's view was Weston Court was unsuitable, but considered the Council took reasonable steps to reach agreement on the proposed changes by discussing her concerns and offering her a visit, which she did not take up. The LGSCO found the Council had due regard to the complainant's views in line with the

	Davey case, and I had no grounds to criticise officers' view that Weston Court could have met the client's needs. As with several of the other cases, the Council issued a revised care and support plan in November 2017 in line with section 27 of the Care Act. However, it was very close to the date when Kentish Road was due to close and should have been issued at the same time as the review so the parties were informed in good time about the proposed changes to care. The delay created avoidable uncertainty for the complaints about the new respite arrangements. This was fault. The Council reviewed the complainant's carer's support plan at the same time as the review of the client's assessment. This is good practice and there is no fault. The Council has accepted there was no review of the number of nights of respite required and during this investigation, agreed to carry out a review. Any agreed changes to the number of nights should be set out in both the carer's support plan and in the individual's care and support plan.
	(Complainant 7) The revised care and support plan, which was discussed with the complainant's advocate shortly before Kentish Road closed, set out Weston Court as the named respite provision. The LGSCO consider the Council acted in line with Care and Support Statutory Guidance and with the Care Act 2014 and the Davey case so there is no fault. The Council accepts it should have reviewed the complainant's carer's assessment. The LGSCO noted the clients respite entitlement was in his care and support plan, but the Council should have also completed a carer's support plan for the carer. The failure to do so is fault. The LGSCO found no fault in the way the Council dealt with the review of the client's care and support plan. Although there was no carer's support plan for the complainant, the LGSCO did not consider this caused her injustice as the respite entitlement was set out on the client's care and support plan. There was some fault in the failure to have in place arrangements for the client to transition to Weston Court which caused avoidable uncertainty and distress. The LGSCO concluded the Council proposed actions and a payment which they consider remedy the injustice.
	(Complainant 8) The revised care and support plan, which was discussed with the complainants shortly before Kentish Road closed, set out Weston Court as the named respite provision. The LGSCO therefore considers the Council

	acted in line with Care and Support Statutory Guidance and with the Care Act 2014 and the Davey case so there is no fault. The Council attempted to address concerns about socialising at Weston Court by suggesting the clients friends could attend at the same time. The LGSCO considered the Council had due regard to the complainant's wishes, although agreement could not be reached on Weston Court. In addition, the Council acted flexibly and without fault by agreeing the overnight respite entitlement could be converted into outreach hours instead. This meant that the complainant benefitted from most of the client's respite entitlement pro-rata, during the period Kentish Road was closed. The Council has carried out an assessment of the client's capacity to make decisions about respite care. This is in line with the Mental Capacity Act, but the Council should have completed it before the changes to his care plan were agreed. So it was too late and this is fault. The Council accepts it should have reviewed the number of respite nights the complainant could have, in particular because she asked for more. The Council accepts there should have been a review of the carer's assessment, although the LGSCO noted she has recently declined a further assessment. They also noted the clients respite entitlement was in his care and support plan, but the Council should also have completed a carer's support plan for the complainant and the failure to do so is fault.
16.	**BACKGROUND TO THE COMPLAINTS / INDEPENDENT REVIEW OF KENTISH ROAD CLOSURE AND ACTION PLAN:**
17.	At the time of its closure in November 2017, Kentish Road was an eight bed respite service, supporting people living with a learning disability and their carers. At the time of the closure, the service was rated as 'requires improvement' by the Care Quality Commission (CQC). The scheme re-opened in July 2018 following refurbishment and re-registration with the CQC having been assessed as meeting current CQC standards. It now operates as a four bed respite service operating from lunchtime on Fridays to lunchtime on Mondays. The current service was recently inspected by the CQC. Feedback on the day of the inspection was positive but a formal response from the CQC has not yet been received.
18.	The purpose of respite care, defined in the Care Act 2014 as replacement care, is to give informal carers (typically family members) a break from their caring responsibilities, in order to help meet their own needs and to sustain the caring arrangements for the person being cared for. From Friday to Monday, Kentish Road provides respite care during the day and overnight, and complements day services provided or commissioned by the Council, which provide respite during the day. Although the primary purpose of respite care is to provide a break for carers, the respite provider has a duty to ensure that the care and support needs of the person staying at the service are met and, wherever possible and appropriate, their preferences are taken into account in terms of location and activities

19.	The vision for the long term future use of the Kentish Road site is being co-designed with carers and their representatives. This work started in September 2018 and a number of options and proposals are being considered by a task and finish group made up of the Cabinet Member for Adult Care, Council officers, carers, representatives such as Southampton Mencap and other providers of respite care in Southampton. The Council has given a commitment to continue to provide overnight respite care from that location in the future.
20.	On 30 November 2017, Cabinet reconsidered its decision made on 14 November 2017 to close the respite service at Kentish Road, taking into consideration the recommendations made by the Overview and Scrutiny Management Committee on 29 November 2017. Cabinet accepted the recommendation to review the processes that had been followed relating to the Kentish Road respite service decision and to identify any lessons that needed to be learnt for any future decisions of this nature.
21.	The Director of Adult Social Services (DASS) subsequently commissioned an independent review covering the period from the Cabinet's decision to consult on the future of Kentish Road in July 2014 to the closure of the service in November 2017. The final report was received by the Council on 4 June 2018 and is attached at Appendix 10.
22.	The purpose of the review was to determine the factual events leading to the closure of Kentish Road including a chronology of decisions and actions for the period in question and specifically to identify whether: • Decision-making and governance routes where followed appropriately and in line with Cabinet resolutions, the scheme of delegation, standing orders and line management accountability • Appropriate and adequate information was provided, updated and given to Cabinet Members, Council meetings and committees in a timely fashion and whether sufficient information was available at all times in order for the relevant decisions to be made • There was a direct link to the strategic objectives which supported this decision and how well this was adequately communicated to relevant stakeholders • All relevant legislation, statutory guidance and governance was followed in relation to the decision and in relation to individuals affected by the decision • Best practice was demonstrated in relation to engagement and consultation with stakeholders including individuals and their carers, the involvement of independent advocates and transition arrangements • Appropriate and proportionate Care Act assessments and plans were produced at appropriate times and whether correct engagement with individuals and their carers was undertaken • Any other actions would have been beneficial, such as transition plans • The structure and organisation of the implementation project was adequate – including how implementation was resourced, project managed, responsibility assigned, progress monitored and reviewed, risks assessed and mitigated and reporting arrangements

	The aim of review was to identify any lessons for future change projects, especially where the decision is likely to be unpopular and lead to challenges, both legal and otherwise.
23.	An Oversight Board was established and chaired by the DASS to consider the findings of the report and to agree and oversee delivery of an action plan to ensure the accepted recommendations were implemented within an agreed timescale (Terms of Reference at Appendix 9). The resultant action plan is attached at Appendix 11. The Oversight Board first met in September 2018 and has met regularly since. The chair of the board changed in November 2018 on the appointment of a new interim DASS.
24.	The report made 15 recommendations. Four of these were not accepted. As at April 2018, eight of the recommendations have been completed and two remain in progress. Implementation of a council wide Project Management Process with governance by the Council Management Team has achieved Recommendation 1, to ensure that for all major changes to service provision, particularly those concerning vulnerable people, that industry recognised project management principles are implemented. The Project plan developed within this process ensures that there is delegation of responsibility for ensuring that internal and external communications are robust and support legal compliance, which is Recommendation 2 and ensures adherence to the Public Service Equality Duty (PSED) under the Equality Act 2010, including through the development of Equality and Safety Impact Assessments (ESIA) at every stage of the decision making process, Recommendation 3. Democratic Services have established a system for tracking the implementation of Cabinet decisions, similar to the OSMC tracker, so that decisions requiring action within timescales are brought forward to Cabinet as required, Recommendation 6. The Council to commissioned independent audits of care and support assessments and plans within learning disability services to assess quality and legal compliance which was recommendation 7. The Project Management Process also includes elements to ensure that public consultation, engagement and co-production approaches are included in project plans and undertaken, where required, in line with legislation and that these continuously inform the service design and decision making process throughout the life of the project, as per Recommendation 11. Also for Recommendation 12 to ensure compliance with the Council's HR policies in relation to managing change and major incidents, so that the staffing implications and capacity and cover issues are planned rather than reactive. All health and care services are only procured when a rigorous assessment of need has been undertaken, including the use of collated information arising from individual assessments of need and this is verified via identified governance routes, as outlined in Recommendation 12. Recommendation 14, to ensure that the re-provision of 32B Kentish Road utilises full engagement and a co-production with service users has been completed.

	Four recommendations were not accepted as it was identified that these requirements were already being achieved. These were Recommendation 4 to amend the finance section of the Cabinet report template and Recommendation 5 to provide an external consultancy role to the Overview and Scrutiny Management Committee (OSMC), to provide expert advice and guidance on appropriate challenge in the area of health and adult social care for a period of one year. Recommendation 9 to ensure that accountability for decision-making and management oversight is provided by a senior manager who has a professional social work qualification, expertise and experience was not accepted nor Recommendation 10 to ensure that all changes relating to service redesign are commissioned by the Integrated Commissioning Unit (ICU) . Two recommendation are still being progressed. Recommendation 8 , using the findings from the independent audit, to provide training and making other required changes and re-audits to track improvement have been scheduled. Recommendation 15 continues to implement actions following a review of respite services across adult services. Further detail on each are set out below.
25.	As a result of lessons learned from this proposal, the Council has now established a Projects and Change Team (formerly known as the Project Management Office) with a robust project management methodology that is now being applied to all in scope projects and programmes. The approach includes four key stages in the lifecycle of a project and sets out in detail the governance arrangements, approval routes and project documentation required for each stage, dependent on financial and other risks. The approach includes clear accountability for internal and external communications, which addresses the failure to communicate clearly and in a planned way with carers and other stakeholders during the period covered by the review. It also provides assurance that equality, safety and other impacts are assessed at every stage of the decision making process. This new process is now being used, for example, in the work being done on the future options for Kentish Road.
26.	A supplementary review of the financial modelling carried out in 2014 and updated in 2017 was carried out by the Council's Internal Audit Service. The report of this review is attached at Appendix 12. It states that the original decision taken in 2014 was based on flawed financial modelling and the decision taken in November 2017 was based on better financial modelling but the auditors were only provided with limited evidence and so the accuracy of the figures has not been proven. Arrangements are now in place in Finance to check the robustness of future financial modelling and to clearly state any assumptions etc. The guidance to authors of Cabinet reports clearly states that all relevant financial information should be added to the report in order that Members have all salient information and this is checked at corporate clearance stage. Recommendation 4 in the main review report to incorporate a tick box in the finance section of Cabinet

	reports was therefore not accepted, as robust enforcement of these arrangements is considered to be sufficient.
27.	As it is considered that the Council discharges its scrutiny function well, with a dedicated Scrutiny Manager, which has previously been held up as an example of best practice nationally, Recommendation 5 to provide additional expert advice to the Overview and Scrutiny Management Committee via an external consultant was not accepted by the Council.
28.	Recommendation 6 was for Democratic Services to establish a system for tracking the implementation of Cabinet decisions, similar to the tracker in use by the Overview and Scrutiny Management Committee, so that decisions requiring action within timescales are brought forward to Cabinet as required. This was implemented in October 2018.
29.	Recommendation 7 was for the Council to commission independent audits of: • Care and support assessments and plans within learning disability services to assess quality and compliance with the Care Act 2014 and the Mental Capacity Act 2005. This to include the assessments and care and support plans of carers, which are outsourced on behalf of the Council. • The decision making at the funding panel to ensure decisions follow from care and support plans and not from assessments, in compliance with the Care Act 2014. • The extent of non-compliance with the Mental Capacity Act in the Deprivation of Liberty Safeguards (DoLS) team in relation to applications for deprivation of liberty safeguards that are not taken forward. On 31 October 2018, a contract was awarded to the National Development Team for Inclusion (NDTI) to complete case audits in learning disability and other social care teams, following a tender exercise, to comply with this recommendation.
30.	The NDTI completed desk top audits of 80 electronic case files in January and February 2019. The audit was of a sample of cases completed over the last three years. Their report following these audits, was received by the Council on 13 February 2019, and is attached at Appendix 13. The Oversight Board had decided to expand this exercise to audit practice across all of adult social care (rather than limiting it to learning disability). These findings are critical of social work practice, as the auditors were not able to find evidence of person-centred, strengths-based approaches to assessments and care and support planning in the majority of cases reviewed. Their report was considered at meetings of the Adult Social Care Improvement Board and the Kentish Road Oversight Board on 12 March 2019. The five recommendations contained in the NDTI report are accepted in full. These recommendations can be summarised as follows: 1. That the council should use the report to brief relevant stakeholders in order to support co-production of a “different culture of practice” moving forward.

	2. Undertake a review of internal learning and development needs and use this to inform a targeted plan for practitioners and first line managers. 3. Improve practice supervision and set aside development time for practitioners and managers to support strengths-based working, backed up by quality and performance management. 4. Work with commissioners to build a more thorough knowledge of resources available to people in their communities and to understand how these can be used to supplement and augment informal and paid support. 5. Benchmark with other authorities; clearly define outcomes for improvement with agreed milestones; measure and review progress. The Boards will consider if current plans are sufficient to meet all of these recommendations or consider if further actions are required. In terms of the case audits, the auditors were hampered by the current IT system, Paris, which does not have a clear care pathway or workflow. Due to deficiencies with Paris, referrals are used to manage workflow (which is confusing and makes reporting difficult) and because not all parts of the system are Care Act compliant, some documents have to be uploaded separately, which does not always happen and means they can be difficult to find on the system. This will all be addressed by the new IT system, CareDirector. The Council made a decision to procure a new, compliant system to support best social work practice and this will be in place by March 2020. Despite the IT system challenges it was highlighted that Social work practice in many cases also fell a long way short of expectations and protocols for case recording were not in evidence. Improvement in practice was being addressed, in advance of the case audits being completed, through a Service Development Programme led by the Principal Social Worker and overseen by the Adult Social Care Improvement Board, with progress against the plan also being reported to the Oversight Board. The Service Development Programme is structured around four themes: • Workforce Development • Strengths-based social work practice • Safeguarding Adults and • Quality Assurance Two additional posts were created as part of a comprehensive restructure of the Adult Social Care Service in April 2018, which have supported delivery of the actions in the Service Development Plan. These are a Principal Social Worker for Adults and an Integrated Service Manager for the Learning Disability Team. A Safeguarding and Service Quality Hub was also created as part of the restructure. The Integrated Service Manager is a joint appointment with NHS Southampton City Clinical Commissioning Group (CCG) and the post-holder

	took up their post on a full time basis in November 2018. The Learning Disability team is now largely made up of new staff, has joined up with the NHS community health team (including nurses, physiotherapists and other therapists) and the CCG's Learning Disability Continuing Healthcare Team and, since January 2019, has been working in a new location in Redbridge to support integrated working. Completed actions in the Service Development Plan include the introduction of a new supervision policy, to ensure regular and consistent oversight of practice and recording quality; the introduction of a quality assurance framework, with monthly audits and reporting processes now in place; the introduction of an Adult Social Care Development Forum for team managers and senior social workers to reflect on and improve practice; the completion of a training needs analysis and delivery of additional workshops on strengths-based practice, mandatory training on safeguarding adults and the Mental Capacity Act, and a full day of legal training for all social work practitioners. A full day staff conference took place in November 2018, which was supported by Lyn Romeo, the Chief Social Worker for Adults at the Department of Health and Social Care and other experts in the sector. In the Learning Disability Team specifically, plans are in train to reduce workload, to develop senior social work practitioners, and to appoint champions for key areas such as safeguarding and mental capacity. A Business Change Manager is supporting culture change in the team and weekly practice quality team training sessions are taking place. Although work continues across adult social care to train people to consistently provide a strengths-based, person centred approach, these audits show that significant work remains to embed this. For these changes to become embedded, social work practitioners must work with people to find person-centred alternatives instead of (as described by NDTI) a "service based solution to the presenting issues in the person's life". Work is also underway through the Integrated Commissioning Unit to develop a range of community solutions, which will help practitioners to link people to community based support and activities. The Council is also reviewing the way that it provides information on care and support options through the online Southampton Information Directory.
31.	The lessons learnt report also highlighted the fact that Deprivation of Liberty Safeguards (DOLS) authorisations may be required for some individuals using the Kentish Road respite service. Since it has re-opened, the Council's DOLS service has received applications for four people who access respite services at Kentish Road. Two of those people also access respite services at another residential respite centre and the Council has received applications for that location as well. Legal advice has been sought on how best to determine these applications in a sensitive and pragmatic manner to avoid any further inconvenience or distress to individuals and family members, and this approach is being followed. The Council has also received four applications for people receiving care at Weston Court and a further 15 for people accessing alternative residential

	respite provision. The Council is using the Association of Directors of Adult Social Services (ADASS) risk matrix to screen all applications, which takes account of matters such as unresolved challenge, exit seeking behaviours and any cases where either physical or chemical restraint is required. The outcomes from the risk matrix are being used to prioritise cases accordingly.
32.	Recommendation 9 in the lessons learnt report was not accepted by the Council, as the current operating model permits accountability from a statutory perspective to be undertaken by a suitable officer, as required, with a direct line of sight to both the Chief Executive in terms of the statutory duties and the Chief Operations Officer and Service Director for both the statutory duties and strategic/commissioning leadership.
33.	Recommendation 10 was also not accepted by the Council, as the current operating model permits the operational re-design of adult social care to be undertaken by the operational service led by the Service Director, whilst commissioning activities are undertaken by the Integrated Commissioning Unit (ICU). There is close working between the ICU and the operational service.
34.	Recommendation 12, to procure services as part of the final stage of the commissioning cycle only when a rigorous assessment of need has been undertaken, including the use of collated information arising from individual assessments of need, when concerning the provision of specialist services, has been implemented. Commissioning processes for health and care services mean that any commissioning decision is based on needs assessment and this is verified through use of the Contract Lifecycle Management Committee (CLCMC) and Joint Commissioning Board.
35.	Recommendation 14 suggested that that the re-provision of 32B Kentish Road should utilise full engagement and a co-production approach with carers. Full co-production was not achieved on the re-provision of 32B but carers did visit the site and gave their opinions as to requirements and suitability. Their feedback significantly changed the plan and that is why part of the main building at Kentish Road (32) was re-opened in July 2018, instead of the annexe (32B). The Council has made a commitment to continue to involve and engage with people who use the service, their families and other partners throughout the process of developing a plan for the future of the Kentish Road site that maximises its potential value. A survey seeking views regarding the service in its current form and options for the future of the site was undertaken from November 2018 to February 2019 and the results of this survey are currently being analysed. The task and finish group including carers and their representatives was also established and has met four times since September 2018. The group is keen to explore ways of complementing the respite service with other services for people with learning disabilities on site, including supported living, training flats, and life skills service provision.
36.	Recommendation 15, the final one in the lessons learnt report, was to undertake a review of respite services, which was completed in November 2018. The review took into account consistency, equity and fairness in respite provision across all groups of service users. This highlighted the need to improve joint working practices and information sharing between Adult Social care and Carers in Southampton, to join up carers assessments with the support provided to the cared for person. Currently this is not achieved as one

	joined up process. Assessment for replacement care remains with Adult Social care and therefore remains detached from the assessment of carers needs so this is not providing carers with a holistic approach. A new social care post was appointed in January 2019 to review the pathway and ensure the achievement of one aligned process. The review also highlighted variable access to respite so work, in partnership with Carers in Southampton, is underway with the aim of considering a replacement care specific resource allocation system. This is a tool for calculating the provisional amount of funding available to the client/carer to meet respite/replacement care social care needs. This would take into account the care and support provided to the cared for person, the support provided to the carer and address any additional replacement care/respite needs, where relevant. The new approach would help ensure a consistent and equitable access to respite/replacement care. Work is being undertaken to widen choice and accessibility to replacement care options and to inform future planning. In addition analysis is being completed to determine future respite needs.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
37.	The remedies offered in this case comprise a number of services (set out in detail above) to be offered to the complainants that will be delivered within existing resources.
38.	In addition to the above, a total of £40,375 in compensatory payments has been agreed in order to remedy the injustice suffered by the complainants arising from the faults identified by the LGSCO. These payments comprise an allocation of £250 per night per person for lost respite care to which individual complainants would be entitled together with further sums (ranging from £250 to £500) in respect of avoidable uncertainty and distress caused by the faults identified and the pursuance of their complaints to the LGSCO.
39.	During 2017/18, Kentish Road did not record a saving, and instead reflected an overspend of £196,000 against controllable budgets. For 2018/19 there is a forecast overspend of £37,000, against a reduced budget of £314,000 (to reflect the reduction in opening hours). Following the February 2019 budget setting process, a budget provision of £600,000 has been set aside for the centre in 2019/20.
<u>Property/Other</u>	
40.	N/A
LEGAL IMPLICATIONS	
<u>Statutory power to undertake proposals in the report</u>:	
41.	The Local Government Act 1974 established the then Local Government Ombudsman for England and for Wales. Wales is now covered by the Public Services Ombudsman for Wales. The Act defines the LGSCO's main statutory functions: • to investigate complaints against councils and some other authorities • to investigate complaints about adult social care providers from people who arrange or fund their own adult social care

	• to provide advice and guidance on good administrative practice The main activity under Part III of the 1974 Act is the investigation of complaints, which it states is limited to complaints from members of the public alleging they have suffered injustice as a result of maladministration and/or service failure. The LGSCO's jurisdiction under Part III covers all local authorities (excluding town and parish councils); police and crime bodies; school admission appeal panels and a range of other bodies providing local services. Under Part IIIA the LGSCO investigates complaints from people who allege they have suffered injustice as a result of action by adult social care providers. The Ombudsman changed its name from the Local Government Ombudsman to the Local Government and Social Care Ombudsman in 2017 to reflect the full scope of its jurisdiction. The Regulatory Reform (Collaboration etc between Ombudsmen) Order 2007 amended the 1974 Act and clarified the powers of the Local Government and Social Care Ombudsman, and the Parliamentary and Health Service Ombudsman, to work together. If a complaint covers both jurisdictions - typically social care and health issues - they can carry out joint investigations with a single point of contact.
42.	Where the Ombudsman upholds a complaint, the report will contain recommendations that the local authority or adult social care provider should follow. These could include: • paying compensation • providing a service that should have been provided • making a commitment to improve procedures in the future. The Ombudsman does not have the legal power to make a council or care provider carry out its recommendations, but it is rare for them not to do so. If a council does not agree to a settlement proposed by the Ombudsman, the Ombudsman will issue a public interest report, naming the council. It must be made available to the public, and advertised in the local press covering the council's area. Where a council does not agree to carry out recommendations in the Ombudsman's report, a further report will be issued. If, after this, the council still does not act on the recommendations, the council must publish a statement in a local newspaper explaining why. Where a care provider does not agree to carry out the recommendations in the Ombudsman's report, the Ombudsman will issue an adverse findings notice. The notice will be shared with the Care Quality Commission (which regulates health and social care in England) and the care provider will be required to publish it appropriately. Where this is not done, the Ombudsman will publish the notice.
<u>Other Legal Implications</u>:	
43.	N/A
RISK MANAGEMENT IMPLICATIONS	
44.	The Local Government and Social Care Ombudsman's findings of maladministration with injustice, and the recommendations made following the

	independent review and case audits detailed in this report, have highlighted where further assurance is needed regarding: • The Council's approach to assessing the care and support needs of individuals and their carers • The provision of respite care and • Governance arrangements for projects This report sets out for the Governance Committee's consideration the steps that are being taken to address these findings and recommendations. Implementation of the Action Plan arising from the independent review is being overseen by the Independent Review Oversight Board, chaired by the Interim Director of Adult Social Services, and delivery of the Service Development Plan is being overseen by the Adult Social Care Improvement Board, chaired by the Chief Operating Officer. Progress against these plans will be added as a standing item to the Cabinet Member for Adult Care's monthly Cabinet Member Briefings. The Chief Executive, Deputy Chief Executive and Service Directors are being updated on progress at meetings of the Council's Management Team. The Council's strategic risk register will be updated to reflect how the risks raised in this report are being mitigated and this will be reflected in the next quarterly update of the risk register. The arrangements for mitigating risks associated with Adult Social Care are also overseen by the Local Safeguarding Adults Board, which has an independent Chair. The quality of the current provision of respite care at Kentish Road has recently been inspected by the regulator, the Care Quality Commission, and the quality and provision of respite care at Kentish Road has been rated 'Good' by the CQC. A further independent audit of adult social care cases will be commissioned to determine progress against the Service Development Plan.
POLICY FRAMEWORK IMPLICATIONS	
45.	The proposals set out in this report are consistent with the Council's approved Policy Framework.
KEY DECISION?	**N/A**
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1-8.	Copies of the LGSCO complaint decisions (x 8)
9.	Terms of Reference of the Oversight Board established to manage Review actions.
10.	Independent Review Report ('Lessons Learned' Report)
11.	Action plan arising from the Independent Review Report
12.	Report of supplementary review into financial modelling carried out by Internal Audit

13.	Independent Adult Social Care Audits – Final Report (carried out by the National Development Team for Inclusion [NDTI])

Documents In Members' Rooms

1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**No**

Other Background Documents
Other Background documents available for inspection at:

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	