Cheshire East Council

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Audit & Governance Committee

Date of Meeting: 05 December 2019

Report Title: Maladministration Decision Notices from Local Government and Social Care Ombudsman – July – August 2019

Senior Officer: Jan Bakewell – Director of Governance and Compliance

1. Report Summary

1.1. This report provides an update on the Decision Notices issued by the Local Government and Social Care Ombudsman (referred to as "the Ombudsman" throughout this report) when his investigations have found maladministration causing injustice to complainants. This report details the decisions made between 1st July 2019 and 31st August 2019. There was 1 decision in which the Ombudsman found that there was maladministration causing injustice; the relevant department has taken the recommended actions and learned lessons from the investigation outcome. It is not possible to report on any Decision Notices issued from September 2019 onwards, as the Ombudsman imposes a three month reporting embargo. Any decisions received after 31st August 2019 will be reported at a subsequent Audit & Governance meeting.

2. Recommendation

2.1. That the Committee notes the contents of this report and makes any further response it considers appropriate.

3. Reasons for Recommendation

3.1. The Terms of Reference for the Audit & Governance Committee include seeking assurance that customer complaint arrangements are robust and that recommendations agreed with the Ombudsman are being implemented.

4. Other Options Considered

4.1. This is not applicable.

5. Background

5.1. The Local Government Act 1974 established the Local Government and Social Care Ombudsman. It empowers the Ombudsman to investigate complaints against councils and adult social care providers and to provide advice and guidance on good administrative practice. Once a complainant has exhausted the Council's Complaints procedure, their next recourse, should they remain dissatisfied with the Council's response, is to contact the Ombudsman.

5.2. The Ombudsman will assess the merits of each case escalated to them and seek clarification from the Council as necessary before making the decision to investigate a complaint. Once the Ombudsman decides to investigate, they will try to ascertain if maladministration has occurred and whether or not there has been any resulting injustice to the complainant as a result of the maladministration.

5.3. In instances where maladministration and injustice is found, the Ombudsman will make non-legally binding recommendations which they consider to be appropriate and reasonable. Although not legally binding, refusal to accept the Ombudsman's recommendation(s) will trigger a Public Report.

5.4. A Public Report is a detailed account of the complaint, outlining the failures by the Council in this particular investigation; this can have a significant damaging effect on the Council's reputation.

5.5. During the period between 1st July 2019 and 31st August 2019 the Council received 1 Decision Notice in which the Ombudsman has concluded that there has been maladministration causing injustice. The details can be found in Appendix 1.

5.6. Adult Social Care Complaint – The complaint was as result of the way in which the Council assessed the needs of the complainants' adult son since 2016 and the level of financial support granted. The complainants specifically raised concerns that they were told that information relating to the assessment had been lost, that there were unnecessary delays in making the direct payments and latterly disagreed with the way in which the post-16 transport policy was applied.

5.6.1. The Ombudsman noted that the Council had continued to support the complainants' son under his existing support plan while attempting to develop a plan more suitable to his current needs and that significant efforts had been made since the start of 2018 to move the matter forwards. Furthermore some of the delays in agreeing the outcome of the assessment and financial support awarded were not solely due to fault by the Council.

However, the Ombudsman concluded that the Council was at fault as a result of officers suggesting that personal information had been lost; although it was later confirmed that the information had not been lost, as well as concluding that the Council could have done more to mitigate the delay in making the direct payments.

5.6.2. The required actions set by the Ombudsman have since been completed. The department have addressed the issues and findings of the Ombudsman with the individual workers via their supervision and by providing further training relating to GDPR and Liquid Logic which will help to ensure that records are correctly updated and filed. Also measures such as reviewing and amending the processes between business support and operational staff within the department have been made, circulated to staff and reinforced at team meetings in order to mitigate the chances of these issues reoccurring. Furthermore, Practice Managers have been reminded to monitor timeliness of assessments and support plans which will also help to address the shortcomings identified by the Ombudsman.

6. Implications of the Recommendations

6.1. Legal Implications

6.1.1. There are no legal implications flowing directly from the content of this report.

6.2. Financial Implications

6.2.1. If fault causing injustice is found, the Council can be asked to pay compensation to a complainant, the level of which is determined on a case by case basis. The cost of such compensation is paid for by the service at fault. In this particular case, the Council was required to make a compensation payment of £300.

6.3. Policy Implications

6.3.1. Adherence to the recommendations of the Ombudsman is key to ensuring that customers have objective and effective recourse should they be unhappy with the way in which the Council has responded to their complaint.

6.4. Equality Implications

6.4.1. There are no equality implications flowing directly from the content of this report.

6.5. Human Resources Implications

6.5.1. There are no HR implications flowing directly from the content of this report.

6.6. **Risk Management Implications**

6.6.1. There are no risk management implications.

6.7. **Rural Communities Implications**

6.7.1. There are no direct implications for rural communities.

6.8. **Implications for Children & Young People/Cared for Children**

6.8.1. There are no direct implications for children and young people.

6.9. **Public Health Implications**

6.9.1. There are no direct implications for public health.

6.10. **Climate Change Implications**

6.11. There are no direct implications to climate change.

7. Ward Members Affected

7.1. There are no direct implications for Ward Members.

8. Access to Information

8.1. Please see Appendix 1.

9. Contact Information

9.1. Any questions relating to this report should be directed to the following officer:

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Appendix 1 - Ombudsman Decisions where Maladministration with Injustice has Taken Place

July - August 2019

Service	Summary and Ombudsman's Final Decision	Agreed Action	Link to LGSCO Report	Action Taken	Measures Implemented	Lessons Learnt
Adult Social Care	Mr and Mrs X complain about the way the Council has assessed the needs of their adult son Mr A, who is disabled, about the level of Direct Payments, the delay in paying Mrs X's carer's Direct Payments, and the way in which the Council has considered the payment of transport expenses for Mr A. They also complain they were told his personal information had been lost. The Ombudsman's conclusion was that there were delays in reviewing Mr A's needs and resolving concerns about transport expenses but they have not been wholly due to the Council. The Council was wrong to tell Mr and Mrs X	Within one month of the final decision the Council will make a payment of £150 to Mr and Mrs X to recognise the distress and anxiety caused by the suggestion that Mr A's personal information had been lost. Within one month of the final decision the Council will make an additional payment of £150 to Mrs X which recognises the delay in making available the carer's Direct Payments to her and the lost opportunities which resulted.	https://www.lgo.org.uk/decisions/adult-care-services/assessment-and-care-plan/16-005-802	The department has issued an apology letter for the failings identified by the Ombudsman.. The payments have also been processed.	Reviewed and amended the processes between business support and operational staff in the department. Circulated changes to procedure to staff. Reminder sent to Practice Managers of the importance of monitoring timeliness of assessments and support plans.	The need to ensure that records are correctly catalogued and filed. The need for better communication between business support and operational staff.

	the previous assessment papers had been lost as that caused considerable anxiety. There was also a delay in making Direct Payments to Mrs X in her role as carer.					