Cheshire East Council

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Audit & Governance Committee

Date of Meeting: 11 November 2020

Report Title: Maladministration Decision Notices from Local Government and Social Care Ombudsman – April – August 2020

Senior Officer: David Brown, 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 "the Ombudsman" when his investigations have found maladministration causing injustice to complainants. The report details the decisions made between 1st April and 30th August 2020. There were 3 decisions in which the Ombudsman found that there was maladministration causing injustice; the relevant departments have actioned the recommendations and learned lessons from the investigation outcomes. It is not possible to report on any Decision Notices issued from September 2020 onwards, as the Ombudsman imposes a three-month reporting embargo. Any decisions received after 30th August 2020 will be reported at a subsequent Audit & Governance meeting.

1.2. The report also provides an updated summary of the referrals the Local Government and Social Care Ombudsman (LGSCO) received about Cheshire East Council during 2019/20. These referrals were reported at the July 2020 Audit & Governance Committee as part of the Annual Report of the Monitoring Officer but, following the Council's receipt of the Ombudsman's annual report, the figures have been updated and are outlined in this report to account for the total number of cases not investigated by the Ombudsman.

1.3. A question was raised at Council on 21 October 2020 about the development of a KPI around LGSCO findings of maladministration to enable a comparison over time. Full details of the numbers of complaints received by the Council, which includes a comparison to the previous year, is reported to the Committee as part of the Monitoring Officer's annual report. Details of specific cases of findings of maladministration, including the LGSCO's recommendations and actions taken by services, and lessons learned are included in these regular reports to Committee. Therefore, members already have sight of this information.

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 with injustice are found, the Ombudsman will usually 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 the particular investigation; this can have a significant damaging effect on the Council's reputation.

5.5. During the period between 1st April and 30th August 2020 the Council received three Decision Notices in which the Ombudsman has concluded that there has been maladministration causing injustice. The details of these cases can be found in Appendix 1.

5.6. **Data Protection** – The complaint, which was originally considered in November 2019, was in relation to the way in which the Council processed a request for social care records from when the complainant was a child. The complainant was dissatisfied with the way in which the information was supplied and that no support was provided when the information was disclosed.

5.6.1. The Ombudsman acknowledged that the Council had upheld the complaint in the complainant's favour when it considered the matter through its complaint's procedure but still found the Council at fault for incorrectly processing the request rather than referring the request to the Regional Adoption Agency. This agency could then have decided the most appropriate way to share the care records.

5.6.2. As a result, the Ombudsman recommended that the Council issue an apology to the complainant and a payment of £300 in recognition of the avoidable distress caused by the fault. The service has completed these recommendations and has also implemented an initial questionnaire when subject access requests are received to help ascertain what information requesters are already aware of. Responses also include a 'distress warning' where necessary, advising individuals to seek support and assistance when reading case files. It has also issued reminders to staff to be more vigilant in identifying requests which should be referred to the Regional Adoption Agency.

5.7. **Fostering** – The complainant raised concerns in August 2018 that the Council reduced her payments when the child she was providing foster care for reached the age of 18 and the care changed from being foster care to a "staying put" arrangement. She also complained the Council had not fully involved her in the planning process during this transition period which left her at a considerable financial loss as a result.

5.7.1. Although the Ombudsman found no fault with the level of involvement the complainant had in the planning process during the transition period, it found the Council at fault for not having provided enough information about the staying put agreement and how it differs from a foster placement. This caused the complainant distress and was left uncertain about the financial implications for her such as leaving her with unpaid mileage expenses she incurred whilst providing support for the foster child. The Ombudsman also found fault in the way in the Council carried out a joint needs assessment of the foster child whilst he transitioned to a young adult under a "staying put" arrangement as the assessment did not fully reflect his needs which at the time were being met by the complainant in her role as foster carer but was uncertain she could continue to do so as a staying put carer with reduced financial support. It also

found the Council at fault for not considering the complaint further under its internal complaints procedure.

5.7.2. The Ombudsman recommended that the Council issue an apology for the faults identified, that it pays £1000 and that it reimburses any mileage costs not paid during the period in question. It also recommended that the Council carry out a fresh needs assessment for the now young adult to clarify his current eligible needs in consultation with the complainant. Once this is completed it should also meet and update the complainant to explain the Councils expectations regarding future care of the young adult and to clarify what it will pay her. Additionally, it has recommended the Council reviews its staying put policy to address the shortcomings identified, that it reminds relevant staff of the need to start planning for transition to adulthood whilst ensuring that carers have sufficient information to make an informed decision about whether to continue to provide care on a staying put basis, as well as reviewing its complaints process to ensure it does not exclude complaints where a person is asking the Council to exercise its discretion over how to apply a policy or when to depart from it.

5.7.3. The required actions set out by the Ombudsman have since been completed. The Fostering Service has also considered the recommendations from this finding within its service improvement plan and is looking at developing a specific Post 18 team which would provide ongoing support to 'Staying Put' carers. Whilst this was not a recommendation made by the Ombudsman the service believes that this would greatly enhance the current offer and provide more stability to carers and the young people living with them.

5.8. **Special Educational Needs Complaint –** The complainant raised concerns in June 2019 that his stepchild's Education, Health and Care Plan (EHCP) annual reviews had not been carried out correctly in January 2018 and 2019. He also complained about the quality of the communication he received from the Council.

5.8.1. The Ombudsman found the Council at fault for failing to identify that despite the child's school incorrectly notifying the Council that the ECHP did not require amending in 2018, from the information supplied with this notification it should have been apparent to the Council that amendments were needed. The Council also failed to issue the statutory notice informing the child's parents that it did not intend to amend the EHCP. However, the Ombudsman concluded this error did not cause any injustice as the school was working in accordance to the amendments it had intended to implement, and the complainant did not raise concern about the delivery of these provisions. The Ombudsman also found fault with the annual review conducted in 2019 as although the Council issued an amended plan within the required timescales, it did not first issue a draft amended plan. Although, the Ombudsman

acknowledged that this fault was unlikely to have caused the complainant further injustice as he wanted the process to complete as soon as possible so he could appeal to the SEND Tribunal.

5.8.2. The Council agreed to issue a payment of £400 in recognition of the injustice the complainant experienced throughout the matter as a result of the Ombudsman's investigation. The Council also explained that since it had considered this complaint it had already completed work to review all procedures relating to the Annual Review process and general record keeping which included the delivery of training and the issuing of guidance to SEND Keyworkers regarding the timescales following annual reviews and ensure accurate records are kept for children and young people with EHCP's. The Ombudsman was satisfied with this action and made no further recommendations.

5.8.3. The service is subject to a Written Statement of Action and is expecting an Ofsted revisit in Spring 2021. The priority for the SEND Partnership has been to address the significant areas of improvement required and therefore annual reviews have not been given priority. Annuals reviews were not a significant area of weakness and therefore have not been given the same level of priority.

5.8.4. However, steps have been taken in the last nine months to improve the annual review process. This has involved coproducing a new process and paperwork with the parent carer forum and the development of a real time tracker so workloads can be monitored. Furthermore, the service is recruiting additional capacity in the permanent teams to develop a sustainable system; though with significant increases in new Education, Health and Care plans, capacity will need to be kept under review.

5.8.5. The service is also looking to reduce the demand on the service with training for schools to ensure we are not receiving requests to amend plans where these are not needed. The Ombudsman has recognised the work that is taking place which is why no further recommendations were made which is a positive recognition that the Local authority is already addressing the issues raised with them.

5.9. **Referrals to the LGSCO**

5.9.1. The number of referrals to the Ombudsman during 2019/20 has been previously reported at the July 2020 Audit & Governance Committee meeting as part of the Annual Report of the Monitoring Officer. However, following the Council's receipt of the Ombudman's annual report, the figures have been updated to account for the 39 cases they decided not to investigate.

5.9.2. The table below provides a comparison to the previous year and appendix 2a and 2b provide a further breakdown of the service areas which the cases relate to.

	2018/19	2019/20
Number of Cases closed	116	112
Number of Decision Notices issued	78	73
Number of Cases Not Investigated	38	39
Number of Cases Not Upheld	14	12
Number of Cases Upheld	14	17
LGSCO Uphold Rate (Upheld vs Not Upheld)	50%	59%

5.9.3. In 2019/20 the Ombudsman carried out detailed investigations on 29 cases. In 17 of these cases the detailed investigation found maladministration with injustice and upheld the complaint in the complainant's favour. In 12 cases the detailed investigation found no fault with the Council's actions and were not upheld. This gives the authority an uphold rate of 59% of the detailed investigations decided by the LGSCO in 2019/20, which is an increase from the 50% uphold rate in the previous year and 3% above the national average uphold rate of 56%. It is worth noting that the number of cases upheld (17) represents less than 1% of the total number of complaints (2345) the Council received during 2019/20.

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 the cases outlined in this report the Council was required to make compensation payments totalling £1700.

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:

Name: Juan Turner
Job Title: Compliance and Customer Relations Officer
Email: juan.turner@cheshireeast.gov.uk

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

April – August 2020

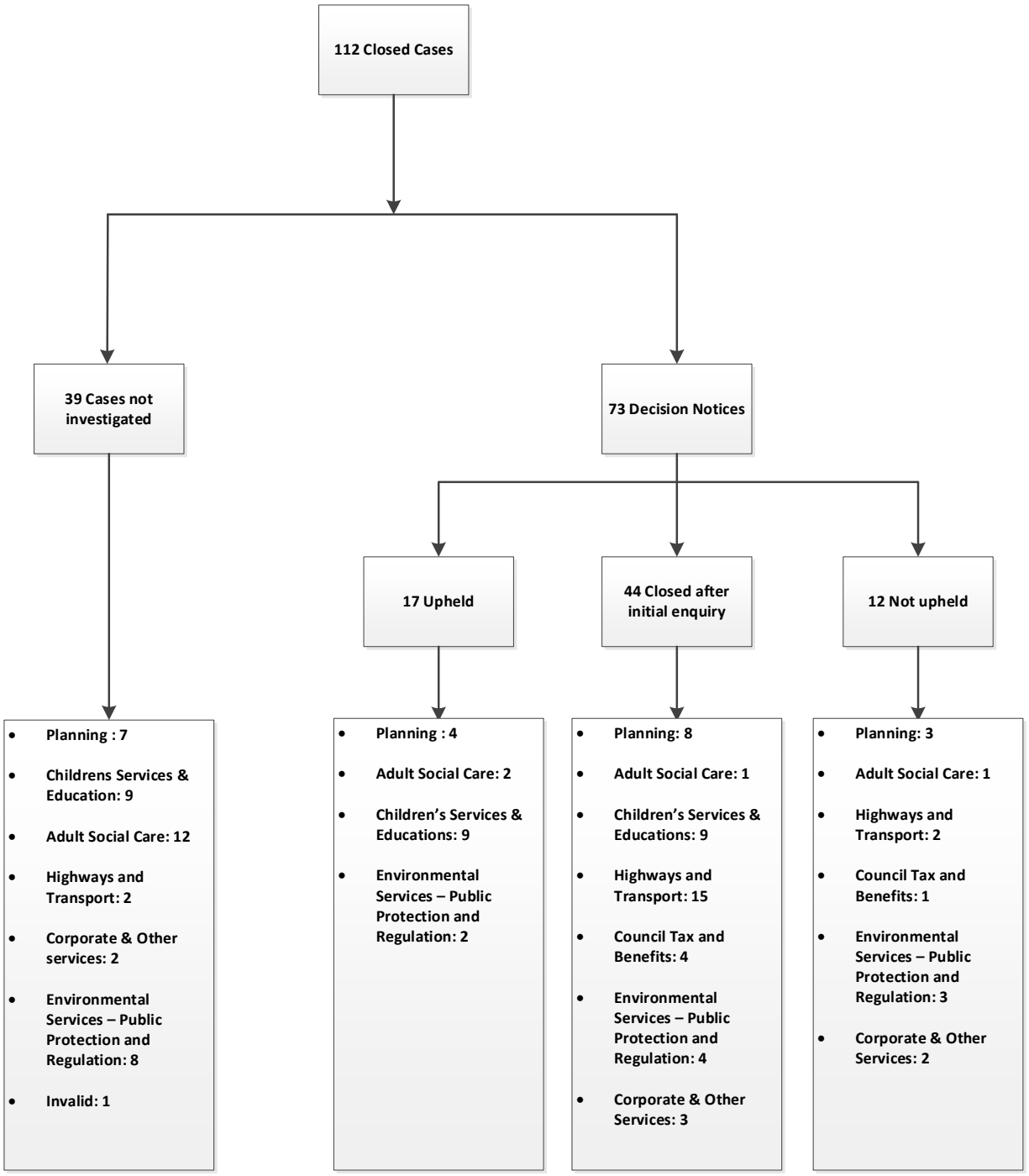
Service	Summary and Ombudsman's Final Decision	Agreed Action	Link to LGSCO Report	Action Taken	Measures Implemented	Lessons Learnt
Data Protection	Mr X complained about the way the Council processed his request for social care records. He said the Council did not share his records correctly which caused him avoidable distress. The Ombudsman found fault as the Council failed to consider Mr X's request for his care records through the correct procedure and recommended that the Council apologise and pay £300 to remedy the injustice caused.	Within one month of the final decision the Council has agreed to apologise to Mr X for how it disclosed his social care records and pay him £300 for the avoidable distress caused by the fault.	https://www.lgo.org.uk/decisions/children-s-care-services/other/19-013-552	The £300 payment and apology has been issued to the complainant.	Revised Subject Access Request form to include details of what the requester is already aware of in their records. Responses include a 'distress warning', where necessary, advising individuals to seek support and assistance when reading case files. Staff have been reminded to be vigilant about requests which should be referred to the Regional Adoption Agency.	Staff to be clear with requesters about what they already know about their past. Ensure the team are aware of the types of requests which should be referred to the Regional Adoption Agency. Avoid sending sensitive responses by email on a Friday.

Fostering	Mrs X complained the Council reduced its payments to her when her care of Y changed from being foster care to a “staying put” arrangement. The Ombudsman found the Council had failed to provide adequate information about the staying put arrangement so Mrs X could make an informed choice about caring for Y on this basis before he turned 18. It recommeded that the Council pay Mrs X £1,000 to remedy the injustice caused and make changes to its processes.	Within one month of the final decision the Council has agreed to apologise to Mrs X for failing to provide adequate information about the financial package for the staying put arrangement failings in the needs assessment that may have impacted on the financial package offered, and failing to clearly explain the changes to her role when she became a staying put carer for Y. It should also pay her £1,000 for the distress and uncertainty caused by these faults. As well as reimburse any mileage costs not paid prior to Y having a car to drive himself to activities. Within 3 months of the date of the final decision the Council should carry out a fresh needs assessment for Y to clarify his current eligible needs. It should consult with Mrs X as part of that assessment. It should meet with Mrs X to explain its expectations regarding Y’s future care in light of the updated needs assessment and to clarify	Not yet published on the LGO’s website	The apology has been issued and the £1000 paymet has been made to the complainant. The ‘Staying Put’ policy has been re-written and is awaiting final approval at the Policy and Procudre working group. The means of identifying any outstanding mileage for this carer has been agreed and the outstanding amount is being processed immediately. The new assessment for Y is being concluded by a social worker from Adult Services.	Policies are being refreshed and will be implemented once finalised. Training developed to be delivered across Children’s and Adult Services. A ‘Post 18 Support Team which will include direct support being offered to ‘Staying Put’ carers and access to ongoing training, normally only available to foster carers is being developed. Adult services have also developed a designsted Transition Team to provide support.	The previous policy was not clear about the financial remuneration that carers of young people with additional needs would receive as ‘staying put’ carers. This has added to confusion for both the carer in this case and the Fostering Service. We need to ensure that we are robust in the working together practice between Children and Adult Services as not being joined up can have a negative impact on the timeline for outcomes of the young person.

		what it will pay her. It should also review its staying put policy to ensure it clearly sets out what it will and will not pay staying put carers and how this differs from arrangements for foster carers. It should remind relevant staff of the need to start planning for transition to adulthood at least 12 months before the looked-after child turns 18 and ensure that carers are given sufficient information to make an informed choice about whether to continue to provide care on a staying put basis; It should also review its complaints process to ensure it does not exclude omplaints where a person is asking the Council to exercise its discretion over how to apply a policy or when to depart from it.				
Special Educational Needs	Mr X complained the Council failed to carry out his stepson, Education, Health and Care Plan annual reviews in 2018 and 2019.	Within in one month of the final decision ensure that that a payment of £400 is issued in recognition of the injusitce casued.	Not yet published on the LGO's website	The £400 payment and apology has been issued to the complainant.	1. The service have set up an interim annual review team who are focusing on overdue reviews.	The service is subject to a Written Statement of Action and is expecting an Ofsted revisit in Spring 2021

	The Ombudsman found the Council at fault when it failed to follow the correct procedures after deciding to amend the Plan. The Ombudsman was satisfied that the Council had offered Mr X £400 to remedy the injustice caused and that it had also demonstrated it has reviewed its procedures around annual reviews.				2.The annual review process has been reviewed and all paperwork has been updated. This was coproduced with our parent carer forum 3.The service have deveoped a real time tracker so that progress on annual reviews is understood and work can be allocated. 4. Schools are being given training on using the portal in order that they can upload their review paperwork straight into the system. Clear messages are being given to schools of when plans will need to be amended following a review haven taking place.	(Potentially delayed by 12 months due to Covid). Priority has been given to the significant areas of improvement required. An additional interim team has been put in place to address overdue reviews. Capacity in the service will need to be kept under review as the demand continues to increase significantly. Analysis of complaints, LGSCO and Tribunals is reviewed by the SEN Management Team to ensure that learning is identifed and practice changed where needed.

LGSCO DECISION NOTICES 2019/20 Appendix 2a



LGSCO DECISION NOTICES 2018/19 Appendix 2b