Nottinghamshire County Council

Report to Governance and Ethics Committee

30 September 2021

Agenda Item: 4

REPORT OF THE SERVICE DIRECTOR FOR CUSTOMERS, GOVERNANCE AND EMPLOYEES

LOCAL GOVERNMENT & SOCIAL CARE OMBUDSMAN DECISIONS: JUNE – AUGUST 2021

Purpose of the Report

1. To inform the Committee about Local Government & Social Care Ombudsman's (LGSCO) decisions relating to the Council since the last report to Committee up to 27th August 2021.

Information

2. Members have asked to see the outcome of Ombudsman investigations regularly and promptly after the decision notice has been received. This report therefore gives details of all the decisions received since the last report to this Committee.

3. The LGSCO provides a free, independent and impartial service to members of the public. It looks at complaints about Councils and other organisations. It only looks at complaints when they have first been considered by the Council and the complainant remains dissatisfied. The LGSCO cannot question a Council's decision or action solely on the basis that someone does not agree with it. However, if the Ombudsman finds that something has gone wrong, such as poor service, a service failure, delay or bad advice and that a person has suffered as a result, the LGSCO aims to get the Council to put it right by recommending a suitable remedy.

4. The LGSCO publishes its decisions on its website (www.lgo.org.uk/). The decisions are anonymous, but the website can be searched by Council name or subject area.

5. A total of fourteen decisions relating to the actions of this Council have been made by the Ombudsman in this period. Appendix A to this report summarises the decisions made in each case for ease of reference and Appendix B provides the full details of each decision where fault has been found.

6. Following initial enquires into eight cases the LGSCO decided not to continue with any further investigation for the reasons given in Appendix A. Copies of the full decisions are available as background papers.

7. Full investigations were undertaken in six complaints. Appendix A provides a summary of the outcome of each investigation. Where fault was found, the table shows the reasons for the failures and the recommendations made. If a financial remedy was made the total amount paid or reimbursed is listed separately. (Reference and page numbers refer to the information in Appendix B).

8. During this period there were five cases concerning Adult Social care, one of which is a Public Report (page 4 in Annex B). There are many reasons why the LGSCO might issue a public report. The main reason is because the Ombudsman believes it is in the public interest to highlight particular issues or problems. He might also issue a public report because what went wrong is significant or because the impact on the person complaining is significant.

9. The complainant in this case complained about the services provided at Berry Hill Park Care Home to his late mother; the services were commissioned by the Council. He also complained about the council's safeguarding investigation. The report notes good social work practice : "*case records show the Council officers involved were empathetic and impartial. Officers were navigating a difficult family situation while keeping Mrs D at the heart of decision making. The records show officers obtaining the views of all involved, responding to Mr C's frequent emails but also maintaining lines of communication with the care home".* However fault was found in relation to the Care Homes actions in restricting the complainants access to the Home, and in relation to a delay in informing him of the outcome of the safeguarding investigations, although no fault was found in relation to the investigation itself.

10. The report made several recommendations which have all been accepted by the Council:
    - formally acknowledge the failures identified in this report and apologise for the frustration, distress, time and trouble the Care Provider's and Council's actions caused him;
    - pay Mr C £650 to reflect:
        - the distress he was caused by the Care Provider banning him from the care home without notice;
        - the distress he was caused from not seeing his mother for six weeks; and
        - his time and trouble in having to raise his complaints with both the Care Provider and Council for the restrictions to be removed;
- through contract monitoring processes ensure the Care Provider:
    - reminds care staff about what actions to take before a person is excluded from a care home;
    - reminds care staff about the importance of recording risk assessments and that these are evidence based rather than opinion;
    - provides training to staff about anti discriminatory recording and behaviours;
- remind staff about the importance of telling people the outcome of safeguarding investigations as quickly as possible;
- remind staff about recording and completing any follow up actions arising from a safeguarding investigation.

11. Some actions have already been completed and Adult Social Care have developed an action plan (attached at Appendix C). The LGSCO will require the Council to evidence that the actions have been completed within the timescale.

12. In two of the remaining cases concerning ASCH (pages 1 and 18 in annex B) the Council remedied the complaint as the Ombudsman was making enquiries, and therefore the complaints were closed, one with no further remedies, and one with agreed actions. One case (page 27 in Annex B) found that the Council had not fully taken into account all the relevant family matters before deciding a service user had "notional capital" to pay for care. This followed a series of gifts and a property transfer within the family. The Council will apologise and will conduct a re-assessment.

13. One complaint spanned adults and childrens services and related to transition planning and withdrawal of support services. The main strands of the complaint: service provision and planning, were not upheld. It was found that there had been confusing communication (which had already been identified and apologies offered before the LGSCO was involved). The decision to deal with additional complaints through the adults complaints process was also criticised, although the robust investigation that resulted was recognised.

14. The final case (page 21 in Annex B) related to children's services, and concerned a tragic case surrounding the care of a young child following the mothers murder by the father. Although the main substance of the complaint was not upheld, fault was found in that a statutory health assessment of the child was not carried out within statutory timescales.

Statutory and Policy Implications

15. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Data Protection and Information Governance

16. The decisions attached are anonymised and will be publicly available on the Ombudsman's website.

Financial Implications

17. Financial remedies from Adult Social Care and Health budget total £900 although £650 has been rejected by the complainant. A remedy of £300 was paid from the Chief Executives Department.

Implications for Service Users

18. All of the complaints were made to the Ombudsman by service users, who have the right to approach the LGSCO once they have been through the Council's own complaint process.

RECOMMENDATIONS

1. That members consider whether there are any actions they require in relation to the issues contained within the report.

2. That there is some detailed work done with Adult Social Care Department, in relation to identifying core issues in complaints that are not resolved at the earliest point.

Marjorie Toward
Monitoring Officer and Service Director – Customers, Governance and Employees

For any enquiries about this report please contact:

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Constitutional Comments (HD (Standing))

Governance & Ethics Committee is the appropriate body to consider the content of this report. If the Committee resolves that any actions are required, it must be satisfied that such actions are within the Committee's terms of reference.

Financial Comments (RWK 16/09/2021)

The decisions detailed in the report and the appendix have resulted in financial remedies totalling £1,200. These costs will be met from within the budget for adult social care (£900) and the Chief Executive's department.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Ombudsman decisions where no fault found.

Electoral Division(s) and Member(s) Affected

- All