

**10 January 2024****Agenda Item: 4****REPORT OF THE SERVICE DIRECTOR FOR CUSTOMERS, GOVERNANCE  
AND EMPLOYEES****LOCAL GOVERNMENT & SOCIAL CARE OMBUDSMAN DECISIONS  
OCTOBER 2023 TO NOVEMBER 2023****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 was completed and therefore any decisions after 30<sup>th</sup> October 2023.

**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/](http://www.lgo.org.uk/)). The decisions are anonymous, but the website can be searched by Council name or subject area.
5. A total of seven 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.
6. Full investigations were undertaken into three complaints. Appendix A provides a summary of the outcomes of the 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.
7. There was fault found in two cases. The first case was in Adults. Mrs X complained about the Council's actions when Mrs X's child, D, who is disabled, moved from children's to adult social

care services. The Ombudsman found that the Council gave Mrs X wrong information about direct payments, failed to keep her updated, and delayed its transition assessment for D which caused a gap in care and support. The Council agreed to apologise, pay a financial remedy of £2300 to the family, and cover the cost of any financial loss caused to Mrs X by the wrong information it provided. It will also review relevant policies and procedures, and issue guidance to its staff.

There are several parts to this complaint and various teams have been involved. In March 2021 the Commissioning Team wrote to Mrs X to explain the changes to how the Council would commission and pay for Payroll Providers (otherwise known as Direct Payment Support Services). Mrs X did not opt to change the payroll provider and continued to receive support through The Rowan Organisation who were not selected to be on the Nottinghamshire County Council's approved provider list. Unfortunately, as the provider is not contracted by Nottinghamshire County Council we are unable to hold the provider to account for any failings in advice given to Mrs X on the redundancy issue. The Council still believes that redundancy isn't due as her circumstances didn't meet the criteria for redundancy. This has been explained to the provider. As there was still a requirement for a PA for D, albeit Mrs Y did not want to continue in this role, this does not satisfy the statutory definition of redundancy. On that basis Mrs X was informed no redundancy payment was owed to Mrs Y. The Short Breaks and Assessment Team even sought advice from the Council's legal team.

As far as the transition to adulthood is concerned, no decision was taken by the Council to postpone D's assessment. The Transition Team received the referral in September 2021 and following triage and allocation, D was first visited in December 2021 when he was 17.5. This is usual practice for someone with D's needs and there was no decision to record.

The assessment of D's needs commenced in December 2021 with an initial support plan started to consider short breaks provision and a carers assessment for Mrs X.

Support planning took longer than usual, due to the additional year at school and Mrs X preferring to access short breaks with a particular provider who were not taking any new referrals at the time and had a long waiting list. Mrs X was aware of this and indicated that she was happy to wait for her preferred provider. Day services were being explored for when D was to leave school in 2023.

Following an already lengthy wait for the preferred short breaks provider, other options were explored and following provider assessments, an alternative provider offered their services in May 2023 and Mrs X subsequently arranged with the provider for D to have his short break at the beginning of August.

Although the original Social Worker was absent from work due to sickness from 9<sup>th</sup> November 2022, another worker was allocated to work with the family on 13<sup>th</sup> December 2022, which did not constitute a significant gap in support or have a significant impact on support planning, as this was delayed more by the wait for the preferred short breaks provider.

However, it is accepted that we could have communicated better with Mrs X about the transition process and what to expect and when and we have taken steps to address this.

8. The other complaint is in Adults too. The complaint from Ms B is about the care and treatment provided to her mother, Mrs C, by a Care Home (acting on behalf of Nottinghamshire County Council) and the Family Medical Centre (the Practice). Ms B complains that the care home and Practice failed to take appropriate action when her mother became unwell in January 2022. She says care home staff failed to report that Mrs C had suffered two falls. The Ombudsman found fault with the care provided to Mrs C by a GP Practice and a care home acting on behalf of the Council. This leaves her daughter, Ms B, with significant uncertainty as to whether the outcome of Mrs C's care might have been different with appropriate care.

We would like to inform Members that Council Officers did speak to the Ombudsman regarding this case to understand their decision. We explained the lengths that the Quality and Market Management Team (QMMT) and the wider system have gone to in relation to the monitoring of quality in all services, provided specific examples of the monitoring visits completed in the service prior to the incident and the training provided to this service (and others) for Restore 2, Home rounds and the react2 package. The ombudsman representative explained that unfortunately despite us being able to prove that we (the council) have provided this level of support and monitoring we would still be held responsible for the care home's lack of action as we have either arranged and/ or are funding the package of care. This is written into legislation so the decision could not be challenged.

The representative did however explain that as we had evidenced the work we have done before and after the incident this will be recognised, in addition he did confirm that the Council is able to charge the provider for the cost of the fine. In response to this case the Council will raise with their regional Association of Directors of Adult Social Services (ADASS) and the Care Quality Commission (CQC) the concern they have in respect of being held accountable for when complaints are found against a private contracted social care services.

The Council is apologising to Ms B and providing a financial remedy of £400 and updating them with actions being taken to ensure adequate monitoring and support for care homes moving forward.

### **Other Options Considered**

9. The other option considered was not bringing regular reports to the Committee detailing the decisions made by the Local Government and Social Care Ombudsman. This option was rejected as by not having oversight of this report the Committee would not receive assurances that the learnings from Ombudsman cases were leading to improvements in services.

### **Reasons for Recommendation/s**

10. To enable members to scrutinise complaints dealt with by the Council that went to the Ombudsman and to inform them of the service improvements being made for the benefit of residents as well as colleagues.

### **Statutory and Policy Implications**

11. 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**

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

### **Financial Implications**

13. The details of any financial payments are set out in Appendix A. £2700 will come from Adults services.

### **Implications for Service Users**

14. 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.

## **RECOMMENDATION/S**

- 1) That members note the findings of the Local Government and Social Care Ombudsman and welcome the lessons learned and actions taken in response to the findings

**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))**

15. 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 (SES 07/11/2023)**

16. The financial implications are set out in paragraph 13 of the report.

17. The details of the financial payments are set out in Appendix A.

### **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.

- None

**Electoral Division(s) and Member(s) Affected**

- All