Nottinghamshire County Council

Report to Governance and Ethics Committee

26th November 2025

Agenda Item: 4

REPORT OF THE SERVICE DIRECTOR FOR CUSTOMERS, GOVERNANCE AND EMPLOYEES

LOCAL GOVERNMENT & SOCIAL CARE OMBUDSMAN DECISIONS AUGUST 2025 TO OCTOBER 2025

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. This is an update of cases on which the Ombudsman has made decisions since August 2025.

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. Whenever a complaint goes through our process they have to be informed of their rights to approach the LGSCO.

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. Since August Nottinghamshire County Council has received and managed 286 complaints in total. This comprises of 121 in Adults, 144 in Childrens and 21 in Place or other areas. The Ombudsman has made decisions on 17 cases in that time period. Many of these cases would have been from complaints the Council would have received and managed before August such is the time it can take for complaints to go through the process as well as time for the Ombudsman to review it. This does show though that less than 6% of complaints currently are ending up at the Ombudsman which is a positive downward trend.

6. The Ombudsman did not investigate 15 cases they received concerning Nottinghamshire County Council. Most of these were in Childrens. The main reason for not investigating further was the Ombudsman could see the Council had taken reasonable steps to remedy the situation or wasn't at fault at all. Other reasons include the fact that the complainant had appeal rights to exercise or they were late with their complaint.

7. There were 2 cases where the Ombudsman found fault. The first case was in Childrens where the complainant states the Council failed to provide her son who is currently receiving education other than at school, with a qualified, trained tutor who had experience in working with young people with autism, despite his Education, Health and Care (EHC) plan requiring it; and b) refusing to fully fund the tutor she found, who is qualified, trained, and experienced. As a result, her son has not received the provision needed.

   The Ombudsman found fault because the EHC plan set out the requirements for the teachers and teaching assistants requiring them to be trained and experienced in working with children with autism and anxiety. Steps weren't taken to ensure the tutor had worked with children with anxiety and no evidence the Council could offer the training or find an alternative tutor. The Ombudsman was satisfied that when alerted to the problem, the Council took steps to ensure the son received what he needed under his EHC plan. They also found no fault with the Council not fully funding the tutor the mother found as the contract was with the provider not the tutor.
   The Council agreed to apologise and reminders have been sent to officers regarding checking to see if alternative providers can be sourced to meet EHCP requirements where it's highlighted this may not be the case.

   The Pre 16 EHC assessment team accepts the decision made by the LGSCO. It is with regret that on this occasion the tutor that was working with the child did not have the experience that was detailed in Section F of his Education, Health and Care Plan. All staff in the service have been reminded and asked to check whether teachers and teaching assistants referred to in EHC plans meet the specified criteria set out in addition to the further actions that the Ombudsman has requested. It is important to note that the current service is being re structured to respond to the increasing number of Education, Health and Care Plans (EHCP) that the County Council maintains. As part of the Statutory SEND Service 0-25 there will be additional staff and a dedicated EOTAS team for children and young people with an EHCP. This will ensure that there is improved support and oversight of provision for children and young people who are in receipt of education otherwise than at school.

8. There was fault found in one Adults case. The daughter complained about the care provided at 2 different providers on behalf of her Mother. She said Home 1 did not take appropriate action to prevent a fall in February 2024, the continence care provided to Mrs D was poor and the Home lost Mrs D's walker. She also complained about an incident in another care home when she was frightened of one of the workers.
   The Ombudsman state that the Council carried out appropriate enquiries into the concerns that had been raised. The Council read the relevant records and visited the care homes in question and identified shortcomings with reporting procedures. The complaint response from the home wasn't adequate to address the behaviour of the staff member at the home. The

Council has agreed to make a reduction of £200 from the charges for the care and is working with the home to ensure record keeping is watertight and they learn from this case.

In terms of direct learning for the Council, QMMT have started to put a warning notice on the front page of our records to ensure that portfolio holders are reminded of key areas for improvement to ensure that they check for embedding of any actions at each contact. This should result in more rigorous and continued monitoring of actions that have been agreed. Officers will also discuss adding findings from S42 safeguarding enquires where allegations have been upheld in the same way. They will review our contract monitoring processes to ensure that all staff are aware of this. The care homes have confirmed that they have reviewed and updated all mobility and falls risk assessments.
Also staff there recently completed training and are working with a physio over the next 6-9 months each week to improve knowledge and look at areas where they can improve managing falls.
They have the latest technology with bed, chair, full floor sensors. This is recorded as a planned care to ensure sensor equipment is checked and signed as a set task on their systems each day and as required, we work closely with the care homes falls nurse to arrange prompt falls assessments.
Weekly sensor checks are made by the management team and we have an up to date record of all sensor equipment in use for each person which we update as required on our monthly risk review, this gives us oversight of what equipment is in use for each individual.

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 consider 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.

Financial Implications

12. £200 will come from Adults Social Care budget.

13. **Local Government Reorganisation Implications**

There are no Local Government Reorganisation implications arising directly from this report**.**

Data Protection and Information Governance

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

Implications for Residents

15. All of the complaints were made to the Ombudsman by residents or their representatives, 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 the lessons learned and actions taken in response to the findings to improve future service delivery

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))

16. 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

17. The financial implications are set out in paragraph 12 of the report.

18. The details of the financial payments are set out in the report.

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 Decision 24 020 005 dated 24 September 2025
- Ombudsman Decision 24 021 386 dated 10 October 2025

Electoral Division(s) and Member(s) Affected

- All