

## London Borough of Hammersmith & Fulham

**Report to:** Audit Committee

**Date:** 13/09/2022

**Subject:** Local Government and Social Care Ombudsman Annual Review Letter 21/22 and Housing Ombudsman Maladministration Findings

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### SUMMARY

This report updates the Audit Committee on the Local Government And Social Care Ombudsman (LGSO) Annual Review Letter. As the Housing Ombudsman does not produce an annual letter it also updates on the findings of maladministration by the Housing Ombudsman in 20/21.

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### RECOMMENDATIONS

1. That Audit Committee note the content of the review letter and comment on the actions to address outstanding issues.
  2. That Audit Committee note the findings of maladministration by the Housing Ombudsman.
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**Wards Affected:** All

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<b>Our Values</b>	<b>Summary of how this report aligns to the H&amp;F Values</b>
Building shared prosperity	<i>Having effective systems in place to monitor feedback from residents enables opportunities to improve services for our residents' benefit.</i>
Creating a compassionate council	<i>Understanding difficulties our residents face in dealing with our services where residents are experiencing their most difficult circumstances or have complex needs</i>
Doing things with local residents, not to them	<i>Learning from our residents' feedback enables us to ensure that we are delivering services that meet their needs.</i>

Being ruthlessly financially efficient	<i>Providing a service that meets residents needs provides value for money. Ensuring we learn from our mistakes and improve services accordingly is financially efficient.</i>
Taking pride in H&F	<i>Providing accessible and effective services to our residents and businesses makes Hammersmith and Fulham an attractive place to live work and do business in</i>
Rising to the challenge of the climate and ecological emergency	<i>A more efficient service increases the opportunity for digital delivery and better facilitates sustainable service delivery.</i>

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## Background Papers Used in Preparing This Report

None.

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## DETAILED ANALYSIS

### Background

When a resident has exhausted the corporate complaints procedure and if they are still dissatisfied with our response, they can make a complaint to either the Local Government & Social Care Ombudsman (LGSCO) or the Housing Ombudsman.

Each year the LGSCO provides an annual review of performance. This report considers the LGSO annual review. The Housing Ombudsman does not provide an annual letter but publishes data (around December). However, as the Monitoring Officer has a duty to report all cases of maladministration to Members, the cases where the Housing Ombudsman found maladministration are also included in this report.

### LGSO Annual Review Letter 2021/2022

The Annual Review letter was received on 20<sup>th</sup> July 2022 and is included as Appendix A.

In addition, the LGSO also provided a spreadsheet showing details of all cases considered during the period, all cases decided and those where the decision was upheld.

During the period (April 21 – Mar 22) the LGSO received **80 cases** (59 cases in 20/21). They are broken down as follows:

Adult Social Care    13  
Benefits and Tax      4

Corporate & Other 4  
 Education and Children's 7  
 Environment and Public Protection 1  
 Highways and Transport 9  
 Housing 28  
 Other (LGSO category) 8  
 Planning and Development 6

During the period the LGSO concluded **79 cases** but only 17 were investigated fully (10 in 20/21) and a decision issued. Others were concluded for a variety of reasons including closed after initial enquiries, giving advice to follow complaints process, closed as incomplete or invalid or referred back for local resolution.

Of the 17 decisions made in the period 13 of those were upheld. This means our percentage of **decisions upheld is 76%**. The average for similar authorities is 71%.

The LGSO also reports on compliance with recommendations and orders and we had **100% compliance** compared to an average in similar authorities of 99%.

The LGSO reports on cases where the authority has satisfactorily resolved the issue prior to the decision being issued. We had **8% resolved** in this way compared to an average of 11%.

Our performance is compared to previous years in the table below:

	18/19	19/20	20/21	21/22
Numbers of full decisions	73	23	10	17
Decisions upheld	72%	43%	70%	76%
Compliance	100%	100%	100%	100%
Resolution prior to decision	15%	0%	0%	8%

NB 20/21 Decisions were lower as the Ombudsman stopped accepting complaints for a period during the pandemic.

### Decisions Made

The breakdown of the 17 decisions made is:

Decisions not upheld:

Adult Care Services	12/11/2021	Other reason not to continue investigation
Adult Care Services	18/02/2022	No maladministration
Housing	16/03/2022	No maladministration
Housing	07/02/2022	No maladministration

No fault or maladministration was found in these cases.

Decisions upheld:

Adult Care Services	20/04/2021	Upheld	maladministration & injustice
Adult Care Services	05/05/2021	Upheld	maladministration & injustice
Adult Care Services	25/08/2021	Upheld	maladministration & injustice
Adult Care Services	11/10/2021	Upheld	maladministration & injustice
Adult Care Services	29/09/2021	Upheld	maladministration & injustice- no further action, already remedied
Adult Care Services	12/11/2021	Upheld	maladministration & injustice
Adult Care Services	25/01/2022	Upheld	Injustice remedied during LGO consideration
Adult Care Services	29/03/2022	Upheld	Remedy agreed during investigation (no finding on mal: no public interest)
Benefits & Tax	22/10/2021	Upheld	maladministration & injustice
Education & Children's Services	05/05/2021	Upheld	maladministration & injustice
Housing	07/07/2021	Upheld	maladministration & injustice
Housing	28/10/2021	Upheld	maladministration & injustice
Housing	04/03/2022	Upheld	maladministration & injustice

Detail on all these cases can be found in Appendix B. Note the case classified above as Benefits and Tax is classified in our records as Temporary Accommodation (failure to advise resident they would be liable for Council Tax when in temporary accommodation)

Of the 13 cases, 11 found maladministration but one of those did not warrant any further action from the Ombudsman as it had been remedied. Another found injustice but no maladministration, but this had been remedied and a further was remedied during the investigation.

Eight of the thirteen cases upheld relate to adult social care. This is unusual as adult social care do not receive high levels of complaints. Also, of note is that fact that adult social care consistently respond to all its complaints within the agreed timescale and are the top council performer in this regard.

Nationally the Ombudsman reported that adult social care had seen increased numbers of complaints during the pandemic. This isn't surprising given the significant increase in overall social referrals and assessments during the pandemic. Also, during this time, the NHS introduced a new 'discharge to assess' policy, which has meant that even more people are discharged home with a very high level of

social care and health needs. This has significantly impacted on the service demand. Quality in terms of home care due to capacity pressures has also been impacted.

Also, of note, is the fact that as H&F gives free home care, demand has increased by 40% since the introduction of this policy. Consequently, combined with covid, the impact on social care service has seen an unprecedented level of demand.

In our regular liaison meeting with the Ombudsman, they commented that the levels of complaints that we had experienced, across all services, that related to the pandemic, were lower than expected and complimented the Council on its Covid 19 response. However, the pandemic does appear to have had impact on the higher proportion of decisions, even though adult social care continued to provide all of its support and services throughout the pandemic, unlike many other Councils who were unable to deliver their social care as they usually would.

Adult social care has no stage two complaints.

Increased referrals in respect of Adult Social Care during the 21/22 year were noted during the year and action taken to analyse the reasons for this and to remedy. In most of the cases where the Ombudsman found unfavourably against the service, the service had identified fault and provided satisfactory remedies during the period of investigation.

Half of the decisions related to services provided on behalf of the Council. In the other half, The Ombudsman considered that the actions of the provider are the actions of the Council. In two of these cases the provider failed to notify the Council of the complaint, but the Ombudsman found they had completed the providers process and therefore the Council's. The service identified that this meant that the Council had no control over the process or opportunity to suggest remedy but had to accept the findings of the Ombudsman.

The service urgently addressed this procedural gap with providers and the service has worked with providers to ensure that all complaint decisions are approved by the Council, and this has resulted in less complaints being escalated.

The service accounts for the only satisfactory remedy before the complaint reached the Ombudsman. The Service has also implemented a learning log from Ombudsman decisions ensuring that it is making changes and acting on learning from the findings of the Ombudsman'. A review of the service complaint procedure will include a further review stage prior to referral to the Ombudsman, and scrutiny of learning for all upheld cases.

### **Timely Compliance**

In last year's annual letter, the Ombudsman noted that whilst there was 100% compliance with the orders and recommendations it was disappointing to note that in three cases this compliance was late. This year the Ombudsman has highlighted that this issue has not continued and the compliance with orders has been timely across all departments.

However, the Ombudsman has pointed out that they encountered delays in request for information from Housing, stating that over 7 cases the average response time was 30 days. Analysis has been carried out to identify where and when these delays occurred, and delays were found to have occurred in 5 cases:

Reference	Service	Date	Delay
20002781	Housing Advice and Assessment	14/05/21	Request for info directed to wrong dept
21001004	Temporary Accommodation	22/04/21	Service delay
21003902	Temporary Accommodation	17/06/21	Service delay – extension was requested and granted
21004560	Housing Advice and Assessment	28/06/21	Service delay
21008396	Tenancy management	14/09/21	Service delay

These delays were identified at the time and are prior to tighter controls and escalation being put in place. We have not experienced such delays since.

### **Housing Ombudsman Maladministration Cases**

During the year 2020/2021 The Housing Ombudsman made ten determinations of maladministration.

Department	Case Reference Number	Date of Final Decision	Compensation Awarded	Complaint Summary
<b>Economy - Repairs</b>	202009699	20.05.2021	£150	The resident is unhappy with the Council's handling of a leak from the property above.
	202013639	28.05.2021	£475	The complaint is about the landlord's handling of repairs to the complainant's balcony.
	202010475	14.06.2021	£500	Asbestos, general maintenance of the communal areas including cleaning & delays in complaint handling
	202100618	09.08.2021	£500	The complaint is about the landlord's handling of the complainant's reports of a leak in his property.
	202013981	30.09.2021	£250	The complaint is about the landlord's handling of repairs to the resident's balcony.

	202102637	27.01.2022	£375	The landlord's handling of roof works following the resident's reports a leak; and
	202102300	14.02.2022	£250	
	202101891	10.02.2022	£270	Handling of repairs to door and window
	202114536	17.03.2022	£750	Repairs to the windows – specifically the quality of works and delays experienced.
	202104254	23.03.2022	£600	The complaint is about the landlord's handling of repairs to the complainant's property.

More detail on these cases is provided in Appendix B. All of the cases of maladministration relate to Repairs. The Council is delivering a focussed and targeted improvement plan in respect of the Repairs Service and one of the areas of focus is the early resolution of complaints. It is anticipated that this improvement will reduce findings of maladministration in respect of Repairs.

Also included in the Appendix B are cases where service failure or injustice has been found as the Ombudsman classifies these as partial maladministration.

### **Overall Analysis and Actions to Improve**

Overall, our numbers of cases being referred to and investigated by the LGSCO Ombudsman are not high. Only 5 London Boroughs had fewer decisions made and fewer decisions upheld. Appendix C show the performance for all London Boroughs

Whilst our numbers of complaints upheld are higher than the average, they are not significantly higher. This is an area for us to consider and ensure that we are addressing all areas of the complaint satisfactorily at stage 2. We are introducing a new quality assurance module in I Casework which will ensure that we have more stringent quality monitoring of responses and are able to quickly address any training needs. We will also review all Ombudsman decisions with the officers that make stage two decisions so that they can learn from the Ombudsman findings. This should hopefully contribute to improved performance in respect of those cases that are fully resolved prior to the Ombudsman investigation where our numbers are lower than the average of 11% at 8%.

It should be noted that during the financial year being reported we have introduced a number of changes to improve the focus on timely resolution of Ombudsman cases and to learn from Ombudsman decisions. These include:

- Continued to report Ombudsman performance quarterly to Strategic Leadership Team Assurance Board on the findings and key issues as a result.
- Provided a presentation to our Managers Forum (comprising of 150 senior managers) to raise awareness of issues and to promote ownership to encourage early and timely resolution

- Improved our processes for escalation to ensure timely compliance with orders. Including automated system prompts and manual prompts as well as weekly monitoring reports.
- All decisions copied to relevant SLT director.
- Introduced cross-council Ombudsman Board where decision are reviewed and learning identified.

## **LIST OF APPENDICES**

Appendix A – LGSCO Annual Review Letter

Appendix B – LGSCO Cases Upheld

Appendix C – LGSCO London Borough Performance 2021/22