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| **Meeting:** | **Cabinet** |
| **Meeting date:** | **13 October 2016** |
| **Title of report:** | **Local Government Ombudsman (LGO) decision and report** |
| **Report by:** | **Monitoring officer** |

## Classification

**Open**

## Key decision

This is not a key decision.

## Wards affected

Countywide

## Purpose

To inform cabinet of a decision by the Local Government Ombudsman (LGO) of maladministration and injustice, and confirm actions being taken in response.

## Recommendation(s)

**THAT:**

**(a) the report and recommendations of the Local Government Ombudsman, at appendix 1, be considered;**

**(b) the findings be accepted and the recommended actions agreed; and**

**(c) in implementing the recommendations:**

**(i) the director for adults and wellbeing undertake to apologise to the parties and ensure training is provided to social workers; and**

**(ii) the monitoring officer makes the recommended payments.**

## Alternative options

1 Not to accept the findings of the LGO. Although the ombudsman cannot compel the council to implement its recommendations, in practice councils almost always do act on them. There is no right of appeal against a decision by the LGO, but it is possible to seek judicial review where it is believed that the legal basis of a decision is flawed. This is not recommended as the LGO findings are based on evidence that is not disputed.

## Reasons for recommendations

2 The Local Government Ombudsman has decided that there was maladministration (fault) causing injustice to Mr B and Mrs D. The Local Government Act 1974 requires that where such a decision is issued, that the report is publicised and considered.

## Key considerations

3 Mrs D, on behalf of Mr B (not real names), complained that the council failed to move Mr B to a suitable care home following assessment and that he did not receive the required speech and language therapy, as assessed and detailed in his care plan.

4 The ombudsman found fault on behalf of the council which caused injustice to the parties and made recommendations. The council is therefore required to consider the report and confirm what action we have or propose to take.

5 Mr B's assessed care needs are that he needs full time residential care. In April 2015, as a result of Mr B's behaviour, a best interests assessment concluded that his existing care home was not able to meet his needs and that in the medium term he should move to a home which would be more able to support him.

6 It was also agreed that a new assessment from a speech and language therapist was required. This was undertaken and confirmed that the existing strategies from 2013 should remain in place. However, only four out of the five strategies were being implemented by the home.

7 Mr B moved to a new care home on 27 June 2016.

8 The ombudsman concludes, as the adults and wellbeing directorate acknowledges, that Mr B's case was not adequately progressed following the assessments in early 2015, with no evidence of any action taking place to secure alternative accommodation between July and October 2015. Mr B should have been referred to the "move on service" in June 2015 rather than April 2016, which would have facilitated the alternative placement. This lack of activity and delay the ombudsman finds as fault.

9 Further fault is found when another care home is considered in the interim period and not proceeded with or secured for Mr B. This care home could have met Mr B's needs and was not adequately progressed.

10 Additionally Mrs D had a preference that the eventual care home where Mr B is now resident was considered. The failure to consider this choice was a failure to follow the care and support statutory guidance and is a finding of fault.

11 The faults set out above caused injustice to Mr B because they resulted in him remaining in an unsuitable care home that was unable to meet his assessed needs, resulting in increased levels of anxiety, for longer than was necessary.

12 Mrs D spent 11 months chasing the department for progress on an alternative placement and experienced anxiety during such time.

13 To remedy the injustice caused, the council has agreed to;

a) apologise to Mr B and Mrs D for the fault identified in the report;

b) make £2,000 available for Mr B to spend on activities he would enjoy or possessions he would like;

c) pay Mrs D £500 in recognition of the time and trouble she has experienced;

d) provide training for social workers on the importance of ensuring they keep accurate case notes and in clarifying the differing roles and responsibilities of the allocated social worker, the vacancy management group and the "move on" support service.

## Community impact

14 The council's corporate plan includes priorities to enable residents to live safe, healthy and independent lives and to secure better services, quality of life and value for money. Whilst the council aims to get things right first time, it also is a learning organisation and the recommendations demonstrate how the council will address the identified shortcomings and take action to secure improvement in order to be able to deliver the priorities of its corporate plan.

## Equality duty

15 None arising from the recommendations.

## Financial implications

16 The recommended action includes the making of compensatory savings of £2,500 which will be managed within existing adult social care budgets.

## Legal implications

17 There is a statutory duty under the Local Government Act 1974 requiring Cabinet to consider this report as detailed above. There are procedural requirements ensuring transparency, which include notices in newspapers, the LGO report available for inspection and information circulated to all members. These have all been complied with. Cabinet must prepare a report set out in recommendation (d) above and a copy sent to every member. The LGO must be notified by 14 November 2016 of the action which the council has taken or propose to take.

## Risk management

18 If the council does not take action to address identified weaknesses, there is a risk that similar shortcomings in service delivery may re-occur. The actions proposed in response to the LGO findings, and in particular the improved training of adult social

care staff mitigate this risk.

## Consultees

19 Not applicable.

## Appendices

Appendix 1 - Local Government Ombudsman report (Reference number: 15 019 902)

## Background papers

- None