Senior Management Review – Case Reference 021783 Housing Ombudsman

1. Executive Summary

This report provides a summary of the above case which received a severe maladministration determination from the Housing Ombudsman Service in respect of repairs including leaks, record keeping, in particular in relation to asbestos, and complaint handling.

The Ombudsman Orders have to be concluded, and a final report issued to the Ombudsman by 6 March 2024.

The report provides a detailed review of the recommendations and actions taken and confirmation that the Orders issued by the Ombudsman have been met.

The Head of Internal Audit will complete an Assurance Review on the actions implemented within 6 months and a copy of their report to be provided to Group Audit and Risk Committee as well as the Customer Experience Committee.

2. Recommendations

A number of recommendations have been highlighted both through the Ombudsman's report and the investigations undertaken as a result of their determination. These recommendations are detailed below:

2.1 Identify any other residents that might be affected by inaccurate data in the landlord's asbestos information database or other asbestos records:

Action

- Clarify how data related to asbestos is stored, updated and used in OHG.
- Carry out a quality assessment of this data.
- Make recommendations on how data quality can be improved.
- Dependent on findings from the above, identify other residents who may be at risk due to inaccurate data. Initial work has now been completed, with further work underway to improve data quality.

2.2 Carry out a self-assessment using the Ombudsman's Spotlight report on knowledge and information management.

Action

- Produce a self-assessment, covering the sections on 'devise key reporting standards' and 'repairs'. This assessment will:
    - Set out where there are policies and processes in place that conform with the recommendations.
    - Identify any policies and processes that do not conform with the recommendations and for these, clarify how compliance will be achieved.

The self-assessment was reported to Executive Directors in August 2023. The action plan is monitored as part of the wider information governance strategy.

2.3 Establish how we will ensure future compliance with the arrangements for access set out in the Repairs and Maintenance Policy.

Action

• Review current practice of placing sole responsibility on a resident to rebook an appointment following no access to complete a repair after two attempts.

2.4 Review staff training needs to ensure all relevant officers understand, and act in accordance with our asbestos information database and/or other asbestos records.

Action

• A training matrix to ensure all relevant officers understand and act in accordance with landlord responsibilities is now in place.
• All staff have now completed basic training and enhanced training programme for all identified roles is in development.

3. Conclusion

The Ombudsman's findings are rightly based on the evidence we submitted. The delay between identifying a risk of asbestos to the asbestos survey being carried out was unacceptable. The investigation following the report has confirmed a need to review how we 'manage' asbestos in our homes. Work has commenced to ensure the risks identified by property are correct.

The delays to the repairs at the property were exacerbated by our practice to place responsibility on the resident to rebook an appointment after a missed appointment. This practice is now being reviewed to ensure repairs are completed before a repair is closed. Delays to the complaint handling process are under continuous review to improve and communications with residents.