Housing Ombudsman Service

Housing Ombudsman Special Report on London and Quadrant

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Introduction

The Housing Ombudsman makes the final decision on disputes between residents and member landlords. Our decisions are independent, impartial and fair. We also support effective landlord-tenant dispute resolution by others, including landlords themselves, and promote positive change in the housing sector.

This special report follows an investigation carried out under paragraph 49 of the Housing Ombudsman Scheme, which allows the Ombudsman to conduct further investigations to establish whether any presenting evidence is indicative of a systemic failing. Where this is the case, it will be referred to the appropriate regulatory body, the Regulator for Social Housing.

The investigation commenced in January 2023. Factors that may be indicative of a wider service failure may include, but are not limited to the following:

- a policy weakness,
- repeated service failure,
- service failures across multiple service areas,
- service failures across multiple geographical locations,
- failure to learn from complaints, or
- lack of oversight and governance to identify and act on repeated issues.

The Ombudsman's wider investigation was prompted by concerns we had over the landlord's handling of complaints and disrepair, in particular from vulnerable residents, following an analysis of cases with the Ombudsman in December 2022. The outcomes of investigations over the monitoring period are set out later in the report.

Furthermore, in 2022-23, L&Q were issued five Type 1 Complaint Handling Orders, because of unreasonable delays in accepting or progressing a complaint through its process. Since April 2023, we have issued three Type 1 Complaint Handling Orders for the same issues.

This report provides insight to help the landlord strengthen its complaint handling and address the substantive issues giving rise to complaints, to help extend fairness to other residents and prevent complaints in future. The landlord has also experienced significant organisational change as its operations have expanded and therefore provides important lessons for merging landlords or landlords operating within Greater London, which accounts for about half of the complaints handled by the Ombudsman.

We also publish the report to help other landlords identify potential learning to improve their own services. This is part of our wider work to monitor landlord performance and promote learning from complaints.

The landlord engaged extensively with the Ombudsman as part of this investigation and proactively sought to implement improvements from the determinations prior to the publication of this report.

Scope and methodology

We reviewed the findings of complaints made to the landlord between March 2019 and October 2022. These were determined by the Ombudsman over a six-month period from January 2023 to June 2023. We also made evidence requests to the landlord which included:

Complaint Handling

- A record of the annual compulsory training that staff need to undertake, and the complaint specific objective for complaint handlers
- The 'Dashboards' for the last 12 months that provide business managers with oversight of complaints managed in their teams
- The 'Detailed Internal Operating Procedures / Complaint Handling Procedures'
- The standards against which the quality assurance checks are made, as set out in its Compensation Policy
- The results of the 'resident complaints surveys' for the last 12 months.
- Complaint Acknowledgment Letters for Stage 1 and Stage 2 as set out in its policy
- Complaint Response Templates for Stage 1 and Stage 2
- The comprehensive compensation guidance
- Links to, or copies of, the 'Annual Residents Reports' for 2019, 2020, 2021 and 2022
- The 'Monthly reports' for the last 12 months provided to the Group and Resident Services Boards
- The 'Comprehensive pack including heatmaps and trends' that is produced for a director level group that meet monthly
- The 'annual complaints report'.

Vulnerabilities

- Any internal procedures/ guidance/ training material on the landlord's approach to identifying, recording and handling vulnerabilities. Including:
    a. Service Adjustment Procedures (Reactive Repairs)
    b. Aids and Adaptations Policy and procedures
    c. Accessible Services policy

- The total number of residents marked as vulnerable and details of how these are identified and recorded on the system
- Repairs dashboard information showing the orders raised for residents marked as vulnerable and how the landlord monitors compliance on those orders.

Repairs

- The Dashboard information on repairs raised over the last 12 months. Including:
    1. Total number of repairs raised their category and urgency classification.
    2. Time taken to resolve each repair and performance against KPI.

- An update on progress made under the Healthy Homes Initiative, including how many damp and mould reports the landlord has received and how many have been resolved.

Housing Management Case Handling Independent Investigation – June 2021

- Details of the landlord's progress against the recommendations in this report and any supporting documentation not already provided.

We also reviewed the landlord's current published self-assessment against our Complaint Handling Code and its response to our Complaint Handling Failure Orders (CHFOs).

About London and Quadrant

The landlord is a large charitable housing association based in London that works alongside local authorities, developers and other partners to deliver social housing. It is responsible for over 105,000 homes, primarily across London, the Southeast and the North West of England.

The landlord has proactively engaged with the Ombudsman during the investigation and responded promptly to evidence requests and clarification points raised with them. Engagement with the landlord has included:

- Discussions between the Ombudsman and the landlord's board
- Regular meetings to discuss the cases considered in this report, emerging themes and review evidence requested from the landlord
- A presentation from the landlord giving an overview of improvements and future plans
- An open dialogue to clarify findings and points of fact.

Investigation Outcomes

Between January and 26 June 2023, we issued 103 determinations, including 24 cases where we found severe maladministration on at least one of the issues raised by the resident – an unusually high proportion.

With a severe maladministration rate of **13.4%**, the landlord has severe maladministration found against it at more than double the national rate of 6.0%.

The cases spanned 30 local authority areas. We ordered or recommended the landlord to pay £141,860 in compensation – **13%** of all compensation ordered in that six months on only 6% of all determinations made at a rate of £1,351 per case.

The most similar sized landlord to London & Quadrant had only £13,044 ordered in compensation on the 27 cases determined in the same time period – a rate of £483 per case.

We ordered 42 apologies to residents for failures in the landlord's services. We also ordered reimbursement of costs and repairs to be carried out to remedy the impact on residents. In total, we made 493 orders and recommendations.

Compensation ordered or recommended

£141,860

Maladministration Rate

76%

Severe Maladministration

13.4%

Please see Annex A for the full case list. This table does not include the findings of 'outside jurisdiction' or 'withdrawn'.

Category	Severe Maladministration	Maladministration	Service failure	Redress	No maladministration	Total
Complaints Handling	9	55	16	17	2	**96**
Property Condition	16	42	8	10	9	**80**
Charges	1	6	2	0	2	**11**
Moving to a Property	1	10	4	1	3	**19**
Anti-Social Behaviour	2	9	1	1	6	**19**
Estate Management	0	1	3	0	6	**10**
Information and data management	1	3	0	0	0	**5**
Staff	1	1	1	1	1	**5**
Buying or selling a property	0	2	0	0	1	**3**
Reimbursement and Payments	1	0	0	0	2	**3**
Health and Safety (inc. building safety)	1	0	0	0	0	**1**
Total	**33**	**129**	**35**	**30**	**32**	**259**

Themes Identified

When deciding if identified failings are indicative of systemic failing, we look at whether the impact of maladministration is limited to a single area or is across different services and resident experiences. We also look at a landlord's complaint handling culture and its ability to learn from mistakes to improve services. We consider the steps the landlord has since taken and recommend further actions to ensure things improve.

The themes identified through our investigation are:

- policies and procedures documented, but not adhered to,
- resistance to constructive feedback and learning from complaints, and
- a poor knowledge and information management culture.

We consider these findings are indicative of a period of wider systemic failure and have shared the determinations with the Regulator for Social Housing. During this period the landlord failed to take sufficient action to address the root cause driving the issues it was facing, and act effectively on its own monitoring and reporting of service provision, as well as the warning signs that were evident in its complaints and independent reviews – leading to a prolonged period of decline in its services.

Rather than address the core issues coming from its interactions with residents and complaints, the landlord continued to firefight individual issues. This resulted in new policies, initiatives and reports, which failed to resolve its failures. From the cases that have come to the Ombudsman this appears to have had little to no impact on resident's lived experience and service delivery.

In the cases that the Ombudsman has reviewed over the last six months, the detriment of the landlord's failings on residents was acute. Residents have experienced prolonged periods of distress and confusion, having to chase the landlord to act on what should at times be straightforward requests, leading to them raising complaints, repeatedly trying to get the landlord to understand the seriousness of the situation and often being met with inaction. The landlord stopped hearing its residents' voice and became desensitised to the issues its residents were facing.

Instead of recognising complaints as an indicator of declining performance and using them as an opportunity to improve the service the resident received, the landlord was at times abrupt in its response. It failed to communicate effectively or appropriately with residents over a prolonged period of time. The landlord's own annual complaint reports for 2021-22 and 2022-23 highlight failings in the quality of complaint responses that show staff were not given the support or training to respond appropriately at the earliest opportunity.

Of profound concern is the landlord's handling of additional needs, including disabilities and mental health. This was often wholly inadequate, and the evidence strongly indicates that this aggravated the distress and inconvenience experienced by some of its most vulnerable residents.

Complaints handling

Complaints are an opportunity for landlords to hear the resident voice and lived experience, learning from its mistakes and driving service improvement. The landlord's complaint policy would appear to reflect that ethos – it is compliant with the Complaint Handling Code; its self-assessment is up-to-date, and it has clear standard operating procedures for handling complaints. It also has a separate compensation policy.

However, simply having the policies and procedures on paper is not sufficient. The landlord's rate of maladministration suggests the organisation was not consistently putting them into practice or following its own Customer Promise to "listen and act" and "put things right". This disconnect between policy and practice is illustrated by the internal notes on one case (202015069) where a complaint handler failed to follow the internal process for escalating a complaint, incorrectly allocating a complaint and leading to no action being taken for two months. Despite being corrected the complaint handler then proceeded to repeat the same error.

The landlord's complaint responses indicate that parts of the organisation did not prioritise listening to residents and acting on their concerns. At times, responses demonstrated little empathy – simply listing the actions it would take, or had already taken, without explaining its investigation and addressing the actual issues raised in the complaint.

Some responses were overtly dismissive – the landlord appeared not to care about the resident or consider the human impact at the heart of the complaint. One disabled resident (202107703) complained about issues they had experienced for 13 years, explaining that they considered it to be severe negligence and detailing how it had impacted on their health and wellbeing. The landlord responded stating the issue was now fixed, and the resident could contact its insurance department in relation to any damage in their home, and the complaint was now closed.

In another case (202114456) it was unduly heavy-handed in its response. It told the resident it would pay the compensation they were offered, but only if they agreed to the addition of a confidentiality clause in their tenancy agreement that read "The terms of any proposals to refund service charges and any admissions of liability are confidential". The landlord cannot compel the resident to accept its proposed variation agreement or withhold due compensation and its significant failings compromised the resident's rights. This is entirely contrary to the ethos of openness and transparency and demonstrating a willingness to learn from complaints.

It was not the only case we saw where the landlord was opaque with residents when discussing service charges and whether they were reasonable – in another case (202013904) a resident queried why he was paying service charges when his neighbour was not and was referred to his tenancy agreement. He repeatedly asked for a copy of his tenancy agreement to see what service charges were included but it was not provided. When finally reviewed, the tenancy agreement did not contain any service charges and when our investigation requested evidence of the tenancy variation paperwork, the landlord stated that it had introduced them in a rent review seven years previously.

On paper its Stage 1 complaint response templates cover the points required by the Code – they contain spaces for the decision to be articulated, as well as the reason for the decision, what remedies are offered, the actions the landlord will take and how to then escalate the complaint if unhappy. However, our casebook demonstrates that those templates were not used consistently. Instead, complaint responses were not genuine attempts to address the complaints – they did not answer the complaint sufficiently and consequently, residents were often requesting an escalation of their complaint, frustrated that the points of their complaint were not answered in the initial response.

This led residents to contact the Ombudsman for advice. In 2022-23 the Ombudsman had to chase the landlord for information on 112 cases including 26 times for the purpose of our own investigations. This was often to get the landlord to progress complaints through its own process. It suggests the landlord failed to consistently accept and escalate complaints, and in many cases, failed to review the responses sent at previous stages, before issuing its next response. This failing is significant not least because under the Complaint Handling Code natural justice is supported at local level by a different person handling the escalated complaint and, ultimately, the resident being signposted to the Ombudsman. Instances included:

- The landlord issued a second stage 1 response, after the resident raised additional concerns relating to their original complaint, and then a third stage 1 response, despite the landlord acknowledging the resident was requesting escalation to stage 2. (202127247)

- One resident's dissatisfaction was not acknowledged as a complaint until four months after it was made, and when the escalation was requested, this was not acknowledged for three months The stage 2 response then contradicted the failures that the landlord had already accepted in their stage 1 response. (202122675)

- One resident requested an escalation of their complaint and was advised within their final response (at stage 2) that they could request an escalation to stage 2 if they were not happy with the response received. (202122562)

When residents came to the Ombudsman the landlord's response to the Ombudsman often failed to grasp the seriousness of the issues and instead the landlord becomes adversarial rather than looking to put things right.

During our investigation, we asked the landlord to provide their annual complaint reports to give us an understanding of their current position, as it stated it had put a number of measures in place since the period of time our casebook covered.

The landlord's annual complaint handling reports for 2021-22 and 2022-23 demonstrate the acute pressure the landlord's complaint handling has been under. It also shows how interventions to date had not addressed the issues. In 2019-20 the landlord averaged 990 complaints a month. In 2021-22 and 2022-23 this had risen to above 1600 a month.

The 2021-22 report acknowledged that complaints escalated to the second stage because of poor stage one responses. The landlord introduced a Housing Quality Assurance team in June 2022 to identify improvements, and a dedicated and expanded team to manage complaints, focussing on ensuring that Stage 1 responses are complete, comprehensive and customer focussed. However, the 2022-23 report continued to show the same issues with a significant number of cases progressing to stage two of the process, partly because of the poor quality of the stage 1 responses.

Key Performance Indicators, L&Q Annual Complaints Report 2022-23

Measure	Target	31-Mar-21	31-Mar-22	31-Mar-23	RAG	Performance Trend
Volume of active complaints	N/A	2205	3495	3762	**N/A**	**Declined**
Complaints acknowledged by the end of the next working day	90%	88.40%	85.10%	88.00%	**Amber**	**Improved**
Complaints with solution offered/decision sent in month within 10 days	90%	80.70%	74.50%	81.30%	**Red**	**Improved**
Average calendar days to close complaints	30 days	32.6	52.5	42.3	**Red**	**Improved**
Complaints older than 6 months	N/A	612	1025	1334	**N/A**	**Declined**
New complaints received monthly per '000 units	14	16.8	16	16.7	**Red**	**Declined**

In correspondence with the Ombudsman the landlord has suggested the introduction of the Ombudsman's Complaint Handling Code contributed to the high level of complaints it was receiving. In its letters to residents, it has said it has adopted a new "thorough" approach to complaint handling as a result of the requirements of the Code. The Code requires that basic standards of good complaint handling are adhered to, and the landlord should have sufficient resource in place to meet the Code and its timescales.

Throughout casework correspondence with the Ombudsman over the last few years, the landlord has been unnecessarily confrontational, even going so far as stating that it would be sharing this "with all the other G15 Housing Associations who have also raised concerns regarding your unreasonable timescales and increase in demand." As recently as June 2023, despite being aware of the emerging themes of this report, the landlord responded abruptly to a simple request for information from the Ombudsman to resolve a complaint as "totally unacceptable" and threatening to escalate the matter internally.

Despite forewarning evident through its own complaint handling between 2019 and 2022, the landlord failed to channel the learning from complaints and use them as a

tool to identify the underlying causes and culture behind the failings. Through the lack of resident focus demonstrated throughout the 103 determinations, it has missed countless opportunities to address failings in its approach to resident feedback and complaints. A positive complaint handling culture, properly resourced complaint function and independent oversight of the complaints system is crucial to demonstrating to residents that they can be heard, and the landlord wants to improve. Too often this has not been the case for the landlord.

These failings demonstrated little consideration of the resident with the onus on the resident and Ombudsman to persevere and continually chase the landlord for action, while facing a defensive reaction for doing so. Repeated cases, approaches from the Ombudsman, and the overall increase in demand should have alerted the landlord to emerging issues, but from the landlord's response to residents and repeated chasing by the Ombudsman to progress complaints it appears these complaints were often seen as an administrative burden rather than an opportunity to finally put something right. The number of cases presenting to the Ombudsman from residents of the landlord remains disproportionately high, even allowing for the size of the landlord and any efforts to improve awareness of the complaint's procedure.

The landlord's communication with residents was often undermined by poor knowledge and information management. This included the landlord not recording information, or checking records to see what they knew about the tenant, and/or their property, before responding. This led to unnecessary delays, and distress to their residents. Evidence of this included:

- Despite a request from a resident's representative that all calls should go through them due to the resident's ill health, the landlord continued to try and make contact with the resident instead. (202122675)
- The landlord acknowledged that it had received correspondence from a resident's former solicitor who was no longer instructed to act for them. It accepted they should deal directly with the resident. However, the landlord subsequently made reference to its solicitors contacting the resident's solicitor so repairs could progress. (202127247)
- The landlord responded to a resident about their handling of a moth infestation in a stage 1 response which the resident then requested be escalated and undertook repairs to stop the moths entering the property. The landlord then issued a further stage 1 response stating that no such moth infestation had been reported. (202120914)

It is clear from engagement with the landlord during this investigation that it recognises it has got things wrong and has needed to urgently improve its approach to communication with residents, especially during complaints handling. We have seen some encouraging changes in the way the landlord communicated towards the end of the monitoring period and it is hoped this results in lasting change for residents.

Following a Complaints Policy Assurance review in September 2022, the landlord established a Complaints Operations Group in January 2023 to support its Complaint Management Learning Group to identify shortcomings in complaints and develop action plans to deliver service improvements and act on the learning from complaints.

In December 2022 the landlord carried out a review of its complaint operating model and agreed a new Complaints Target Operating Model in January 2023, with an aim to complete roll out by July 2023. The landlord commissioned an external review of the proposal by the Housing Quality Network, which ratified the landlord's proposed approach. The new model embeds dedicated complaint handlers within service teams with the ability to escalate more complex complaints. The complaints team has also undergone training in more empathetic complaint responses. The model includes a Quality Assurance team with a responsibility to conduct quality checks on stage 1 responses to address the known issues. In May 2023, when we asked the landlord for evidence of the Quality Assurance team's checks, we were told the landlord still needed to implement these checks. The landlord now confirms these checks are in place.

The landlord has put in place a Resident Services Board to scrutinise its performance. The aim is to involve residents in the quality assurance of specific areas of its performance such as complaint handling and scrutinising its new housing management model. It has also adapted its training and induction programme where staff hear directly from residents about their experiences. While this is encouraging, the landlord now needs to put measures in place to ensure this change is embedded and assure itself that it is effectively handling complaints and communications with the diverse communities it serves sensitively and appropriately.

Compensation

It is important for a landlord to put things right when there are service failures. This includes the payment of compensation. During this investigation, the Ombudsman has ordered a significant amount of compensation. In one case this amounted to a total payment of almost £12,000. (202203890)

Although the landlord has a standalone Compensation Policy, the level of compensation ordered by the Ombudsman shows the landlord was not consistently awarding compensation in a fair, reasonable or consistent way. This compounds what has often become a fractured relationship with residents.

In case 202203890 a resident with mobility and mental health issues, reported persistent leaks through her ceiling. The landlord described the leaks as "uncontainable" and took 27 months to respond to the resident's complaint about the leak in her lounge, but it did not consider compensating her for the damage caused to her belongings. The Ombudsman ordered £900 in compensation for this aspect of the complaint.

The resident was subsequently permanently moved because of the major repairs required. This means under its Compensation Policy the landlord must pay home loss compensation. However, our investigation found no evidence that the landlord advised the resident of how to claim a home loss payment as set out in its procedure, or that any payment was made to the resident. The landlord's policy also says the amount is £6,300, but this is a statutory payment, and the amount is set by the Government each year.

In another case (202110801) a resident experienced damp and mould for two years. Following an attempt to clear the mould, which was unsuccessful, the landlord noted the “house still smells strongly of damp”. However, it informed the resident it could not consider any compensation for damage to her belongings through its complaints process, despite the landlord’s Compensation Policy stating that it “will” consider paying compensation where “our negligence with carrying out day-to-day repairs has caused damage to the customer’s home and/or belongings”. It also directed her to contact its insurance team direct to make a claim, despite the policy stating that the landlord was responsible for referring a claim to the insurance team for her, within 28 days.

Delays in its complaint handling also meant the claim period expired and she had not had the opportunity to make a claim. In this case, the Ombudsman awarded nearly £6,000 for the distress and inconvenience, and loss of amenity given the disrepair, whereas the landlord had awarded less than £500.

The landlord’s consideration of compensation was not only narrow, limited and unreasonable given the commitments it made in its own policy, the landlord also failed to consider the time and inconvenience caused to residents having to repeatedly chase the landlord because of its own failures in service or complaints handling. It is critical landlords consider reasonable awards for both time as well as distress.

Case Study – 202122562

Mr C experienced damp and mould and continually reported it to the landlord. He was told it was a communal issue and the landlord had raised a job. Throughout the complaints process, Mr C experienced a lack of communication from his landlord.

After further complaints, the landlord sent a stage one response. They said it was an open case under its Healthy Homes Initiative and the healthy homes team and specialist contractors would inspect the property and roof. Mr C requested an escalation of his complaint as the property had already been inspected and scaffolding erected. He raised concerns that he had been breathing the black mould spores for eight months and as a result, had a continuous cough and chest issues.

Mr C contacted the landlord to say that the scaffolding had been taken down without completion of works on the roof. Internal notes on the landlord's system said that although landlord's specialist contractors had inspected the property, there was no report on the system recommending works. It was also unclear whether the work to the roof had been carried out before the scaffolding was removed.

Following contact from the Ombudsman, the landlord issued its 'final decision letter'. They said that the roof would be inspected, and the required repairs raised.

Mr C once again had to chase for an update. As a result, the landlord sent an internal email saying "as you can imagine the resident is beyond frustrated with having to chase for information and need things to move quickly. Is there any chance we can decant [the resident], whilst we investigate this, as it is affecting his health and it won't be too long until we are on ITV again." The same month, the landlord sent a stage two response detailing the next actions it would take to investigate the leak.

We found severe maladministration by the landlord in its response to the resident's reports of damp and mould at the property. The landlord delayed carrying out remedial works, did not implement any ongoing monitoring to address the persistent ongoing damp and mould problem. We also found maladministration in the landlord's complaint handling and the record keeping.

The Ombudsman ordered the landlord to pay a total of £4,684 and inspect the property and the building and investigate the ongoing causal issue of damp and mould in the property.

Case Study – 202107623

Miss O began having issues with a leak from her shower tray and continued to report further leaks to her landlord, as well as damp and mould in her home. Miss O raised a formal complaint with the landlord about the leak and broken ventilation in the bathroom. The landlord didn't respond to the complaint.

Further leaks and blocked drains forced Miss O to chase the repairs, reporting that the issues were impacting on a household member's health condition. Miss O said she felt ignored by her landlord. She raised a further complaint about the outstanding repairs in the bathroom, including the shower tray leak, which had been ongoing for three years.

The landlord issued a complaint acknowledgement and decision letter, raised an order for the outstanding works, and said they would review compensation once the works were completed.

Miss O opened a disrepair claim against the landlord. She continued to contact the landlord about the repairs, but the landlord said that, because of the disrepair claim, the complaint was now on hold. This further delayed the repairs.

The landlord issued a stage two response. It acknowledged it had not managed the repairs and communication effectively and offered compensation. As part of the pre-action protocol, a property inspection took place and orders were raised to carry out works. These were marked as completed 36 months after the first complaint was made.

We made a finding of maladministration of the response to the resident's reports of ongoing leak and associated damp and mould in the property. It delayed carrying out the repairs to the leak in the bathroom and associated damp and damages with multiple appointments made, which failed to resolve the problem.

We also found maladministration with the complaint handling and ordered the landlord pay compensation of £3,390 to the resident and conduct staff training on complaint handling.

Vulnerabilities

The landlord has a *Vulnerable Residents Policy* setting out its approach towards ensuring vulnerable residents can access its services, and to support colleagues to "do the right thing" when dealing with a vulnerable customer. Under the Equality Act 2010 organisations must make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else. The landlord's policy refers to the Act and recognises that it requires organisations to make reasonable adjustments to ensure individual needs are met. In 2018, following a vulnerability and support needs research project, the approach of "*Think, Respond, Record",* was added to the policy to encourage staff judgement when dealing with

residents. The policy was most recently updated in 2022, introducing an 'Assurance' section for the landlord to be able to review, against certain criteria, whether it is complying with the policy.

Our casework shows the landlord failed to embed this policy in its daily dealings with residents. It repeatedly failed to accurately record when a resident was vulnerable or needed additional support, and as a result, it did not adapt its approach to residents who most needed help. Examples of this include:

- The landlord failing to adequately support a domestic abuse survivor who was seeking a managed transfer due to damp and mould issues and needed to move to specific areas that were considered to be safe. The resident said she felt "ignored" by the landlord. (201914143)

- One resident with health conditions, including chronic asthma, experiencing an avoidable delay of 18 months for the landlord to carry out necessary repairs to her windows and boiler. (202001052)

The landlord consistently failed to review residents' vulnerabilities and be open to their changing needs over time or consider the impact on vulnerable residents when addressing complaints and when awarding compensation. The landlord's policy recognises that "residents could meet the definition of vulnerability" for a number of reasons, including:

- physical disability
- chronic illness
- age-related frailty
- mental wellbeing, including mental health or addiction issues,
- personal circumstances including domestic abuse, financial, or
- vulnerable because of their ability to communicate, for example difficulty with English, or because of a learning disability.

Contrary to their own policy principles of "*Think, Respond, Record*", in some instances (202127247 and 202014885) the landlord asked residents to provide evidence of their vulnerability, which for some, according to the landlord's own definition of vulnerability, is simply not possible.

The failure to adhere to its own policies exacerbated the impact of the landlord's service failings on residents. Residents who should have received the most support had to repeatedly complain and chase the landlord simply to have their voice heard and their issue acknowledged.

While the landlord has policies and procedures in place which mean it should be able to identify vulnerable residents, act on repairs, track its actions and review assurances, the evidence shows a prolonged period where these policies failed to make it into the landlord's routine, everyday actions. The policy itself, while adequate, could also have been stronger, with the emphasis on repairs primarily around health and safety and tone and empathy appearing in an appendix rather than being central to its approach. Over the three year period our investigations cover, a resident's experience almost became a lottery, dependant on who picked up the phone, responded to an email or

carried out the visit. The landlord's inability to embed policies and procedures into everyday practice meant there was no consistent approach to resident issues, having a direct impact on the resident experience.

Crucially, the landlord had no systems in place to appropriately share information with relevant contractors and service areas, reducing the chance of meeting a resident's needs.

The landlord has a Service Adjustment Needs (SAN) procedure to set out how it records and identifies (flags) vulnerable residents. A SAN report published at the end of 2022 to monitor the progress of the SAN records demonstrated high level of error rates in the recording of vulnerabilities and highlighted that "there is a *clear lack of understanding and knowledge of SAN processes… and no current training…to ensure colleagues are aware of the purpose and the importance of the flagging process*". It is regrettable it took the landlord until 2022 to put in place the actions required to minimise errors and ensure staff are aware of the importance of recording vulnerabilities.

Following a Housing Management Restructure, launched in June 2022, the landlord says it has a more visible and local housing management service which will enable it to better capture resident vulnerability and act on individual resident needs. The landlord has plans for a new Housing Management system for improved information capturing and reporting and has started to roll out training in vulnerability flags. The landlord has also started a project to review the flags that they do have and introduce new ones.

Case Study – 202119915

Miss M is a resident with cerebral palsy that uses a wheelchair.

She had reported damp and mould to the landlord periodically since the start of the tenancy. The landlord had previously responded to the damp and carried out works to block rats entering her home.

After ten years in the property, Miss M's MP wrote to the landlord raising several issues including the return of "extreme damp" on the bedroom wall. Miss M reported that rats had returned with a further two complaints recorded that year. Several months later, the landlord raised an order to seal a large gap on the rear wall of the property behind the bedroom.

Miss M contacted the landlord to report mould on possessions and a strong smell of damp. The landlord arranged an inspection by its damp contractor but two months after the inspection the landlord had still not carried out the recommended work. Miss M was worried about living in the damp flat in the winter months and said she had been sleeping on her sofa for several years.

The landlord sent a stage one response the following week, detailing actions it would take. Miss M requested an escalation of her complaint stressing that living in one room had severely affected her mental health. She told the landlord the mould had now spread to her front room, which was the last space in the property that she could live. Miss M subsequently decided to leave the property and live elsewhere, asking the landlord to move her.

We made a finding of severe maladministration by the landlord in its consideration of the resident's disability, health and wellbeing. There was a heightened detrimental impact to the resident which the landlord had a responsibility to be mindful of and address through its Vulnerability Policy.

We also found maladministration by the landlord in its handling of the resident's reports about damp and mould, its handling of her pest infestation reports, and her rehousing request.

There was no maladministration by the landlord in response to her compensation request for damage to her possessions, and we consider that the landlord offered reasonable redress for its complaint handling.

We ordered the landlord to pay £1,633.71 compensation and to arrange and complete the outstanding works and inspection of the resident's property.

Case Study – 202113866

Ms F wrote to her landlord saying she had been reporting damp and mould in the property for three years, and the landlord had previously agreed the loft insulation was unsatisfactory. She was awaiting an inspection from the landlord's mould contractor and followed the advice the landlord provided about the management of mould.

An inspection by the landlord's damp specialist found numerous issues with the external wall and recommended repointing. Ms F asked for the repointing to be as soon as possible, given the already extensive delays. She reported that she suffered from severe depression, anxiety, and autism and referred to her full-time care duties to one of her children. In response, the landlord brought forward the appointment.

Over the next 20 months, multiple inspections took place at the home. The resident received contradicting reports of works needed and scheduled work was cancelled without any explanation.

The landlord replied to the complaint apologising for the delay, setting out the completed jobs, and the works outstanding. Ms F requested an escalation to stage two. Five months later, the landlord issued their stage two response and completed the works four months after that.

We found severe maladministration in relation to the landlord's response to the resident's reports of damp and mould. There were severe and significant delays to the works promised to the resident for nearly two years, with no explanation of the landlord's decisions.

The landlord knew Ms F was a vulnerable resident yet left her expecting works to be carried out and chasing a job which the landlord repeatedly cancelled without explanation.

We also found severe maladministration in relation to the landlord's complaint handling, with significant delays in the complaints process. We ordered the landlord to pay the resident within four weeks' compensation of £1,600.

Repairs

In 2022-23, 73% of all complaints made to the landlord were about repairs and maintenance issues. The Ombudsman's special report into Birmingham City Council highlighted how a landlord's response to repairs goes a long way to setting the tone for its relationship with residents. Landlords should have systems in place to be able to accurately triage repair requests, record assessment reports and monitor progress through to completion.

The Ombudsman found in the cases we investigated that the landlord repeatedly failed to meet its obligations under the Landlord and Tenant Act 1985 and was slow to respond to hazards. This is demonstrated by the significant findings of

maladministration for its response to disrepair. Our casework shows staff were unclear or unfamiliar with their responsibilities.

The landlord has a repairs policy in place that sets out a triage process and timeframes, including adjustment of service standards where a delay would put a resident at risk, but our casework showed the landlord rarely put this into practice. It was also unable to demonstrate that its staff following the code of conduct within the policy to “Show they care about the resident, are committed to helping and can be trusted to do what they say they’ll do”.

Overall, 47% of the Ombudsman’s findings of severe maladministration related to property condition. There were common and repeated areas of failure:

- Residents suffered excessive and unexplained delays, sometimes over a period of years while living with the disrepair.
- Poor record management led to a failure to diagnose the cause of the issue at the first attempt with conflicting views from different contractors leading to a confused picture over what was needed to resolve the issue.
- Appointments were missed or duplicated as the landlord has no idea who had visited properties and when, let alone what the issue was and whether it was resolved.
- The landlord raised the same repairs on multiple occasions, often closing an issue as resolved only to reopen it when the resident got back in touch to say the issue was not resolved.
- Residents were not kept informed of the progress of their repairs leading them to chase and complaint about issues.

The Ombudsman investigated cases where the landlord’s actions and attitudes of some staff were extremely poor, dismissive and, at times, callous. For example, one resident (202114537) asked the landlord to send a surveyor to inspect their property. Instead, the landlord sent a supervisor to attend with internal notes on that decision showing that it was intentionally misleading the resident about how seriously it took their concerns by sending the supervisor because “at least he looks like a surveyor”. The landlord offered the resident compensation at the end of the service request, but when the resident called to accept the offer, the landlord told them that they could not give compensation to a resident in arrears. Although the compensation policy does include the statement “we will partly or fully offset a compensation payment against any debt owed to us by a customer, including rent and service charge arrears…”, this should have been explained to manage the resident’s expectations. The landlord did not then apply the credit to her rent account for a further year, after the resident eventually made a formal complaint.

A pregnant resident (202010808) had no smoke alarms or lighting in her kitchen for four months after the landlord removed the ceiling. On one occasion the landlord noted the resident was “crying and upset” and felt “bullied” by the landlord. Despite being aware that the resident had demonstrated signs of distress during a telephone contact with the landlord to about her repairs, the landlord did not respond to her for a further nine working days. Contrary to their repairs policy, and consideration for vulnerable residents, the landlord did not consider whether it could attend the property within a quicker timeframe. The landlord did not consider the impact on the resident or show

empathy to her situation. The landlord raised the same repairs on multiple occasions over a considerable length of time because of repeated failures in their record keeping, which contributed to the resident's frustrations. The Ombudsman had to intervene three times to get the landlord to respond, and it did not compensate the resident for time and trouble.

At times the resident would know more about the progress of the repair than the landlord, such was the poor communication and record keeping with contractors, which also often meant residents received multiple visits for the same issue from different staff, who then gave different advice and outcomes.

Residents were left with situations that were exacerbated by confusion and a lack of action, repeating themselves over and over again to different staff to try and get things done, while the disrepair continued to worsen.

One resident (202107623) became so frustrated with the delay on the repairs needed to their property, the lack of acknowledgment or response to complaints, and feeling ignored by the landlord, that they instructed a solicitor. Unfortunately, this resulted in further delay as the landlord stated it would not continue with both the complaint and the legal process. The resident moved out following 30 months waiting for a damp and mould repair.

In the cases we reviewed, the landlord showed a narrow, fragmented approach to repairs – only dealing with what was presented at the time, rather than looking at the overall picture to resolve issues and stop them happening again. There was no tracking of repair progress, contributing to excessive delays.

In another case, (202014885) the landlord initially refused to attend a repair to a leak in a resident's bathroom, stating that because it had been privately installed by the resident, it was not their responsibility. However, the bathroom had been fitted by the local authority the previous year under a disabled facilities grant, and the landlord was made aware of this at the time. The landlord later acknowledged this, and agreed it was their responsibility to maintain. However, when the Ombudsman chased compliance with our order to remedy the issue with the bathroom, the landlord reverted to asserting that because the bathroom was not installed by them it would not be carrying out any further works on it. The entire conversation about why it was their responsibility had to be repeated.

The landlord provided conflicting information to one resident (202012566) regarding asbestos in her property – the survey recommended that the material be managed as asbestos, but the landlord told the resident the property was clear. When later challenged by the resident, the landlord then said there was asbestos present. When the resident complained about being given false information, the landlord said the staff had not been able to see the asbestos report to communicate its findings to the resident, because it had been sent to the wrong department. This is despite there being evidence that the resident had been categorically told there was no asbestos. Compounding these failings, the landlord then stopped progressing the repairs when the resident escalated her complaint. It took six months for the landlord to respond, delaying the repair work further.

Case Study – 202122675

Mr S was an elderly resident in poor health. After emergency services forced entry into his property, the attending carpenter said the door was beyond repair. The landlord failed to install a new door for six weeks, which meant Mr S could not live at home safely, severely impacted Mr S's mental health.

On returning home, Mr S told the landlord the property had no heating and hot water. The landlord arranged a repair for the next day, but the gas engineer failed to attend. When Mr S's advocate spoke to the gas engineer, they told them that there had not been a repair order raised. The advocate called the landlord, and it arranged a new job. A gas contractor attended two weeks later but the boiler required parts that were out of stock.

Mr S's advocate complained to the landlord. They were told there was another appointment booked, but again the gas engineer failed to attend. The landlord sent its stage one response. Mr S remained unhappy and asked the landlord to escalate his complaint. The landlord did not acknowledge the escalation until three months later. Following Ombudsman intervention, the landlord issued a stage two response six months later.

We found severe maladministration by the landlord on the resident's boiler repairs. We found maladministration of the front door repairs. We made a further finding of maladministration for the landlord's complaint handling, with a delay of 204 working days in responding to the complaint.

The Ombudsman ordered the landlord to pay a total of £1,059.81, and senior member of its staff to apologise for the failings identified.

Major repairs

At times repairs were so large, and took so long to resolve, the landlord had to rehouse residents as it carried out major renovations and overhauls of properties that could have been avoided with earlier intervention and a more proactive approach and knowledge of its housing stock.

In one case, (202203890) a resident with mobility and mental health issues, reported persistent leaks through her ceiling over several years. The landlord visited the property multiple times but had no record of what work, if any, was done on each occasion. Each visit was taken in isolation as the landlord failed to assess the overall scale of works required. Eventually, after 16 months, it rehoused the resident when it decided that the leak was caused by structural issues and was "uncontainable".

In the last 12 months the landlord has agreed a Major Works Investment Programme of over £3bn to invest in its stock over the next 15 years. It has also implemented an ongoing stock survey programme and has committed to improving its response to repairs. While this will deliver long term benefits, the landlord needs to ensure this does not lead to a sticking plaster approach to major repairs as residents in unsuitable

properties wait their turn for major repairs as part of the programme. While progressing the programme the landlord needs to ensure it can accurately identify properties where more substantial works are needed following a report of disrepair and prioritise accordingly.

Case Study – 202012865

Ms C complained to the landlord about ongoing damp and disrepair concerns with the property. She said the property was “very cold”, and her family experienced several health issues including chest problems.

The pandemic halted all non-emergency works and the resident had no further contact from the landlord about repairs to the property. Ms C’s MP contacted the landlord on three separate occasions to escalate the complaints and prompt the landlord to respond.

A survey highlighted 19 areas of concern with the property. The following year, the landlord inspected the property and supplied a list of works arising from the inspection. It issued an “informal” complaint response with the actions it would take and closed the complaint.

Over the next six months, various inspections and repairs took place. Ms C told the landlord that chasing repairs and correcting mistakes caused her stress and health problems which contributed to her anxiety. She said additional repairs were now required because of the amount of time that passed since the surveyor’s inspection.

The Ombudsman requested a stage two response from the landlord. Internal emails showing a lack of organisation and confusion about how to manage the repairs. The landlord issued a stage two response where it apologised and told the resident it would complete a joint inspection with its building contractor.

After receiving no communication from the landlord since the inspection, Ms C contacted them explaining the impact the situation was having on her. Works were finally completed in the following year at a cost of more than £30,000.

We found severe maladministration in the landlord’s response to the resident’s disrepair concerns. The landlord was responsible for an inappropriate delay of around 17 months.

We also found severe maladministration and significant failures in the landlord’s complaint handling, with a finding of maladministration in the landlord’s response to the resident’s ongoing damp and mould concerns.

The landlord’s failing to adopt a proactive approach was distressing for the resident and family. We also found significant problems with the landlord’s record keeping, which may have contributed to the overall delays, and so made a finding of maladministration.

The Ombudsman ordered the landlord to pay the resident £2,552.98, to reinspect the property for damp and mould, and to look at reimbursement for decorating works.

Damp and mould

In 2021 the Ombudsman published a Spotlight report on damp and mould, highlighting what landlords need to do to tackle the issue. We have since issued a follow up report and the Government has introduced legislation around the inspection and repair of damp and mould.

Within its own internal correspondence considering the decant for a resident with a persistent cough because of mould exposure, the landlord is clear it must act or risk appearing on ITV. The landlord can be under no doubt over how important it is to tackle damp and mould and the serious consequences of not doing so for its residents.

Despite having a Healthy Homes Initiative setting out its expectations around damp and mould, in reality this was not consistently applied in the cases we have seen and can be seen as yet another policy the landlord failed to consistently embed. Too often the landlord failed to identify damp and mould as the root cause of many of its disrepair cases.

The poor record keeping and approach to disrepair already identified in this report led to reports of damp and mould being treated in isolation, repeat visits, and an overall failure to consider the presence and seriousness of damp and mould in disrepair cases.

The landlord visited one resident's home 18 times in two years (202110801) as they lived with damp and mould. Although it carried out a damp and mould assessment, it failed to install the humidifiers recommended in its Healthy Homes Initiative. At one point the resident told the landlord her GP was treating her for fluid on the lungs caused by the situation. Contractors and operatives seemed unaware of the potential seriousness of the case, with no evidence of the landlord altering its approach to account for the impact on the resident.

Alongside the landlord's investment into its homes, it has also expanded its Healthy Homes Project and launched a new Repairs Change Project to improve the way it delivers repairs, committing to a first-time fix approach for as many cases as possible. The new approach includes a new operating model that is intended to increase the number of repairs the landlord can carry out every day. The landlord has also introduced a new repairs platform to address duplication and the speed of its response to repairs. The landlord has already noticed a reduction in outstanding repairs and turnaround times.

Case Study - 202114537

Miss M called the landlord to report water and debris coming through the vent in her son's bedroom. The landlord completed some work on the property however rejected a further job to look at the guttering. The blocked gutter was causing mould and damp meaning her son, who has asthma, could not sleep in the bedroom. Miss M was told that she would receive compensation for water damaged items and raised a complaint again as the problem continued.

The landlord responded at stage one saying they would repair the guttering and offered compensation for time and effort, distress, and inconvenience. Miss M asked about compensation for the water damaged bed, however there is no evidence that the landlord responded to this.

Following works to clear the guttering and seal leaking joints, Miss M accepted compensation and asked again about the bed and mattress. Her landlord said it could not give her compensation as she was in arrears, and they would not pay compensation for personal belongings. She emailed again on the same matter but received no response.

Miss M had not received the promised compensation and the works carried out had not fixed the issue. The landlord responded to her second complaint, saying they had now paid the compensation and a surveyor would inspect the property.
Internal emails following the landlord said that the job did not require a surveyor but that a contractor supervisor could be sent instead, because "at least he looks like the surveyor!". Despite this, there were no inspections for another six months.

Miss M chased decoration works again, and the landlord issued their stage one response. They said they would remove the vent and block it up. They again offered compensation for inconvenience as well as decorating vouchers. Miss M declined the compensation and requested an escalation of her complaint and later that year, the landlord issued their stage two response.

We made a finding of severe maladministration in response to the resident's reports of a leak from a vent in the bedroom. There was a delay of more than three years in completing an effective repair, during which time Miss M's son, who has asthma, could not use his bedroom due to damp and mould.

We also found maladministration in response to the resident's request for compensation for water damaged items and the landlord's complaint handling. Miss M waited a total of 468 days for complaint responses.

We ordered the landlord to pay £6,428 compensation for distress and inconvenience, time and effort, and compensation for items.

Anti-social behaviour (ASB)

The landlord has a responsibility under the Housing Act 1996 to prepare a policy and procedure on ASB. The Regulator for Social Housing's Neighbourhood and Community Standard sets out how landlords are required to work in partnership with other agencies to tackle reports of ASB.

The landlord has a policy on ASB. However, the cases we have seen show its failure to follow it. The policy sets out how it will review all reported incidents and explain its reasons for not taking any action. It says the landlord will take account of vulnerabilities, carry out a risk assessment and set out a plan of action. In reality, in the cases we investigated, all reported incidents were not acted on, and vulnerable residents were exposed to ASB for a prolonged period of time.

One resident (202206602) complained over a period of six years, from 2015, about the impact of noise from their neighbour's laminate flooring. Despite interventions from the resident's MP the landlord did not log an ASB case until 2021. Even after logging the case, the landlord failed to follow through on its commitment to resolve the issue by installing carpets. The landlord failed to apply its ASB policy and missed opportunities to investigate and resolve the issue, severely impacting the resident's health.

Another resident (202107597) reported feeling terrified in their own home due to ASB, with her daughter subject to racial and homophobic abuse. The resident asked to be rehoused but the landlord failed to suitably consider the ASB when handling the resident's request to be permanently rehoused. The landlord also failed to escalate the issue to the police or local authority or consider information shared from them in its investigation. It also failed to keep the resident informed, with no action plan or regular communication.

Case Study – 202119571

Mr B contacted the landlord in 2021 to complain about noise from laminate flooring in the flat above. He had previously made a similar report in 2020 about noise from the same flat but a different neighbour.

Mr B said his new neighbour had been abusive to him when he had attempted to discuss the noise. Mr B continued to report the issue through 2021 and completed diary sheets for the landlord. The landlord said the noise was “day to day” noise despite little evidence of an investigation. Mr B complained in 2022 but the landlord failed to progress the complaint and the Ombudsman issued a Complaint Handling Failure Order. Following this the landlord assured Mr B it would replace the floor but by April 2022 Mr B told the landlord he “could not take it much longer” as he was constantly being intimidated by his neighbour.

Internal records show discussions between the landlord’s ASB and Neighbourhoods team over new flooring but by August 2022 the issue was still not resolved. Mr B said he was afraid for his safety due to his neighbour’s behaviour. The landlord recommended Mr B be rehoused. In September 2022 it installed new flooring, but Mr B continued to report noise and abusive behaviour up to April 2023. As of June 2023, Mr B had still not been rehoused.

The landlord failed to follow its ASB policy and carry out an initial risk assessment which would have helped it prepare an effective action plan and timeframe to tackle the issue. There is no evidence it carried out a full investigation and only visited Mr B a year after he reported the issue. The landlord failed to consider Mr B’s diary sheets, carry out effective enquiries of the neighbour or consider what action was appropriate under its ASB policy. It still does not know if it has installed new flooring and told the Ombudsman Mr B had not submitted any diary sheets, despite then sending them to the Ombudsman in its evidence return.

At no point has the landlord had a clear picture of what was happening and what is needed to resolve it. It missed an opportunity to remove the flooring during a void period when the old neighbour moved out. It failed to consider the serious impact the ASB had on Mr B. While it told MR B the noise was day to day noise, its ASB team said the issue was serious enough to warrant special consideration of rehousing.

Compliance / Remedies

Orders and recommendations

In the 103 cases determined, we ordered and recommended the landlord to pay more than £143k in compensation to residents. More significantly, we asked the landlord to cascade the learning from our determinations to its staff and made several orders and recommendations, sometimes repeatedly, to try to prevent the same problems happening again.

The individual orders and recommendations can be found on the investigation reports on our website. Our decisions are published to our online casebook three months after determination. In some cases we may decide not to publish a decision if it is not in the resident's or landlord's interest or the resident's anonymity may be compromised. Full details of what and when we publish are set out in our publication policy.

Key orders and recommendations made:

Complaint Handling

- Review its complaint handling procedures and staff guidance to ensure complaints are handled in line with the Ombudsman's Complaint Handling Code and its own complaint policy, particularly in relation to:
    - Escalations
    - Addressing all of the complaint
    - Clearly identifying failings
    - Establishing learning points
    - Suspending complaints
    - Adhering to policy timescales
    - Handling complaints with associated disrepair claims
    - Allocating complaints
    - Calculating redress
    - Closing complaints
    - Updating residents during complaints
- Carry our staff training on effective complaint handling and lessons learned exercises on complaints.

Vulnerable Residents

- Promote and retrain staff on its Vulnerable Residents Policy and markers system to ensure vulnerability issues are identified and escalated as needed.
- Carry out a review of its Vulnerable Residents Policy.

Repairs

- Review its record management so it can accurately monitor the progress of repairs to completion and track outstanding repairs.
- Review its property inspection process to allow for early and accurate identification of disrepair.

- Provide an update to the Ombudsman regarding the replacement of the current housing management system and confirm that this will be able to meet specific accessibility needs.
- Implement a new procedure of giving reasonable notice to residents when its employees or contractors need to enter either the communal areas or residents' rooms within the premises.
- Check the repairs history for a property when logging new reports.
- Ensure that staff are aware of the need to escalate a matter where there is a history of repeat or similar reports.

Damp and mould

- Review its approach to responding to reports of disrepair, in particular damp and mould, particularly with reference to the Spotlight report and HHSRS.
- Review its contractor arrangements to ensure better management of damp and mould cases from end-to-end.
- Consider remedies when condensation is considered to be the root cause of damp and mould.

Anti-Social Behaviour

- Carry out an exercise to understand why its procedures around ASB were not followed and then carry out any training identified as a result.
- Read and self-assess against the Spotlight report on Noise.
- Review the policies and procedures surrounding the handling of domestic abuse reports.

Conclusions

In December 2020, following a county court judgement that went against the landlord, the landlord's Resident Service Board commissioned a Housing Management Case Handling report focused on its handling of vulnerabilities, to try and prevent a repeat of previous mistakes. In that judgement, the court expressly found that the landlord had been overly defensive, failed to proactively resolve the resident's issues and had been insensitive in its handling of her case – the exact issues that our review has found.

The report set out detailed recommendations and encouraged the landlord to embark on a "bold comprehensive improvement programme which put residents at the heart of its service". The landlord has undertaken a range of actions following the report, but these have not yet resulted in improved performance from the cases that have come to the Ombudsman.

The landlord has commissioned and undertaken reviews, of various designs, of its complaint handling process four times in the last twelve months alone which were to ratify its new approach to complaint handling. This is entirely illustrative of the core issue with the landlord's response historically when failings were identified – the landlord commissioned reviews, created new policies and procedures, or amended existing ones, that appear sufficient to address the issues. But these have not yet resulted in an improved experience for resident's who have approached the Ombudsman and have not yet been embedded in the landlord's everyday interaction with residents.

The evidence of this investigation suggests that when the landlord did react to identified failings, it did not take the necessary steps to embed the new policies or procedures it created. Nor did it coordinate the action to ensure that various projects avoid conflict or duplication. Instead, the illusion of activity is presented. This is crucial if the landlord is to successfully implement the recommendations of this report.

Absent until recently appears to be adequate oversight and governance of previous actions, and planned evaluation of the success of any action plan to foster change. Instead, a further review was commissioned. The landlord has attempted to address this by creating a cross-organisation complaints project to oversee the many complaints related initiatives underway. It is hoped this addresses the issue.

It is this constant cycle of inadequate action that resulted in the failings identified in this report. The increase in the Ombudsman's findings of maladministration and severe maladministration show that over several years the landlord failed to put words into action and recognise that listening to complaints and acting on them to improve the resident experience would have allowed it to address these issues much earlier, and without Ombudsman intervention.

From its engagement with the Ombudsman during this investigation it appears the landlord is now willing to learn and act on its failings, but it must demonstrate that this results in an improved resident experience.

It is clear the landlord has undertaken a fundamental rethink of its objectives as an organisation, initiated by the senior leadership in 2021. The landlord implemented a complaint handling restructure in June 2022, and it is hoped this results in meaningful change. Whether the landlord is succeeding will be seen in resident feedback, complaints and approaches to the Ombudsman over the coming months and years.

Policies and procedures are a key tool in shaping how a landlord and its employees behave. They set standards and expectations, creating a culture of improvement and accountability, reflecting a landlord's values and priorities. However, policies and procedures alone cannot shape a landlord's culture or the impact it has on residents. They require effective implementation, comprehensive training and ongoing monitoring to ensure they are embedded into everyday actions.

While the landlord often had suitable policies and procedures in place it failed to ensure these were implemented, meaning they had little impact on a resident's experience. Staff training has been variable– and policies little more than a document that was referred to, but not consistently acted upon. The landlord's operating model meant resources were stretched, creating an environment where it was difficult for staff to implement the landlord's policies and procedures, let alone consider training and improvement.

This led to a decline in professionalism, with findings of maladministration across different service areas shown on page 5. It does not appear to have been one single event or moment where its service response declined, but a gradual normalisation of poor responses. While the Ombudsman did see examples of committed and effective action by staff, across over 100 individual investigations, the landlord repeatedly failed to meet reasonable expectations for professional standards. In particular, the dedicated and committed staff who do work at the landlord are being let down by the poor culture and professionalism of others.

The landlord accepts in its own complaint reports for 2021-22 and 2022-23 that complaint responses are "poor". Landlords need a positive complaint handling culture and good governance arrangements to ensure a culture where everyone within the organisation is open to improvement and acts as it wants them to. Regardless of the number of initiatives, policies, processes and reports, it is a landlord's culture which will ultimately dictate the experience of its residents.

The evidence from the Ombudsman's casework points to repeated failings in the landlord's interactions with residents, and evidence it lost sight of the importance of the resident voice, learning from mistakes and tracking success against improvements. Vulnerable residents have been faced with excessive delays in repairs, poor complaint handling and confused, sometimes dismissive communication. Documents provided by the landlord as part of this investigation show a history of missed opportunities, with the landlord trying to address the issues but so far failing, on the cases we have seen, to get to the root cause.

In our recent Spotlight report, we said getting knowledge and information management right is the closest thing the sector could get to a silver bullet, but the data needed to provide an effective and efficient service is often missing. Our casework shows this to be true for the landlord, with limited processes, or training, in place for the handling of

data. Consequently, the landlord has attempted to operate with one arm tied behind its back. The landlord says its new Housing Management system, due to be in place by April 2024, will improve its ability to capture and record information and allow the landlord to respond to the recommendations in the Ombudsman's Knowledge and Information Management Spotlight report. The landlord has also now commenced mandatory record keeping training to all staff.

The evidence shows a history of inadequate action and missed opportunities within the landlord. As well as failing to embed its processes and procedures, put in place adequate knowledge management and prioritise the resident voice, the landlord has consistently missed opportunities to put things right and act on the feedback from its residents and its own insight. The landlord missed opportunities at every stage of investigating resident concerns, whether that be investigations into anti-social behaviour, disrepair, complaints or when the Ombudsman asks the landlord to put things right. While the landlord took action, there is no evidence of the landlord understanding why things were going wrong and taking decisive action to address the failings.

Since engaging with the Ombudsman on this investigation the landlord has shared its plans to finally address its failings. If put into practice the landlord has the potential to transform the resident experience and become a resident-focused organisation. However, this must be balanced with the findings of the 103 Ombudsman determinations covering over three years of complaints to the landlord. It is still not clear what success looks like for the landlord and whether it will result in an improved resident experience. It has embarked on improvement plans and new policies before to little effect – the landlord has already missed countless opportunities to address the issues identified and carry out meaningful change.

The landlord's failure in the cases we reviewed gives rise to the concern that any plans put in place to respond to this investigation could be short lived and true culture change in the areas needed will remain elusive. This time it is imperative that the landlord's leadership has a relentless focus on ensuring these changes are embedded.

It is essential this period of poor services is not repeated. The key now is for the landlord to put measures in place where it can track their implementation and success, so they have a lasting impact, and the landlord fulfils its promise in its vision that "everyone deserves a quality home that provides them with the opportunity to live a better life".

Recommendations

As part of this investigation the landlord provided the Ombudsman with an action plan of the work, they have undertaken within the last 12 months and the actions they intend to take over the next three years. It is vital this results in meaningful change for residents. We have reviewed the action plan and made further recommendations to ensure this happens.

We encourage the landlord to publish and provide the Ombudsman with an update of its progress against the updated action plan within three months of this report.

Complaint handling

1. Appoint a member of its governing body to have lead responsibility for complaints and support a positive complaint handling culture, in compliance with section 7.3 of the Complaint Handling Code.

2. Ensure the quality assurance checks on complaint responses to both residents and the Ombudsman are in place and happening as planned. Provide the Ombudsman with the standards the checks are completed against.

3. Review the assurance section of its Complaint Handling Policy to ensure the assurances can be measured and progress reported. The landlord should be able to:
    - Analyse and report on its complaint handling performance in line with the Complaint Handling Code.
    - Ensure it is awarding compensation on a consistent basis.
    - Use the intelligence from its complaint handling to improve services for residents and identify staff training.
    - Provide regular updates to senior leadership and governance groups, including its Member Responsible for Complaints, on its complaint handling performance.

4. Complete the planned roll out of refreshed complaint handling training and design a programme of regular periodic refresher training.

5. Review the equalities information held on the cases that formed part of this investigation. This will form the basis for an objective assessment of whether the diverse communities it serves are being appropriately communicated with and are receiving an appropriate quality of complaint handling.

Vulnerabilities

6. Following the landlord's SAN review and corresponding staff training on its Vulnerable Residents Policy and recording vulnerabilities, carry out a new SAN report and provide the Ombudsman with a copy.

7. Continue its review of its Vulnerable Residents Policy, having particular regard to its obligations under the Equality Act.

8. Review the assurance section of its Vulnerable Residents Policy to ensure the assurances can be measured and reported. The landlord should be able to:
    - Analyse and report on its recording and handling of interactions with vulnerable residents, including in complaint handling.
    - Quickly identify and address instances where it is not following its Vulnerable Residents Policy.
    - Provide regular updates to senior leadership and governance groups, including its Member Responsible for Complaints, on its vulnerabilities performance.

Repairs

9. Review the assurance section of its Repairs policy to ensure the assurances can be measured and reported. The landlord should be able to:
    - Analyse and report on its response to repair requests and complaints about repairs.
    - Ensure it is adapting its response to repair requests from vulnerable residents.
    - Quickly identify and address instances where it is not following its Repairs policy.
    - Provide regular updates to senior leadership and governance groups, including its Member Responsible for Complaints, on its repairs performance.

Anti-social behaviour

10. Complete the review of its ASB policy and Standard Operating Procedures and update the action plan with associated actions.

11. Design and roll out associated staff training on the ASB policy and procedures.

Staff learning and development

12. Complete the review of the recommendations in the Ombudsman's spotlight report on Knowledge and Information Management, including the completion of the phased approach to its staff training around record keeping.

13. Expand the training programme on empathetic resident communication to all staff who deal with residents to ensure the landlord communicates to residents with courtesy and respect at all times.

14. Design a programme for regular periodic refresher training on the above.

15. Design and implement quality assurance processes to evaluate and ensure the learning from the various training programmes has made an impact and elicited change.

16. Consider a review of its recruitment process for all front-facing staff to assure itself that customer focus and the landlord's stated values form the backbone of the testing process.

17. Consider a review its job descriptions for all front-facing roles, including complaint handlers, to assure itself that customer focus and the landlord's stated values are present throughout.

18. Implement feedback mechanisms for possible disciplinary action where courtesy and respect is found to be at fault, either through a complaint or feedback.

Statement from London and Quadrant

From L&Q's Group Chief Executive, Fiona Fletcher-Smith

We recognise that we've got things wrong, and we welcome this extremely valuable learning process.

My senior leadership colleagues and I are personally contacting the residents whose complaints the Ombudsman judged to have involved service failure or maladministration on our part. We have apologised for the completely unacceptable service they have received. L&Q has let them down, and I'm truly sorry for that.

What really matters to us is putting things right for residents and using the report's learnings to correct historic failings, continue building a resident-centred culture, and ensure we deliver a quality service every time.

The Ombudsman's investigation draws conclusions from complaints made between March 2019 and October 2022 - a period when our services were severely disrupted by the coronavirus pandemic. As the Ombudsman has recognised, when I became Chief Executive in 2021, the Board and I put in place a new five-year improvement and investment strategy to tackle the problems that had emerged. This was developed through listening to residents, and resolutely focused on the safety and quality of existing homes and services.

I'm pleased the Ombudsman has endorsed these plans, and I welcome both residents' and the Ombudsman's input on how we can further strengthen, accelerate and embed the positive changes we're making.

Central to our approach is putting residents at the heart of our decision-making, and I wholeheartedly agree with the Ombudsman about the importance of the resident

voice. We published a report in May 2023 setting out how we will embed resident involvement at every level of L&Q and put residents in control of the decisions that affect them. This builds on what we've already done to place residents at the top of our governance through our resident-led Resident Services Board, regional committees, and 600-strong body of involved residents.

We've also made significant progress to address the operational issues highlighted in this report, and these are already delivering improvements:

Our £3 billion, 15-year major works investment programme, launched last year, is making sure every resident's home is safe, decent and more energy-efficient, and will also drive down repairs. In 2022/23 alone we installed over 1,500 new bathrooms, 1,400 new kitchens, and almost 2,800 new windows. Every resident will experience improvements to their home or building, and when completed we will have fitted 42,000 new kitchens and 50,000 new bathrooms through our programme.

We deliver 400,000 repairs each year, and we're transforming the quality and responsiveness of this service so we can deliver more repairs each day, and a first-time-fix whenever possible – this has already increased by 20% across day-to-day repairs. We're also progressing further improvements to tackle damp and mould through our Healthy Homes Project, which has already carried out 20,000 home visits and installed 14,000 humidity sensors.

The new, localised housing management approach we implemented last year is putting 30% more front-line colleagues in local neighbourhoods where they're better placed to proactively support residents and communities and be more responsive to the needs of vulnerable residents. We've also established an extensive training programme for resident-facing colleagues to help us deliver an empathetic and responsive resident experience and manage poor performance.

We are overhauling our complaints handling, investing in additional staff, training and other resources, prioritising efficiency and good communication, and embedding learning from complaints in our process. We're already seeing a reduction in the time it takes to resolve complaints and in the number progressing to stage 2. The Ombudsman's report acknowledges the improved quality of our complaint responses.

Underpinning these changes is a £40m investment in a new housing management system and other technologies that will improve how we manage our data and information, and how we communicate with residents, and in particular vulnerable residents who may need different types of support.

We have a clear plan, a dedicated and committed team to deliver it, and we are confident that the changes we're making will ensure residents receive the quality homes and services they deserve. We are grateful to the Ombudsman for their work, and we look forward to ongoing collaboration to make further improvements.

Annex – List of cases

Our decisions are published to our online casebook.

	Severe Maladministration	Maladministration	Service Failure	Redress	No maladministration
201914143	• Complaint Handling	• Moving to a Property			
201915363		• Charges • Complaint Handling			
202001052	• Property Condition	• Complaint Handling			
202002926				• Complaint Handling	• Anti-Social Behaviour
202007116		• Anti-Social Behaviour • Complaint Handling			
202007203		• Property Condition • Complaint Handling	• Property Condition	• Property Condition	
202010808	• Complaint Handling	• Property Condition			
202012566	• Health and Safety (inc. building safety) • Complaint Handling	• Property Condition • Information and Data Management		• Property Condition	• Property Condition

202012728		• Property Condition • Complaint Handling			• Reimbursement and Payments
202012865	• Property Condition • Complaint Handling	• Information and data management • Property Condition			
202013732		• Charges • Complaint Handling			
202013904		• Charges		• Complaint Handling	
202014739					• Anti-Social Behaviour
202014885		• Property Condition • Property Condition		• Complaint Handling	
202015069		• Complaint Handling • Complaint Handling			• Estate Management
202015388			• Property Condition • Complaint Handling		
202101343				• Complaint Handling	• Property Condition

202104537	• Property Condition	• Complaint Handling			
202104810			• Complaint Handling	• Property Condition	
202107597		• Anti-Social Behaviour • Moving to a property • Complaint handling			
202107623		• Property Condition • Complaint Handling			• Property Condition
202107703	• Complaint Handling	• Property Condition			
202107935					• Buying or selling a property
202108737		• Anti-Social Behaviour		• Complaint Handling	
202108899		• Property Condition • Property Condition			• Property Condition
202109130		• Property Condition			
202109888		• Property Condition		• Property Condition • Complaint Handling	

202110801	• Property Condition • Property Condition • Complaint Handling				• Property Condition
202110867		• Moving to a Property		• Complaint Handling	
202111330		• Staff	• Moving to a Property	• Property Condition	
202111468			• Charges	• Complaint Handling	
202111543		• Complaint Handling Charges			
202111758		• Complaint Handling • Property Condition			• Estate Management
202112228		• Property Condition • Property Condition • Property Condition	• Complaint Handling		
202112268		• Charges • Complaint Handling			
202113505		• Complaint Handling			• Estate Management

		• Complaint Handling			
202113866	• Property Condition • Complaint Handling				
202114044					• Estate Management
202114179		• Complaint Handling • Property Condition			
202114456	• Charges	• Complaint Handling			
202114537	• Property Condition	• Complaint Handling • Complaint Handling			
202114933		• Anti-Social Behaviour		• Staff	• Anti-Social Behaviour
202115442		• Estate Management	• Complaint Handling		
202115485	• Property Condition • Reimbursements and Payments	• Complaint Handling			
202115995		• Complaint Handling • Property Condition		• Property Condition	• Charges

202116921	• Property Condition	• Property Condition • Property Condition • Complaint Handling			
202117221	• Property Condition		• Complaint Handling		• Staff
202117372		• Complaint Handling • Moving to a Property			• Anti-Social Behaviour
202118322			• Moving to a Property • Complaint Handling		
202119074			• Complaint Handling	• Property Condition	• Moving to a Property
202119188		• Property Condition	• Complaint Handling		
202119571		• Anti-Social Behaviour • Complaint Handling • Complaint Handling	• Moving to a Property		
202119915	• Staff	• Property Condition • Property Condition		• Complaint Handling	• Reimbursement and Payments

		• Moving to a Property			
202120419		• Property Condition			
202120914		• Complaint Handling			• Property Condition
202120968		• Moving to a Property	• Complaint Handling		
202121458		• Moving to a Property • Complaint Handling • Anti-Social Behaviour			• Property Condition
202121497			• Property Condition	• Complaint Handling	
202121929			• Moving to a Property • Complaint Handling		
202122466		• Property Condition • Complaint Handling			
202122562	• Property Condition	• Complaint Handling • Information & Data Management			

202122675	• Property Condition	• Property Condition • Complaint Handling			
202122730		• Property Condition • Anti-Social Behaviour	• Complaint Handling	• Moving to a Property	
202123029	• Anti-Social Behaviour	• Complaint Handling			
202123452	• Property Condition	• Complaint Handling • Complaint Handling • Complaint Handling			
202125138	• Property Condition	• Anti-Social Behaviour		• Complaint Handling	
202125842		• Charges	• Complaint Handling		
202126008		• Complaint Handling	• Property Condition		
202126529			• Property Condition	• Complaint Handling	
202127247	• Complaint Handling	• Complaint Handling • Property Condition • Property Condition			

		• Property Condition			
202127272		• Complaint Handling	• Estate Management		
202127357		• Buying or selling a property • Complaint Handling			
202127442		• Buying or selling a property			• Property Condition
202127907		• Property Condition • Complaint Handling			
202128131		• Complaint Handling		• Property Condition	
202128192			• Estate Management		
202128247		• Property Condition • Complaint Handling			
202200540		• Property Condition			• Property Condition

		• Complaint Handling			
202201126			• Anti-Social Behaviour		• Estate Management • Complaint Handling
202201145		• Complaint Handling	• Staff		• Anti-Social Behaviour
202202115		• Property Condition • Complaint Handling			
202202845			• Complaint Handling	• Property Condition • Property Condition	
202203033		• Property Condition • Complaint Handling			• Moving to a Property • Charges • Complaint Handling
202203488		• Property Condition	• Complaint Handling		
202203890	• Property Condition • Moving to a Property • Complaint Handling				
202204023		• Complaint Handling			

		• Property Condition			
202204123	• Property Condition			• Complaint Handling	
202204216		• Moving to a Property	• Complaint Handling		
202204225		• Complaint Handling		• Complaint Handling	
202204734				• Complaint Handling	• Moving to a Property
202205075			• Property Condition		
202205146		• Property Condition • Complaint Handling			
202205532			• Property Condition	• Anti-Social Behaviour • Complaint Handling	
202206262		• Anti-Social Behaviour • Complaint Handling • Moving to a property			
202206543		• Property Condition			

202206602	• Anti-Social Behaviour • Complaint Handling • Information and Data Management				
202206955		• Complaint Handling	• Charges		
202207761		• Complaint Handling	• Property Condition		
202207948		• Moving to a Property • Complaint Handling			
202208849			• Estate Management	• Complaint Handling	• Estate Management
202209429		• Property Condition			
202212263		• Property Condition • Complaint Handling			
202213796			• Complaint Handling		• Anti-Social Behaviour

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