Leicestershire County Council

Adult Social Care

Statutory Complaints and Compliments Annual Report April 2022 – March 2023

Business Services
Corporate Resources Dept

Contents

1. Purpose and Context of Report

1.1. Purpose & Scope

The purpose of this report is –

- To report on Leicestershire County Council's (LCC) adult social care complaints and compliments activity from 1 April 2022 to 31 March 2023.
- To set out future developments and planned improvements.
- To meet the Council's statutory duty requiring the production of an annual report each year.[1]

This report provides analysis and comment for Adult Social Care Services on all complaints managed under the statutory complaints process. Those complainants not qualifying under the statutory process have been considered under the County Council's Corporate Complaints and Compliments Annual Report presented to the Scrutiny Commission.

1.2. Background Context

The Adult Social Care Service sits within the Adults and Communities Department, and both arranges and supports the provision of a wide variety of services.

This includes helping people to remain living independently in their own homes with increasing levels of choice and control over the support they receive. When this is no longer possible, the department supports residential or home care as well as having lead responsibility for safeguarding adults at risk of harm.

10,421[2] people received long-term support from the Social Care service during 2022-23. This was a 2.3% increase on the previous year (10,184)

The department always aims to provide high quality services that meet the needs and circumstances of individuals and their families. The department actively promotes involving clients and carers in shaping services; using their skills and experiences to help ensure they meet customer needs. However, given the personal and complex nature of some adult social care services, sometimes things do go wrong.

The complaints process is a mechanism to identify problems and resolve issues. If things go wrong or fall below expectation, the County Council will try to sort things out quickly and fairly. Learning from our mistakes and concerns that are raised is used to make changes and improve services.

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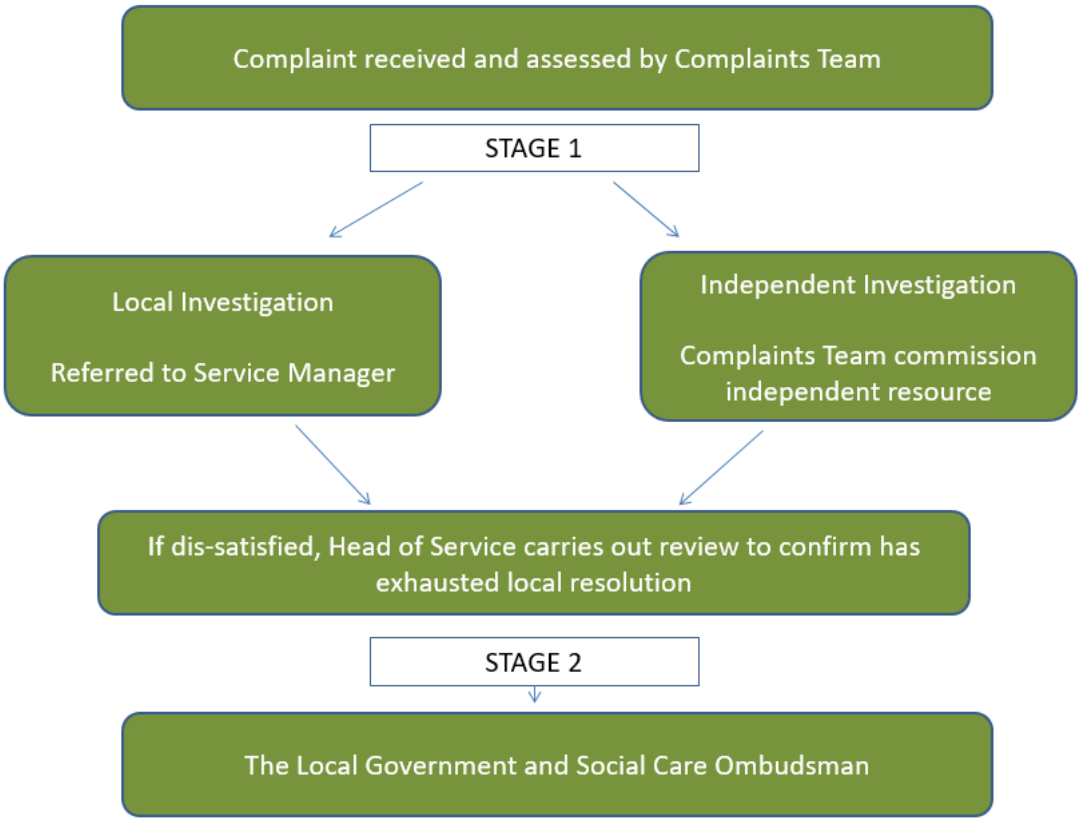
[1] Statutory Instrument 2009 no.309 (18)

[2] Figures supplied by Performance and Business Intelligence Team

Analysis of information about complaints received during 2022 -23 gives Adult Social Care an opportunity to reflect on the quality of the services it provides and consider how well it listens and responds to service users.

2. Adult Social Care Complaints Procedure

The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 outlines the statutory responsibilities of the County Council. This is broadly set out below:



The above procedure was designed to offer Local Authorities flexibility to resolve complaints in the most appropriate manner. Stage 1 resolution can therefore consist of several processes (for example meetings or reviews) but the Local Authority must not unduly delay finalising this process which should always be concluded within 65 working days.

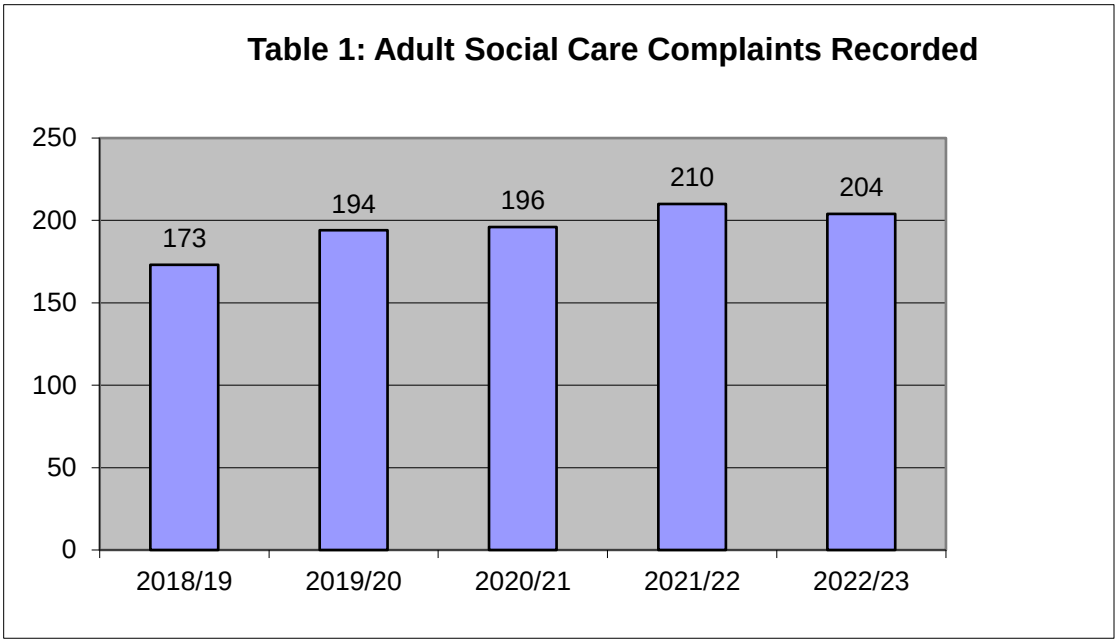
The Local Authority must advise all complainants of their right to approach the Local Government and Social Care Ombudsman should an agreed resolution not be found.

During 2022-23, no independent investigations were commissioned.

3. Complaints and compliments recorded in 2022-23

3.1 Complaint Volumes

Graph 1: Adult Social Care Complaints recorded over last 5 years



As illustrated above, the total number of social care complaints responded to this year reduced by 6 (-3%). Volumes over the 5 term period also present as a very stable picture.

When considered against the context of service users in receipt of long-term support, complaints continue to represent a relatively low number at 1.9%.

3.2 Complaints by District

Wherever possible, complaints have again been recorded by District during the year. The breakdown appears below along with respective uphold rates.

It is important to note that for some complaints this information was either not captured or the complaint was more policy related rather than any specific area.

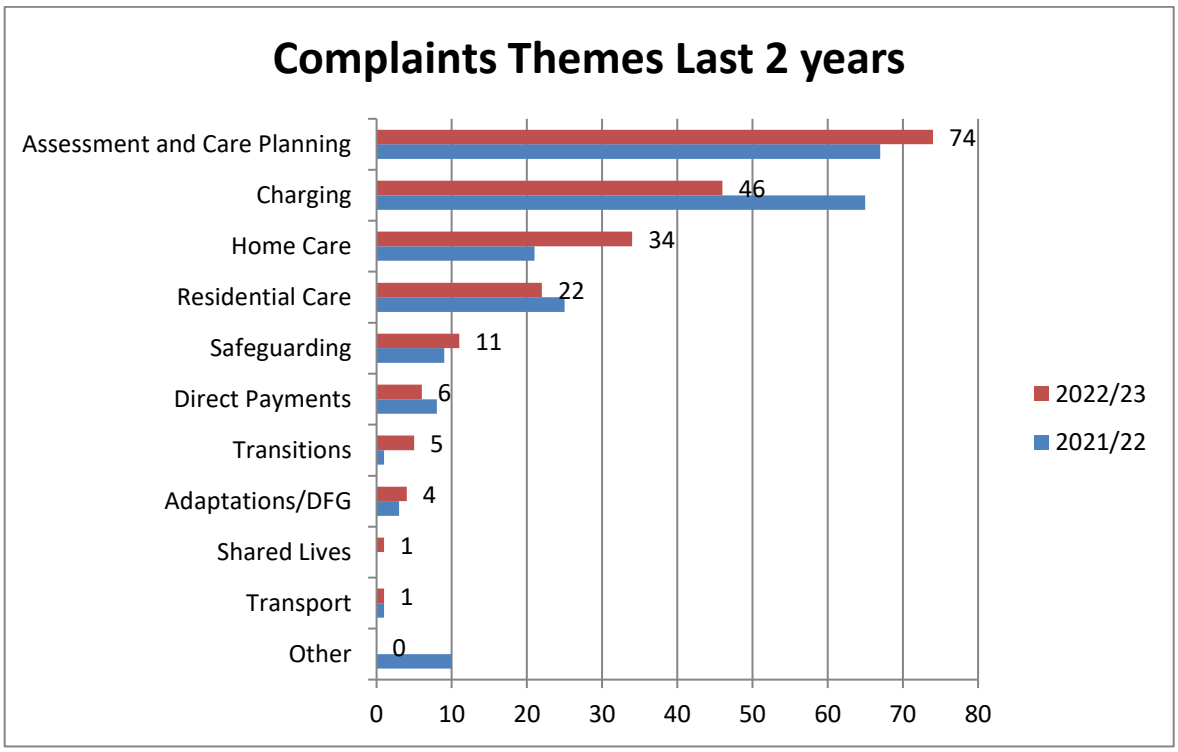
District	Number of Complaints	Number (%) Upheld
Hinckley	29	12 (41%)
Harborough	23	5 (22%)
Blaby	18	4 (22%)
Melton	32	4 (13%)
North West Leics	33	9 (27%)

District	Number of Complaints	Number (%) Upheld
Oadby & Wigston	30	17 (56%)
Charnwood	31	9 (29%)
Unknown	8	1 (12%)
TOTAL	**204**	**61 (30%)**

Although there are some variances in Locality volumes and uphold rates, nothing that presents as a significant outlier.

3.3 Complaints by Theme

Graph 2: adult social care complaints by theme



Complaint themes mirror the Local Government and Social Care Ombudsman classifications and can provide helpful insight as to the underlying topics that are generating complaints.

As last year, the largest segment is also the broadest category around Assessment and Care Planning. This equates to 36% of the overall volume.

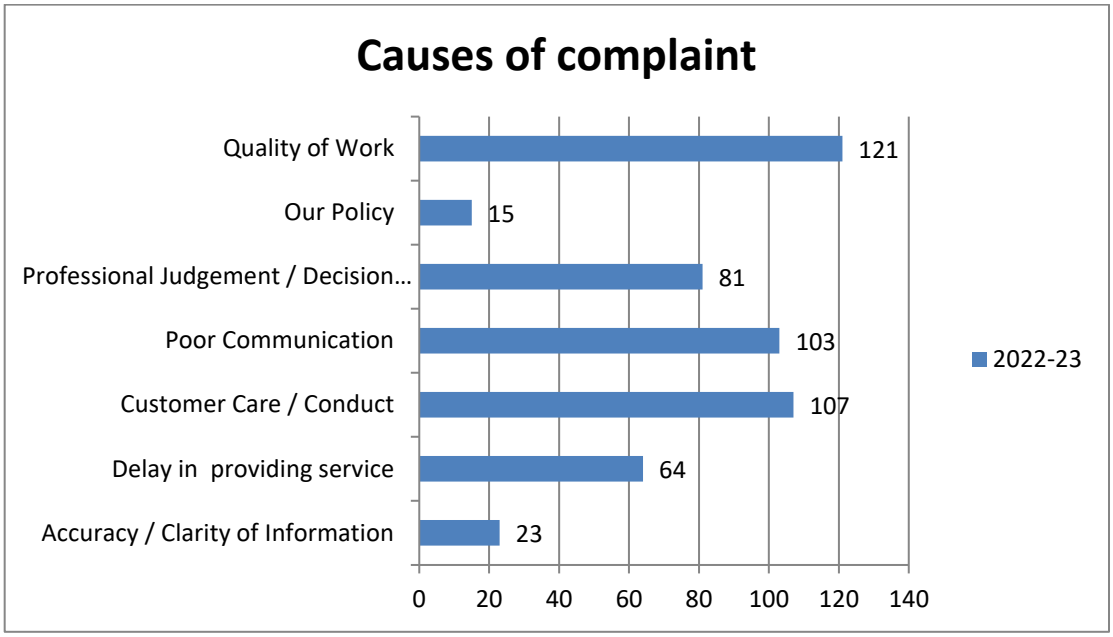
Complaints were mostly about poor communication, delays and waiting times for assessments rather than the actual decisions made.

It is important to note the reduction in Charging complaints during the year. This has been an area of focus and it is pleasing to see a healthy reduction in this area.

Significant work has taken place on improving the clarity of information provided and this is starting to show an impact here.

The Complaints team also undertake analysis of each complaint to try to understand any significant factors. This can help prioritise areas for the department to focus on improving.

Graph 3: Complaint causes for Complaints resolved in 2022-23



Recording allows for multiple causes to be selected. So, if a complaint features "delay" as well as "Customer Care" then both will be selected. It follows that the data above will not match the overall number of complaints resolved.

Quality of Work remains the most frequently identified topic cited within complaints. This is of little surprise as it is the broadest category, including for quality of home and residential care.

3.4 Joint Complaints

The Health and Social Care complaints regulations place a duty on Local Authorities to work together with health partners in responding jointly to complaints[3]. Leicestershire County Council accordingly has a joint complaint handling protocol, supported by a multi-agency group, which sets out common guidelines and approaches to this.

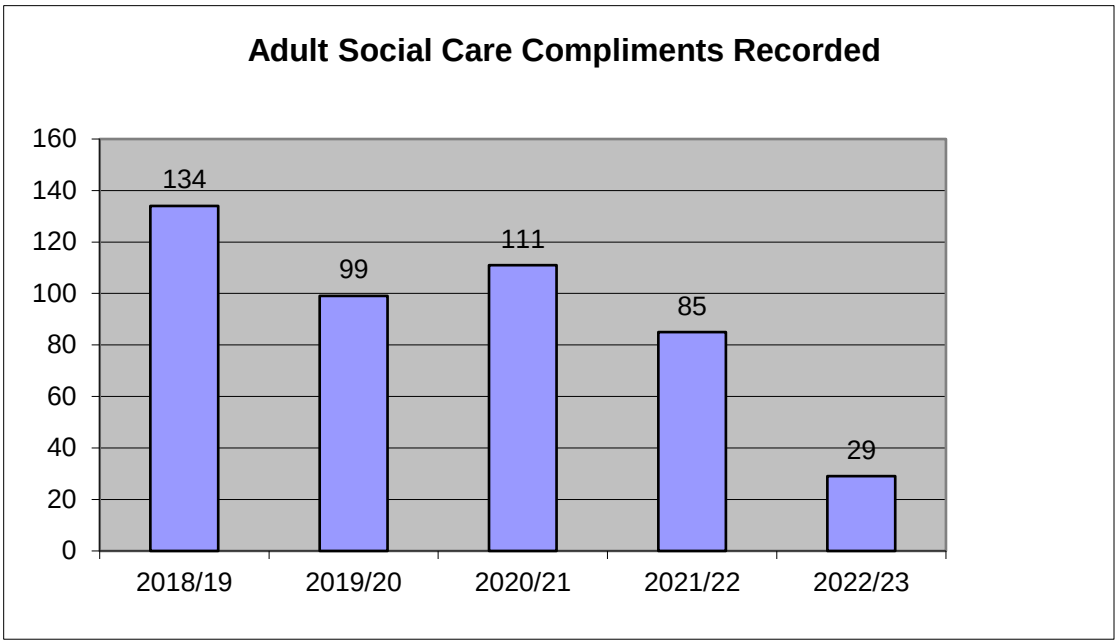
[3] Statutory Instrument 2009 no. 309 (9)

Members include Leicester City Council, the Integrated Care Board (ICB), University Hospitals Leicester (UHL) and the Leicestershire Partnership Trust (LPT).

During the year 2022-23, four complaints were considered using the Joint Complaints protocol. No difficulties were experienced this year with partnership working.

3.5 Compliments received 2022-23

Graph 4 below shows the long-term trend in compliments recorded.



There has been a decrease in compliments recorded during 2022-23. As many compliments are received directly by front line team, it is hard to say whether fewer were received or whether some have not been passed on to the Complaints and Information Team.

It is always important to recognise the good work that is being delivered by the department and to provide balance within the complaints annual report. For this reason, the complaints' function does encourage the recording of un-solicited compliments which can either be submitted directly online or if received by council officers should be passed on for central recording.

A small selection of the compliments received can be found in Appendix A. They show some of the 'real-life stories' where Adult Social Care makes a huge difference to peoples' lives.

The Complaints team will continue to work closely with the department to try to reflect all the unsolicited feedback received across the teams and ensure visibility in annual reports.

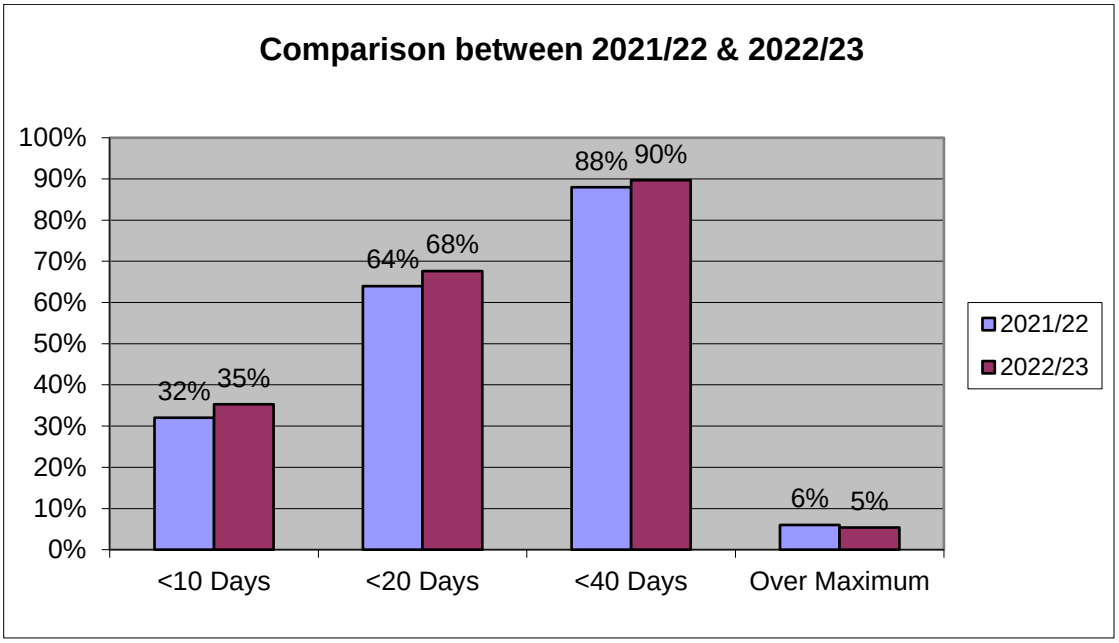
4. Complaints resolved 2022-23

The key performance indicators for speed of response, outcomes, causes and identified learning are linked to complaints that have been *resolved* within any given reporting period rather than received.

This is important as it ensures that full data sets can be presented, both to departments on a quarterly basis, and at year end. It also avoids the scenario whereby Ombudsman findings of maladministration might not appear in annual reports (where outcomes are not known at the time of production).

4.1 Responsiveness to complaints

Graph 5: Adult Social Care Performance at Stage 1



The above graph shows a slightly improved performance at each of the performance indicators. 68% of all complaints were responded to within 20 working days and 95% within the statutory timescale of 65 working days.

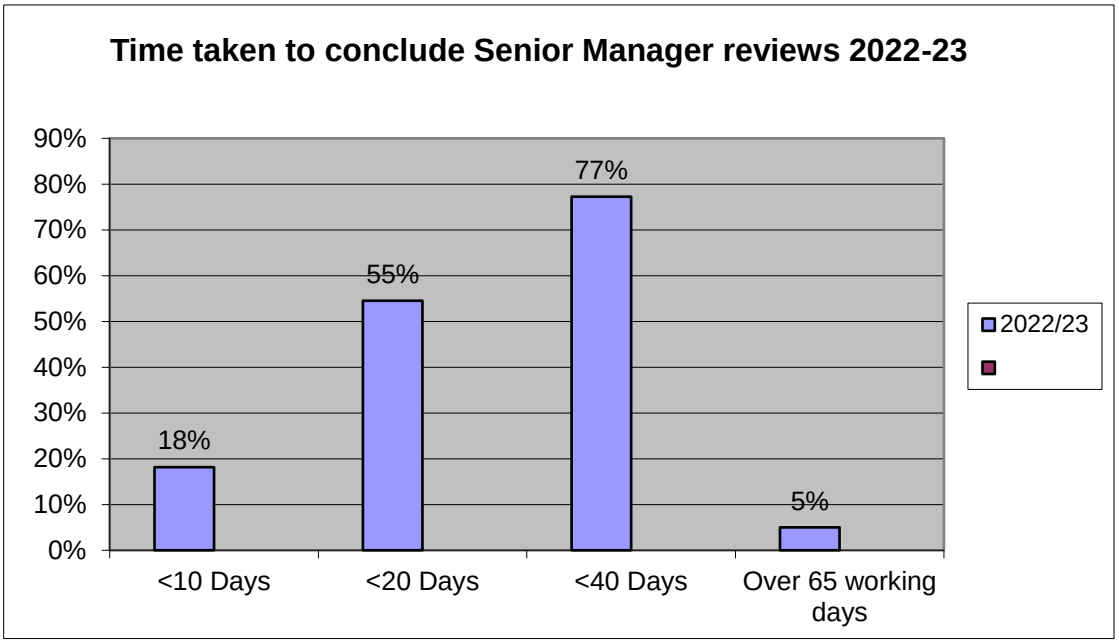
Whilst the statutory regulations give wide flexibility in terms of response times and allow up to 65 working days for complaints to be resolved, a key expectation of the public is that their concerns are dealt with promptly and this report provides good assurance of the department's commitment to this despite the challenges seen this year.

Adult Social Care Performance at Review Stage

44 complaints requested escalation to the Council during the year and were reviewed by a senior manager. This year, reporting is available for each of these as to how long these reviews took to complete and as displayed in the table below.

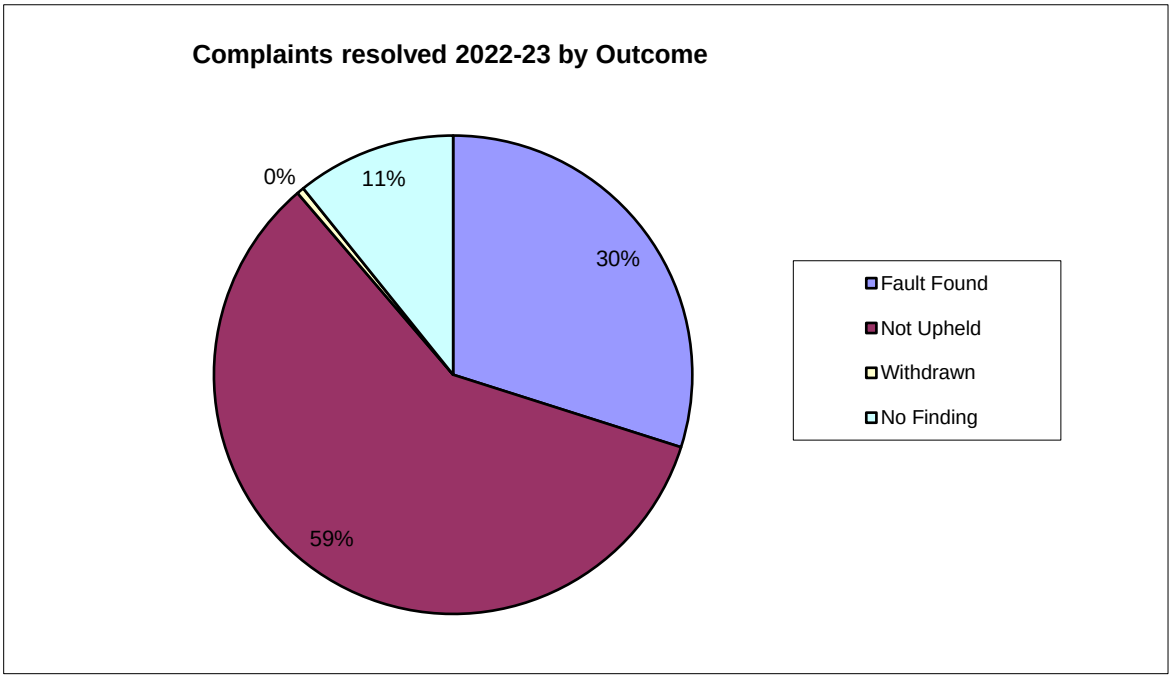
As this is new reporting functionality there are no comparative figures available. Work is ongoing however to raise the response rates within 20 working days.

Graph 6: Adult Social Care complaints reviewed by Senior Managers



4.2 Complaint Outcomes

Graph 7: Adult Social Care complaints recorded by outcome



Graph 6 above shows that 61 (30%) complaints were upheld. This is a significant decrease on the previous year (44%) with the principal reason being the reduction in complaints solely about delays.

Prompt acceptance and ownership of any mistakes can help prevent costly complaint escalation including to Senior Managers and the Local Government and Social Care Ombudsman.

5. Learning from Complaints

Complaints are a valuable source of information which can help to identify recurring or underlying problems and potential improvements. We know that numbers alone do not tell everything about the attitude towards complaints and how they are responded to locally. Arguably of more importance is to understand the impact those complaints have on people and to learn the lessons from complaints to improve the experience for others.

Lessons can usually be learned from complaints that were upheld but also in some instances where no fault was found but the Authority recognises that improvements to services can be made.

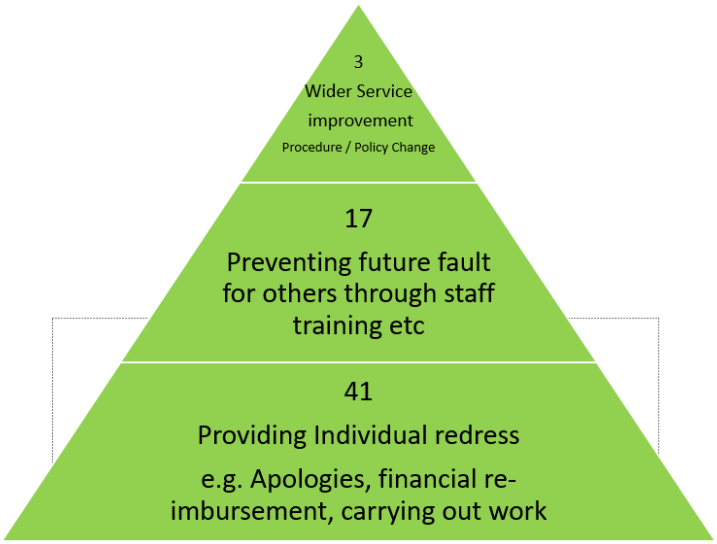
Occasionally during an investigation, issues will be identified that need to be addressed over and above the original complaint. The Complaints Team will always try to look at the “bigger picture” to ensure that residents receive the best possible service from the Council.

5.1 Corrective action taken

All the 61 complaints where fault has been found have been reviewed by the Complaints Team to ascertain what action the relevant department has taken, both in remedying the fault, and any wider learning to avoid such issues occurring in the future.

Remedial action typically consists of both individual redress (e.g., apology, carrying out overdue work) and wider actions that may affect many. The diagram below shows the actions taken during 2022-23. 33% of complaints upheld resulted in clear actions that should improve service for other residents. This is a slight increase on the previous year (26%)

Graph 7: Actions taken for upheld complaints 2022-23



The most common action taken was staff training. There are lots of good examples of this taking place both at individual and team level. This includes reminding teams of the need to keep accurate records, refresher training on procedures for raising invoices amongst others

The most powerful are whole system changes, where it is identified that a process or policy needs amending. There were 3 such scenarios during the year arising from local investigation. These were around account finalisation, oversight of safeguarding concerns at the front door and oversight of carer support grants.

Financial redress was also arranged on several occasions this year and to ensure that the complainant was put back in the position they would have been in had the fault not occurred. Typically, this is re-imbursement of care costs where these had either been calculated wrongly or there was evidence that clear explanations were not given.

The Local Government and Social Care Ombudsman expects Councils to consider such financial redress as appropriate and has introduced new reporting this year highlighting those occasions where Councils have already put things right before consideration by the Ombudsman.

6. Local Government Ombudsman

6.1 New complaints received by the Ombudsman 2022-23

Should a complainant remain dissatisfied following internal consideration of their complaint, they can take their complaint to the Local Government and Social Care Ombudsman to seek independent investigation.

The Ombudsman will usually check with the Authority whether the complaint has exhausted the Local Authority's complaints procedure. Where this has not been done, the Ombudsman will usually refer the complaint back to the Authority, to give us an opportunity to attempt to resolve the complainant's concerns through our internal complaints processes first.

The Local Government and Social Care Ombudsman opened enquiries on 23 complaints during the year. This represents approximately 12% of the overall complaints.

6.2 Complaints resolved by the Ombudsman 2022-23

The Ombudsman made decisions on twenty-four cases during the year with fault being found in 9 cases (37%). This represents a higher number of adverse decisions to last year (5) but a reduced proportion of fault (50%).

One of the decisions was issued as a Public Report. This was considered by Cabinet as required by the statutory guidance.

Brief details for the nine cases where fault was found appear below:

1. **Fault found on how the Council communicated that charges would apply for care**

The Ombudsman found fault that the Council failed to provide clear information following a review of reablement. This caused injustice as the family were not properly informed about charges that were then applied.

The Council agreed to waive 6 weeks worth of charges, make a symbolic payment of £150 in recognition of the distress caused and review its guidance on informing service users about the outcome of reviews.

2. **A complaint regarding the quality of care delivered by a Residential care provider.**

The Ombudsman found fault that the provider had failed to keep accurate monitoring records and had failed to properly assess a resident.

As the commissioning organisation, the Council is accountable for actions of providers and agreed to apologise, make a symbolic payment of £250 in recognition of the fault found and to undertake improvement work with the provider.

3. **A complaint regarding a care provider not delivering care calls in line with the agreed plan.**

The Provider had responded to a formal complaint explaining that staffing issues had led to some calls either being delivered late or with carers that were not fully trained to deliver all aspects of the care package. An apology was given. The Council was already working with the provider to help them with recruitment issues.

The Ombudsman welcomed the work already taking place but ruled that in addition to apologising the Council should make a payment of £500 in recognition of the partial delivery of the care plan. The Council accepted this finding.

4. **A failure to ensure eligible care needs were delivered following temporary suspension during the pandemic**

This decision was issued as a Public Report on the grounds of there being significant fault and resulting injustice.

The Council was found at fault for extensive delay in carrying out both a needs assessment and financial assessment. This left the Service User without eligible support for a significant period of time.

The Council agreed to make a compensatory payment of £10,020 to reflect the lost support that would have been in place. The Ombudsman also asked the Council to review other cases that may have been similarly affected.

The Council accepted the findings and identified some 5 other families that potentially were affected. All were written to but none sought further investigation or support. It also issued a number of reminders to teams on the importance of record-keeping and timely communication with families.

5. **A failure to ensure continuity of home care provision following a number of changes of provider.**

Fault was found that there was a gap in home care provision which was not adequately bridged by the Council following several breakdowns in placement. Although care was in place, afternoon calls were not for a period of 2 months

The Council agreed to apologise and deduct £200 from outstanding care invoices to reflect the lack of home care in line with the support plan.

6. **A failure to provide appropriate advice and support to a carer**

This complaint centred on poor advice and support when the complainant approached the Council seeking support.

The Council had by this point backdated personal budget support but the Ombudsman found that it should also apologise for the distress caused and take steps to improve how it communicates with those who are experiencing stress or difficulties in understanding information being given. An additional distress payment of £150 was also agreed.

7. **Concerns that the Council placed a family member in an unsuitable care home.**

Although the Ombudsman did not conclude that there was any evidence the placement was unsuitable, there was evidence of poor record keeping and inadequate communication with the family by the care provider.

The Council agreed to apologise and make a payment of £300 in recognition of this. CQC were already working with the provider so no wider recommendations were made

8. **Concerns regarding top up charges requested by the Council**

This complaint had already been upheld by the Council who had agreed to waive the charges and make a further payment of £200.

The Ombudsman concluded this was an appropriate offer which adequately addressed the fault

9. **Concerns regarding quality of care in a residential care home**

The Ombudsman found fault in how the provider dealt with family members during end of life care and how it responded to safeguarding concerns raised.

Both the Council and provider were asked to formally apologise to the family and set out the actions being taken to generate improvements and how the learning would be taken from this complaint.

For the remaining fifteen complaints

- In nine cases the Ombudsman decided not to investigate, either because there was no evidence of any fault, or the matter had already been appropriately addressed by the Council
- In three cases, the Ombudsman, after detailed investigation, was satisfied with the actions the Council had taken.
- In two cases the Ombudsman concluded initial enquiries with a finding that the matters complained about were outside of his remit

- In one instance the Ombudsman ruled that the complaint was raised too late to be accepted.

The Ombudsman also monitors remedies being carried out by the Council where fault has been found and remedial actions proposed. Failure to carry out remedies within agreed timeframes is recorded as non-compliance and can lead to public reports being issued. All 5 of the above cases were recorded as compliant (100%). This compares to the national average of 99%

7. Monitoring the Process

The Complaints Team continues to support Adult Social Care Services to manage and learn from complaints. The key services offered are -

1. Complaints advice and support
2. Production of Performance Reports
3. Liaison with the Local Government and Social Care Ombudsman
4. Quality Assurance of complaint responses
5. Complaint handling training for Operational Managers
6. Scrutiny and challenge to complaint responses

Assistance continues to be routinely provided to Service Managers and other associated managers in drafting responses to complaint investigations. This helps ensure a consistency of response and that due process is followed.

Complaints training has been offered this year on a quarterly basis. This has included several new managers within Adult Social Care

Quarterly performance reports are produced and delivered at Senior Leadership Team (SLT)

8. Final Comments

There has been a very slight decrease in complaint volumes this year. In the context of increased demand pressures that is pleasing to see.

It is also good to start seeing a decrease in charging complaints following 2 years of this being a significant area of challenge. Not only are volumes coming down but there are far fewer upheld complaints in this area and only one instance where fault was found by the Ombudsman.

Other areas remain largely stable although there is a slight rise in Home Care complaints. This may be linked to new providers that we are working with but it is difficult to draw any definite conclusions.

Complaints data is routinely shared with our Quality and Improvement team who work closely with providers in making improvements as required.

It is vital that service users are provided with a complaints process that is easy to access and fair. This year's Annual Report shows that Adult Social Care does listen and provides a number of examples of how complaints intelligence directly drives and improves service delivery.

Appendix A: Sample of compliments received 2022-23

- Thank you, C for the support that you provided a service user and also for your professional and helpful manner.
- Thank you to S for all the work you have done on Dad's case. I am grateful that you dealt with him with such empathy and respect.
- Thank you C for arranging to get my front step and rail outside done, it is so much easier for me to negotiate.
- Thank you K, we are are truly grateful for all your help and support over the recent weeks.
- Thank you, E, for all your help with this case and for being wonderful, caring, cautious and very professional in your approach.
- Our grateful thanks to R, on how she has dealt with our daughter's move from her old accommodation to her now perfect one.
- Thank you, M for all your support & also for your professional and helpful manner, which made a difficult situation easier.
- Thank you, Y for everything that you have done for mum, we really do appreciate it.
- Thank you, Z for all your help with a complex service user, your approach has helped in building a trusting relationship with him.
- Thank you Z for all the help and support that you provided to my parents during a very difficult time.
- I just wanted to say a massive thank you to G for supporting the case for my dad to stay at the Willows and for all your help.
- Thank you to S for your contribution at Park Road & Little Glen & for the improvements to the wellbeing of the tenant at Park Road.
- Thank You P, for all your help and support when I had to take over my young sisters care.
- Thank you so much A, for the things you have provided for me. The rails are amazing honestly & also great for my son.
- Thank you O for all your help and support, I no longer feel alone and my Quality of life has improved.