

## **Adult Social Care**



## **Statutory Complaints & Compliments Annual Report April 2016 – March 2018**

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# **1. Purpose and Context of Report**

## **1.1 Purpose and Scope**

The purpose of this report is –

- To report to members and officers detailing Leicestershire County Council's (LCC) adult social care complaints and compliments activity from 1 April 2016 to 31 March 2017
- To set out future developments and planned improvements.
- To meet the Council's statutory duty requiring the production of an annual report each year.<sup>1</sup>

The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 outlines the statutory responsibilities of the County Council.

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 within the Adults and Communities Department arranges and supports the provision of a wide variety of services to help 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 nursing care as well as having lead responsibility for safeguarding adults at risk of harm.

This year 10,112<sup>2</sup> people received long-term support from the Social Care service during 2016-17. This figure is a 1% reduction from last year.

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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<sup>1</sup> [Statutory Instrument 2009 no.309 \(18\)](#)

<sup>2</sup> Figures supplied by Performance and Business Intelligence Team

Analysis of information about complaints received during 2016 -17 gives Adult Social Care an opportunity to reflect on both the quality of the services it provides and also consider how well it listens and responds to service users.

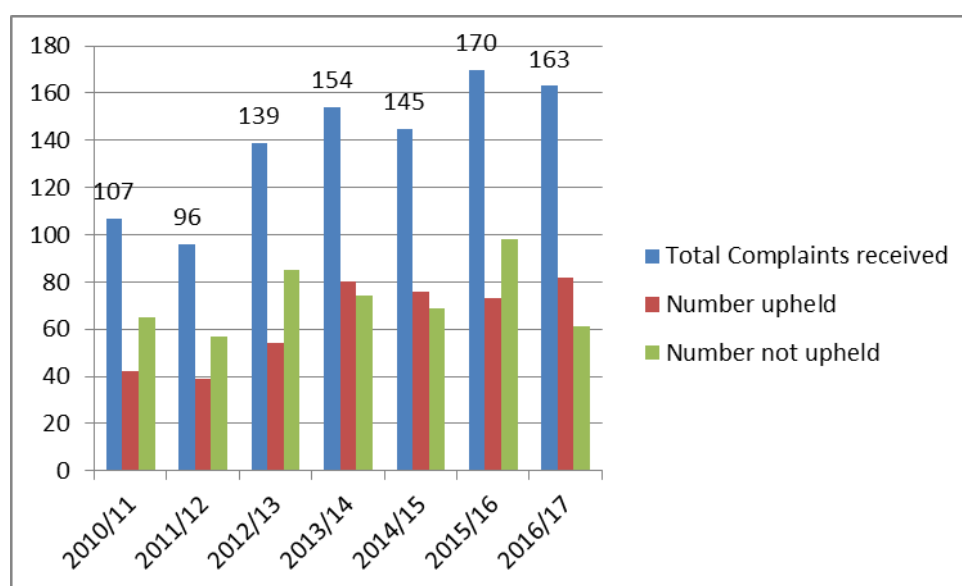
### 1.3 Local Government Ombudsman Review of adult social care complaints

The Local Government Ombudsman has committed to again [publish their annual review of adult social care complaints](#). At the time this annual report is submitted the report is not available but once available this will be published online.

## 2. Complaints and compliments received 2016-17

### 2.1 Complaint Volumes

Table 1: Adult Social Care Complaints recorded and upheld

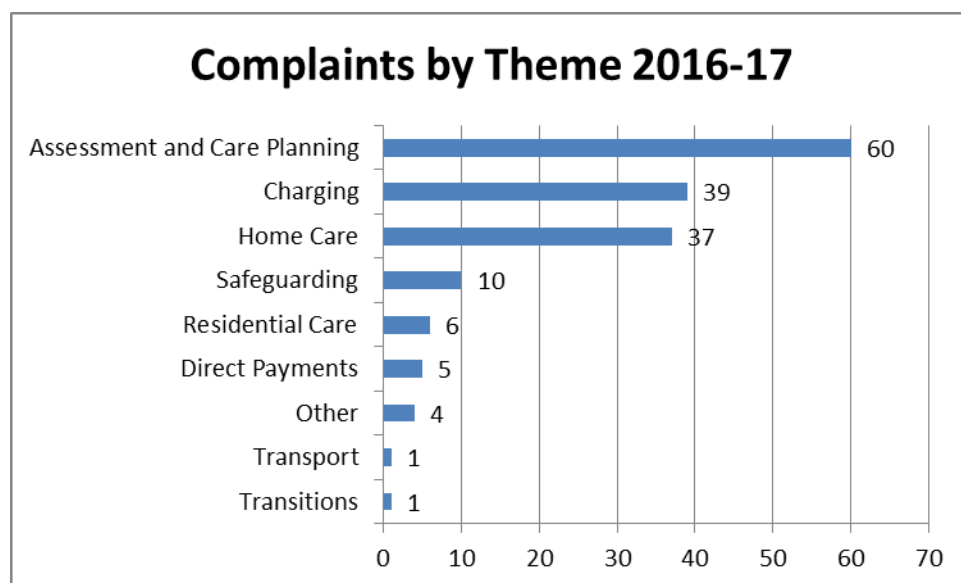


As illustrated above the total number of complaints received this year has decreased very slightly from 2015-16 (-4%).

Complaint outcomes are considered in more detail later in this report. The numbers upheld each year are however included in the above graph to show the longer term trend. This year saw a higher proportion of complaints being upheld (50%). This is not of itself a negative as significant work has been done equipping managers to investigate and respond to complaints appropriately. A significant part of this is the ability to recognise where fault occurred.

## 2.2 Complaints by Section

Table 2: adult social care complaints by theme



This year, the complaints team have sought to segment complaints data against a broad theme. This mirrors Local Government Ombudsman data classifications. As this is the first year data has been classified in this way, no comparative data is available. Discussions are also taking place at a regional level with a view to being able to benchmark data using these categories in future years.

Unsurprisingly, the largest segment is the broadest category around Assessment and Care Planning. This equates to 36% of the overall volume. This mirrors the most common theme within the most recent Ombudsman report<sup>3</sup>

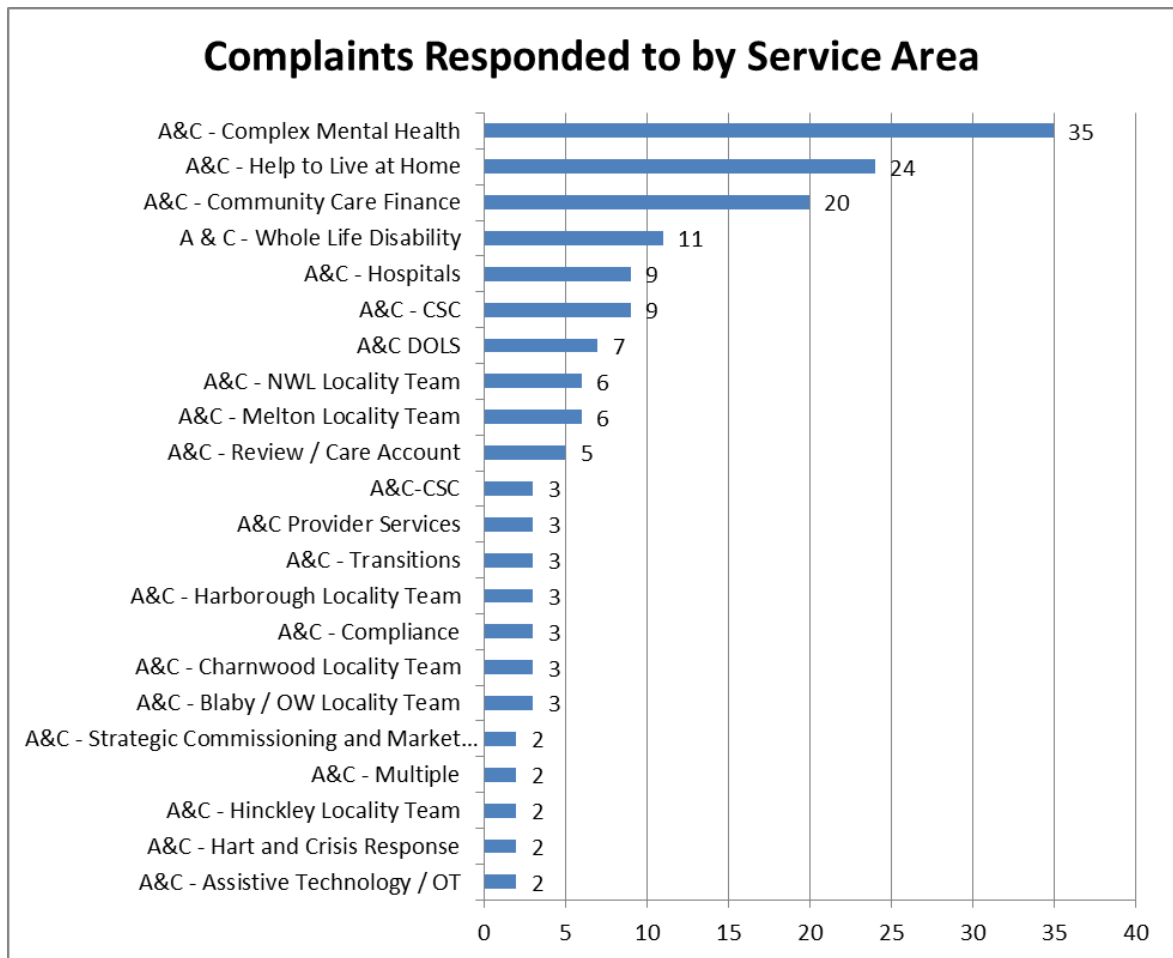
Charging and Home Care are the next highest areas with very similar volumes. This is where the Council sees significant differences to the national picture (as recorded by the Ombudsman) with Residential Care complaints recorded by the Council being significantly lower than the proportion recorded by the Ombudsman. (4% LCC v 20% LGO)

Without significant additional analysis no firm conclusions can be drawn from this, especially as the Council would not necessarily expect to see complaints regarding privately funded care homes. Assurance will however be sought that those care homes the Council contracts with are managing and recording complaints appropriately.

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<sup>3</sup> Local Government and Social Care Ombudsman – Review of Adult Social Care Complaints 2015-16

Table 3: Adult Social Care Complaints by Service Area



The above graph (Table 3) breaks down complaints by teams.

Reporting at this level may help identify any areas that may be over or under-represented, though with the numbers involved, caution needs to be exercised in drawing any firm conclusions.

It is worth highlighting that the seven highest areas are all County-wide functions rather than restricted to a specific locality. It follows that these are always likely to generate a higher total volume than locality teams.

Help to live at home complaints will in future be assigned to the relevant locality team for a response but during the implementation period, responses were co-ordinated between the Project team, Compliance and Complaints.

It is pleasing to note the reduction in complaints that Community Care Finance responded to (reduction of 46%) which reflects positive improvements made to working practices.

For the services that are restricted to locality areas rather than cross-county functions there are no notable trends emerging.

## 2.3 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<sup>4</sup>. Leicestershire County Council accordingly has a joint complaints handling protocol, supported by a multi-agency group, which sets out common guidelines and approaches to this. Members include Leicester City Council, the Clinical Commissioning Groups, University Hospitals Leicester (UHL) and the Leicestershire Partnership Trust (LPT)

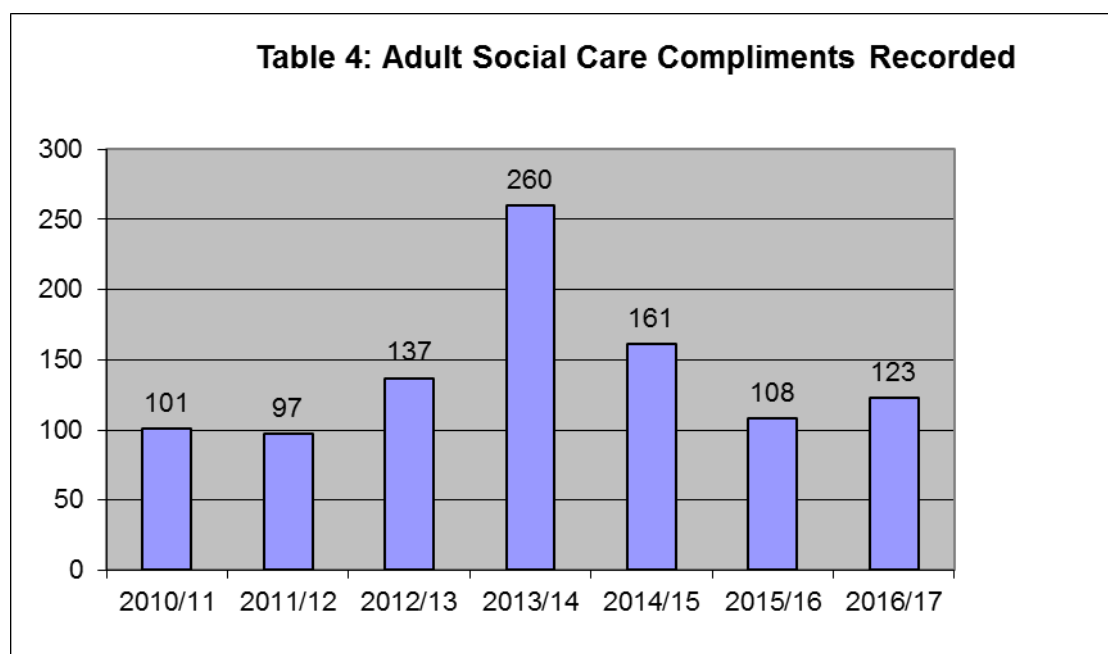
During the year 2016/17, fourteen complaints were considered using the Joint Complaints protocol. This is an increase on last year (9)

There continue to be large-scale changes in management responsibility for complaints within partner organisations and this has prevented significant progress being made to streamline joint complaint handling.

Nevertheless, a quarterly meeting has been re-established during 2016-17 to help drive improvements forward. The main challenge continues to be cases which are CHC funded and under the responsibility of the CCG. Management of such cases has been delegated to Arden GEM and more recently Mid Lancashire CSU. There have been significant issues co-ordinating and responding to such cases. It is too early to say whether the change to Mid Lancashire CSU will resolve these issues.

## 2.4 Compliments received 2016-17

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



There has been a slight increase in compliments recorded during 2016-17.

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<sup>4</sup> [Statutory Instrument 2009 no. 309 \(9\)](#)

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 encourages 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.



### 3. Complaints resolved 2016-17

#### 3.1 Foreword

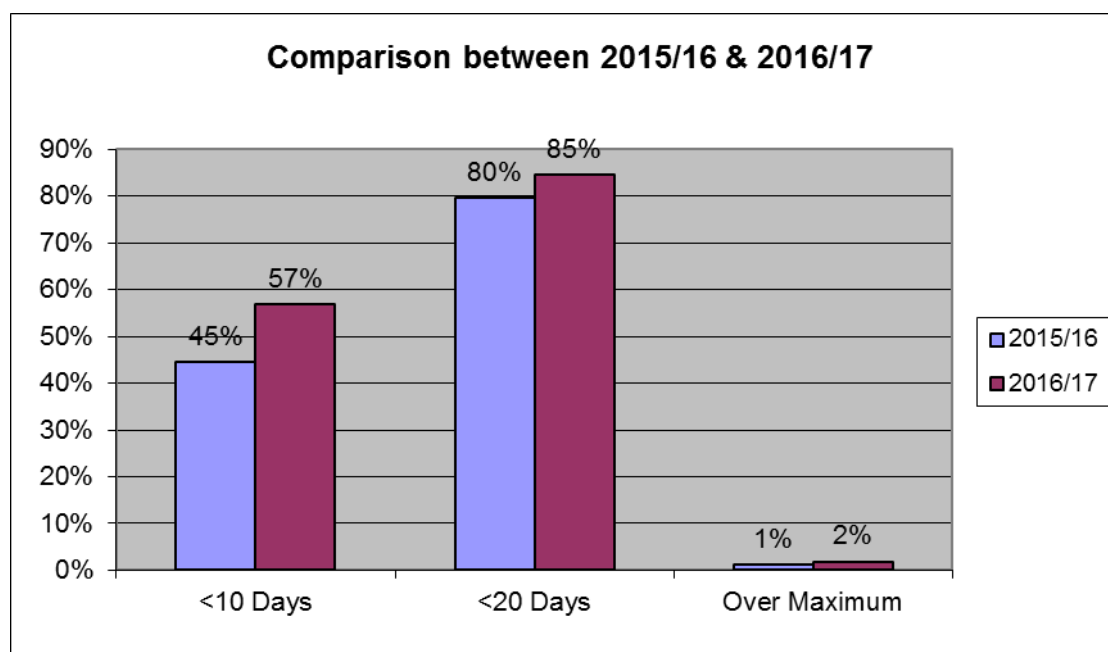
To counter historical gaps in reporting on information where complaints remain open, a change has been made to the mechanism of reporting. This change is reflected in this annual report and sees the key performance indicators for speed of response, outcomes, causes and identified learning being linked to complaints *resolved* rather than received during the reporting period.

This change will ensure that full data sets are able to be presented, both to departments on a quarterly basis, and at year end. It also closes a gap (particularly relevant to Ombudsman complaints) where outcomes did not appear in annual reports as the complaint remained open at the time of issue.

It follows from all of the above that the figures presented below will not match the data presented in section two of this report which focused on complaints received.

#### 3.2 Responsiveness to complaints

Table 5: Adult Social Care Performance



There has been a significant improvement in responsiveness to complaints during 2016-17, with a 12% improvement in those responded to within 10 working days and 85% being responded to within 20 working days. Given the complexities of social care, these are healthy figures and compare well to neighbouring authorities.

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

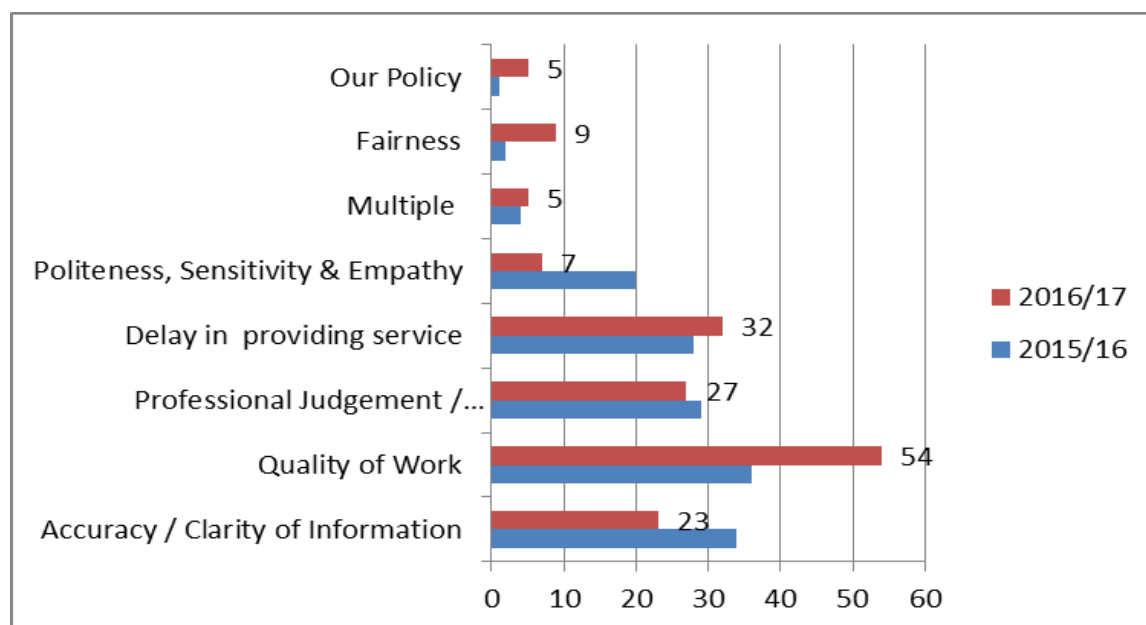
complainants is that their concerns are dealt with promptly and this report provides good assurance of the department's commitment to this.

Just 3 complaints were not responded to within the statutory maximum timescale of 65 working days. One was a joint complaint and where delay was attributable to a partner organisation. The other two cases were during the difficult Help to Live at Home implementation where volume of cases was a significant factor. The Complaints Manager is confident that improvements have been made in this area.

### 3.3 Complaint Causes

The Complaints team undertake analysis of each complaint to try to understand the significant factor. This can be an insightful way of highlighting areas for the department to work on improving. The results for 2016-17 are represented below along with comparative data for 2015-16

Table 6: Complaint causes



There are some interesting variances this year, in particular:

- 1) A significant drop in complaints regarding accuracy of information. This reflects positive work done within Community Care Finance to improve how invoices are generated. There is still work to do to further reduce complaints of this nature but positive progress
- 2) Rise in complaints which featured quality of work as the key issue. This is a broad category and was heavily impacted by Help to Live at Home complaints in Q3 (scheduling issues, lack of knowledge of care plans)
- 3) A reduction in complaints citing staff attitude / conduct as a primary feature. This has reduced to just 7 complaints
- 4) An increase in complaints citing delay in receiving services as the main factor. Predominantly this was down to the pressures on the Mental Health wait list in Q2 through Q3.

### 3.4 Complaint Outcomes

Table 7: Adult Social Care complaints recorded by outcome

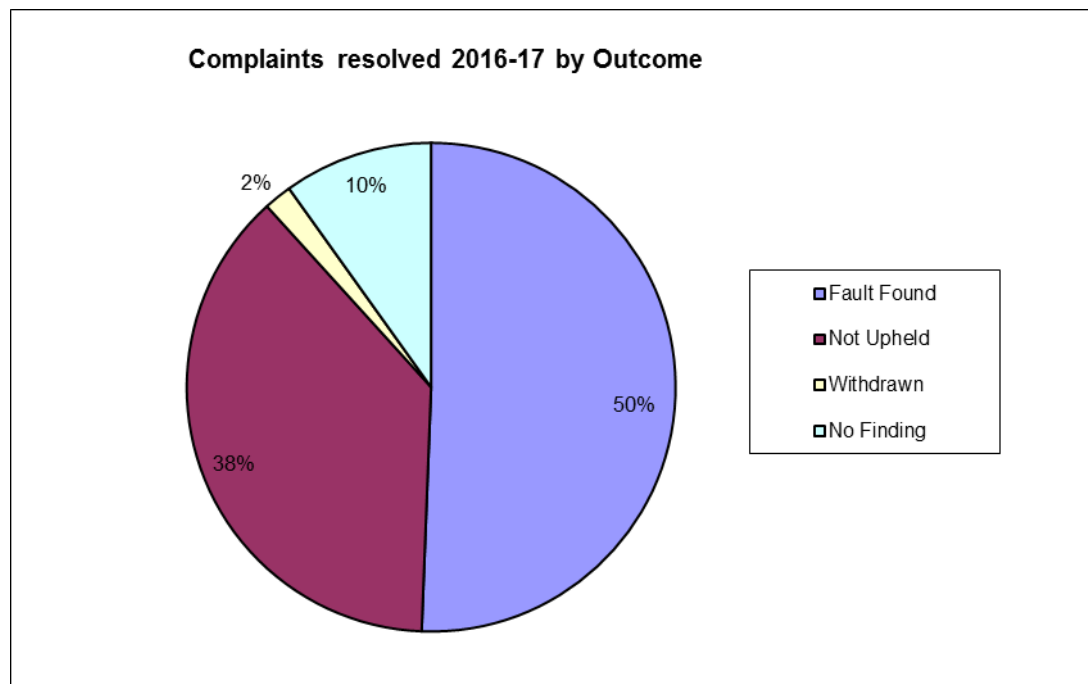


Table 7 above shows that 50% of complaints were upheld. This is an increase on last year by 7%.

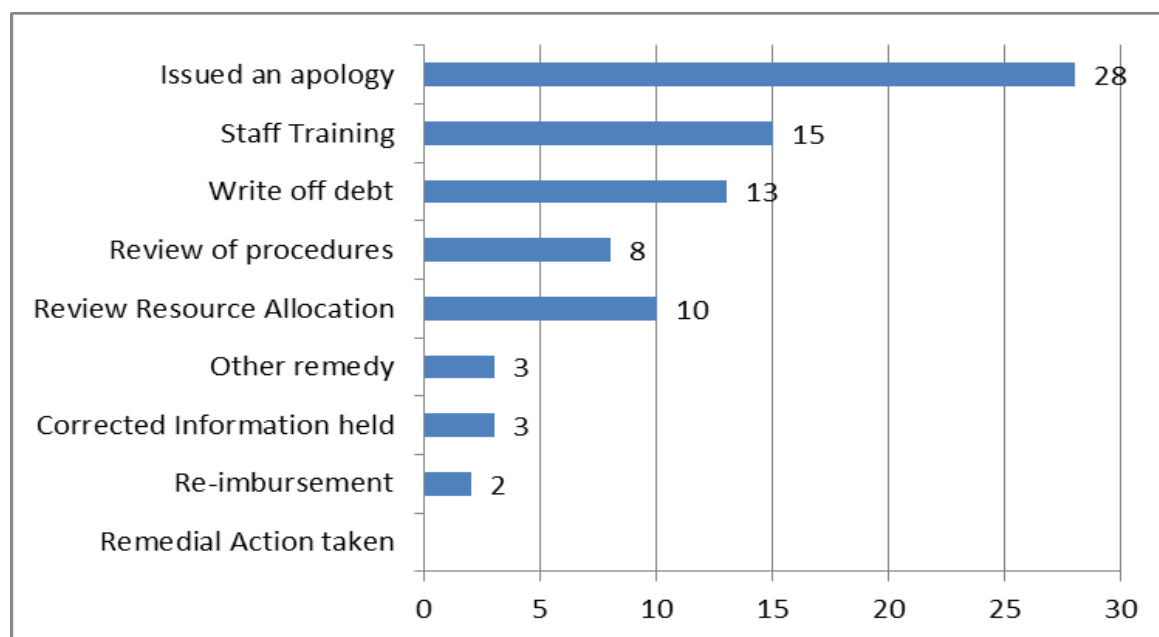
Whilst the Ombudsman has not yet published their annual report on social care this year, it is timely to remind that the top level findings from their annual review for 2015-16 highlighted adult social services as the area most likely to be upheld at 58%.

## 4. Learning from Complaints

### 4.1 Corrective action taken

Each of the 82 complaints either partly or fully upheld have been reviewed to ascertain what action the department has taken to learn from the complaints and avoid such issues occurring in the future. The results are shown below.

*Table 8: Actions taken in response to complaints*



In 28 cases (34%) an apology was seen as the appropriate action, typically when events had moved on or the issues had already been addressed.

Investigating officers are also asked to explore whether there are systemic issues which need further action to prevent future complaints. The most likely additional action here was undertaking staff coaching or training (15 cases). This included the following:

- Reminder of our customer service standards and the need to issue timely responses to phone calls / e-mails
- Whole team reminders on our Transport policy
- Significant training done with teams around safeguarding
- Diversity training
- Refresher training on use of IAS

During the year, complaints volumes have been heavily impacted by two key areas as follows:

- Complex Mental Health
- Help to Live at Home

Both areas have been discussed at the department's senior leadership team and a number of clear actions taken to improve the position. These are set out as case studies below

### **Case Study 1 – Complex Mental Health complaints**

During Quarters 2 & 3 it was clear that there was significant pressure on waiting times for allocations of social workers within this area. This manifested itself in complaints intelligence and the problem was flagged as an urgent priority in Q3.

In response, SLT came up with a number of remedial actions as set out below.

- The residential review team were asked to take non-complex cases in residential care
- The Council retained agency cover that had been taken over establishment and this helped to cover vacancies as they arise.
- Additional temporary capacity was introduced and we increased this (agency staffing). This resource specifically targeted the older persons waiting list.
- Less complex cases were managed by other areas of the business, flexibly using additional management capacity.

In February 2017, a review of the above actions was carried out and it was clear that significant progress had been made. This was reflected in complaints data for the final quarter of the year.

### **Case Study 2 – Help to Live at Home complaints**

In November, a major project aimed at rationalising the numbers of Home Care providers was launched. The late withdrawal of one of the 8 providers led to a difficult implementation period as packages for this area needed to be covered at very short notice. Inevitably this led to a number of complaints.

It became quickly apparent that there were transitional difficulties with 3 providers with one in particular generating significant volumes of complaints (Fosse Healthcare)

In response, officers from the Compliance team met with Fosse to go through these and support them in stabilisation. Fosse Healthcare were asked to draft replies to these complaints and to feedback to Compliance that they had resolved the issues and what measures they had taken.

The Quality Improvement team have also worked closely with Fosse to ensure that the standards of care delivery are improved. The compliance team carried out monthly quality monitoring visits and contract management meetings.

Improvements are now being seen in the delivery of care and accordingly there has been a large reduction in the number of complaints (formal and informal) being received. This work is on-going but it has led to a sharp reduction in complaints being received during the first quarter of 2017-18

In addition to the above, the following are other examples of positive actions taken this year to improve service delivery

You said	We Did
You are not clear enough with families around explaining charges that may apply	Increased the training and guidance to staff about importance of clear explanations being given and clear case-recording to evidence this
You didn't respond promptly when a lifeline was triggered	The issue here was recording of all contact numbers given.  Changes have been made to how we capture, store and refer on this information
There is a lack of information flowing between carers and social workers	Accepted that communications book had not been completed appropriately.  Our compliance team have issued reminders to the care provider.
You don't take enough care when sending sensitive information through the post	Accepted that the materials sent should have been sent recorded delivery. Best practice guidance is within our mandatory data protection e-learning module and there is a major push on all staff completing this.
Family member was not supported appropriately by carers	Clear that there were some issues with moving and handling. Carers reminded of their duties to ensure staff appropriately trained and follow-up checks made
You don't get back to people quickly enough when work is going onto waiting lists	The real issue here was the lack of capacity to assign a worker. Accepted however that we need to find a way to ensure updates are given to better manage expectations.

All of the above demonstrate good evidence of how learning from complaints is helping shape how we deliver our services.

## 5. Local Government Ombudsman

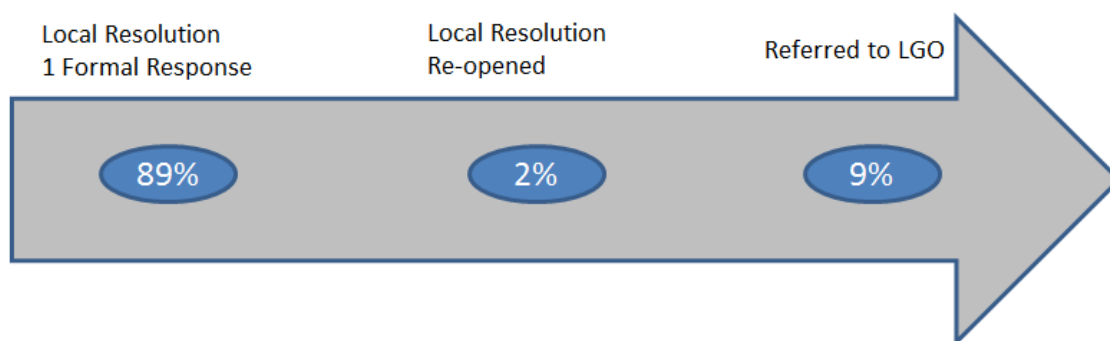
### 5.1 New complaints received by the Ombudsman 2016-17

The statutory social care procedure is a two stage process with the Ombudsman as the second stage. However, before complaints are escalated to the Ombudsman, it is important that a flexible approach is taken to ensuring that every opportunity has been taken to resolve the matter.

On occasions, complaints are re-opened for further investigation prior to an Ombudsman referral. Predominantly this is where new issues arise or it is felt there is an opportunity to further clarify responses made at Stage 1. With this in mind, it is interesting to look at where complaints are resolved along the pathway.

The Local Government Ombudsman made enquiries of the Council on 13 complaints during the year.

*Table 9: Complaint escalations*



### 5.2 Complaints resolved by the Ombudsman 2016-17

The Ombudsman made decisions on fourteen cases during the year with seven cases being upheld. The details for these cases appear below:

1. Complaint regarding charges levied for a period in residential care and where concerns had been raised as to the level of care received. The Council had accepted that the concerns had not been dealt with appropriately and offered to offer £200 reduction on the invoice in recognition. The Ombudsman agreed that this was a satisfactory offer of redress.
2. A wide-ranging complaint regarding charging, safeguarding and PA support. The Ombudsman accepted the Council's argument that the PA support was a private matter but found some fault with how the Council explained the charges that would apply and how a safeguarding referral was handled. The Council agreed to offer an apology, remind officers of the importance of recording decisions and make a payment of £150 in recognition of the distress caused by failure to clearly advise of charges.
3. A complaint regarding how the Council dealt with a safeguarding referral. The Council accepted that there were some administrative faults but that

ultimately these did not lead to any injustice. An apology was deemed sufficient redress although the Council also pledged to undertake additional training with the workers involved.

4. A complaint regarding the Council's consideration of a fuel allowance claim. The Ombudsman found some administrative fault with how the Council had assessed this. The Council had proposed a fresh review which the Ombudsman noted but also asked the Council to make a time and trouble payment of £150. The Council accepted this.
5. A complaint that the Council unfairly changed its charging policy and that the implications were not fully explained. The family were therefore not able to make informed decisions re care provision. The Ombudsman found fault that the Council had not done enough to explain the changes given the complainant was suffering from dementia. The Council agreed to issue an apology and waive an outstanding balance of £335.01
6. A complaint that the Council's advice left an individual without PA support for a period of 3 months and failed to properly assess a request for mileage payments. There was no fault with the mileage assessment but the Ombudsman did find fault that the complainant was left without PA support. The Council agreed to make a remedy payment of £300 to remedy the distress this caused.
7. A complaint that the Council failed to properly consider the complainant's transport costs and needs. The Ombudsman found fault that the Council did not apply our policy correctly by failing to escalate to senior managers under exceptional circumstances. The Council agreed to carry out a fresh review, issue an apology and provide additional guidance to officers on our Transport policy.

For the remaining cases –

- In four cases the Ombudsman decided not to investigate, either because there was no evidence of any fault, or the complaint concerned matters outside of her jurisdiction.
- In three cases, the Ombudsman, after detailed investigation, was happy with the actions the Council had taken.

Although the proportion of complaints upheld by the Ombudsman increased this year, there were no significant remedy payments made.

Administrative fault relating to safeguarding appeared as a feature in several cases and there has been a significant amount of refresher training undertaken in this area.



## **6. Monitoring the Process**

The Customer Relations 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 Local Government 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 Locality Managers in drafting responses to complaint investigations. This helps ensure a consistency of response and that due process is followed.

The Customer Relations Manager also meets with the department's Intelligent Client each quarter to talk through complaints matters.

Quarterly performance reports are produced and delivered at Strategic Leadership Team (SLT) and shared with the Lead Member for Adults and Communities.

## **7. Final Comments**

In times of change and austerity 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.

The Complaints Manager would also highlight one key theme that remains an issue affecting a number of complaints

- **Importance of ensuring accurate Care Package Line Items (CPLI ) data**

This is an issue at the heart of most of the charging complaints this year. If CPLI's are not correctly updated, this drives erroneous invoices which not only leads to service user complaints but has created issues with payments to suppliers and key partners.

This has been recognised as an issue by senior leadership team who are working on a number of actions to drive improvement in this area.

## **Appendix A: Sample of compliments received 2016-17**

- Thanks to all the team for helping secure the successful grant application for a stairlift. This is making a massive difference to quality of life. – **Assistive Tech**
- A quick e-mail to say how pleased we both our with your "Hart" team carers. They are truly a godsend and are helping so much....You only ever hear of the negatives in the press but the service we are receiving is fantastic – **HART**
- Special thanks to Luke for the help he has consistently provided over last few weeks in ensuring D is now at the right place...there were a number of issues and concerns which he raised in a caring and sensitive way. – **BLABY LOCALITY**
- I was adamant that I would be able to manage my wife's needs following hospital discharge. This was until Julie took the time to sit down with me and explain in simple non-medical terms what the problems were and the challenges that would be facing me...Without this advice, I would not have accepted the carers and certainly not have coped as well as I have. Julie is a great credit for your department – **NORTH WEST LOCALITY**
- Thank you for all your help and support in placing my dad at BCR Hall...Your professionalism, honesty and help has been so valuable to us at this difficult time – **CHARNWOOD LOCALITY**
- Just a little note to say a big thank you for showing such kindness and understanding when you came to assess me as a carer. It's so refreshing to have someone who is prepared to listen and show empathy – **MELTON LOCALITY**
- Thanks to Linda for her support and professional approach in her recent dealings with the family – **SAFEGAURDING**
- A very big thank-you to Stephen for all his kindness, consideration and general thoughtfulness in helping when my husband was placed into care...he listened and cared which is a great commodity these days - **MENTAL HEALTH**
- Over the years, key workers, specialists and social workers have all come and gone with promises mad and broken. We have struggled on alone....until Lisa who took the time to listen, rang me with every development and didn't get up and ignore my plight...I can truly say that without Lisa my son would not be making the amazing progress he is and gaining confidence daily..he now has something to get up for every day – **WHOLE LIFE DISABILITY (HINCKLEY)**
- A's condition over the past two months regarding his breakdown has improved possibly around 50% I am relieved to say after 12 months of being in that dark place, not out of woods yet but getting there...Thank you Claire once again for your support in this matter that has been a lifeline and continues to be so for us both. With your advice help and information we both have been able to move on from the terrible place that we unfortunately were put into – **DOM REVIEW**
- Mandy, what an awesome person you are, I can't find the words to thank you enough you've helped my family big tme and pulled me back from insanity,

your our knight (ess) in shining armour, I can't thank you enough – **HINCKLEY LOCALITY**

- I am very grateful for the support you (Emma Musson) have given me to date I am sure that between us we can solve communication problems you are doing brilliantly so far thank you – **PERSONAL BUDGETS**
- Huge thank you to the team that managed to get emergency care at Westview House last Wednesday afternoon for my father. You dug us out of a very deep hole – **MELTON LOCALITY**