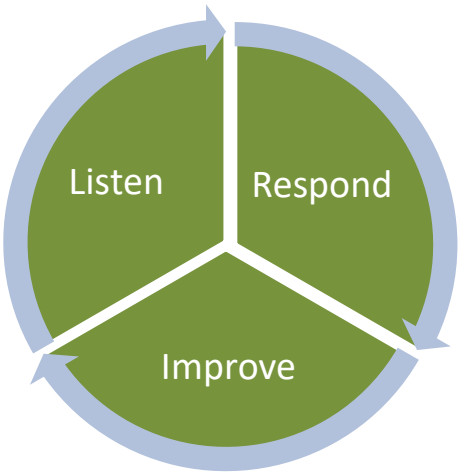
Leicestershire County Council

Adult Social Care



Statutory Complaints and Compliments Annual Report April 2019 – March 2020

Business Services
Corporate Resources Dept

CONTENTS

1. Purpose and Context of Report

1.1. Purpose & Scope

The purpose of this report is –

- To report to members and officers on Leicestershire County Council's (LCC) adult social care complaints and compliments activity from 1 April 2019 to 31 March 2020.
- 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.

9,503[2] people received long-term support from the Social Care service during 2019-20. This figure is very similar to the previous year (9,626)

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

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

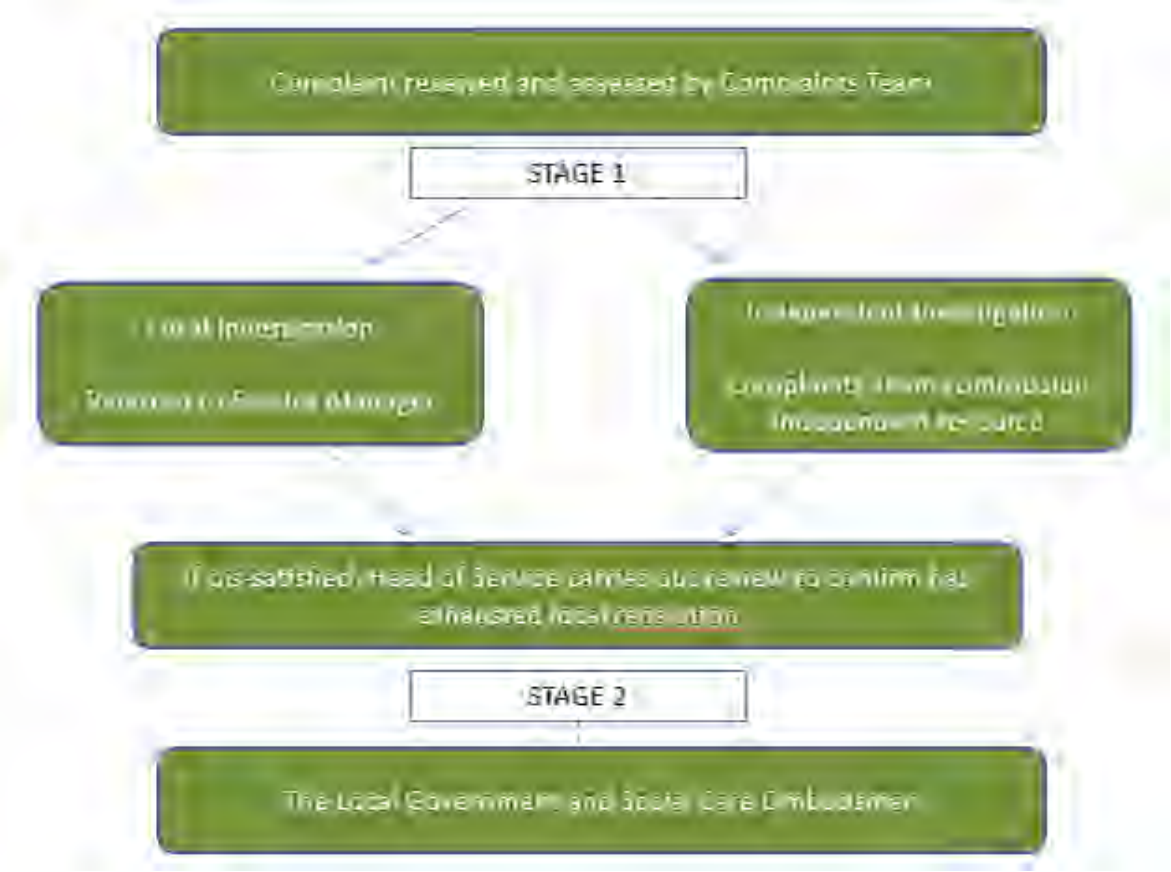
[2] Figures supplied by Performance and Business Intelligence Team

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.

Analysis of information about complaints received during 2019 -20 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 a number of processes (for example meetings) 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.

In 2019 following learning from an Ombudsman complaint and where the local response had not been sufficiently robust, the Council formally added a “review” step to the procedure. This means that before signposting to the Ombudsman, a Head of Service (or higher) is asked to confirm they are satisfied the complaint has exhausted local resolution.

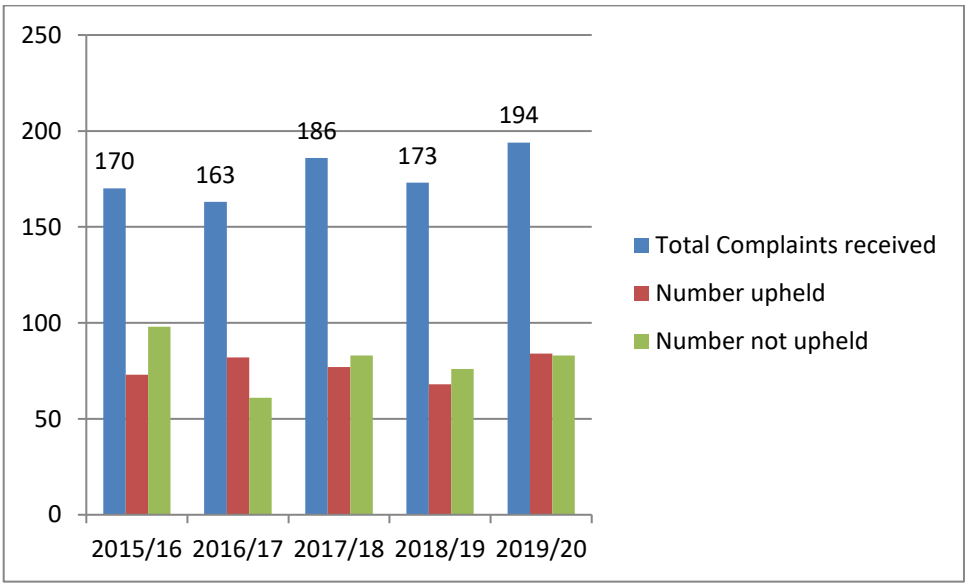
The addition of this stage has implications for response timescales as is explored within this report.

During 2019-20, no independent investigations were commissioned

3. Complaints and compliments received 2019-2020

3.1. Complaint Volumes

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



As illustrated above, the total number of social care complaints received this year increased from 2018-19. This reflected a rise across the board and mirrors the national picture.

3.2. Complaints by District

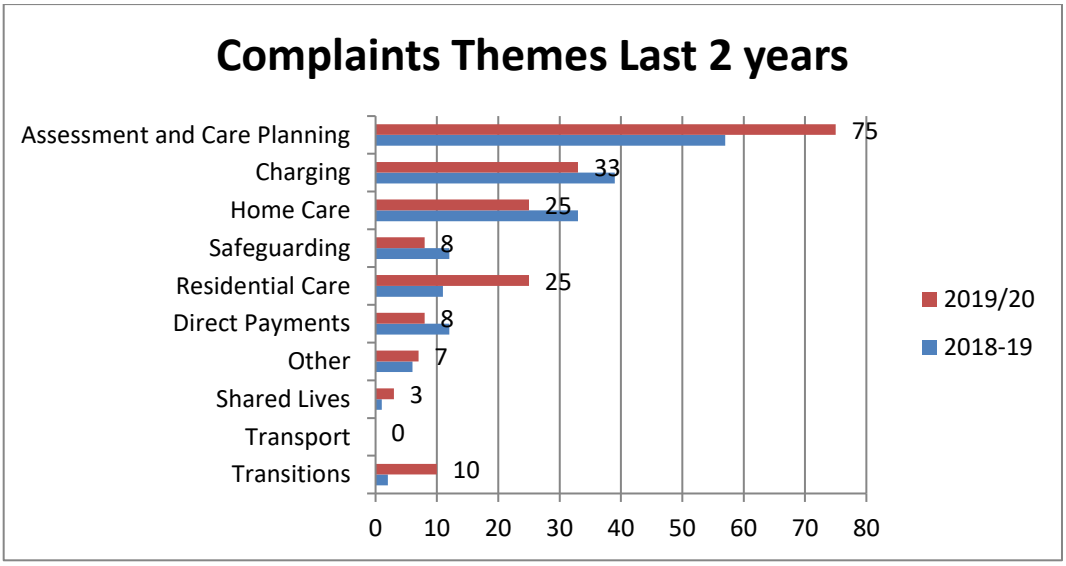
Complaints have started to be recorded by District during the year. This recording started from 01 October 2019 and for 75 complaints. The breakdown appears below along with respective uphold rates.

District	Number of Complaints	Number (%) Upheld
Hinckley	16	11 (69%)
Harborough	14	5 (36%)
Blaby	12	2 (17%)
Melton	9	6 (66%)
North West Leics	9	3 (33%)
Oadby & Wigston	8	2 (25%)
Charnwood	7	1 (14%
TOTAL	**75**	**30 (40%)**

Full data sets will be available in the 2020-21 reporting year and this may allow for more detailed benchmarking over time.

3.3. Complaints by Theme

Table 2: adult social care complaints by theme



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

Unsurprisingly, the largest segment is also the broadest category around Assessment and Care Planning. This equates to 39% of the overall volume and a significant increase from previous year.

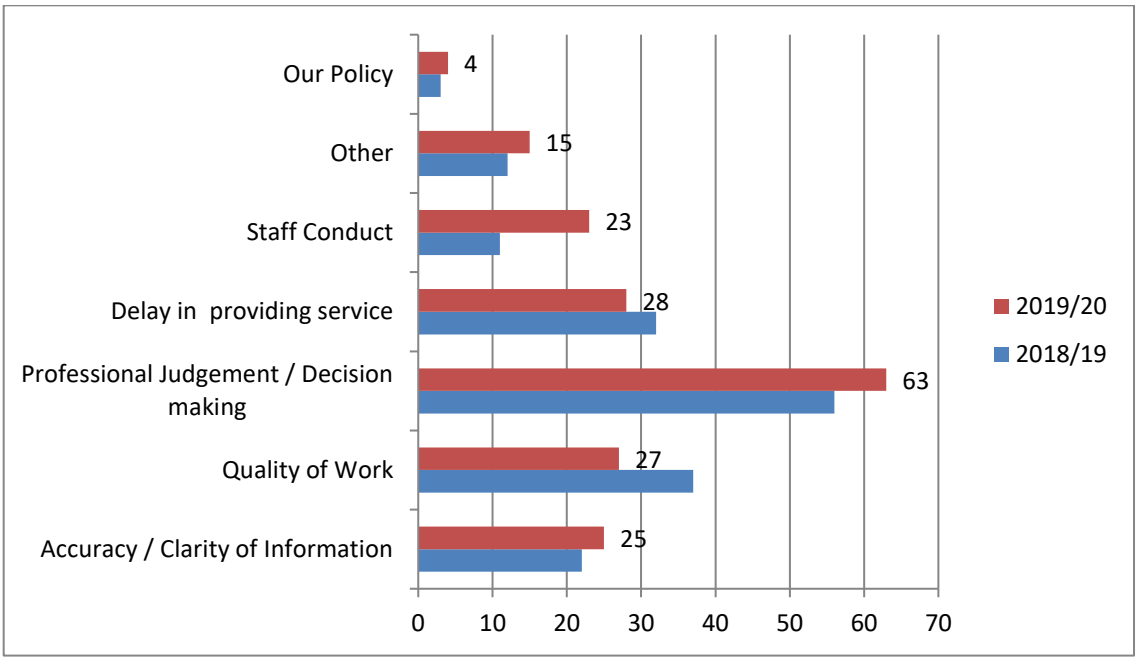
Care planning accounted for 40 of the complaints with 35 citing the assessment as the primary cause of their complaint.

The most notable change from 2018-19 is the increase in Residential Care complaints.2019-20 marks the first time for several years where more complaints were received regarding residential than home care.

Of note was the reduction in Direct Payment complaints. This was flagged as an area of concern in 2018-19 and it is pleasing to see the reduction here. This follows significant work carried out on improving guidance materials for staff.

The Complaints team also undertake analysis of each complaint to try to understand the significant factor. This can help prioritise areas for the department to focus on improving. The results for 2019-20 are represented below along with comparative data for 2018-19.

Table 3: Complaint causes last two years



Decision making remains the highest single cause, with delay and quality of work making up the top three categories. This mirrors data for 2018/19 but cases have reduced for both delay and quality categories.

3.4. Joint Complaints

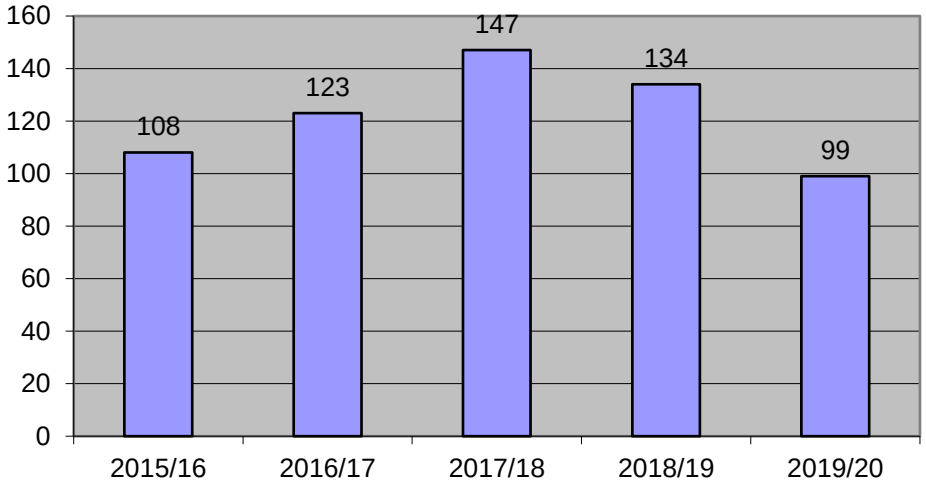
The Health and Social Care complaints regulations place a duty on Local Authorities to work together with health partners in responding jointly to complaints[3]. Leicestershire County Council accordingly has a joint complaints handling protocol, supported by a multi-agency group, which sets out common 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 2019-20, ten complaints were considered using the Joint Complaints protocol. No difficulties were experienced this year with partnership working.

3.5. Compliments received 2019-20

Table 3 below shows the long-term trend in compliments recorded.

Table 3: Adult Social Care Compliments Recorded



There has been a decrease in compliments recorded during 2019-20. That said, 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

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

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.

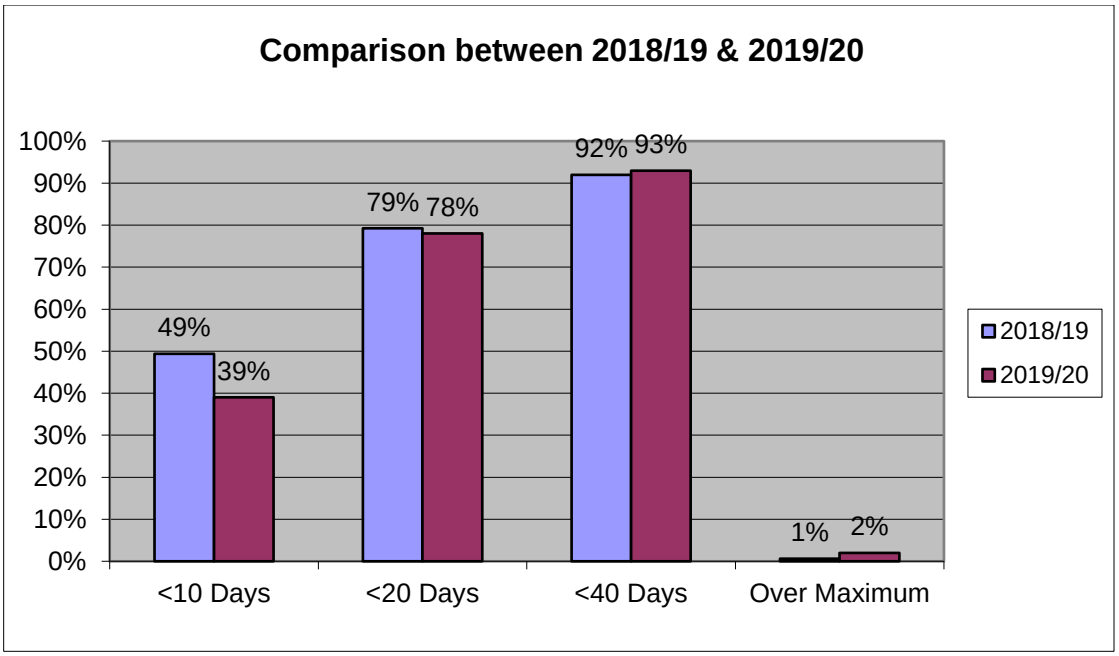
4. Complaints resolved 2019-20

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 are able to 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

Table 4: Adult Social Care Performance



There has been an additional indicator added this year to measure responsiveness within 40 working days. Although there has been a dip in responsiveness at 10 working days, it is important to note that we have added a "review" stage to the

statutory complaints procedure this year and this will have impacted on this as the timescale measures overall time taken. With 93% of complaints responded to within 40 working days and just 4 complaints exceeding the statutory maximum, this continues to be healthy performance.

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.

4.2. Complaint Outcomes

Table 5: Adult Social Care complaints recorded by outcome

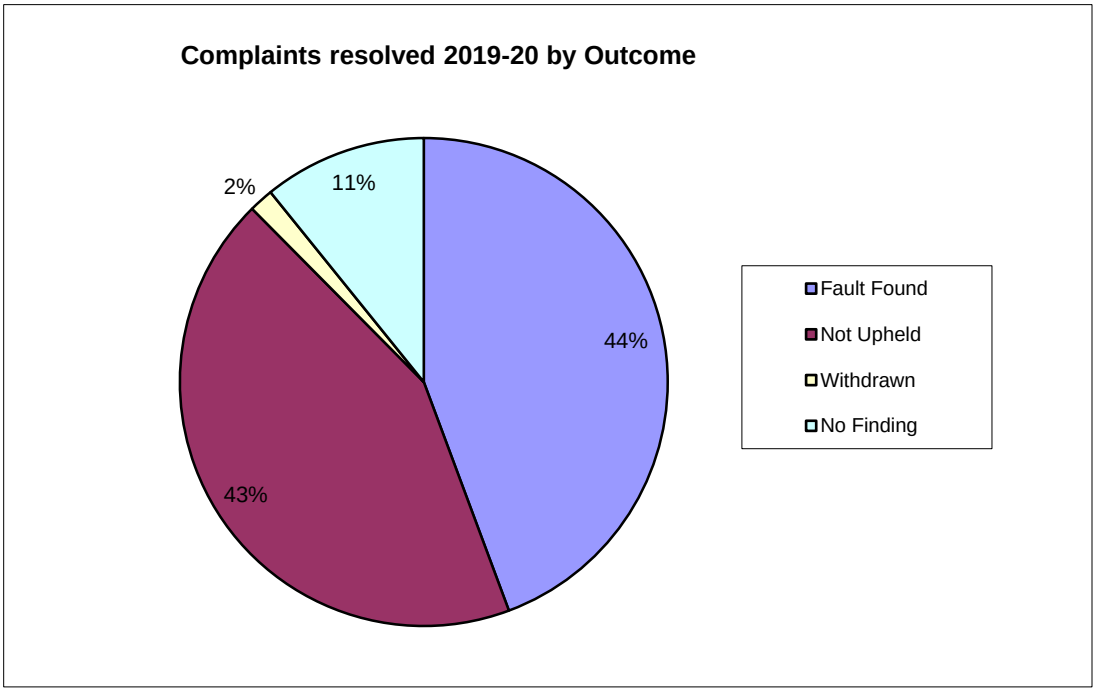


Table 5 above shows that 82 (44%) complaints were upheld. This is consistent with the previous year (43%)

Prompt acceptance and ownership of any mistakes can help prevent costly complaint escalation.

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 the course of 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 82 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 2019-20. 29% of complaints upheld resulted in clear actions that should improve service for other residents. This is a slight reduction on the previous year (31%)

Table 8: Actions taken for upheld complaints 2019-20

The most common action taken was staff training. There are lots of good examples of this taking place both at individual and team level.

Much rarer are those clear examples of where procedures have been changed following fault. Just two examples were clearly evidenced within complaint responses this year and this is an area where improvement can and should be made.

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

5.2 Service Improvements during 2019-20

Research shows that a primary driver for making complaints is so that lessons can be learned, and processes improved. It is also a key part of an effective complaints procedure to demonstrate this organisational learning so that in turn the public can feel confident that complaints do make a difference.

Case studies can be a powerful way of promoting this and to illustrate some of the positive action taken this year from complaints, several examples are set out below:

5.2.1. J's Story – Delay by care provider in seeking medical help

J was a resident in a Council commissioned residential setting. Following a fall, her son complained to the Council that carers had not sought prompt medical assistance.

The Council's findings

When investigating the complaint, the Council could not find evidence that the Care provider had followed their emergency procedure and whilst the GP had been called there was delay in doing so. Further examination of provider records indicated gaps in how the provider fulfilled the support plan.

Actions taken

As the commissioner of the placement, the Council maintains responsibility for the actions (or failings) of care providers.

Our Contracts monitoring team work with all providers and have used the complaint to remind the provider of their responsibilities to:

- Ensure that complaints are formally investigated when raised and that complainants are signposted to the Local Government and Social Care Ombudsman with a copy sent to the Council for monitoring purposes.

- Ensure all carers were aware of the providers emergency procedure

- Ensure accurate records of daily care logs were appropriately made and recorded.

In recognition of the above, the Council offered to write-off some of the outstanding care costs which was accepted by the family.

5.2.2. D's story – Failure to properly explain costs that social care would meet

D contacted the Council unhappy that he was not given clear enough information upon which to make decisions regarding his father's care. This led to the family incurring costs which they had presumed the Council would meet

The Council's findings

The Council identified that the allocated worker had not clearly explained what costs would be met by social care and particularly had not challenged an opinion given by the GP regarding care required. The family had relied on this and clearly discussed it with the worker.

Actions taken

The Council apologised, explained what costs would be covered and arranged re-imbursement of costs incurred privately by the family until this point.

This complaint highlighted the importance of clear and timely communication with families often in times of crisis. Although there has been a gradual reduction this year in complaints regarding charging this was a timely reminder that this is a highly complex area for families to understand and therefore a need for the department to explain things very clearly and maintain clear evidence of this.

5.2.3. H's story – Inappropriate reduction of care calls

H contacted the Council unhappy that, as part of an annual review into her mother's care, one care call had been removed without any clear rationale. The complainant was left with the clear impression that this was down to budget pressures as her needs had not changed

The Council's findings

The Council identified that the review worker had not clearly explained the rationale for this decision. Although part of the review team's work is to challenge whether current support is needed, removal of support should only be considered when it is clear there is no longer a requirement or that can be met in a better way. It was evident that this had not been properly explored and agreed with the family in this instance.

Actions taken

The Council apologised, re-instated the care call and carried out a briefing session with all Review Team members reminding of the need to clearly evidence and discuss with families how needs could continue to be met if a proposed reduction was implemented.

6. Local Government Ombudsman

6.1 New complaints received by the Ombudsman 2018-19

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 investigative enquiries of the Council on 15 complaints during the year. Due to a change in how premature enquiries are recorded this is not directly comparable to the data from 2018-19, but this represents approximately 8% of the overall complaints.

6.2 Complaints resolved by the Ombudsman 2018-19

The Ombudsman made decisions on ten cases during the year with fault being found in 3 cases (30%). This represents a decrease from last year (5 cases or 38%)

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

1. **A failure to arrange timely home care**

The Council was at fault for failing to arrange home care for Mr B within a reasonable timescale after assessing his needs. This meant he stayed in residential care for five weeks longer than he needed to and incurring additional costs for the family

The Ombudsman recommended compensatory payments of £1,100 in recognition of this injustice

2. **A complaint regarding a care home's failings to provide reliable and quality care**

The Council had initially responded to this matter by opening safeguarding enquiries into the care provider. This was concluded as not substantiated. Following a complaint letter, a more detailed explanation was provided through the local complaints procedure, but the family remained dis-satisfied and escalated the complaint to the Ombudsman.

The Ombudsman found fault that the Council did not pick up on the many deficiencies with the care provider's records and that they did not seek assurances

that the provider had recognised its faults in trying to apply charges for attending a hospital appointment. There was also criticism of the lack of engagement with the family by the safeguarding worker meaning that they were not in full possession of some of the evidence later submitted to the Ombudsman

The Council accepted the conclusions and agreed to make a compensatory payment of £500, write-off 10% of outstanding care costs and undertake refresher training with staff on carrying out safeguarding investigations.

3. **A complaint regarding both the Council's failure to offer an affordable care placement and poor standard of care from a provider.**

The Council had partially upheld this complaint at local investigation finding several gaps within its safeguarding investigation into the home which substantiated an allegation of neglect. The Ombudsman agreed with those findings but felt the Council should have offered a financial remedy in recognition of the distress. A payment of £500 was agreed.

The Ombudsman also found fault that the Council had not done enough to clearly identify an affordable care placement which, in part, resulted in the family having to pay top-up fees. A further payment of £250 was agreed in response to this aspect along with wider staff training on the need to identify and document at least one affordable care placement.

For the remaining seven complaints

- 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 investigation, was satisfied with the actions the Council had taken.

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 3 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 is also offered every quarter to managers and 10 social care managers took part in this training during the year. Virtual options are being considered currently to keep this important course running.

Quarterly performance reports are produced and delivered at Strategic Leadership Team (SLT) and shared with the Lead Member for Adults and Communities. Over the last year every other quarter a more in depth discussion is held with SLT allowing for greater focus on emerging themes and actions that need to be taken.

During 2018-19, a Customer Satisfaction Performance Clinic was established in response to reduced satisfaction survey results. The Complaints Manager continues to assist with this work on an advisory basis and to ensure complaints data and intelligence is utilised fully.

8. 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.

This report highlights Residential Care complaints as a clear area where we can continue to make improvements. Both our own local data and recent Ombudsman case-work shows the importance of effective complaints handling arrangements by providers and mechanisms to monitor this performance. There is also a need to improve the interface between safeguarding enquiries and complaints in the future.

Appendix A: Sample of compliments received 2019-20

- "Customer grateful for the speedy of getting a care package in place for his Father" – **ADULTS CSC**
- "Occupational Therapist appreciated L going the extra mile for resident to return to her house from care" – **OA MELTON**
- "Parents impressed with C's very detailed support and care assessment and keeping them well informed during each stage" – **OA CHARNWOOD**
- "Customer commented how wonderfully caring the team are who provide home care services" – **HELP TO LIVE AT HOME PROVIDER**
- "Thank you to the HART team for all your care and advice". – **HART**
- "Thank you to A in the DoLS Team for your exceptional work in delivering services" – **DOLS TEAM**
- "Niece of service user impressed with help and described S as a role model for social services" – **WAA NWL**
- "Customer appreciated N's hardwork helping her Husband try to obtain funding and through a safeguarding investigation" – **WAA HARBOROUGH**
- "Thank you to the Crisis Care Team for the wonderful care given to my husband" – **CRISIS TEAM**
- "We wish to thank the OT department for the outstanding care they have given. Thank you so much" – **LIGHTBULB**
- "Thanks to G for her assistance with rehousing"– **OA HARBOROUGH**
- "Thank you for setting up a DP for community activities for service user who has Alzheimer's Dementia".– **OA HINCKLEY**
- "Appreciate the professional attitude of son's move to supported living. Delivered exceptional work" - **WAA MELTON**
- "Delivered great care and support to husband on release from hospital" – **HOSPITALS TEAM**
- "Praising courtesy and help of finance team" – **FINANCE TEAM**
- "Thanks for installing adaptations - has made life so much easier" – **OT TEAM**