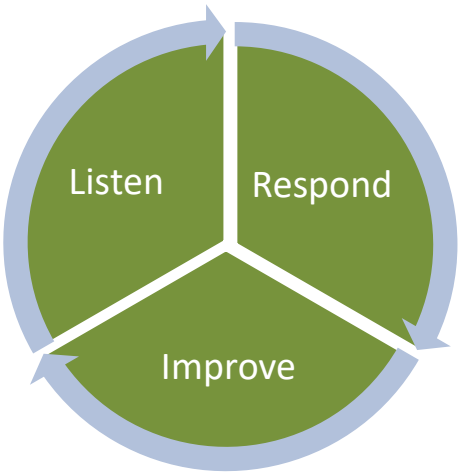
Leicestershire County Council

Adult Social Care



Statutory Complaints and Compliments Annual Report April 2020 – March 2021

Business Services
Corporate Resources Dept

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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 2020 to 31 March 2021.
- 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 2020-21. 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)

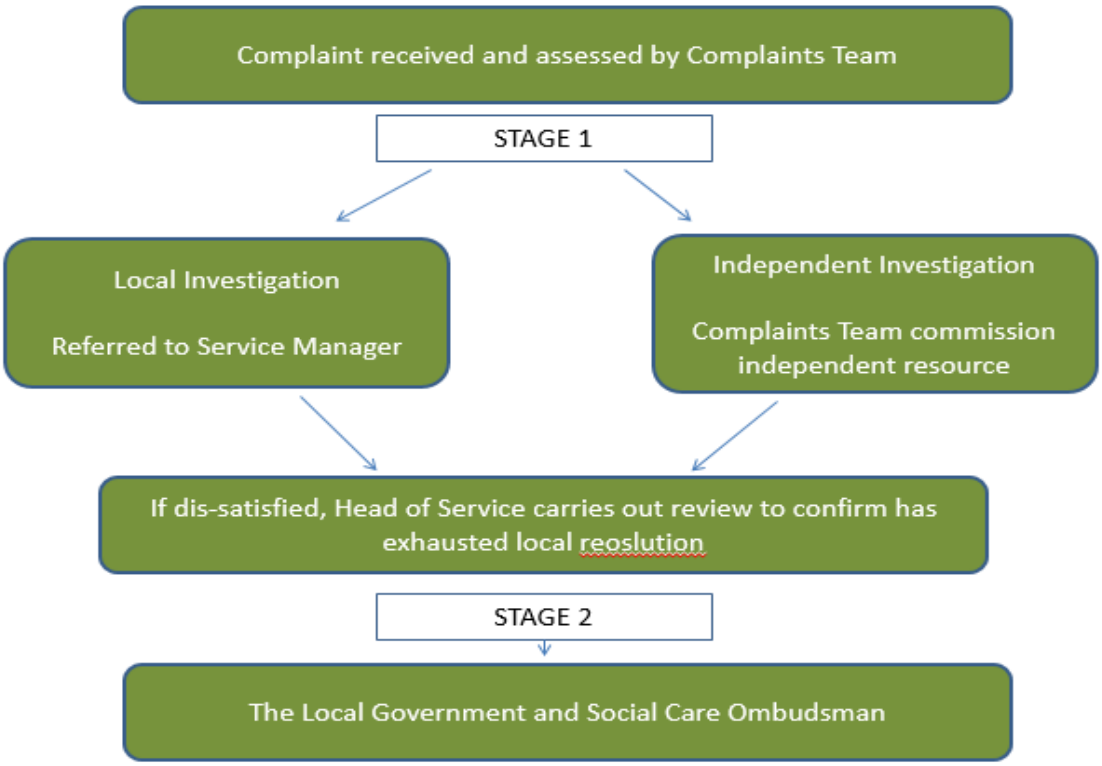
[2] Figures supplied by Performance and Business Intelligence Team

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 2020 -21 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) but the Local Authority must not unduly delay finalising this process which should always be concluded within 65 working days.

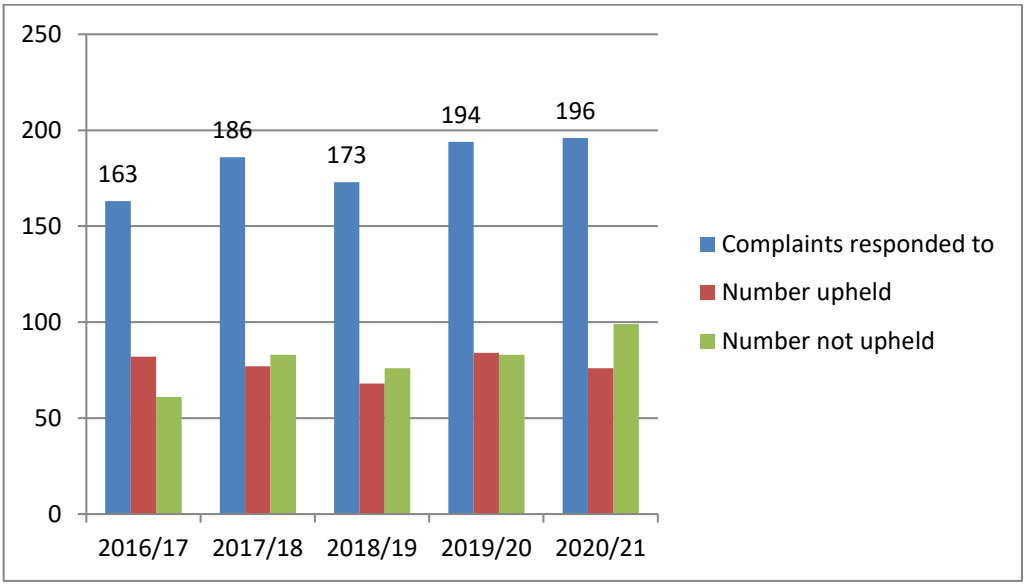
The Local Authority must advise all complainants of their right to approach the Local Government and Social Care Ombudsman should an agreed resolution not be found.

During 2020-21, no independent investigations were commissioned

3. Complaints and compliments recorded in 2020-21

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 responded to this year was almost identical to last year.

3.2 Complaints by District

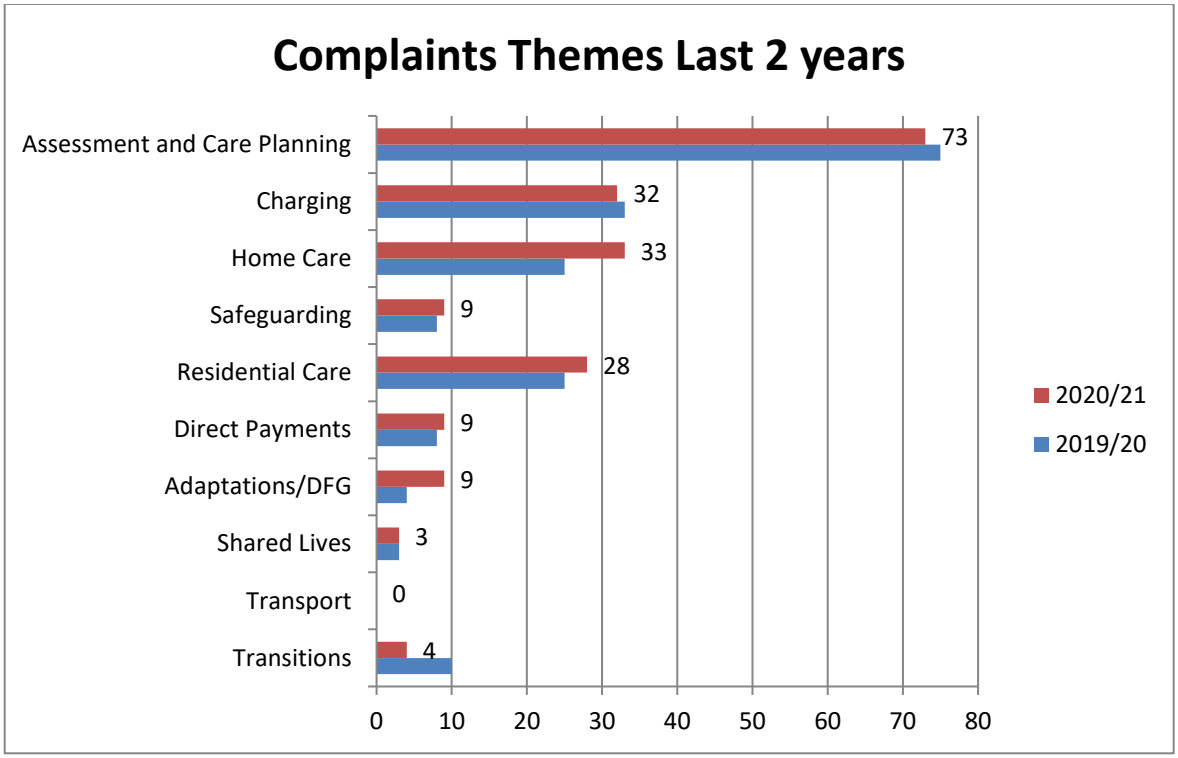
Complaints have again been recorded by District during the year. The breakdown appears below along with respective uphold rates.

District	Number of Complaints	Number (%) Upheld
Hinckley	24	10 (42%)
Harborough	30	17 (56%)
Blaby	23	11 (48%)
Melton	22	9 (41%)
North West Leics	31	10 (32%)
Oadby & Wigston	32	13 (41%)
Charnwood	34	9 (27%)
TOTAL	**196**	**79 (39%)**

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

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.

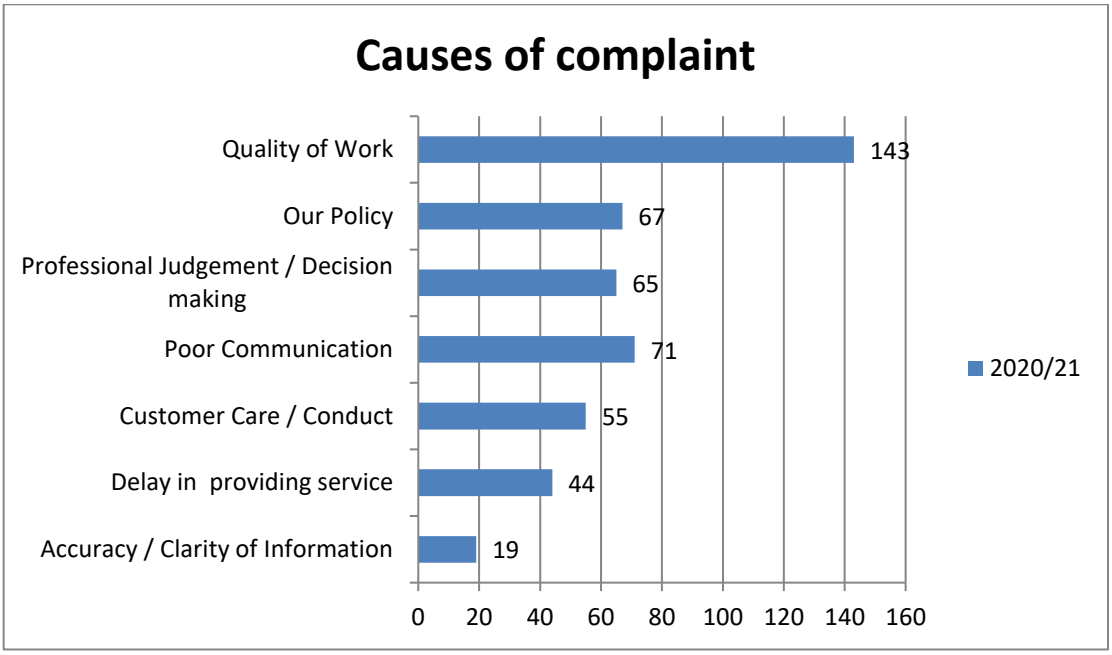
As last year, the largest segment is also the broadest category around Assessment and Care Planning. This equates to 37% of the overall volume. This was very similar to 2019/20 (39%)

Care planning accounted for 34 of the complaints with 39 citing the assessment as the primary cause of their complaint.

There is little by way of notable change from 2019-20 with slight increases in residential and home care being the only real variants.

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.

Table 3: Complaint causes for Complaints resolved in 2020-21



Recording now 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 is 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.

It is pleasing to note the reduction in complainants citing delay as a factor this year.

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. Members include Leicester City Council, the Clinical Commissioning Groups, University Hospitals Leicester (UHL) and the Leicestershire Partnership Trust (LPT).

During the year 2020-21, ten complaints were considered using the Joint Complaints protocol. No difficulties were experienced this year with partnership working.

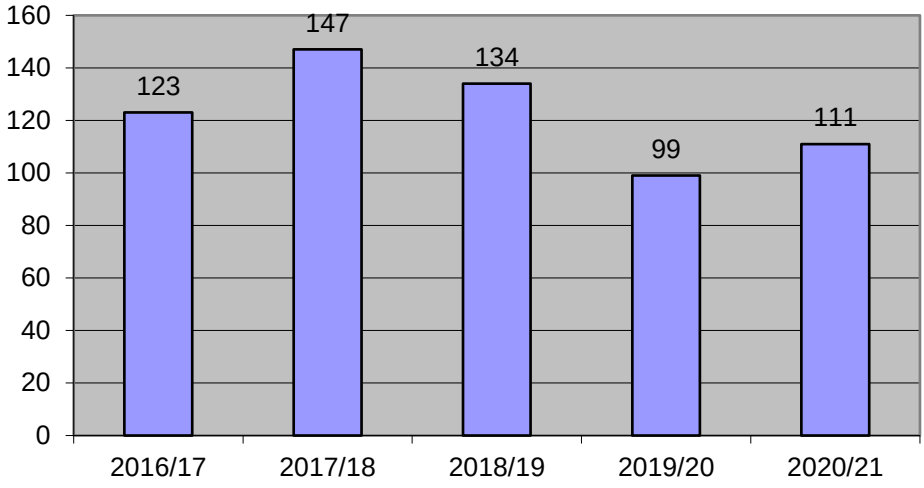
[3] Statutory Instrument 2009 no. 309 (9)

The most common joint complaints were around hospital discharge arrangements.

3.5 Compliments received 2020-21

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

Table 3: Adult Social Care Compliments Recorded



There has been an increase in compliments recorded during 2020-21. 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.

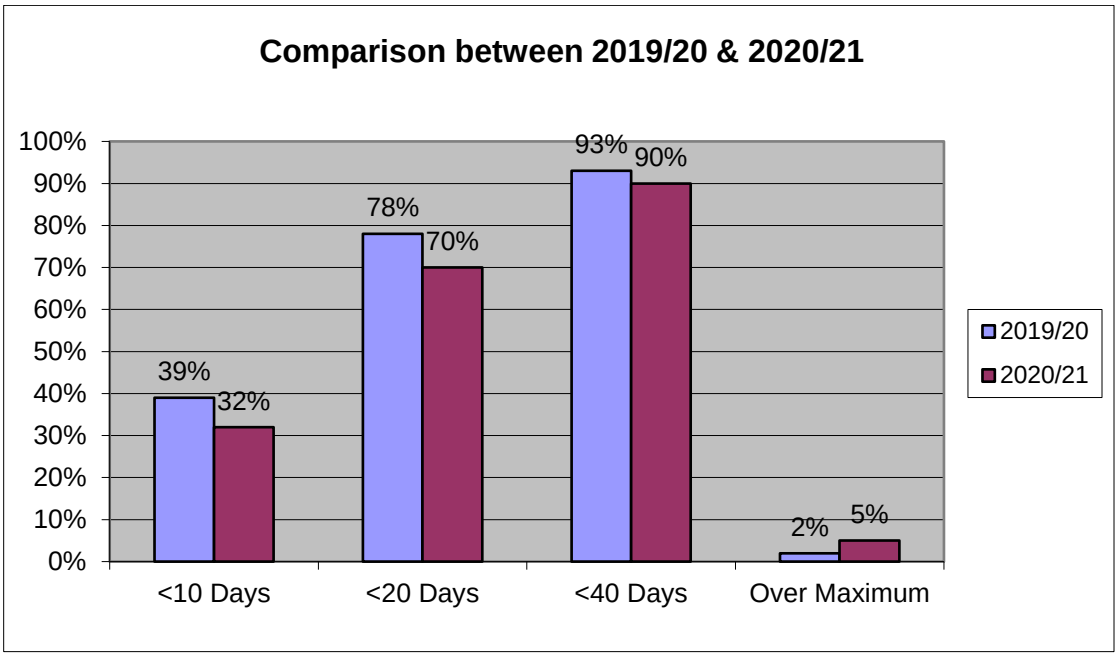
4. Complaints resolved 2020-21

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

Table 4: Adult Social Care Performance



The impact of the pandemic pressures during 2020-21 can be seen in the above graph. Despite this, it is positive that just 10 complaints (5%) were responded to outside of the statutory maximum of 65 working days.

The above timescales are for the completion of both a response and, where requested, a review undertaken by a Head of Service.

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 unprecedented impact of Co-vid 19.

4.2 Complaint Outcomes

Table 5: Adult Social Care complaints recorded by outcome

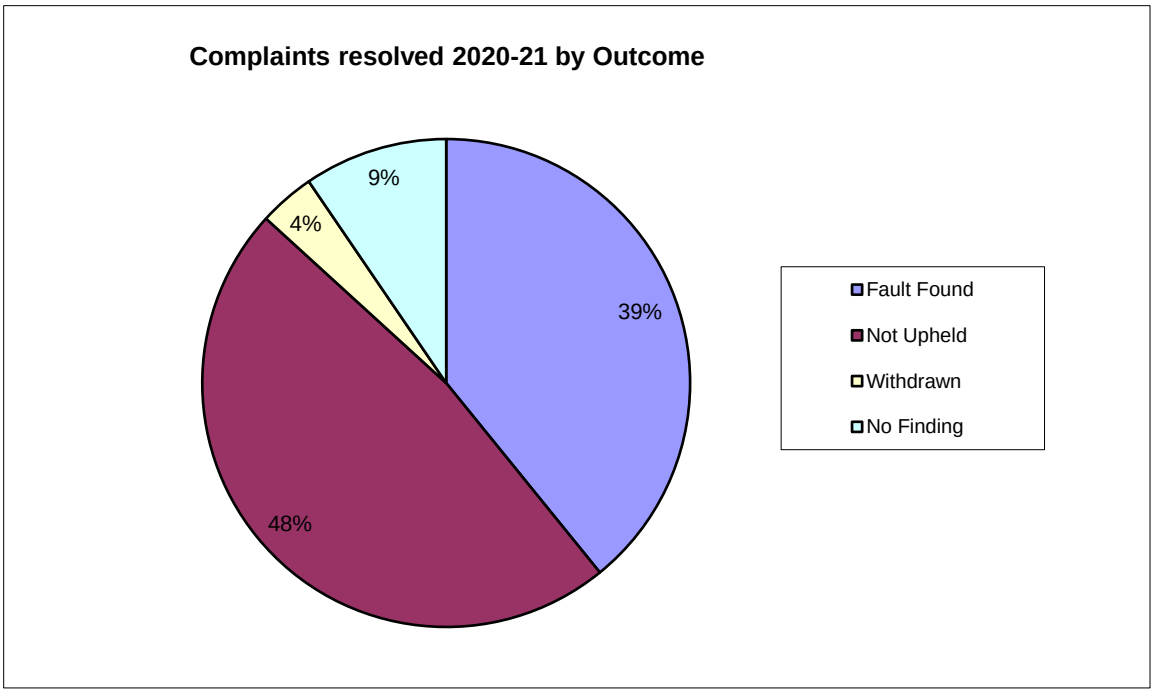


Table 5 above shows that 79 (39%) complaints were upheld. This is a reduction on the previous year (44%)

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.

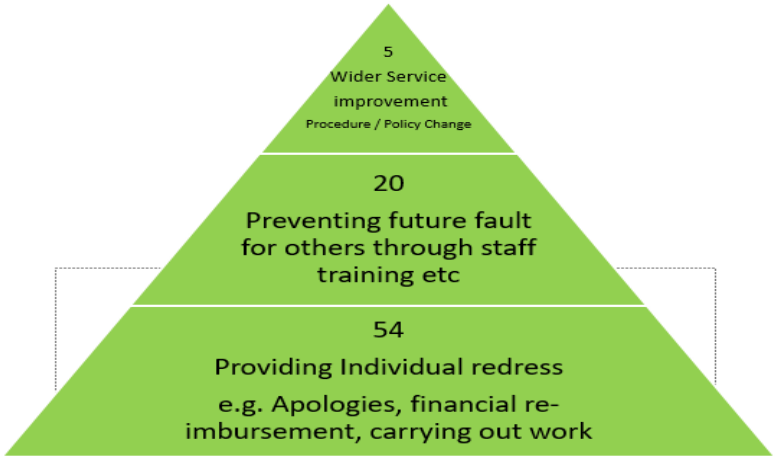
Occasionally during an investigation issues will be identified that need to be addressed over and above the original complaint. The Complaints Team will always try to look at the "bigger picture" to ensure that residents receive the best possible service from the Council.

5.1 Corrective action taken

All the 79 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 2020-21. 32% of complaints upheld resulted in clear actions that should improve service for other residents. This is a slight improvement on the previous year (29%)

Table 8: Actions taken for upheld complaints 2020-21



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

The most powerful are whole system changes, where it is identified that a process or policy needs amending. There were 5 such scenarios during the year arising from local investigation and as set out in Paragraph 5.2 of this report. This was a healthy increase on last year (2) and shows good evidence of Managers probing more within complaints responses.

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 2020-21

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:

Case Study 1 B's Story – Issues with payments being taken

B contacted the Complaints team as he was concerned with multiple payments being taken from his account relating to a social care invoice

The Council's findings

When investigating the complaint, the Council identified that there were isolated issues with notifications of payments being received not being sent to our Finance team and hence automated systems would seek to take payment again.

Actions taken

The Council apologised to Mr B and quickly refunded monies taken. It was explained that we had already implemented work to change providers and work was in place to close this gap with there being a unique identifier for each payment, which means a duplicate payment cannot be made against the unique reference.

Case Study 2 – Difficulties contacting out of hours team

C contacted the Council's emergency out of hours team trying to report 2 vulnerable adults who needed urgent support. There was no answer and no facility to leave messages.

The Council's findings

The Council identified that there was a fault in our out-of-hours Crisis Response telephony system which meant that some calls were being diverted from an IVR to a number that had been de-commissioned.

Actions taken

The Council apologised and immediately asked our IT service to review the IVR set-up to ensure all calls were routed correctly. The Council also took the opportunity to add a voice-mail facility. Thorough testing was carried out to ensure the systems were working correctly.

Case Study 3 – Unsafe discharge from Hospital

J contacted us to complain that his father was discharged from hospital to a placement without an appropriate package of support being in place.

The Council's findings

The Council identified that there had been issues with a lack of clarity in responsibilities in situations where an individual is discharged to a designated placement not home. This had been a relatively new process and it was clear it needed review and more thorough guidance for all staff.

Actions taken

The Council had already arranged crisis support whilst the package of care was re-started and apologised for any stress caused. New processes were put in place to ensure all of the team were clear about roles and responsibilities.

Case Study 4 – Delay in responding to a referral from EMAS

S contacted us to complain that it took the Council 3 weeks to respond to a referral received from EMAS

The Council's findings

The Council identified that there had been issues with capacity within the Customer Service Centre which had delayed this being responded to. Although in this instance there was no further action required, it did raise the question whether the referral process from EMAS and other agencies was adequate.

Actions taken

The Council committed to working with EMAS and others on a better referral process and introduced new steps to improve triaging of these requests to mitigate the risk of this sort of delay in the future.

Case Study 5 – Issues with respite care

T contacted us to complain that a pre-arranged respite care stay did not happen as the Home were closed. No contact had been made advising of this.

The Council's findings

The Council identified that there had been a conversation with an officer where T raised the suggestion that the respite home was closed. Our records did not suggest this but there was clearly some doubt which should have been investigated further.

Actions taken

The Council contacted T and apologised. The situation at the time was very fluid with pandemic pressures on homes affecting their provision. The complaint did however expose a gap in our processes in that we relied too heavily on the information on our systems and what should have happened is contact being made to confirm the placement. This was added to our processes and training rolled out to all staff.

6. Local Government Ombudsman

6.1 New complaints received by the Ombudsman 2020-21

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 10 complaints during the year. This represents approximately 5% of the overall complaints.

6.2 Complaints resolved by the Ombudsman 2020-21

The Ombudsman made decisions on nine cases during the year with fault being found in 4 cases (44%). This represents a decrease from last year (5 cases)

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

1. **A failure to explain need for a re-assessment of needs**

The Council was at fault for failing to arrange a review of a service user. It had elected to do a fresh assessment but had missed opportunities to explain the reasoning behind this to the individual. There were also issues identified with actions not being progressed

The Ombudsman recommended an apology for the faults identified and asked the Council to complete their re-assessment promptly and offer support with a Housing application. The Council accepted these findings.

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

The Ombudsman found fault that a Care Provider working on behalf of the Council failed to deliver consistent and timely care causing anxiety and frustration.

The Ombudsman asked the Council to audit the care logs and make a compensatory offer of 50% of all calls delivered late. A further distress payment of £250 was also requested. The Council was further asked to undertake a wider review of the care provider's performance.

The Council accepted the conclusions and recommendations which have all been carried out.

3. A complaint regarding the Council's failure to undertake a proper CO-VID risk assessment when attending under safeguarding enquiries

The Ombudsman found fault that the Council had relied on a generic risk assessment which did not dynamically assess the different environments that workers may find.

The Ombudsman requested the Council review their risk assessment framework and ensure staff are reminded to complete these before visiting and record them appropriately. The Ombudsman asked the Council to apologise to the individual for any distress caused.

The Council accepted the findings and carried out the remedies.

4. A failure to make appropriate adjustments when supporting a service user

This complaint was that the Council ignored requests for an assessment of support needs and failed to provide independent advocacy when requested.

The Ombudsman found the Council had offered advocacy, but it had not been taken up. The individual had been on a waiting list for a worker to pick up the assessment, but the Ombudsman determined this was too long a wait and there were missed opportunities to explain this which caused some distress.

The Ombudsman asked the Council to make a compensatory payment of £100 in recognition of this which the Council agreed to.

For the remaining five complaints

- In two 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 two cases, the Ombudsman, after investigation, was satisfied with the actions the Council had taken.
- In one case the Ombudsman was making 3rd party enquiries as the investigation was into Leicester City Council

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 4 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 not been offered this year primarily due to the pandemic pressures but also some capacity within the team.

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

8. Final Comments

It has been an unusual year in the context of the pandemic. This has impacted slightly on response times to complaints, but these have remained healthy.

It is likely also that the pandemic is behind some of the differences seen this year in complaint topics. There has been a drop in complaints about assessments which is likely reflective of the fact that much routine work has been paused or changed during the year. It is also perhaps unsurprising that Home Care and Residential Care also saw a slight increase as both will have had challenges in delivery during the year.

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 2019-20

- Thank you to Melanie.(OT) and team for all your help and support for my granddad – **REABLEMENT**
- Thank you to Glenda (Social Worker) for all your help and support. A very challenging case which required lots of patience – **OA HARBOROUGH**
- Thank you to Christopher for all your help and support in finding a respite placement for my husband. – **OA NWL**
- Great service by the HART ladies – **HART TEAM**
- Thank you to Vittoria for all your care and compassion helping me and mum. – **OA HARBOROUGH**
- Thank you, Leah, for everything you have done to ensure that SU is able to remain in her current placement – **TRANSITIONS**
- Thank you, Madeleine, for all your help and support to me as a carer– **WAA HINCKLEY**
- Customer appreciated our support helping her Husband try to obtain CHC funding – **OA MELTON**
- Thank you, Pam, for your help with completing the finance assessment form – **FINANCE TEAM**
- Thank you to Jemma, you've been fab...and your communication, help and organisation of everything has been excellent. - **WAA MELTON**
- Thank you, Nicole, for being constructive, caring, and professional in your meeting with me. – **REABLEMENT**
- Thank you for all your recent help and support in organising the move to supported accommodation. – **OA HINCKLEY**
- Thank you to Laura and team for arranging a grant to improve SU's garden - **DOM REVIEW**
- Thank you, Sharon, for the kind, caring and expert support that you provided to mum during her transition into a care home.– **OA NWL**
- A very big thank you to Michelle for taking the time to come out earlier today and restore my Echo Loop System to full working order – **ASSISTIVE TECHNOLOGY TEAM**

- Thank you, Pippa, for all the kindness and empathy that you have shown and for all your help and support arranging direct payments – **OA HARBOROUGH**