

Local Government &
Social Care
OMBUDSMAN

Review of Adult Social Care Complaints 2016/17

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Ombudsman's foreword



I'm pleased to present our Review of Adult Social Care Complaints for 2016/17. This report publishes our complaints data for our entire adult social care work, and fulfils our statutory duty to publish an annual report of our independent care provider jurisdiction.

I want to reiterate the importance of remedying complaints and the value they add to improving adult social care services for everyone.

Last year councils and care providers acted on more than 1,300 recommendations from us to put things right where we had identified failings. This is an 11% increase on the previous year.

I am pleased that in all but one case, councils and care providers acted positively to implement our recommendations. Despite the well-publicised challenges for the sector, this demonstrates a mature attitude to acknowledging fault, remedying the injustices people have suffered and learning from complaints.

The single outlier was a care provider, Albemarle Rest Home in Leamington Spa. In this case, we were given no option but to publicise the provider's non-compliance with our recommendations and publicly hold it to account for refusing to remedy a complaint.

We upheld 63% of adult social care investigations last year, which is the highest proportion of the main areas of our work. It is, therefore, particularly important councils and care providers continue to work constructively with us to put things right.

Our recommendations not only put things right for individuals, but also aim to help councils and care providers avoid the same problems affecting others.

¶ ¶ We are highlighting the stories of some people whose complaint enabled us to identify wider injustice ... These cases demonstrate the power that one person speaking up can have in changing services for the better for everyone.



Where we think a fault was caused by a procedural or policy issue, we recommend ways to review and change those practices. Councils and care providers made nearly 180 procedural changes, and carried out more than 50 staff training recommendations last year.

In particular, in this report, we are highlighting the stories of some people whose complaint enabled us to identify wider injustice affecting many others. These cases demonstrate the power that one person speaking up can have in changing services for the better for everyone.

Our investigations can also give service providers reassurance they are doing all they should to remedy a complaint. I welcome that, in nearly 50 investigations, we decided the council or provider had acknowledged its faults and offered a suitable remedy before the complaint reached us.

I firmly believe strong leadership in the sector is essential to foster a true learning culture from complaints. Good leaders empower their staff to respond quickly and with confidence to customer concerns, and ensure the learning from complaints is actively owned at a cabinet or board level. This allows complaint outcomes to be scrutinised effectively by committees and the public.

Earlier this year we changed our name to bring the words 'social care' into our official title. While we have talked about our powers within the sector for some time, the move aims to drive further awareness of our position as the last

resort for complaints about all parts of the social care system.

The number of complaints we received solely about independent care providers continued the upward trend of previous years. I welcome that increase and thank those providers who have listened to our calls to make the complaint process more visible, and to inform people of their right to come to the ombudsman. I would urge others to set the same example.

We are positioned at the apex of the local complaints system. Although we investigate relatively small numbers of complaints, they can be the tip of the iceberg and act as an early warning of wider problems. But most importantly, the value of learning from complaints lies in listening to the real experiences of people at the sharp end of the care system.



Michael King

**Local Government and
Social Care Ombudsman**

November 2017

How we can help with good complaint handling

It is in everyone's interest for complaints to be resolved quickly and effectively by councils and care providers, before people feel the need to escalate problems to us.

Online resources

Our website hosts a rich suite of advice and tools to help support good complaint handling:

- > [Care provider resources](#) – template documents to adapt, including complaint procedures; complaint response letters; checklists and guides to help signpost people to the right places
- > [Leaflets](#) – available to print and give to care users
- > [Our decisions](#) – searchable resource of all our published decisions
- > [Guidance on Remedies](#) – our staff guidance on recommending appropriate remedies so others can apply the same standards
- > A range of [new e-newsletters](#) including adult social care content

Complaint handling training

We provide a range of courses that help to improve good complaint handling, in which participants can draw on our experience of more than forty years of investigating complaints.

We hold a general Effective Complaint Handling course, and a course tailored to adult social care complaints, relevant for both councils and care providers.

We have more recently started providing Effective Complaint Handling courses aimed at social care providers, and one specifically for frontline care staff – both designed in partnership with an independent care provider.

More information is available at www.lgo.org.uk/training

Case Study: Somerset Care – learning from complaints

Somerset Care contacted us because they were interested in training their managers in complaint handling. We worked together with them to produce and trial a course in investigating and resolving complaints, based on our Effective Complaint Handling course for local authorities, but aimed at staff working in the independent care sector. This was successful and Somerset Care rolled it out to all their managers.

We then worked together to produce a course for frontline supervisory staff, focusing on customer care, early resolution of complaints and good record-keeping.

After some trials this resulted in a half-day course for frontline staff which Somerset Care rolled out to all of its supervisory staff last year.

Altogether we have trained more than 100 managers and nearly 300 supervisors.

Both courses received good feedback from delegates and were praised by Somerset Care's Chief Executive.

Somerset Care was the first care provider we trained, and because of its help and cooperation we now offer two courses to care providers:

- > Effective complaint handling for care providers
- > Complaint handling for frontline staff

Due to demand, we have started providing these courses as "open" events – allowing any care staff to attend without a single provider needing to host the course.

Adult social care complaints 2016/17 - at a glance

3,061
complaints
and enquiries
received

Since 2015/16:

3%

increase in all complaints
and enquiries about adult
social care

16%

increase in complaints and
enquiries about care arranged
privately with independent
providers

Our decisions



We upheld:



Complaint numbers and trends

Overview

In 2016/17 the number of complaints and enquiries we received across the whole adult social care sector rose by 3% from the previous year.

It is too simplistic to believe that more complaints will always indicate a drop in the quality of adult social care services. Equally, it may mean more people feel able to speak up and raise a concern about something they are unhappy with, and the fact that councils and care providers are taking a mature approach to encourage this feedback as a way of learning and improving services. It is for this reason that we focus our reporting on complaint outcomes, and in particular, the value an investigation by us can add through the recommendations we make to remedy complaints for the individual and improve services for the many.

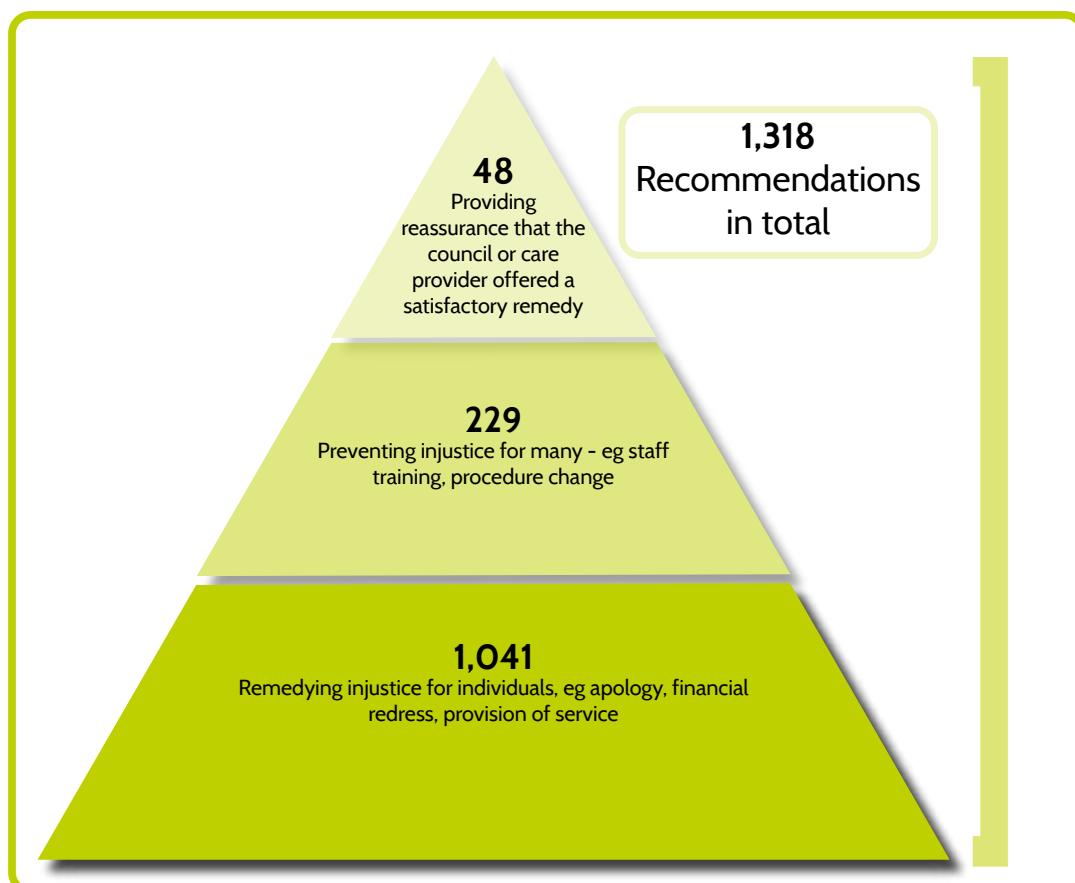
We found fault in a higher proportion of investigations about adult social care – 63% – than any other main area of our work, reflecting the well documented pressures the sector faces. This has meant we have recommended more remedies to put things right. The chart below shows the type of recommendations we made.

During 2016/17, we made 1,318 individual recommendations in 683 cases.

Often when people complain about social care they tell us they don't want the same to happen to others.

Around one in three complaints remedied included service improvements to address systemic problems and improve services for people in future.

Our recommendations to put things right and improve services for others



Arranging social care

Councils with responsibilities for social services are required to make arrangements for people in their area who have social care needs, and take lead responsibility for safeguarding adults at risk of harm or abuse.

What we saw

The most common types of complaints we received about councils arranging social care, and the proportion of complaints we upheld following an investigation, are shown below.

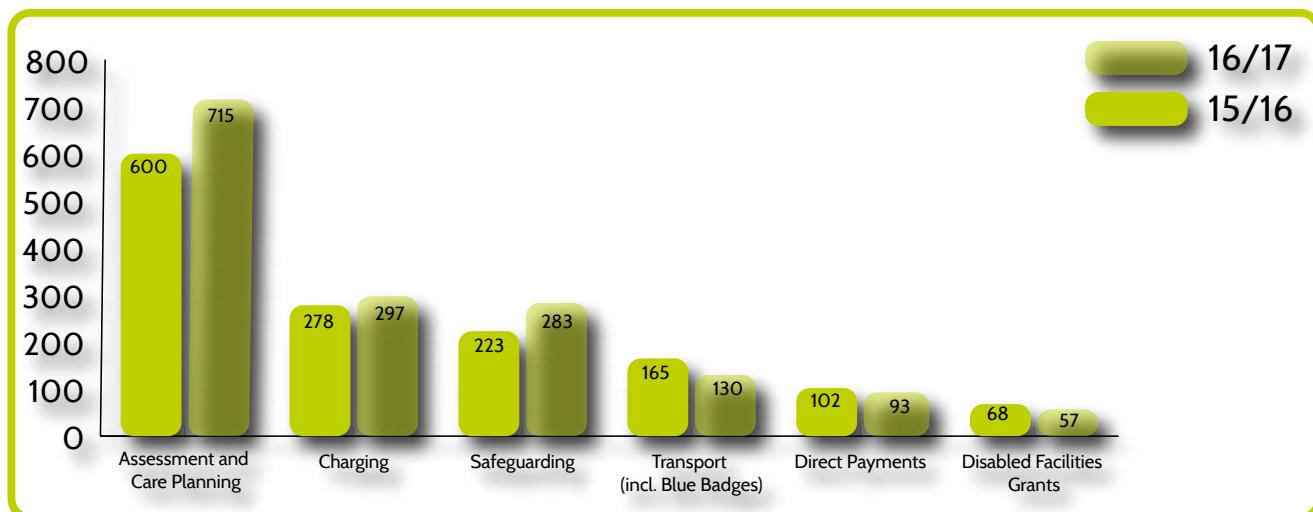


Figure 1: Cases received by category

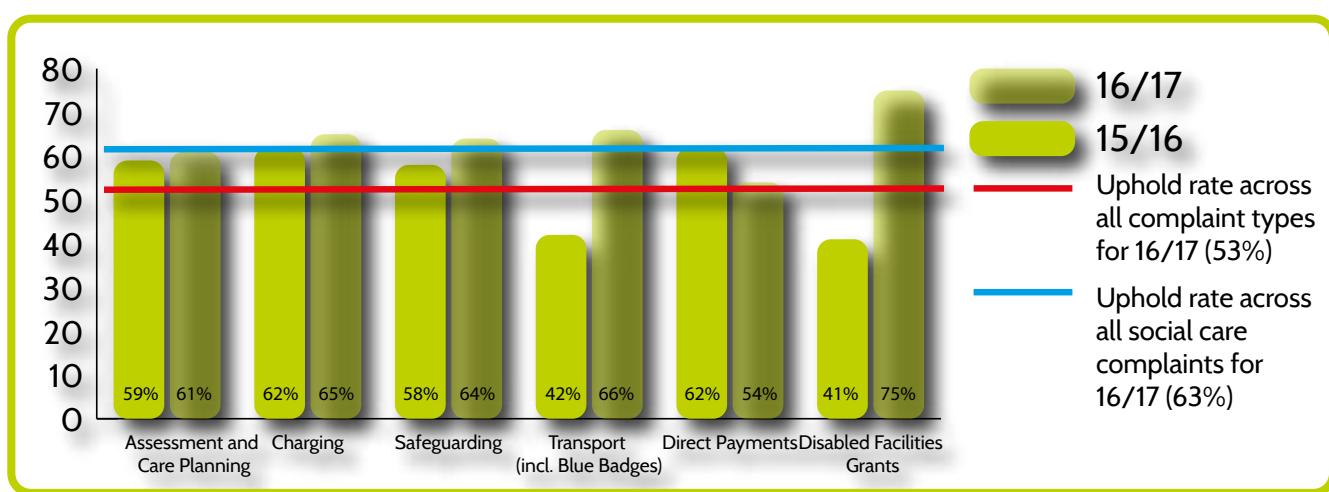


Figure 2: Proportion of complaints upheld after investigation

Assessment and care planning, charging for social care and safeguarding continue to be the top three areas we receive most complaints about.

During 2015/16, we saw a fall in the number of complaints and enquiries about councils' responsibilities to safeguard adults at risk. However, this trend reversed this year with an increase of 27% in the number of such complaints. This makes it the fastest growing area of complaints across our social care jurisdiction. More significantly, we found fault in a larger proportion of safeguarding complaints we investigated, with 64% of complaints upheld, 6% more than the previous year.

Providing social care

We have the power to investigate unresolved complaints about any social care provider who is, or can be, registered with the CQC. Where a council commissions care from the independent sector, we are clear the council remains accountable for the actions of the provider they have commissioned. For transparency, we will name the care provider, as well as the commissioning council, in our decision statement or report.

What we saw

Social care is provided in a range of settings. We categorise complaints about the most common types of provision. Unsurprisingly, residential care and home care are the two largest areas of complaints. Supported, or independent, living describes settings where people live in self-contained accommodation with support provided where it is needed; and Shared Lives schemes offer disabled adults and older people respite or long-term placements in family homes. There are a range of other services, such as day care, that we would include in 'other provision'. The number of cases we received, and the proportion of complaints we upheld following an investigation, are shown below.

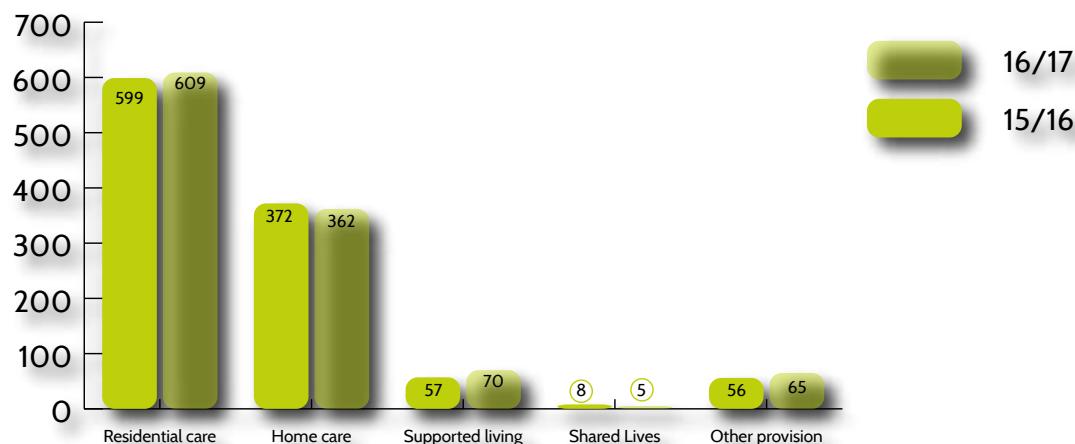


Figure 3: Cases received by category

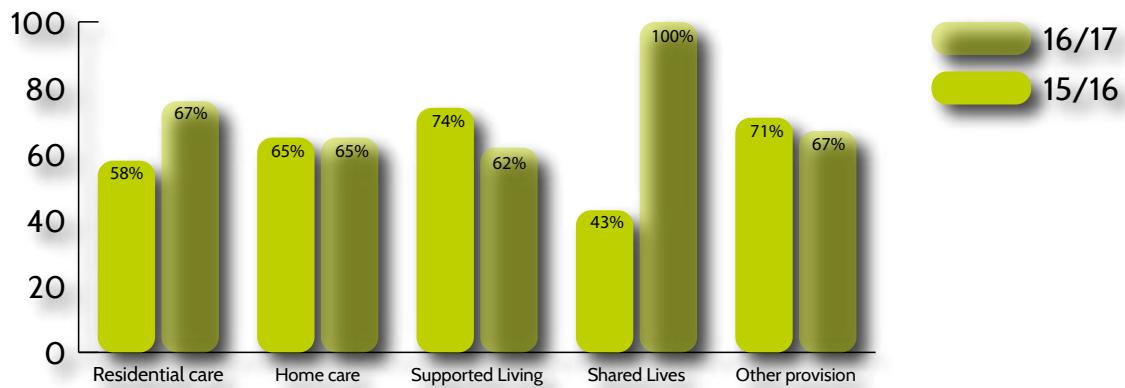


Figure 4: Percentage of complaints upheld after an investigation

* Shared Lives: the number of complaints in this area is very small, so the number of upheld complaints is not necessarily indicative of any wider themes in this aspect of care.

Care arranged and funded privately

We investigate unresolved complaints about all independent social care providers. This includes complaints from people who are self-funding their care without any involvement by the council. In 2016/17, we received 447 complaints and enquiries about individual care providers, which is 16% up on the previous year. The chart below shows the number of complaints and enquiries we receive continued to increase year on year.

We welcome this increase as a sign of growing awareness of our role in the independent care sector and as a reflection of the increasing value of complaints as a learning tool among care providers.

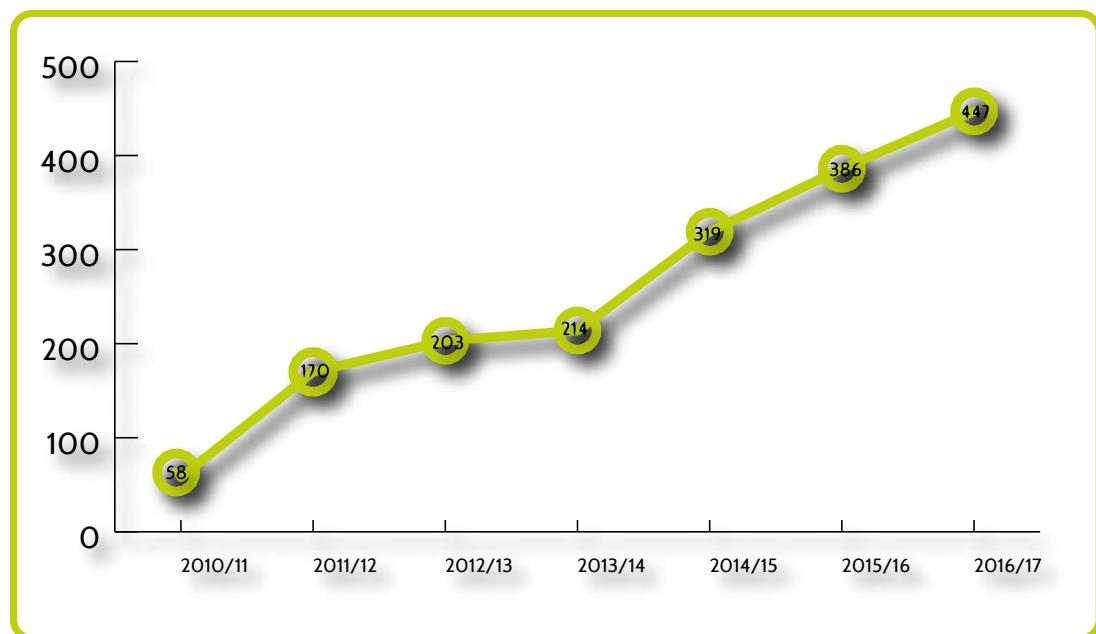
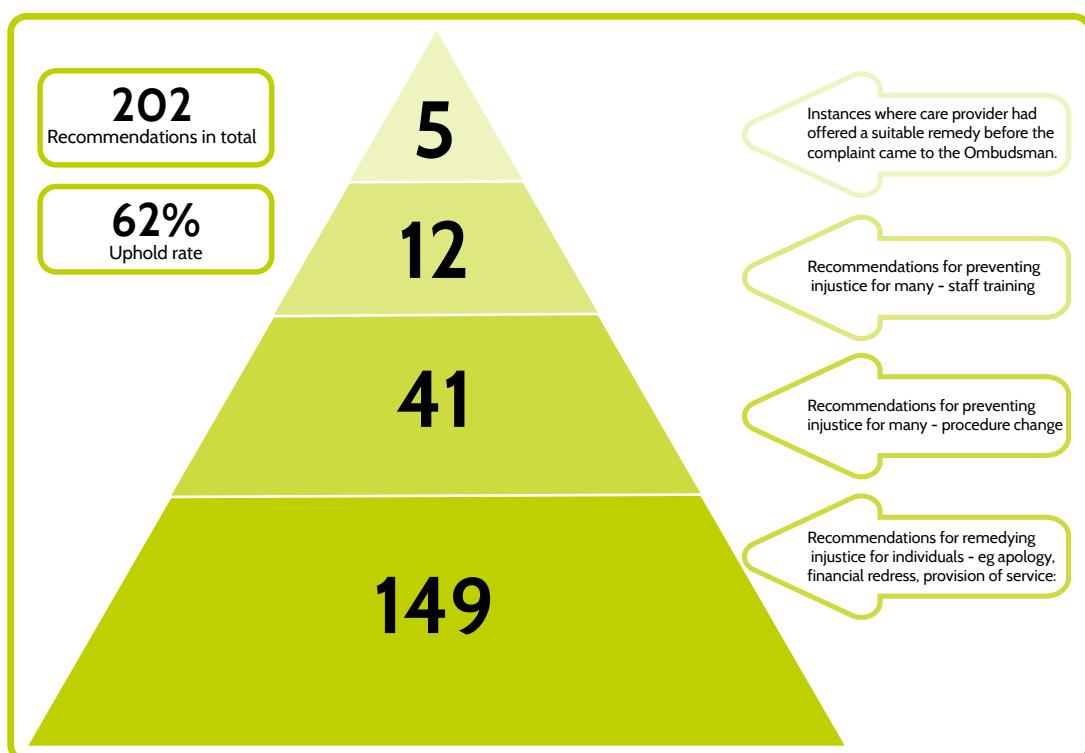


Figure 5: Number of complaints and enquiries received about care arranged and funded privately

This year we upheld 62% of investigations about independent care providers. Those complaints led to a wide range of remedies to resolve injustice for individuals and improve services for others. The chart below shows the outcomes we recorded last year:



Impact of our recommendations

As well as ensuring injustice for individuals is remedied, we often ask councils or care providers to address systemic failings through our recommendations. This may be ensuring changes are made to policies and procedures or providing staff training so that the maladministration or injustice is not repeated.

Practical examples this year included:

- > A care provider agreed to implement changes to ensure all its residents were provided with a written statement of fees and costs. This recommendation followed a single investigation that revealed injustice caused by a failure to set out the costs of care clearly in writing.
- > A care provider putting in place specific training for staff about the importance of understanding the difference between service users making informed and uninformed decisions. This complaint showed the negative consequences that uninformed choices, for example refusing food, may have on someone's wellbeing.
- > Following a case involving a failure to appropriately protect a woman from falls during a respite stay, a care provider agreeing to update its practices for using of bedrails to prevent similar problems from happening again.
- > A care provider agreeing to review its procedures to ensure an inventory is made of a resident's belongings when they move into a care home.
- > A council agreeing to review the information it produces about choosing a care home and ensure people are given a choice of care homes including at least one without top-up fees.

Accessing our data

To access our full data for 2016/17, visit our [website](#). It publishes the numbers of complaints and enquiries received and the decisions made on all adult social care cases.

Councils and care providers should use this data, alongside the range of other information sources they have, to determine the effectiveness of their complaints processes and the outcomes achieved for people when things go wrong.

In addition, all our published complaint decisions can be searched and filtered in range of ways by visiting at our [decisions page](#).

The stories we hear

In 2008, our legislation was changed to allow us to extend the scope of our investigations and look at wider injustices caused to people other than the person who complained to us. Below are examples of this power in action where we recommended remedies not just for the person who complained to us, but also for others who were affected by the failings we identified.

Andrew's story

Andrew's family complained to us about the way the council calculated the cost of his care. They believed the council incorrectly calculated the contribution Andrew should pay towards the care he was receiving at home. The family argued the approach taken by the council led to it overcharging Andrew.

When undertaking a financial assessment for Andrew, the council took into account the joint resources he and his wife had. As the capital they jointly shared was above the limit of £23,500, the council decided Andrew had to pay the full cost of his care. We found the council was wrong to say Andrew was liable for all the costs of his care. Its decision was not consistent with the government's guidance at that time.

In this case, only Andrew and his family complained to us. But our investigation revealed the council's faults may have caused injustice to a further 60 older people in the borough – instances where the council may have demanded charges after assessing their finances incorrectly.

Following our investigation, the council agreed to our recommendations to put things right for Andrew but also to review the financial assessments of those other affected people and ensure any overpayments will be returned to them.

Jane's story

Jane has learning disabilities and requires care. She lives with her sister and her brother in law. They were told by the council their respite care allowance would be reduced from eight weeks a year to only four. The family's concern was that Jane's needs were likely to increase due to her recent diagnosis of dementia.

Jane's sister and brother-in-law were unhappy the allowance had been cut without the council undertaking a needs assessment. They complained the council should not be applying a blanket policy of a maximum of four weeks.

Our investigation found the council's decision to reduce the respite provided to Jane was part of a wider policy to make savings. Following our enquiries, the council acknowledged it had reduced the respite in error, and had failed to carry out a full needs assessment.

To remedy the injustice, the council offered to reinstate the family's respite to eight weeks a year and award any respite missed because of their incorrect reduction.

We identified that others may have been affected by the council's policy. The council agreed to our recommendations to not only put things right for Jane, but also review its process for allocating respite more broadly. 69 people also had their respite care reinstated, thanks to our investigation.

Sharing our intelligence

As the social care ombudsman we work closely with partners across the social care landscape. This includes sharing relevant information with Care Quality Commission (CQC), the regulator for health and social care, to ensure systemic issues identified in our complaints inform regulatory action. We have a memorandum of understanding and information sharing agreement in place with CQC.

Under these arrangements, the Intake teams in both organisations have linked up so we can efficiently transfer members of the public by phone from CQC, to us if they wish to register a complaint, and vice versa.

- > During 2016/17, 1,455 people were routed to the most appropriate organisation as a result of these arrangements.
- > 34 of these have involved ‘warm transfers’ with CQC directly transferring adult social care complaints to us while the complainant is still on the same call.
- > Of the ‘warm transfers’ received during this period, we have been able to track 13 cases where we carried out a full investigation of the complaint. We upheld 9 of these complaints.

In addition, we alert CQC when we believe, following an investigation, there has been a potential breach in a fundamental standard for care that is commissioned by the council or delivered directly by the care provider. This gives a valuable source of intelligence to CQC and allows it to identify any risks which may warrant an early inspection of a care provider.

Every month we provide CQC with information about all adult social care complaints received during the month, including a summary of cases where the complaint has been upheld.

CQC inspectors also have the capability to signpost our ‘best practice’ resources and guidance directly to providers during inspections. This includes information for providers on how both CQC and we handle complaints and the raising of concerns.

‘Quality matters’ initiative

This year, we have been actively involved in the [‘Quality Matters’](#) initiative along with CQC and other national bodies. Published in July 2017, this sets out six priorities to improve the quality of care in adult social care, including acting on feedback and concerns.

Together with Healthwatch England, we are leading a work stream which will produce a single complaint statement and an online complaints tool to ensure service users, their families and carers receive information about making complaints that is clear and consistent.

Our role as social care ombudsman

A one-stop-shop for independent redress

Since the Local Government Ombudsman was established by Parliament in 1974, we have been able to consider complaints about the functions of councils, including the adult social care services they operate and commission. From 2009, our role in providing independent redress was extended to all adult social care providers eligible to be registered with the Care Quality Commission (CQC), the regulator for health and social care. This means we also investigate unresolved complaints about care arranged, funded and provided without the involvement of a local council. To reflect that, we changed our name this year to the Local Government and Social Care Ombudsman.

We also have statutory powers to carry out joint investigations with the Parliamentary and Health Service Ombudsman (PHSO). To do that most effectively, we operate a joint team of investigators. This provides a seamless service to those people whose complaint involves both health and social care. In a landscape where social care and health are increasingly integrated locally, a single investigation provides a more effective way of ensuring complaints are resolved and lessons learned.

**Local Government and Social Care
Ombudsman**

PO Box 4771
Coventry
CV4 0EH

Phone: 0300 061 0614
Web: www.lgo.org.uk
Twitter: [@LGOmbudsman](https://twitter.com/LGOmbudsman)