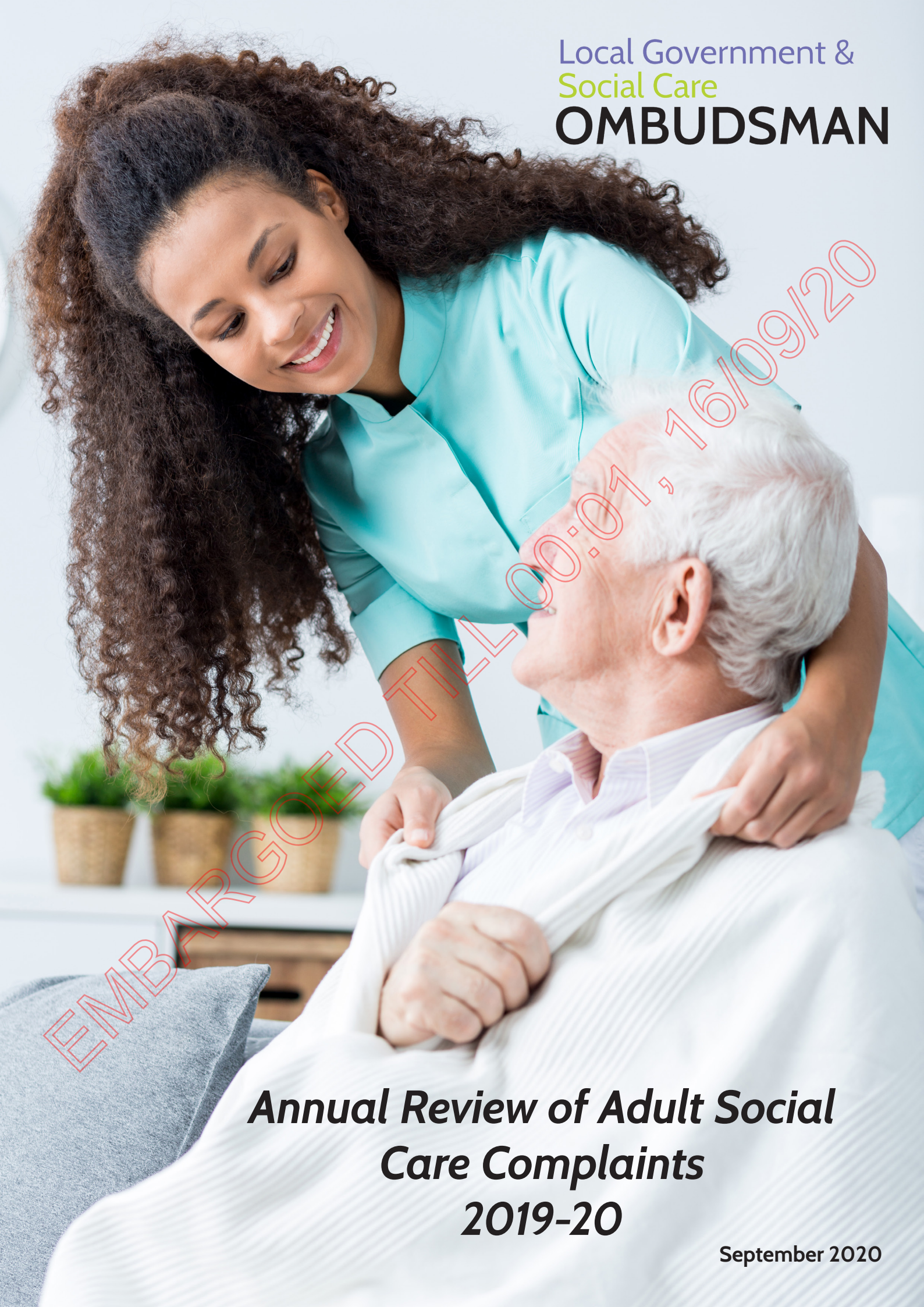


Local Government & Social Care OMBUDSMAN

Annual Review of Adult Social Care Complaints 2019-20

September 2020

Contents

Ombudsman's foreword

I am pleased to present our Review of Adult Social Care Complaints for 2019-20.

For adult social care, we are the one-stop shop for complaints about publicly and privately funded services, and we see the issues that have not been resolved locally; the real-life experiences of people who use services and the challenges faced by councils and care providers.

As the reporting year came to a close in March 2020, we paused our casework in response to the exceptional operational challenges councils and care providers faced because of the Covid-19 pandemic. While we did not take this decision lightly, it was the right thing to do to allow those at the frontline of care and support the space to deliver crucial services.

We have since resumed our casework and are taking new complaints again. We have promised that no one will be denied justice because of that disruption and will flex our usual rules to make that a reality. We stand ready to investigate all concerns about people's care during the crisis and guarantee a truly independent analysis of the facts.

Those who arrange and deliver care are likely to be adjusting to new operational realities also and I urge you not to lose sight of the value of effective complaints mechanisms at this time. Understanding the experiences of people who use services and their families can offer the insight you need to continue to deliver responsive, quality services.

It is with this in mind that I reflect on the static number of care complaints we have received in the past three years – an anomaly which is notably out of step with trends in other parts of our work. It is particularly concerning that complaints from self-funders have plateaued and continue to be under-represented in our work, some 12 years into us being able to accept such complaints. There are likely a range of reasons for this, not all of which we can fully assess from our position at the apex of the complaints system. Certainly, opportunities are being missed; redress for care users and learning and improvement opportunities for care services.

We do know that people can only come to us if they know about our role. This is why we strongly support and call for a statutory requirement to be placed on care providers to signpost people to the local complaints process and to their right to seek the independent view of the Ombudsman. We consider this will help people who use services, their families, and advocates to make complaints and pursue matters with confidence.

We believe that mandatory signposting will be better for business too. The social care complaints system in England is not a voluntary scheme – the law applies equally to all care providers. Yet the current level of engagement varies considerably, potentially placing greater burdens on more conscientious providers whilst allowing weaker operators to avoid public accountability. That undermines fair competition and consumer choice. Instead, we think there should be a level playing field, where the rules are applied consistently – in the best interests of users and business.

Significantly, we found fault in 69% of care complaints we investigated during the year, 7% higher than across all our casework. We saw familiar areas of concern within those complaints: charging for care, safeguarding, assessment and care planning and residential and home care services.

We believe that mandatory signposting [to us] will be better for business too. The social care complaints system in England is not a voluntary scheme – the law applies equally to all care providers.

This report relates largely to the period prior to Covid-19, and we do not yet know the full impact the pandemic has had on those who rely on care services. We know the system is already under pressure from high demand and scarce resources, leaving little scope for additional pressures to be easily absorbed. While we acknowledge these challenges, we will continue to apply our usual principles and thresholds to our decision-making and remain committed to exposing failings when we find them.

One of the tools we use to expose those failings are public interest reports and we have published more this year than ever before. Importantly, these reports help us to share the learning from our investigations.

Where we find fault, achieving a remedy for the individual and improving services for others continues to be our focus. Harnessing the potential of a single complaint, we have again increased the number of service improvement recommendations we made during the year, and we are grateful to the efforts of councils and providers who willingly learn from mistakes and implement our recommendations. It is also pleasing to see providers and councils are getting it right first time more often. We credit councils and providers when we are satisfied with the remedy they offered before we considered the complaint.

Compliance with our recommendations continues to be high. We made recommendations in 687 cases during the year and in only two cases did providers refuse to implement what we had asked. These exceptional cases are detailed later in the report.

Alongside this report we publish complaints data at council and care provider level. This data provides important context about an organisation's approach to resolving complaints. Our data is only part of the picture however, and I encourage you to use your local data to assess the health of your complaints system.

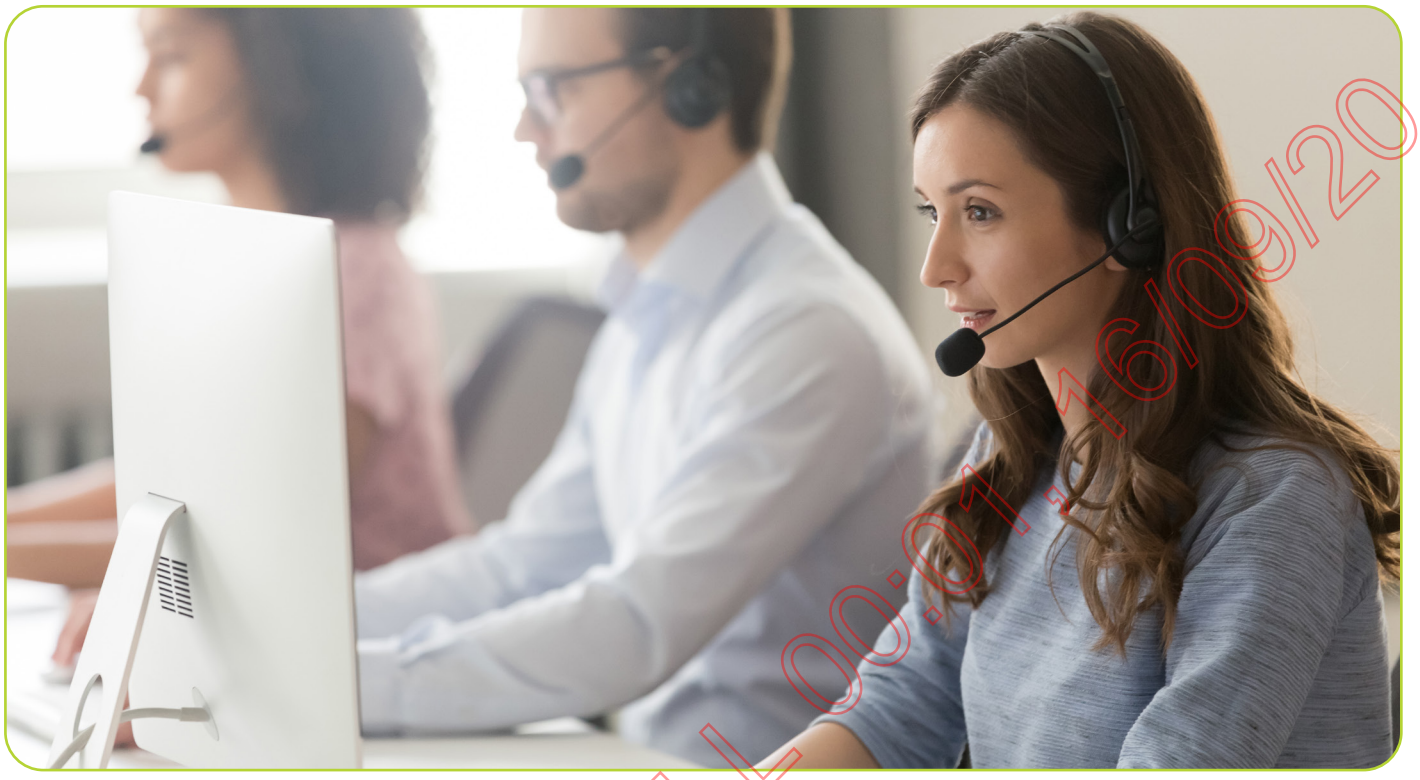
I hope this report, and the accompanying data, will help care providers and councils to maximise the valuable potential of complaints and drive improvements in care services.

Michael King

Local Government and Social Care Ombudsman

September 2020

Complaints - getting it right first time



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. Our website contains a suite of practical advice and useful tools to help support good complaint handling:

- We issue guidance documents where we identify common themes or practice issues.
- Template complaint procedures, response letters, checklists, posters and guides for signposting people to the right places are available for care providers to use and adapt for their service
- The sector's single complaints statement sets out best practice for councils and care providers receiving and dealing with comments, complaints and feedback about services.
- You can sign up to receive our regular e-newsletters

Complaint handling training

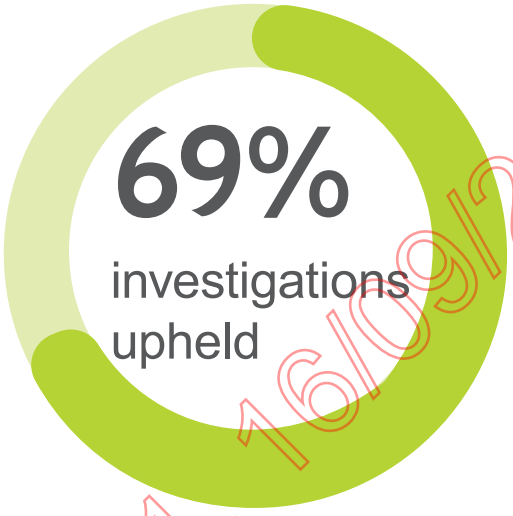
While we have paused our face-to-face training courses for the foreseeable future, we now provide online training courses to help improve local complaint handling. Our *Effective Complaint Handling* course is available for both councils and care providers.

Courses are delivered online by an experienced member of our staff. More information is available at: https://www.lgo.org.uk/training/

If you wish to discuss your training needs please get in touch with our External Training and Relationship Coordinator, Alan Park, at: a.park@lgo.org.uk.

Putting things right

687
cases with recommendations to put things right



investigations upheld

596
recommendations to improve services for others

10%
upheld cases where we agreed with the council or care provider's remedy

1,294
recommendations to remedy personal injustice*

** In many cases, we will recommend more than one type of remedy. For example, we may recommend an authority makes an apology, pays a sum of money, and reviews a policy or procedure.*

Decisions and reports

We are one of the only Ombudsman schemes to publish every social care decision we make. We do this to share learning and improve the transparency of our work.

Our decisions are published at www.lgo.org.uk/decisions and can be searched by theme, key word, category, decision outcome, date and organisation.

Where a council commissions care from the independent sector the law is clear that the council remains accountable for the actions of the provider they have commissioned. For transparency, we will generally name the care provider, as well as the commissioning council, in our decision.

Cases about councils that raise serious issues or highlight matters of public interest are given extra prominence and issued as public interest reports; we published 14 during the year. Additionally, we published two further reports after councils failed to implement the recommendations we made in previous reports.

Adult care services

Published reports

- LB Barking and Dagenham - charging
- Staffordshire CC - assessment and care planning
- Wirral MBC - domiciliary care
- Bolton MBC - assessment and care planning
- Suffolk CC - direct payments
- Somerset CC - assessment and care planning
- Staffordshire CC - assessment and care planning
- Somerset CC - assessment and care planning
- Sheffield City Council - transport
- Salford City Council - assessment and care planning
- Derbyshire CC - safeguarding
- Nottinghamshire CC - direct parents
- Norfolk CC - assessment and care planning
- North Yorkshire CC - assessment and care planning

Further reports

- Lincolnshire County Council - charging
- Dudley MBC - charging

3,073
complaints and enquiries received

of which

430
were from people who fund their own care

Compliance with recommendations

Our recommendations are non-binding but are almost always accepted and implemented by care provider and councils. We follow up with care providers and councils to ensure what has been agreed to is implemented and within agreed timescales.

We were satisfied with care providers' and councils' compliance with our recommendations in 99.1% of cases. However, we are concerned that in 18% of cases compliance was late. This is perhaps a reflection of the pressures in the sector, but risks undermining public trust in the current system of redress.

We take appropriate follow-up action to pursue compliance where we are not satisfied with the actions of a council or care provider. This may involve either opening a new investigation into the injustice caused by the failure to comply or, where we have issued a public interest report, publishing a further report to highlight the matter.

> **We were satisfied with care providers' and councils' compliance with our recommendations in 99.1% of cases. However, we are concerned that in 18% of cases compliance was late.**

We reached the final step in our process on two occasions during the year by publishing a statement holding the body to account for formally refusing to implement our recommendations. Both cases involved independent care providers and we published Adverse Findings Notices against each.

- Foxley Lodge Care Ltd in Deal, Kent had not responded to our investigation after we asked it to stop demanding a 25% fee increase from a care user, retract its threat to evict them if payment was not received, and review its complaint handling processes.
- The Hawthornes Care Home, run by Burlington Care in Yorkshire, refused to accept our recommendation to waive care fees for a woman with dementia for the few months she was in their care. Our investigation found the care she received was well below expected standards. After the noticed was published, we welcome that the provider reflected on its actions and committed to refund the fees.

The cases were also shared with the regulator, the Care Quality Commission.

Key complaints and outcomes

The case summaries below illustrate the real-life experiences of people who use services and the challenging environment that councils and care providers operate in. They also show the clear stance we take in holding bodies to account against the relevant legislation, standards, guidance and their own policies.

Failure to properly investigate falls contributed to the avoidable death of care home resident
Case reference: 16 006 195

Our investigation found multiple failings at a care home owned and operated by a county council, including with a safeguarding investigation undertaken following the death of resident. We found the council failed to properly investigate a series of falls suffered by the woman and there were serious shortfalls in its care planning around falls management and in its monitoring of her weight and nutrition.

We asked the council to apologise to the woman's brother, who brought the complaint, make a payment to a charity of his choice, and pay for a memorial for the woman, such as a tree or park bench. It also agreed to review its procedures to improve audit trails of care assessments and conduct a wholescale review of its adult safeguarding procedures.

Supporting good practice

Safeguarding investigations often involve complex multi-agency working. Since 2015 we have operated a joint team of investigators with the Parliamentary and Health Service Ombudsman to investigate cases that span both health and social care services. Our 2016 focus report, Working together to investigate health and social care complaints highlights a failure to deal with safeguarding issues as one of the key themes the team deals with.

70%
safeguarding complaints upheld

Key complaints and outcomes

Flawed reassessment leads to reduced care package
Case reference: 17 017 535

Our investigation found that a council took more than a year to reassess a woman's social care needs following a stay in hospital and used a flawed assessment to reduce her support from 67 to 25 hours per week. We found the reassessment was conducted with the intention of reducing the woman's support and did not consider her actual needs, despite the clear evidence. The reduction in support caused the woman significant problems in carrying out basic daily activities.

The council responded quickly to our recommendations and reinstated the woman's personal budget, apologised, and paid a sum of money to the woman and her personal assistant.

We were concerned the council had used the same approach with other people in its area and asked it to review reassessments from the last 12 months that resulted in complaints about reduced care packages. We also asked it to take steps to ensure all future assessments are conducted in line with relevant law and guidance.

Supporting good practice

Our 2018 focus report Under Pressure sets out the stark financial challenges and service demand councils have faced in the past decade. Through our casework we identify common faults when councils review their eligibility and charging policies and set out guidance for getting it right first time.

68%
assessment and care planning complaints upheld

Key complaints and outcomes

Council and care provider accountable for providing confusing fee information
Case reference: 18 002 772

A council and care provider agreed to change their charging policies after our investigation found a resident had paid too much for her care. We found the council and care home had provided confusing and sometimes incorrect information about fees, and that the care provider delayed its invoice for the resident's care, resulting in a large bill. In addition, we found the council at fault for the way it contracted out collecting client contributions to the care provider, which is not permissible under current social care guidelines.

The council agreed to repay half the resident's contribution for her care and the care home agreed to pay a sum of money to reflect the distress caused.

The council also agreed to ensure written top-up agreements between third parties and the council are in place in all cases where a person is paying a top-up fee, and to review its fee collection arrangements to ensure they are in line with law and guidance.

The care home agreed to stop entering into third-party top-up arrangements where a council has arranged the placement and to remove references to third party top-ups in its private contract.

Supporting good practice

Our 2015 focus report, Counting the cost of care sets out common issues that families encounter when paying top-up fees for their relatives' care. We provide guidance for councils to make sure their procedures do not put people at risk of paying too much.

69%
charging complaints upheld

Key complaints and outcomes

Unclear contract results in Funded Nursing Care payments being refunded
Case reference: 19 007 959

Our investigation found that a care provider was receiving Funded Nursing Care (FNC) payments for one of its residents but had not reduced their care fees accordingly. FNC payments are made to directly to care providers to fund nursing care. We found the provider had not provided written information about fees before the placement started, and that the care home's standard contract did not explain what happens once FNC payments are agreed by the NHS.

We asked the provider to refund the nursing element of care and review its contract terms to ensure it provides clear information about fees at the outset. The provider also agreed to review the contract and fee arrangements of all its current residents and refund the nursing element of their care if the NHS had approved FNC for them.

Supporting good practice

In 2018, we issued guidance to care providers after we saw a rise in complaints from self-funders about Funded Nursing Care payments. We share learning from our casework to help providers respond to complaints about FNCs.

75%
residential care complaints upheld

Raising the profile of complaints

Complaints are a cost-effective way to identify concerns and issues early and drive improvements; the best organisations will view them as central to good governance and accountability.

Care providers and councils can use the data we publish, alongside their own local information, to review the effectiveness of their complaints processes and assess how effectively they learn the lessons from complaints.

Use these suggested questions to check the health of your organisation's approach to complaints:

- **Do you actively seek feedback about your services?**
- **Is your complaints procedure visible in care settings?** People should be able to request information about complaints in a format that best suits them.
- **Do you use the Single Complaints Statement to guide your approach to complaints?**
- **Does your organisation set out a timetable for responding to complaints and keep people informed if there are delays?** Long delays and poor communication during the complaints process can cause additional distress for people making complaints.
- **Do contracts between commissioners and providers contain clear processes for handling complaints?**
- **Does your organisation have clear processes in place with local partners to provide a single investigation and response to people with a complaint about multiple bodies?**
- **Does your organisation's complaints procedure clearly signpost to the Ombudsman?** If people have been through all stages of your complaints procedure and are still unhappy, they can ask us to review their complaint.
- **Do you regularly review your organisation's local complaints data and the outcomes of complaints?** Do your elected members or board members regularly scrutinise complaints data and outcomes?
- **How does your organisation ensure it shares the learning from complaints, across care locations or council functions to prevent the same issues affecting others?**
- **How often does your organisation offer a suitable remedy for a complaint before it reaches us?** This is a good sign that your service can accept fault and offer appropriate ways to put things right for people.
- **What is your organisation's compliance rate?** This indicates our satisfaction with the evidence your organisation has provided to implement a recommendation it has agreed to. Compliance below 100% is rare. Does your organisation have a 100% compliance rate? If not, what is it doing to scrutinise complaints where it failed to comply?

Our role as social care ombudsman

A one-stop-shop for independent redress

Since the Local Government and Social Care Ombudsman was established by Parliament in 1974, we have been able to consider complaints about the functions of councils, including their adult social care departments and 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 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.

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 that complaints are resolved and lessons learned.

We work closely with partners across the social care landscape to share our intelligence and experience of complaints. This includes sharing information about our investigations with the CQC in order to inform regulatory action.

Alongside a range of health and social care bodies, we are signatories of the Emerging Concerns Protocol; a mechanism for sharing information and intelligence that may indicate risks to people who use services, their carers, families or professionals.

We are partners in the sector-wide Quality Matters initiative, which aims to improve the quality of adult social care. Developed alongside Healthwatch England, we set out what service users, their families and representatives can expect when making a complaint about their care.

Local Government and Social Care Ombudsman
PO Box 4771
Coventry
CV4 0EH

Phone: 0300 061 0614
Web: www.lgo.org.uk
Twitter: @LGOmbudsman