Local Government & Social Care OMBUDSMAN

Annual Review of Adult Social Care Complaints 2020-21

September 2021

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Ombudsman's foreword

Earlier this year, the local authority officers responsible for delivering adult social care sounded a stark warning about the state of the system over which they preside. Their annual survey for 2021 declared that 'There is a growing disconnect between increasing social care need and the financial ability and confidence of Directors to meet that need."*

That stark disconnect, between need and delivery, has never been more clearly manifest in our casework. Last year we found fault in a staggering 72% of the care complaints we investigated. This is an increase on the previous year. It is also higher than we see across local government as a whole. Most worryingly, it continues a relentless rise over the last decade in the proportion of complaints where we find injustice to care users and their families.

Viewed through the lens of complaints from the public, this is a system that is increasingly failing to deliver for some of those who need it most.

Behind those headline figures, our investigations evidence the human cost of this crisis. This year we have, yet again, seen families facing unexpected debts and excessive charges. We have seen examples of poor communication, short staffing, and poor care. And in a system that is meant to be centred on the person, we have seen families divided unnecessarily, sometimes even in the final moments of a loved one's life.

But, make no mistake, the faults we find are generally not one-off errors of judgement, that can be blamed on staff working under pressure – although that pressure is all too real and evident in our casework. Increasingly this is a system where exceptional and sometimes unorthodox measures

are being deployed simply to balance the books – a reality that is frequently pleaded in defence by the councils we investigate.

To add to those pre-existing pressures, councils and care providers have operated this year against the ever-evolving backdrop of the COVID-19 pandemic. I do not underestimate the impact this has had on services. While the nature of our work means we are focused on things that have gone wrong, I credit the care and support sector for its response to the challenges faced during the year.

Our own response to the pandemic saw us stop taking new complaints, or progressing existing cases, for three months during the initial wave, to allow councils and providers to focus their resources where they were needed most. The impact of this pause is played out in the statistics we publish today, with the number of cases received and decided being lower than in previous years.

Since we re-started our casework, we have closely monitored the complaints we have received that involve COVID-19. Our early view is that the pressures of the pandemic have served to exacerbate existing concerns, rather than create a raft of new ones; we outline some of the emerging themes later in the report.

In terms of specific themes within adult care, we found fault more regularly in almost all of our complaint sub-categories. There were particularly significant spikes in the uphold rates for complaints about supported living settings, transport and disabled facilities grants. This perhaps reflects the challenges of those who rely on care services for their independence and daily needs, at a time when accessing external settings was restricted.

Where we find fault, we want to put things right for the individual, as well as improve services for others and share any learning across the sector.

> ***Viewed through the lens of complaints from the public, this is a system that is increasingly failing to deliver for some of those who need it most.***

I welcome that, from all the recommendations we made in the year, a higher a proportion were aimed at improving services than the previous year.

I am pleased to report compliance with our recommendations remained very high, with 99.8% agreed to and implemented. For this, I commend councils' and providers' commitment to putting things right despite the challenges they face and seeing the opportunities complaints provide to improve services. The only negative in this area is that we have experienced a small number of care providers, after this reporting period, looking to undermine our authority by refusing to implement recommendations without good reason, potentially forcing us to publish a formal statement of non-compliance about them.

At a time of pressure in the care system it is more important than ever to listen to public concerns. They provide free intelligence to spot problems and drive improvement. And in the independent care sector, empowered, informed, and confident consumers are one of the best ways to create a healthy and competitive market. However, we think more could be done to increase awareness of adult social care complaint systems, increase transparency around how care providers manage complaints, and better support providers to learn and improve when things go wrong. To this end, we set out in more detail later in this report where legislative changes could achieve this.

These include eliminating some gaps in our jurisdiction and powers to investigate some sections of the care sector, which currently leaves some people without a means of redress. And a new statutory role setting complaints standards across the care sector would achieve more consistency in complaint handling, offer clarity to care users about what to expect and increase accountability. We will continue to pursue our proposals and look forward to engaging with the care sector as we do so.

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. However, I recognise that those incremental improvements, valuable as they are, are only one part of the picture. The wider context that we see through our investigations is perhaps best reflected in the words of the Social Care Directors I quoted earlier, *"Under investment means that more people are in need of social care and support, but fewer are getting it and many are getting less."** The recent government announcement has moved structural reform of the system off the backburner, but with more details seemingly to be discussed. I therefore hope this report and the evidence it contains can also help contribute to that debate about what a more sustainable care system will look like in the future.

**ADASS Spring Survey 2021*

Michael King

Local Government and Social Care Ombudsman

September 2021

Complaints and COVID-19

During the year, councils and care providers faced a range of unprecedented challenges responding to the COVID-19 pandemic. Those who arrange and deliver care and support will have spent the year adjusting to new operational realities.

We know that effective complaint mechanisms are of huge value during times of disruption, and we encourage councils and providers to continue to pay close attention to the complaints they receive. Understanding the experiences of people who use services and their families can offer the crucial insight that providers and commissioners need to deliver responsive, quality services. It led us to publish guidance on good administrative practice in responding to COVID-19.

From our casework to date, we can identify some emerging themes that we are sharing to support wider learning. Many are issues that existed before COVID-19, but have been exacerbated by the pandemic, others can be more directly attributed. We will continue to monitor our casework in this area and report back to the sector any systemic issues we identify.

Emerging themes

- **Delayed assessments** preventing timely discharge from hospital and moves between providers
- **Poor communication** between hospitals and care homes both working in crisis conditions
- Care settings and councils being **inflexible** and failing to properly communicate access to and availability of services, particularly when lockdown rules changed
- Care providers **failing to manage risk** appropriately, for example around the use of PPE and with symptomatic staff
- Prolonged **delays** in accessing occupational therapy services and assessment and provision of aides and adaptations

In general, we have found care homes applied visiting rules appropriately.

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

Supporting good practice

Through regular monitoring and oversight arrangements, Sheffield City Council ensures all its commissioned care providers signpost to the local complaint procedure, and then to the Ombudsman.

A simple, but effective way to ensure people know where to go with a complaint that we encourage other councils to replicate.

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.

Supporting good practice

Durham County Council takes a proactive approach to complaints training and offers our training course to all its commissioned care providers, helping to ensure good complaint handling standards across the care provision within its area.

Putting things right

588
cases with recommendations to put things right

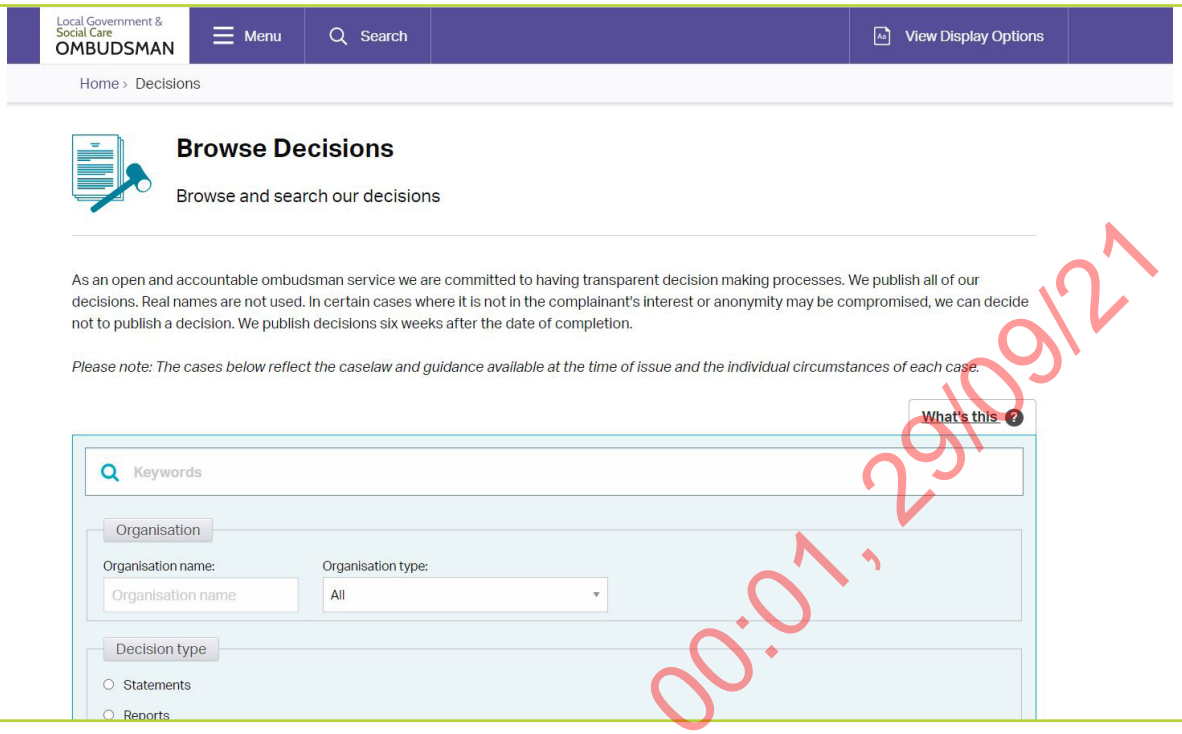
546
recommendations to improve services for others

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

1,096
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 were one of the first Ombudsman schemes to publish the decisions we make. We do this to share learning and be transparent.

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

Cases that raise serious issues or highlight matters of public interest are given extra prominence and issued as public interest reports; we published 12 during the year.

Supporting good practice

The law is clear that a council remains accountable for the actions of care providers they commission. We will generally name both the care provider and commissioning council in our decisions.

Adult care services

Public interest reports

- LB Barking & Dagenham – transport – 19011326
- Hertfordshire CC – assessment – 19000200
- RB Windsor & Maidenhead – home care – 18015872
- LB Harrow – transport – 19002266 et al
- Westminster CC – assessment – 19007605
- Brighton & Hove CC – assessment – 19000201
- Hampshire CC – assessment – 19016357
- Cornwall C – direct payments – 19004581
- Cornwall C – charging – 19019385
- Lincolnshire CC – charging – 19006248
- Nottinghamshire CC – assessment – 19015363
- Surrey CC – residential care - 19020697

Compliance with recommendations

Our recommendations are non-binding but are almost always accepted by care providers and councils. We will always seek evidence that what has been agreed to is carried out and within agreed timescales. In 2020-2021 we were **satisfied with care providers' and councils' compliance with our recommendations in 99.8% of cases**, with only a single case of non-compliance during the year. In that instance, we opened a new complaint to investigate the failure to comply with the original recommendations.

While it is encouraging that compliance has remained high, especially during such a challenging year, in 17% of cases, compliance was not completed within the agreed timescales and was late. This may reflect the pressures in the sector, but remains concerning as delays in putting things right can add to the injustice already experienced by complainants and risks undermining public trust in the system of redress.

> ***"We were satisfied with care providers' and councils' compliance with our recommendations in 99.8% of cases...[however] in 17% of cases compliance was late."***

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.

Care costs refunded and councils reminded about applying fixed fees
Case reference: 19 006 248

Our investigation found that Lincolnshire County Council charged a fixed fee for respite care without assessing if people could afford it.

In this instance, there was no individual complaint, we used our powers to investigate after the issue was uncovered as part of a previous investigation.

The council agreed to our recommendations to review and refund cases where people had been overcharged for respite care and amend its policy in line with guidance, preventing future users from the same injustice.

All councils are reminded that statutory guidance states that charges should be affordable for the individual, therefore an assessment of income is necessary.

72%
charging complaints upheld

Key complaints and outcomes

Delayed assessment keeps man away from his family for five months
Case reference: 19 015 363

We found Nottinghamshire County Council's delays resulted in a man remaining in a care home away from his family for five months. The man, who has dementia, had been placed in a care home while his wife and carer took time to care for their terminally ill son. The placement was intended to be temporary, but his wife decided she would need additional help when he returned to the family home. The council did not complete a review or assessment of the man's needs, nor the woman's needs as his carer. It also failed to complete an assessment of his mental capacity or his ability to agree to his placement and the care costs involved.

When the council eventually carried out an assessment five months later, it found he did not have the mental capacity to decide where to live or to make a decision about his finances. Despite this, the family was charged for the man's care for the time he was in the home – incurring debts of more than £15,000.

The council was keen to help resolve the case and took steps to improve its Mental Capacity Act documentation and guidance during our investigation. It contacted the care provider to take responsibility for the outstanding care fees, apologised to the family, and made payments to acknowledge their distress, time and trouble. Finally, the council showed it is committed to learning from the complaint by producing and carrying out an action plan for improvement that included case reviews, and briefings, training, and improved resources for staff.

73%
assessment and care planning complaints upheld

Key complaints and outcomes

Prolonged poor care left a woman and her family in distress
Case reference: 20 000 904

We found the care provider, RV Care Homes Limited, provided an unacceptable level of care for an elderly woman.

The woman's family had regularly raised concerns with the provider over an 18 month period, and being unhappy with the response raised a safeguarding alert with the local council. The safeguarding investigation found no evidence of alternative strategies being used when the woman declined personal care or refused food and fluids on many occasions.

Our findings chimed with those in the safeguarding report: care records showed personal care was refused numerous times without it being offered again. At one point the woman refused food and fluid for five days and there was no evidence the issue was escalated.

We found the care provider showed a persistent inability to act on concerns raised by the family and improve the care given.

To put things right, the care provider agreed to apologise and pay the family £5,000 to acknowledge the poor care it gave. To improve things for everyone, it agreed to report back to us how it would ensure staff followed the right procedures around care planning, communicating with families and recording care notes.

74%
complaints about independent care providers upheld

Key complaints and outcomes

Poor communication and standards of care cause family distress
Case reference: 19 020 697

Our investigation found Surrey County Council arranged and funded care for an elderly woman from Puttenham Hill Care Home that fell below the standards expected. When the woman's health declined, we found there were insufficient qualified staff on duty at the care home, a delay in contacting emergency services, and a failure to work effectively with the NHS to ensure timely medical care.

There was also poor communication with the woman's daughter meaning she was not with her mother when she died and was not made aware that she was seriously ill.

The council agreed to work with the care home to ensure it is regularly assessing staffing capacity and requirements so there are enough appropriately qualified staff at the care home. It also agreed to ensure all care staff at the home receive training in communication skills and bereavement.

75%
residential care complaints upheld

2,033
complaints and enquiries received

of which

270
were from people who fund their own care

Strengthening the system

Good complaints handling is fundamental to the improvement of the adult social care sector. Clear and accessible complaint systems empower care users to feedback on their care and ensure they receive the services they should. Information about complaints helps people make decisions about their care and which providers to choose. Complaints help the provider learn from any mistakes and improve their services.

There are ways in which we think the current system of redress could be improved and strengthened - pragmatic changes that would benefit both care users and providers to get more from complaints.

There are gaps in our jurisdiction which currently mean some service users have no independent route to redress. Closing these gaps would enable more providers to learn from complaints and improve service quality.

Currently, adult social care providers are not required by law to signpost to our service, even though we are part of the statutory complaints process. This allows some weaker businesses to undermine the market and disempower their consumers by not doing so. To stop this from happening we believe mandatory signposting to our service should be introduced for all care providers.

We know from our dialogue with the sector, particularly smaller providers, that there is often a lack of awareness of our service. Another way to improve access to the ombudsman is to increase awareness of our role within the sector, potentially in the form of an outreach programme.

Good complaints handling is fundamental to providing good service. Complaints allow providers to learn from mistakes and put things right for the consumer. Complaints also help give the consumer a voice and say in how a service is run. Providers need to be accountable for and transparent about the way they respond to people's complaints. We would like to see all providers put complaints data at the heart of the information that measures their performance, though an annual review of their complaints.

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.

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?

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