Local Government & Social Care OMBUDSMAN

# Review of Adult Social Care Complaints 2018-2019

September 2019

# Contents

# Ombudsman's foreword

I am pleased to present our Review of Adult Social Care Complaints for 2018-19. This report reflects on the cases we have investigated during the year and provides a window into real-life experiences at the front line of adult care. Regrettably the picture painted by the complaints we have received is a challenging one.

While overall enquiry numbers were broadly static last year, the adult care complaints we saw were ever more serious – reflected in the fact we had to carry out a higher proportion of detailed investigations than we did in the previous year. Most tellingly, our decisions showed another increase in upheld complaints. Nearly two thirds of our investigations are now finding faults in the system – many of which appear to be driven by attempts to ration scarce resources. We received more complaints about charging for care and found fault in a larger proportion of those we investigated. And we are regularly seeing problems with how budgets for care packages are calculated and the way fees and charges are communicated.

The level of fault we find has now risen from 43% of cases upheld in 2010 to 66% today, reflecting mounting pressures on those who work within the care system and those who rely upon it for their independence and daily needs.

However, there are also many positive lessons that can be drawn from our findings. I am clear that the main value of complaints lies in how they can inform and support everyday improvements in public services. At a time of stretched resources, they represent an important source of free intelligence. We therefore place our focus, not on how many complaints a body receives, but on the quality of each organisation's response to fault, and how willing it is to put things right when they go wrong. This review aims to contribute to that learning process.

Alongside the report itself, we publish complaints data at council and care provider level. This year, as well as the number of complaints received and the decisions we have made, we are publishing a new set of remedy and

compliance data. This data provides important context about an organisation's approach to resolving and learning from complaints and I hope it is useful to you.

However, public feedback depends on people knowing where to turn when they have a concern. So, the importance of good signposting and clear procedures remains my key message to care providers and councils. For the second consecutive year, we have seen no growth in the number of complaints we receive about care arranged privately; despite that sector being under-represented in our work. There may be a range of reasons for this, but I am concerned that some self-funders of care are not being properly signposted to our service. Providing information on how to make a complaint should be done at the start of any care journey and the contact details for the LGSCO should be clearly displayed in all care settings and in all complaint procedures. I recommend care providers and councils use the Single Complaints Statement to guide their approach to complaints.

> ***"I am concerned that some self-funders of care are not being properly signposted to our service."***

Care providers who are unfamiliar with our role and what might be involved in an investigation may also find our report Caring about Complaints useful. We share the lessons from our decade of casework experience investigating complaints about independent care providers and detail what you can expect during an investigation and how to work with us to put things right. The severity of the issues we investigated last year is reflected in several public reports we issued, examples of which are contained within this review. While I recognise the challenging environment both commissioners and providers are operating within, I am clear that any attempts to reduce costs must also properly consider the impact on the rights and dignity of people who use services, and must comply with both the letter and the spirit of the Care Act 2014.

Despite the pressures, it is good to see that compliance with our recommendations to remedy complaints continues to be high. Although we dealt with over 3,000 care complaints last year, there was only one instance when the provider refused to implement our recommendations. This exceptional and highly regrettable event is detailed later in the report.

I would encourage councils and care providers to use this review and the data we publish alongside it, to focus on the cost-effective role complaints can play as an early warning sign of service problems and failing policies, and as invaluable lessons from which we can learn and improve.

**Michael King**

**Local Government and Social Care Ombudsman**

**September 2019**

# Adult social care complaints - at a glance

**3,070**
**complaints and enquiries received**

**435**
**complaints and enquiries from people who fund their own care**

**1,220**
**investigations completed (up 8%)**

**66%**
**investigations upheld (up 4%)**

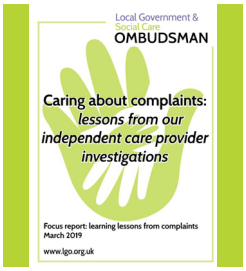
**73%**
**investigations upheld about residential care (up 5%)**

**73%**
**investigations upheld about charging for social care (up 6%)**

# 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.

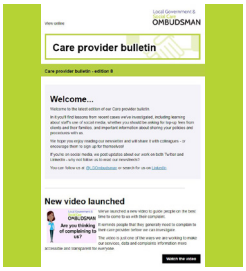
Our website contains a suite of practical advice and useful tools to help support good complaint handling:




We issue focus reports where we identify common themes or practice issues. This year, we published Caring about Complaints, which focuses on lessons from our investigations about independent care providers, and highlights the opportunities for complaints to improve services.


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

We provide a range of adult social care training courses to help improve complaint handling. Our Effective Complaint Handling course is available for both councils and care providers, and we have a specific course for frontline care staff.

Courses can be delivered to single organisations or we offer open courses, which allow staff from any council or care provider to attend. We are running two open courses in Coventry and London this winter. More information is available at: https://www.lgo.org.uk/training/

Here are some examples of the positive feedback we receive from course participants:

- "*Very, very good training – exceptional trainer – would recommend to others*"
- *"I think this training would be useful to all staff as it would allow both sides to learn what is expected from each other when making complaints"*
- "*Brilliant course; very enjoyable; good presentation and delivery*"

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.

# Key complaints and outcomes

Our role is to remedy injustice and share learning from investigations to help improve local public services, including adult care services. Our decisions are published at www.lgo.org.uk/decisions and can be searched by category, key word, outcome, date or organisation.

Cases that raise particularly serious issues or which highlight matters of public interest are given extra prominence and are issued as public reports. During the year we published 11 public interest reports about adult social care.

Where a council commissions care from the independent sector we are 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 statement or report.

## Case summaries

We encourage councils and care providers to accept responsibility when things go wrong, to learn from mistakes and make changes to improve services. Where we find fault, we will make recommendations to remedy the complaint. We will make recommendations to put things right for the individual who has complained, and often ask the council or care provider to take steps to prevent the fault from reoccurring and affecting others. We can also ask that other people potentially affected by the same issue have their situations similarly remedied.

The following case summaries 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 home fails to properly communicate fee increase

**Case reference:** 18009786

We investigated a care provider's failure to notify a care home resident about an increase in its fees as required within the contract and failed to provide a detailed breakdown of charges in its final invoice. We also found that it failed to deal properly with the complaint and that its complaints policy did not refer to the role of the Ombudsman and the right of its residents to complain to us.

**The care home completed the following actions to our satisfaction:**

*An individual remedy*

We recommended the care provider should:

- apologise and make a payment to acknowledge the time and trouble bringing the complaint and recalculate the final invoice

*Service improvements for all*

We recommended the care provider should:

- introduce a system to ensure it periodically informs residents in writing when arrears build up
- ensure its complaints policy, information it provides to its residents and its complaint letters properly refer to us

## Home care workers late getting medical attention for vulnerable woman

**Case reference:** 18001676

Our investigation found that care workers took too long to call for medical attention for a woman receiving home care services. The woman's son complained to us, unhappy with the council's investigation into his complaint.

Our decision was made against the council, but highlighted fault in the actions of its commissioned care providers. The case is a timely reminder of the need for local authorities to maintain oversight of outsourced contracts delivered on their behalf.

We found faults with the care provider's actions, including that it did not follow its own emergency procedures, that workers missed a lunchtime visit, that care logs were incomplete or there were questions about their accuracy, and information was not passed on between workers.

**The council completed the following actions to our satisfaction:**

*An individual remedy*

We recommended the council should:

- apologise and make a payment to acknowledge the time and trouble bringing the complaint

*Service improvements for all*

We recommended the council should:

- ensure the care provider has trained all staff on its emergency procedures and on accurate and complete record keeping
- review its adult social care complaints procedure to clarify how it deals with complaints against commissioned care providers

## Family wrongly charged for intermediate care

**Case reference:** 16018163

We exposed failings by a council that wrongly tried to charge for the first six weeks of intermediate care by calling the service by another name. We found the council had confusing and conflicting information on its website and leaflets about its 'enablement service'. Intermediate care, where people are receiving support with the intention of returning home, cannot be charged in this initial period.

**The council completed the following actions to our satisfaction:**

*An individual remedy*

We recommended the council should:

- apologise and reimburse charges paid incorrectly

*Service improvements for all*

We recommended the council should:

- review its charging policy and procedures to ensure compliance with the Care Act 2014
- identify adults who have received 'enablement' care since April 2015, who should have been entitled to free intermediate care
- write to those affected and arrange to refund their costs for the first six weeks of their enablement package

## Cut to family's support package for disabled son

**Case reference:** 16005445

A man with autism and other needs, and his mother had been in receipt of support, which included one-to-one care, transport costs and a placement in a care centre.

The council cut the level of one-to-one support at short notice, without reassessing the family's needs, leaving the man's mother to support her son during the holidays. At the same time, the man's day-care centre closed, and the council failed to identify an alternative placement, or pay a comparable amount to fund replacement care. Again, the mother had to provide the care, while the man missed out on accessing stimulating activities outside of his home.

When the council did pay the family for the care, the money they received was not paid in consistent amounts, or at fixed times. The council suspended the payments for 17 months as the mother could not provide the evidence the council rightly needed to account for the money. But when the council backdated the money, it put it into a holding account that the mother could not access. This meant there was no money available to support the man during the holidays.

When his mother complained to the council about her circumstances, it never replied or responded to her complaint.

**The council completed the following actions to our satisfaction:**

*An individual remedy*

We recommended the council should:

- apologise and make a payment to reflect the time and trouble taken and distress caused

*Service improvements for all*

We recommended the council should:

- review all care and support packages on at least an annual basis
- review its use of 'holding accounts' so emergency money is immediately accessible to individuals
- train officers to ensure complaints are responded to fully

## Blue badge denied without proper assessment

**Case reference:** 17014970

Our investigation found a council denied a man with Down's Syndrome a blue badge without ever assessing him in person.

The council wrongly told the family that walking difficulties arising from cognitive impairments could not be considered when assessing someone for a badge. The family completed an application, which was turned down, and the father complained. Instead of assessing the son in a face-to-face meeting, a second paper assessment was conducted and, again denied the family a blue badge.

We criticised the council for saying the son would not be eligible because he had cognitive rather than physical difficulties, and because it did not properly consider the variable nature of the son's condition.

The council has since conducted a face-to-face assessment and concluded the son is eligible for a blue badge.

**The council completed the following actions to our satisfaction:**

*An individual remedy*

We recommended the council should:

- apologise and make a payment to acknowledge the time and trouble bringing the complaint

*Service improvements for all*

We recommended the council should:

- review the way it deals with applications for blue badges to ensure it does not discount people with variable conditions and properly takes account of people with hidden or non-physical conditions that affect walking ability

# Key learning points

We welcome the positive attitude of the organisations in the cases we have higlighted who accepted and implemented our recommendations and encourage others to learn from the findings:

## Commissioning care

✓ Councils should ensure they maintain oversight of outsourced contracts that deliver services on their behalf, including ensuring clarity about how complaints will be dealt with.

## Charging for care

✓ Councils should be clear about what constitutes intermediate care and that they cannot charge for the first six weeks of intermediate care.

✓ Care providers should ensure changes to fees are clearly communicated according to contract terms and that they operate systems to inform residents when arrears are accrued.

## Assessment and care planning

✓ Councils cannot change care packages at short notice and without making proper assessments of need.

## Assessing for blue badges

✓ Councils should ensure their assessments properly take account of people with hidden or non-physical disabilities that may affect their ability to walk.

## Complaint handling

✓ Care providers and councils should ensure they clearly inform people of their right to bring a complaint to the Ombudsman. The contact details for the LGSCO should be clearly displayed in all care settings and in all complaints policies.

# Using our data

Complaints can be a cost-effective way to drive improvements and complaints data is a valuable source of intelligence for organisations.

The number of complaints a service receives only reveals so much about its quality or the experience of the people who use it. We consider a council or care provider's ability to accept fault where it has occurred and its willingness to put things right a more insightful marker of its attitude to complaints and how it will learn from them.

As such, we now seek evidence that the recommendations we make have been complied with (not only agreed to) and record where we are satisfied that a recommendation to remedy fault has been achieved (or otherwise). This means we can now report how a body has complied with the recommendations we have made to remedy complaints about them.

## What we publish

You can download adult social care complaints data tables for 2018-19, which provides data at council and care provider level.

The data tables include:

- the number of complaints and enquiries received about councils and care providers, categorised by service area (e.g. assessment, home care etc.)
- the decisions made against councils and care providers
- **NEW** - the number of complaints where councils and care providers offered a suitable remedy to resolve the matter before it came to us
- **NEW** - councils' and care providers' compliance with the recommendations we made to remedy complaints.

In addition, councils can use our new interactive map to view their annual performance data and track the service improvements they have agreed to.

# Key lines of enquiry

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

We suggest some key lines of enquiry for care providers and councils to consider:

## Our decisions:

✓ Do we refer a high number of complaints back to your organisation to consider first? This may indicate that people are not aware of how to complain and are not being properly signposted to the local complaints process.

✓ The uphold rate shows the proportion of investigations in which we find some fault and can indicate problems with services. Compare these with the overall uphold rates in this report and against those of other organisations to build a picture.

## Putting things right:

✓ 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.

✓ How does your organisation ensure it shares the learning from complaints across care locations or council functions to prevent the same issues affecting others?

## Complaint handling:

✓ Does your organisation's complaints procedure clearly signpost to the Ombudsman?

✓ How quickly are complaints responded to? Long delays and poor communication during the complaints process can cause additional distress for people making complaints.

✓ Complaints often involve more than one organisation. 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?

# Recommendations to put things right

We choose to focus on the outcomes of complaints we investigate, and the value an investigation by us can add through our recommendations to remedy fault.

We found fault in 66% of adult social care cases we investigated, up 4% on the previous year, and 8% higher than across all our casework. Where we find fault, we will usually make recommendations to put things right.

### Types of recommendations

✓ Recommendations to remedy personal injustice typically include: an apology, financial redress, provision of services, writing off a debt, or a new appeal or review of a case. They can also encompass creative recommendations to fix things based on the person's circumstances.

✓ Recommendations to improve services typically include: a review of policies, change to practices, training staff, and awareness raising of issues within the authority and to the public. We can also ask authorities to put things right specifically for others that did not directly complain to us but may have been affected by the issues found within an investigation.

**699**

**cases with recommendations to put things right**

**1,279**

**recommendations to remedy personal injustice***

**559**

**recommendations to improve services for others***

**9%**

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

**In many cases, we will recommend more than one remedy. We have changed the way we record and report this data, so it more accurately reflects the number of recommendations we make. It means this year's data is not directly comparable with 2017-18*

# Compliance with recommendations

Our recommendations are non-binding but are almost always accepted. We value the positive action taken by most councils and care providers to agree and implement the recommendations we make.

- We were satisfied with councils' and care providers' compliance with our recommendations in 99% of cases. But, in 9% of cases this compliance was late.
- In 1% of cases we were not satisfied with councils' or care providers' compliance with our recommendations.

The care provider, Corden Assist Limited, trading as Bluebird Care in Wandsworth refused to comply with our recommendations, which included an apology and a small payment for the time and trouble the representative had gone to in bringing the complaint. In response we used our powers to publish an Adverse Findings Notice to hold the provider publicly to account for its actions.

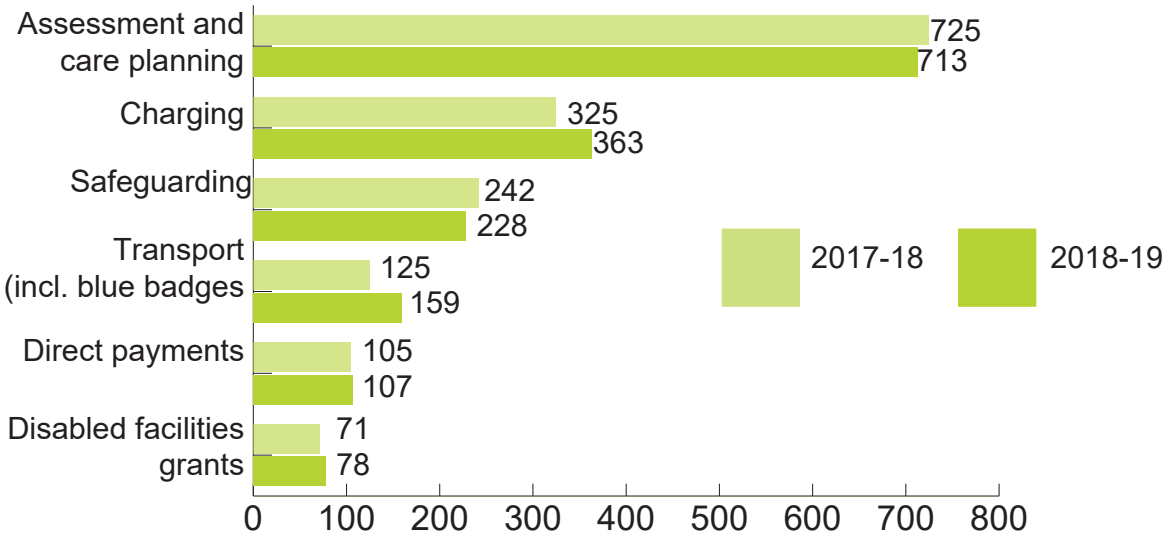
In several other cases we opened new complaints to investigate the injustice caused by the failure of the body to comply with recommendations they had previously agreed.

# Arranging social care support

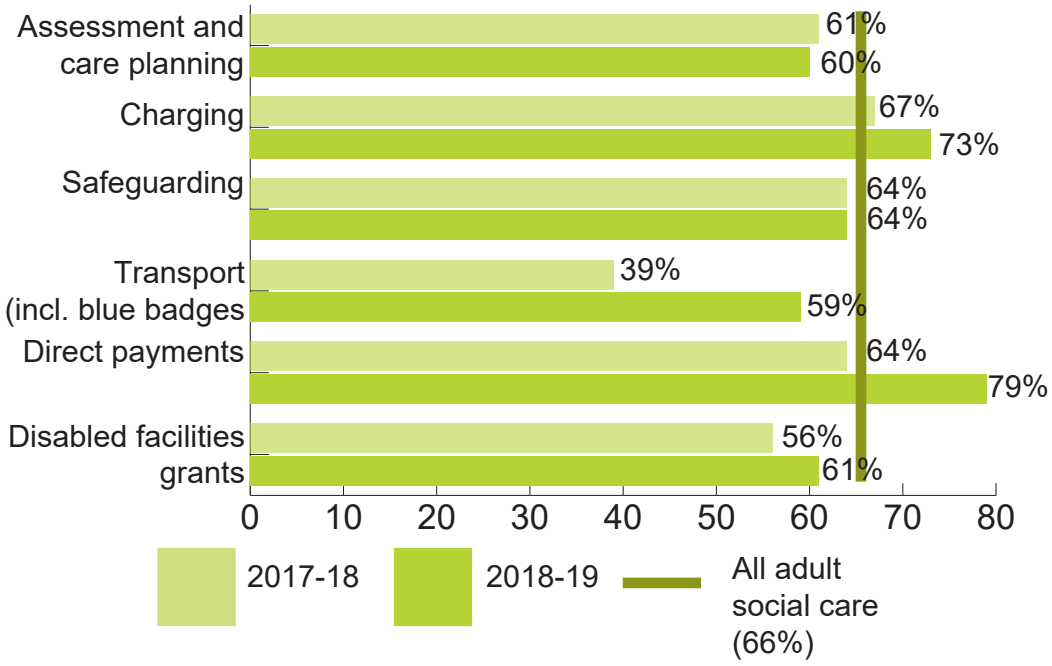
Councils with responsibilities for social services are required to plan for people in their area who have social care needs and take lead responsibility for safeguarding adults at risk of harm or abuse.

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

## Complaints and enquiries received



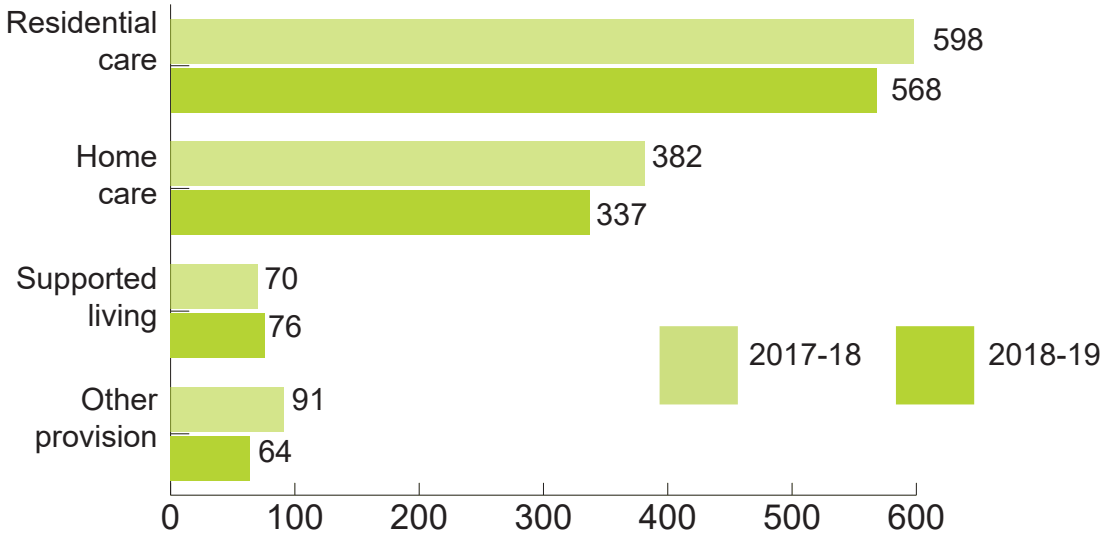

## Uphold rates



# Providing social care

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

## Complaints and enquiries received

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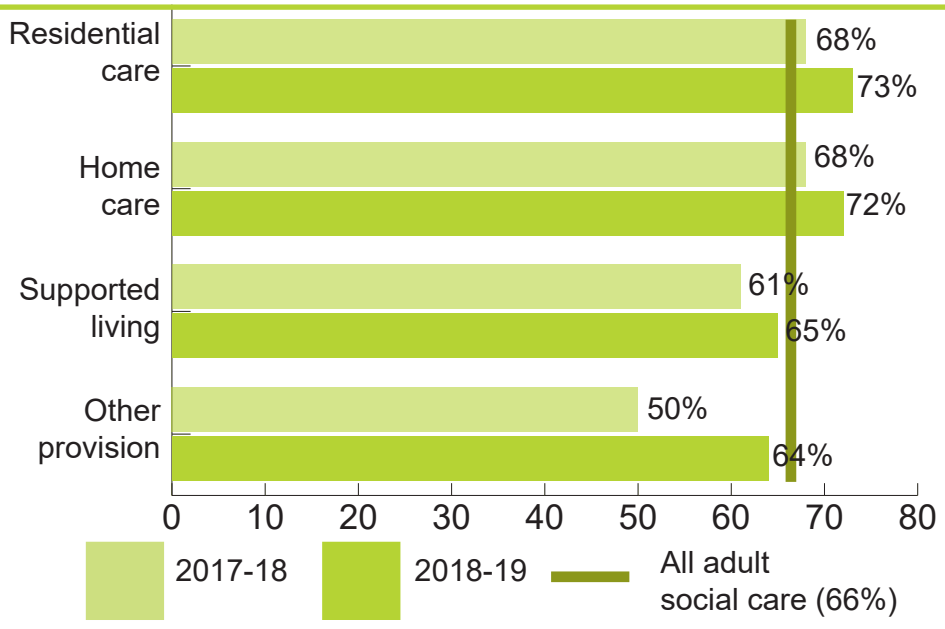

# Our role as social care ombudsman

## 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.

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