Local Government & Social Care OMBUDSMAN

Annual Review of Adult Social Care Complaints 2021-22

October 2022

Contents

Ombudsman's foreword	1
Guidance and support for councils and care providers	3
Putting things right	4
Decisions and reports	5
Compliance with recommendations	6
Key complaints and outcomes	7
Raising the profile of complaints	10
Our role as social care ombudsman	11

Ombudsman's foreword

The long-standing and well evidenced issues within the adult social care sector are, once again, reflected in the complaints we investigate. People entitled to care and support are navigating complex and challenging journeys to access what they need. We upheld a huge 70% of the cases we investigated during the year, finding fault more often than across local government as a whole.

The issues we see are not new nor surprising, but do indicate a system with a growing disconnect between the care to which people are entitled, and the ability of councils to meet those needs. And while I am sympathetic to the challenges leaders and frontline staff face, I am frustrated to once again be reporting my view of an under-resourced system unable to consistently meet the needs of those it is designed to serve.

Care assessments, care planning and charging for care have been key features of the majority of our landmark cases this year, some of which are detailed later in this report. A common theme is councils failing to provide care, or limiting care, while using cost as the justification. This finding is reflected by the Levelling Up, Housing and Communities Committee's recent report into the long-term funding of adult social care. It found users and carers reported assessments and reviews "can feel like an opportunity to save the council money rather than assess the level of support…". The duties of the Care Act remain clear, and we will continue to hold authorities to account for what they should be doing, not what they can afford to do.

We are able to investigate complaints about care arranged by councils and privately with the independent sector, giving us a broad overview of a complex and fragmented sector. This year we have seen a significant fall in the number of complaints we have received about adult social care for the first time since 2010 (when our role investigating independent care providers was established) – we received 16% fewer complaints than two years ago, and complaints about care arranged privately fell by 21%. The fall follows, but outperforms, a general trend across our casework.

We will monitor this trend, but I am concerned that more than a decade of rising demand and unmet need have left people who use services, and their carers, disillusioned, feeling there is no point in making a complaint. I want people to know that their voice matters. What can at first appear a simple error affecting a single individual can trigger a change in practice affecting many others. We can't investigate every complaint, but we can, and do, use our powers to achieve the maximum impact from our investigations.

> ***I want people to know that their voice matters. What can at first appear a simple error affecting a single individual can trigger a change in practice affecting many others.***

To do this we will always aim to remedy a complaint for the individual and make wider service improvements. I am pleased to report we are recommending more service improvements than ever before. Pleasingly, compliance with our recommendations remains high at 99.3%, I am grateful to those organisations that work with us to achieve a good outcome after things have gone wrong.

It is always unfortunate when organisations refuse to comply with the remedies we suggest, particularly when there is no good reason to do so. We published four statements of non-compliance against care providers during the year, the details of which can be found later in this report.

Taking these challenges together - an apparent challenge to our authority through non-compliance, a fall in complaints received, and a persistently high uphold rate - and there is a mandate for making the changes to the system that we have been calling for. Mandatory signposting to increase awareness of our role and outreach and support for smaller providers, annual complaint reports from care providers to encourage transparency, and clarity and consistency to service users with a new set of complaints standards across the sector. We will continue to pursue these proposals and hope they will further enhance accountability within the sector.

You can't operate a good service without a good complaints service; it is fundamental. I urge councils and care providers to use the data we publish today and this report to assess the health of their complaints system and ensure they are harnessing its potential - a source of free intelligence that can lead to responsive, engaged and improved services.

A sustainable care system is long overdue; I hope we can continue to shape a new system with the needs of the people who use it at its centre; how well we listen to their concerns will be an important measure of our success.

Michael King

Local Government and Social Care Ombudsman

October 2022

Guidance and support for councils and care providers

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

Our website provides practical advice and useful tools to help support good complaint handling:

- We issue guidance documents where we identify common themes or practice issues. Our Effective Complaint Handling for Local Authorities guidance offers practical advice on how to run complaints systems that are effective, fair and have service improvement at their centre.
- Care providers can use and adapt our template complaint procedures, response letters, checklists, posters and guides.
- 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
- We offer online training courses to both councils and care providers, delivered by our experienced 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 Co-ordinator, Cameron Black at c.black@lgo.org.uk

Putting things right

713
cases with recommendations to put things right

investigations upheld

631
recommendations to improve services for others

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

1,357
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 the outcomes of our investigations. Our decisions can be easily searched and provide a useful resource for care providers and councils to see the approach we take in our investigations and the recommendations we make to put things right.

Cases about councils that raise serious issues or highlight matters of public interest are given extra prominence and issued as **public interest reports**. Links to the 13 reports we published during the year can be found here, and a handful of these cases are summarised on pages 7 to 9 of this report.

By law, 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

13 public interest reports

- Devon CC: Charging
- Dudley MBC: Home care
- Essex CC: Assessment
- Gloucestershire CC: Assessment
- Kent CC: Assessment
- LB Bexley: Charging
- LB Croydon: Care plan
- LB Ealing: Safeguarding
- Lincolnshire CC: Charging
- North Yorkshire CC: Charging
- Northumberland CC: Charging
- Nottinghamshire CC: Safeguarding
- Rotherham MBC: Safeguarding

Compliance with recommendations

We made around 2,000 recommendations to councils and care providers to resolve 713 cases during the year. Our recommendations are non-binding but are almost always accepted by organisations and in 99.3% of cases we were satisfied that the council or care provider had complied with our recommendations.

Adverse Findings Notices

There were five cases of **non-compliance** during the year, four of which resulted in **Adverse Findings Notices** (AFNs) being issued against care providers, highlighting their refusal to implement our recommendations satisfactorily. In the fifth case, against London Borough of Haringey Council, we opened a new complaint to investigate the failure to comply.

We will work with care providers and councils to agree a timescale for implementing the recommendations they have agreed to. It is therefore concerning that in almost a fifth of cases councils and care providers missed deadlines and **compliance with recommendations was late**. We know there is significant strain on resources and pressure within the sector, but it is important that this final stage in the redress system is not undermined by unnecessary delay. A timely remedy can help to rebuild complainants' trust and confidence after things have gone wrong, while prompt implementation of recommendations to improve services can prevent failings recurring.

What are AFNs?

Where a provider fails to comply with recommendations to our satisfaction, we have the power to issue Adverse Findings Notices. These require the provider to publish the reasons for their non-compliance in the media. We will also publish the notice on our website alongside a media release and provide both to the press.

Should a provider fail to publish, we will do so and claim our costs back from the provider.

We have had the power to issue AFNs since our jurisdiction was expanded to include independent providers in 2010, and have so far published fewer than 20 notices, highlighting just how exceptional such non-compliance is.

However, this year we issued notices to:

- Care 1st Limited
- Foxley Lodge Care Limited
- Hamilton Care Limited
- Peepal Care Limited

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.

Nursing home resident forced to move because of funding blunders
Case reference: 19 011 943

Devon County Council and Swimbridge House Nursing Home failed to act properly when the council took over the funding of a care home placement. The failure to pay the care home's charges resulted in the eviction of the complainant, who had dementia and was more than 100 years old.

The council failed to consider alternative options to maintain the placement and did not take into account the risk and impact on the woman's wellbeing of moving to a new care home. We criticised the care home for serving the eviction notice without doing more to resolve the payment issues. Had the council and care provider put the woman at the centre of their considerations, it is unlikely she would have had to move.

Both agreed to make payments and apologise to the woman's family and to review procedures around transition from self-funded to council-funded care.

71%
charging complaints upheld

Both the council and care provider agreed to make payments and apologise to the woman's family and to review procedures around transition from self-funded to council-funded care.

Maximising impact: more for most

We will look to put things right for the individual who complained to us and may use our powers to widen our investigation, if we consider others have been similarly affected. We seek evidence that the recommendations care providers and councils agree to have been implemented.

Following an investigation into Lincolnshire County Council's defective policy on flat rate care charges, we recommended the complainant be refunded and that the council contact others who may also have been overcharged. As a result, the council contacted 735 service users who could be due refunds totalling £276,000.

Council fails to take on board expert advice when assessing woman's care needs
Case reference: 19 014 556

Our investigation found that Gloucestershire County Council failed to act in line with the Care Act when it did not meet the eligible care needs of a woman with multiple health and dietary needs, after it ignored professional advice from the woman's GP and dietician.

It also failed to provide enough care hours for support workers to carry out the tasks she needed help with. As a result, the woman was not eating enough, was at risk of malnutrition and was hospitalised twice.

The investigation also found the council did not ensure a proper carer's assessment was carried out on the woman's former partner when he asked for support and respite.

A simple failure to listen to the woman, her partner or other professionals, led to the fault.

64%
assessment and care planning complaints upheld

We asked the council to apologise and make a payment to the woman and it agreed to undertake an independent review of its adult care processes and pathways, as well as its complaints procedure.

2,596
complaints and enquiries received

340
were from people who fund their own care

Failure to support man with autism in his new home
Case reference: 20 003 686

Our investigation found that London Borough of Croydon Council failed to properly assess and meet the needs of a man with autism after he moved from his family home to supported accommodation. It also failed to support his mother in her caring role and had no contingency plan in place to support her. The council did not provide a personal budget, or support plan and gave no choice of provider.

The case highlighted the need for social care staff to have the skills and knowledge to support people with autism. Without proper involvement in his care, the man was left feeling anxious and frustrated, with his mother bearing the consequences.

The council agreed to apologise and make a payment to both the man and his mother, and to conduct a reassessment. It also agreed to review its overall strategy for providing services to people with autism.

Man wrongly banned from visiting his mother following care home dispute
Case reference: 19 019 681

Our investigation found a care home commissioned by Nottinghamshire County Council inappropriately banned a man from visiting his mother after he raised safeguarding concerns.

The ban was enforced without warning or discussion, and without proper consideration of the social and emotional needs of the man's mother.

The council agreed to make a payment to the man and to make changes to its contract monitoring processes to ensure providers have robust procedures in place when considering restricting visits.

65%
safeguarding complaints upheld

Raising the profile of complaints

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

Care providers and councils can use the [data we publish – link to data tables], alongside their own local information, to ensure their complaints processes are working well, both for people who use their services and the organisation itself.

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 work 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?**

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