HARTLEPOOL BOROUGH COUNCIL

Annual Report of Adult Social Care Complaints and Compliments 2021/22

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Appendices

1. Introduction

Welcome to Hartlepool Borough Council's Annual Report of Adult Social Care Complaints and Compliments. The report covers statutory complaints and compliments received for adult social care services for the period 1 April 2021 to 31 March 2022.

The report outlines:

- Details of the complaints and compliments received over the reporting period;
- Actions implemented and resulting improvements following enquiries into complaints;
- Performance in relation to handling of complaints.

2. Background

Complaints and compliments are valued as an important source of feedback on the quality of services. Each complaint is investigated and, where appropriate, redress is made. Equally important is the work to improve services to prevent a repeat of failure in service quality and continually improve services.

2.1. What is a complaint?

A complaint is any expression of dissatisfaction about a service that is being delivered, or the failure to deliver a service. The Local Government and Social Care Ombudsman define a complaint as "*an expression of dissatisfaction about a council service (whether that service is provided directly by the council or on its behalf by a contractor or partner) that requires a response.*"

A complaint can be made in person, in writing, by telephone or email or through the council's website. It can be made at any office. Every effort is made to assist people in making their complaint and any member of staff can take a complaint.

2.2. Who can complain?

A complaint can be made by:

- A person who uses services;

- A carer on their own behalf;
- Someone who has been refused a service for which they think they are eligible;
- The representative of someone who uses services or a carer acting on their behalf. This could be with the consent of the service user or carer or in the case of someone who does not have the capacity to give consent (within the meaning of the Mental Capacity Act 2005), where they are seen to be acting in the best interests of that person; or
- Anyone who is or is likely to be affected by the actions, decisions or omissions of the service that is subject to a complaint.

3. Adult Social Care Complaint Framework

3.1. Complaint management arrangements

The statutory complaint function for adult social care sits within the Quality and Review Team under the management of the Head of Service (Quality and Review). The remit of the Complaints Manager's function is:

- Managing, developing and administering the complaint procedure;
- Providing assistance and advice to those who wish to complain;
- Overseeing the investigation of complaints that cannot be managed at source;
- Supporting and training staff; and
- Monitoring and reporting on complaints activity.

3.2. The complaint regulations and procedure

A single level integrated complaints process was introduced on 1 April 2009 with the implementation of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

These regulations place a duty on NHS bodies and adult social care organisations to coordinate handling of complaints and to advise and support complainants through the procedure.

The complaints procedure aims to be as accessible as possible. The policy is flexible to ensure that the needs of the complainant are paramount and allows the Department and the complainant to agree on the best way to reach a satisfactory outcome. On receipt of a complaint the level of impact is determined and complaints are screened according to their content as being red (high impact), amber (moderate impact) or green (low impact). The process for handling the complaint is dependent on the impact.

3.3. Timescales for the resolution of complaints

Staff will always try to resolve problems or concerns before they escalate into complaints and this ensures that, wherever possible, complaints are kept to a minimum.

Since the introduction of the 2009 regulations the only mandatory timescale is that the complainant receives an acknowledgement within 3 working days. The legislation allows for a maximum 6 month timescale to investigate and respond to a complaint. This offers a more flexible approach to the amount of time in which complaints should be dealt with. The Council's policy aims for even the most complex of complaints (red) to be resolved within 65 working days. If timescales cannot be met, a new timescale should be discussed with the complainant. Locally, timescales have been introduced for amber and green complaints of 40 and 20 working days respectively.

There is a time limit of 12 months from when the matter being complained about occurred to when a complaint may be made. After this time, a complaint will not normally be considered. However, there is discretion to accept a complaint after the 12 month time limit where the local authority is satisfied that the complainant had good reason(s) for not making the complaint within that time and where it is still possible to investigate the complaint effectively and fairly.

Whilst the Council accepted all adult social care complaints made and continued with its ongoing complaint investigations during the worldwide health crisis, Covid-19, in 2021/22 there were minor practical adjustments made with different ways of working implemented to eliminate any face-to-face meetings taking place. In some cases, these adjustments increased the timescales to respond but complainants were kept informed at regular intervals and

acknowledged the unprecedented situation which was beyond the Council's control.

3.4. Referral to the Local Government and Social Care Ombudsman

If, at the end of the complaints procedure, the complainant remains dissatisfied with the outcome or the way in which their complaint has been handled, they may ask the Local Government and Social Care Ombudsman (LGSCO) to investigate their complaint. Complainants may also approach the LGSCO directly without accessing the complaints process. In these cases it is usual for the LGSCO to refer them back to the Council for the complaint to be examined through the relevant complaints process before they intervene.

4. Principles and outcomes

Good handling of complaints and representations involves:

- Keeping the complainant at the centre of the complaints process;
- Being open and accountable;
- Responding to complainants in a way that is fair;
- Being committed to try to get things right when they go wrong; and
- Seeking to continually improve services.

Statutory complaints are underpinned by the following:

- A procedure that aims to be fair, clear, robust and accessible;
- Support being available to those wishing to make a complaint;
- Timely resolution following enquiry into complaints/representations;
- Action taken following complaints and the quality of services improved as a result; and
- Monitoring being used as a means of improving performance.

5. Public information

Information about the complaints and representations framework is accessible via the Council's public access points and also the Council's website at:

https://www.hartlepool.gov.uk/info/20076/adults_and_older_people/93/get_in_touch

Service users and carers are provided with factsheets explaining the procedure when they take up a new service and when support plans are agreed and reviewed.

Information in other formats such as large print, Braille or translation in languages other than English are made available upon request.

6. Summary of representations

6.1. Compliments

Compliments are generally recognised to be an indicator of good outcomes for service users and carers. They also serve to provide wider lessons regarding the quality of services.

During 2021/22, 57 compliments were received relating to adult social care. This is a decrease of 9 compliments from 2020/21. These range from an expression of thanks and appreciation in the form of a thank-you card to written communication. In particular, they broadly reflect the work being delivered across adult social care, service users expressing thanks for pieces of equipment which improve their daily living and a general appreciation of the social work teams who have made a difference to the lives of service users and their carers. Appendix A provides some examples of compliments received during the period.

6.2. Complaints received in 2021/22

A total of 25 complaints were received during 2021/22. The number of complaints received has remained the same as last year. Of the 25 complaints received, 6 complaints were not considered further leaving 19 complaints investigated. This is an increase of 1 more complaint being investigated in 2021/22 compared to the previous year when 18 of the 25 complaints received were investigated.

Of the 6 complaints not considered further, this was because:

- 1 complaint was not accepted for investigation because the person making the complaint was not the appointed independent Relative Person's Representative under Deprivation of Liberty Safeguards;
- 3 complaints were not accepted for investigation because the service complained about was not provided by the Council. The complainants were signposted to the correct organisations concerned;
- 1 complaint was not accepted for investigation under the complaints framework before relevant safeguarding enquires had been completed. The complainant was advised that their concerns must conclude the appropriate safeguarding enquiries (S42 of the Care Act 2014) before a complaint investigation could begin, if they remained dissatisfied following the conclusion of the safeguarding enquiries; and
- 1 complaint was withdrawn by the Complainant and was therefore not considered any further.

Of the 19 complaints investigated in 2021/22, 17 complaints have concluded local statutory complaints processes and 2 complaints remains ongoing which will be carried forward to 2022/23.

6.3. Client groups and general data

Adult Social Care			
Client group	**2021/22**	**2020/21**	**2019/20**
Older Persons	9	10	15
Learning Disabilities	2	3	5
Physical Disabilities and Sensory Loss	1	3	3
Adult Mental Health or AMHP function	4	5	4
Contracted Services	9	4	3
Carers	0	0	5
Total number of complaints received	25	25	35

In 2021/22:

- Complaints were received from 9 males and 16 females.
- Complaints which were considered either complex or have a number of elements to them are usually investigated by someone independent of the Council. Independent Investigators were appointed to 4 of the 19 complaints investigated. The remaining 15 complaints were investigated and responded to internally.
- Of the 25 complaints received, 9 complaints were received for the older person's service as well as 9 complaints being received about contracted service providers followed by 4 complaints within the adult mental health service. There was a decrease of 1 complaint within both the older person's and mental health services compared to the number of complaints received in 2020/21 but an increase of 5 complaints about contracted service providers. Complaints received about the learning disability service decreased by 1 whereas complaints about physical disability and sensory loss decreased by 2 compared to the previous year.
- Of the 25 complaints received, 5 complaints were received directly from the person concerned. There were 11 complaints received with the signed consent of the person concerned for someone else to represent them and act on their behalf in the matter of the complaint, 5 complaints were received from someone acting on behalf of a deceased relative in bringing their complaint and 3 complaints were received from someone who represented the person who lacked capacity within the meaning of the Mental Capacity Act 2005.

6.4. Timescales and the Grading of Complaints

There is a maximum 6 month statutory timescale for investigating and responding to a complaint relating to adult social care. However, the overall aim is to respond to complaints in a timely manner. The likely timescales for investigation are discussed with the complainant at the outset of a complaint investigation and updates on progress of the investigation are provided by the Investigating Officer at regular intervals. There are a range of factors that can impact upon timescales such as:

- Whether the complaint has been considered low, moderate or high impact;

- The number of points of complaint for investigation;
- The availability of the complainant and other key people the Investigating Officer needs to interview;
- The time taken to conduct interviews with key people;
- Seeking appropriate consent for obtaining information from partner agencies and awaiting the necessary information to inform the complaint investigation;
- Reading case files and records and obtaining copies of local policies and procedures;
- Consideration of all available information and the drafting of a complaint investigation report; and
- Carrying out factual accuracy checks on the draft report and providing feedback to the complainant before finalising and submitting the final report.

6.5. Complaints carried forward to 2022/23

Of the 19 complaints investigated, 2 complaints remained the subject of investigation as at 31 March 2022 which have been carried forward to 2022/23.

6.6. Complaints considered by the Local Government and Social Care Ombudsman (LGSCO) in 2021/22

There were 5 complainants who approached the LGSCO about their adult social care complaint in 2021/22. Of these, 3 complainants concluded the Council's adult social care complaint process in 2020/21 and 1 complainant concluded the process in 2021/22. The 1 remaining complainant who escalated their complaint onto the LGSCO in 2021/22 did so after a contracted service provider, who delivered the service being complained about on the Council's behalf, responded to the complaint which had been made directly to them.

The LGSCO determined that they would not investigate 3 of the 5 complaints. In 2 of these 3 complaints, this was because there was not enough fault or significant injustice to warrant an investigation by them and, in the case of the remaining one complaint, the Ombudsman decided it could not add anything further to the Council's response to the complaint.

The LGSCO decided it would investigate 2 of the 5 complaints. Following their enquiries, they determined that there was no fault with the Council's actions in relation to these 2 complaints.

7. Actions taken following complaints

Actions implemented are an important aspect of the complaints framework. Appendix B outlines some improvements that have been put in place as a direct result of complaints and representations received in adult social care during 2021/22.

8. Conclusions and way forward

8.1. Going forward

There is an ongoing commitment to ensure that a person-centred approach is adopted for the handling and investigation of each complaint. The Council is focused on ensuring that: complainants receive appropriate and timely feedback on complaints; appropriate apologies are offered; any redress is made and any service improvement recommendations are delivered.

8.2. Action plan

Actions for 2022/23 are as follows:

- Review the adult social care complaints procedure, including the interface between an appeal and complaint process, and clarify expectations with contracted services providers about complaints they receive.
- Review the adult social care complaints public information material.
- Review the training needs of managers and commission training for those managers who are allocated complaints to investigate.
- Develop a dedicated toolkit for those managers allocated to investigate adults social care complaints.
- Continue to raise awareness of lessons learnt from complaints and ensure that they are fed into policies, procedures and practice.

- Continue to remind and encourage the workforce to inform the Quality and Review Team when expressions of thanks have been received. These provide an indication of satisfaction with services and should be recorded and reported.

Appendix A: Examples of compliments received across Adult Social Care

"The service that I received during my recent illness to help and support me was outstanding. The dedication was second to none. They came to my home full of happiness and made me feel special and that I was not a burden to them. Keep up the good work."

Service User about Reablement Services

"Mrs P advised that the girls who attended were absolutely lovely and very reassuring, just helped her out and made sure she was safe."

Service User about the Telecare Service

"Thank you, your team and everyone involved in the support you have shown mam during her illness, from the very beginning with the adaptations support until the end through carer support. We as family really appreciated it, as we know mam did."

Carer about the Hospital Discharge Team

"You have not been my Social Worker for long but in the time you have you stepped in and made an important difference to my situation MASSIVE THANK YOU and if you are willing to work with me you can have a job for life. If you must change to someone else because of any reason please swap with someone kind and patient and helpful like you."

Service User about the Preventative Mental Health Team

"D was kind enough to tell us of other options and anything we would like to consider. However I did feel my need was only temporary and am progressing nicely. Thank you to all who made the difficult decision and effort to get us this help, it was greatly appreciated and wouldn't hesitate if at any time in the future, our circumstances changed."

Service User about a Social Work Team

"The full team were amazing from start to finish nothing was any bother for them. The contractor you sent was the best workman you could ask for, thank you the shower has made my life a lot easier."

Service User about OT Services

"I would particularly like to thank you and all the team for the care and compassion showed to my mother over the past few years."

Service User's family about User Property and Finance Team

"I massively enjoyed S's company, on a professional level she has been hugely supportive and reassuring. The improvements I feel I have made due to her support have been incredible, but on a personal level, it's been like having a very dear friend, one I will miss greatly."

Service User about Reablement Services

"Mrs H wanted to say how grateful she was for all the care she received. Mrs H went on to say that these last 6 weeks have been the best 6 weeks of her life during this difficult period, just having a friendly face visit her over the past 6 weeks has done wonders for her mental health, she said just having a chat and meeting all of our lovely carers has been an absolute tonic for her and she could never say how much gratitude she has for the service we provide to the elderly. She said we all deserve medals for being in this caring sector and if she could buy us all the world she would."

Service User about the Direct Care and Support Team

Appendix B: Examples of complaints and actions taken in Adult Social Care

Details of complaint/Outcome	Actions following findings
The complainant (a representative of a deceased service user) alleged that: • her late relative's support plan was generally inadequate and was not amended when his health deteriorated; • the quality of care provided by a domiciliary care provider was inadequate; • the family were not asked about sentimental items they may have wished to retain when her late relative moved house; • information about her late relative's finances were not provided; and • the Social Worker failed to discuss making a will with her late relative. The complaint was independently investigated.	Although only one element of complaint was upheld, the Independent Investigator provided a clear explanation about what had happened and findings against each area investigated. The complainant thanked the Independent Investigator for a very comprehensive report commenting that it was professionally written and answered a lot of things that they had not understood. An apology was provided for the one element of complaint that was upheld and a recommendation implemented about reminding staff to routinely record all text message exchanges in case records.

The complainant (a representative of a service user) expressed his dissatisfaction about an unannounced visit from a Social Worker and the upset this had caused his relative. The complaint was responded to by a Head of Service.	Having looked into the complainant's dissatisfaction, it was found that there had been some miscommunication between the workers involved in the case which had led to the unannounced visit. The Head of Service apologised for this as well as the upset caused to his relative and implemented steps to avoid a repeat situation.
The complainant (a representative of a service user who lacked mental capacity) expressed that adult social care had not managed his relative's care and support needs adequately and that the care his relative received in a care home was not to an acceptable standard. The complaint was independently investigated.	Given the Independent Investigator had partly upheld an element of complaint, the Council conveyed an apology to the complainant in this regard. The Independent Investigator made recommendations for the care home which were accepted and implemented by the Council. This included checks being made, via regular monitoring meetings between the Council's Commissioned Services Team and the care home, to see if the care home's system for closed records was fit for purpose and review whether the training for staff who carry out resident weight checks was appropriate and staff are trained accordingly.
The complainant (a representative of a service user who lacked mental capacity) was unhappy with the care her relative received whilst she resided in a care home. The complainant was of the view the care was inadequate. The complaint was responded to by a Head of Service.	An apology was provided to the complainant about a lack of communication between the care home and the service user's family regarding an unwitnessed fall and the Council's Commissioned Services Team raised how the care home records communication with family members during one of their regular routine monitoring visits with the care provider. The complainant was satisfied with this outcome.

The complainant (a representative of a service user) was unhappy about an assessed financial contribution and her relative's care and support needs following a care provider having ceased work with her relative. The complaint was responded to by an Assistant Director.	The complainant was contacted to explain the financial assessment process and how this can take some time to work through when there is disability related expenditure to appropriately consider and determine. It was agreed the assessed financial contribution would start from the date a new service begins. The complainant was assured adult social care were actively resolving the matter of a new care provider for her relative and this was being overseen by a Head of Service. This matter was resolved swiftly to the complainant's satisfaction.
The complainant (a representative of a service user) alleged there was a lack of communication in relation to her relative's care and support needs. The complainant was unaware of the process followed for this, how charges were applied and where to pay. The complaint was responded to by a Head of Service.	A Head of Service telephoned the complainant to discuss her complaint and understand matters from her perspective before exploring the issues raised. It was found that the: • importance of recording information as soon as possible had fallen short of expectations and the staff concerned were reminded about this in supervision; and • complainant's family had not been fully included in discussions about their relative's care and support package. This meant that their choice to continue to deliver their relative's morning and evening calls, as they had done prior to his hospital admission, was removed from them. An apology was provided for this and the relative was reimbursed 50% of the cost of his care to remedy the matter.

The complainant (a representative of a deceased service user) was unhappy that no one had contacted the family to inform them of the service user's hospital admission. The complaint was responded to by a member of the Commissioned Services Team.	Although records indicated that the care home had tried to contact family members and left an answerphone message asking that they telephone the care home, the care home has implemented an additional measure as a result of this complaint. They have introduced that if no telephone call has been received from family members by shift changeover, contact will be attempted again by the incoming team.
The complainant (a representative of a deceased service user) alleged that his late relative's care in a residential care home was inadequate, there were delays in communication with him and he was unhappy with the care home's response to his request for further information. The complaint was independently investigated.	Although the Independent Investigator found that there were delays in communication and the complainant's request for further information could have been handled more sensitively, there was no evidence to suggest that inadequate care had been provided. Despite finding no evidence to suggest that inadequate care had been provided, the Independent Investigator did find evidence to indicate that recording of information could be improved upon. The complainant thanked the Independent Investigator for an excellent report which he felt was very thorough and considered that he had been listened to. An apology was provided for those elements of the complaint that had been upheld and the areas identified about how recording could be improved upon was shared and discussed as part of a regular monitoring meeting between the Council's Commissioned Services Team and the care home.