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I'm pleased to present our Annual Review of Adult Social Care Complaints for 2017-18 alongside our complaints data.

Sharing the learning from complaints is an important focus of this report, we detail key cases and outcomes and demonstrate how our remedies seek to improve services for others and prevent the same fault reoccurring. Our public interest reports are our mechanism for doing this. We published twice as many reports about adult social care this year, demonstrating our commitment to share the lessons from our cases. I encourage all care providers and councils to consider the systems they have in place to ensure learning from complaints is shared locally.

In the report, we look back at complaint volumes and uphold rates since 2010-11. That year was significant for us, marking the start of our jurisdiction over independent care providers, enabling us to look at complaints from across the adult care sector.

Continuing the trend since 2010, the number of complaints and enquiries we receive about adult social care continues to grow, and accounts for 16% of our total work. You will, however, note we investigated fewer complaints this year. There are often a range of forces at work when it comes to understanding trends in complaints, but in this instance, I am confident the fall reflects the significant pressures on my organisation’s capacity to process the complaints we receive, and is not indicative of any broader trend in the adult care sector.

Complaint outcomes continue to be the most revealing part of our data and are likely to be of most interest to colleagues in the sector. Across all our local government work, we uphold 57% of cases we investigate, in adult social care cases this increases to 62%. We will always seek to make recommendations that prevent the same thing from happening to others. This year we made 274 recommendations to improve procedures or undertake staff training, up 20% on the previous year.

“We will always seek to make recommendations that prevent the same thing from happening to others. This year we made 274 recommendations to improve procedures or undertake staff training, up 20% on the previous year...”

It is good to see that, despite the well-known pressures in the adult care sector, compliance with my recommendations to remedy complaints continues to be high. An organisation’s
willingness to put things right when they have gone wrong can be a clear sign of its general attitude towards complaints and ability to learn from them. In all but one instance, my recommendations were accepted by care providers and councils. The single outlier to this trend, a care provider, is detailed later in the report.

While it is positive that care providers and councils are working with us, there remain significant areas of concern in our casework. Assessment and care planning, and how care is paid for remain some of the biggest areas of complaint. Even more concerning is that the issues we see are often not mistakes occurring in one-off circumstances, but systemic issues where a policy or procedure is being regularly incorrectly applied. Some of these cases are outlined in this report and I urge councils and care providers to learn from them.

Michael King
Local Government and Social Care Ombudsman
November 2018
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 hosts a suite of practical advice and useful tools to help support good complaint handling:

> 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

> With Healthwatch England we launched a single complaints statement setting out best practice for councils and care providers receiving and dealing with comments, complaints and feedback about services. A second statement sets out what people who use services should expect to happen when they make a complaint.

> We publish our decisions so anyone can see the type of findings and recommendations we make

> Guidance to our staff on recommending appropriate remedies is available so others can seek to apply the same standards

> You can sign up to receive our regular e-newsletters

Complaint handlers’ network

Our adult social care complaint handlers’ network provides an opportunity for care provider and council staff at the frontline of complaints to identify, share and learn from best practice. If you are interested in joining the network please get in touch with our External Training and Relationship Coordinator, Alan Park, at a.park@lgo.org.uk.

Care provider events

Care providers are invited to sign up to attend a session to meet the Ombudsman and to find out more about our work. Places will be reserved on a first-come, first-served basis and there is a nominal charge of £50 per person, which includes refreshments and lunch.

Local Government and Social Care Ombudsman Provider Events 2019

The Ombudsman and You: An opportunity for care providers to meet the Ombudsman and learn about our work

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<tr>
<td>Thursday 7 February 2019</td>
<td>10am – 2pm</td>
<td>Doubletree Hilton, Bristol</td>
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<tr>
<td>Tuesday 5 March 2019</td>
<td>10am – 2pm</td>
<td>Jury’s Inn, Birmingham</td>
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<tr>
<td>Wednesday 27 February 2019</td>
<td>10am – 2pm</td>
<td>The Met Hotel, Leeds</td>
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<tr>
<td>Wednesday 13 March 2019</td>
<td>10am – 2pm</td>
<td>De Vere West One, London</td>
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Early booking is recommended as spaces are limited. If you wish to reserve a space, please complete the attached booking form and return it to event@lgo.org.uk

Please note that delegate places will be limited to two per care provider in the first instance.
Complaint handling training

We provide a range of training courses to help improve complaint handling, including an adult social care course, relevant for both councils and care providers. Last year, we launched specific courses for social care providers and frontline care staff, designed in partnership with an independent care provider.

Due to demand, we have this year launched open courses, which allow any care staff to attend without a single provider needing to host the course. We have delivered two open courses to date and details of the next open course will go online shortly.

More information is available at: https://www.lgo.org.uk/training/

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

“I found the course really useful in relation to the content and exercises; I also found it to be a useful networking opportunity.”

“Useful course for introducing a positive approach to handling complaints for frontline staff; it was good delegates were able to have discussions and share experiences.”

“The course has given me further resolve to do something good and feel like I make a real difference for my organisation, people we support, families and complainants. Dealing with complaints head on, and knowing the only way to find out where we go wrong is to embrace them, isn’t always easy…..It is about changing the way we look at complaints and how we approach them.”
Our data at a glance

- 3,106 complaints and enquiries received
- 4,468 people helped to speak to right organisation with CQC
- 1,130 investigations completed
- 62% investigations upheld
- 621 complaints remedied
- 1,274 recommendations to put things right
- 274 recommendations to improve procedures or undertake staff training
- 68% of investigations about residential care upheld
- 68% of investigations about home care upheld
- 64% of investigations about safeguarding upheld
- 67% of investigations about charging upheld
- 61% of investigations about assessment and care planning upheld
Key complaints and outcomes

Our decisions are published at [www.lgo.org.uk/decisions](http://www.lgo.org.uk/decisions) and can be searched by category, key word, outcome, date and organisation.

We publish a public interest report where we find particularly serious or systemic issues and think lessons from the complaint should be shared more widely. These hold councils to account publicly for their actions. If the complaint is against a care provider we will issue an Adverse Findings Notice.

During the year we published 18 public interest reports about adult social care cases. Eight of these focused on charging for social care, which is a recurring area of concern for us.

Landmark Cases

As well as putting things right for the individuals who have complained, our investigations often ask the council or care provider to address systemic failings to prevent the fault from reoccurring. We can also ask that other people potentially affected by the same issue have their situations remedied.

The case summaries below demonstrate the impact a single complaint can have when they result in changes to services that benefit others.

### Top up fees charged incorrectly

Case reference: [16013790](http://www.lgo.org.uk/decisions)

Our investigation found a council charged a top-up fee incorrectly after wrongly arguing that property should be taken into account when assessing a person’s ability to pay.

Councils should not take into account the value of a person’s property when making assessments of people’s ability to pay for their care in a care home during the first 12 weeks of their stay. The council should have offered a placement that did not require a top up fee to be paid.

We recommended the council should:

> Waive the top up fee that had been paid

> Check if they had charged other people in the county in error and remedy those identified

> Improve the information offered to families when they are seeking help with care home placements.
Council wrongly conclude ‘deprivation of assets’

Case reference: 16006552

We found a council wrongly concluded that an elderly woman had deliberately gifted sums of money to avoid paying care costs, resulting in the termination of her care home contract where she had been paying her full care costs for nine years. Our investigation found that a full financial assessment was not completed and no evidence was found to show how the council had concluded that the monetary gifts the woman had made were with the intention of avoiding care charges.

We recommended the council should:

> apologise and make a payment to the woman’s daughter to recognise the distress caused and complete a full financial assessment

> review its procedures and guidance for staff about how to deal with cases where deprivation of assets may have occurred

> review other cases to determine if the same errors had been made and remedy those identified.

Couple separated for 10 months due to lack of available homecare

Case reference: 16007469

Our investigation found a council failed to provide a suitable placement for a woman after a hip operation. She was placed in a dementia care home, despite not having the condition, and 15 miles away from her home, because the council’s contracted providers did not have capacity to care for her. Overall, the woman spent 10 months away from her family.

The case shone a light on commissioning practices that all councils can learn from. Contracts had been put in place with preferred care providers to deliver all homecare in their ‘zone’ to stabilise the local market. However, when the provider in the woman’s case did not have capacity to meet her needs, there was no suitable alternative available.

We recommended the council should:

> make payments to the woman and her husband to recognise distress caused and to reimburse travel expenses incurred

> identify where others had been affected by these issues and provide a remedy to the families affected.
Single complaint leads to more than £500,000 being repaid to people overcharged for their care

Case reference: 16000571

Our investigation found a council delayed carrying out a financial assessment after contributions from the Independent Living Fund ended, despite it being requested several times, resulting in the complainant incorrectly paying contributions to their care package.

We recommended the council should:

> refund the contributions made

> offer new financial assessment to all former users of the Independent Living Fund to determine if they had been overcharged since the fund closed. The council conducted its review and found that a further 143 people were affected by the error and a total of £581,340.01 has since been repaid.

Unclear contract leads to overcharging

Case reference: 16014670

Our investigation found a contract provided by a care provider to a woman in their care was unclear and failed to deduct an NHS Funded Nursing Care (FNC) payment from her care charges.

We recommended the care provider should:

> write off arrears and review the contract to be clear about what happens with FNC payments

> review other residents who may be similarly affected and ensure that their contracts are clear.

We subsequently issued practical guidance to care providers on how to deal with FNC issues.
Joint Investigations with the Health Ombudsman

Adult social care is often provided alongside health services. With the Parliamentary and Health Service Ombudsman, we operate a team of investigators that conducts a single investigation for complaints that involve both health and social care. The joint team investigated the case below.

Council, CCG and Trust failed to ensure a woman received funding for a care home placement

Case reference: 16017505

After a period of mental and physical ill health, and an admission to a mental health unit, a woman should have been entitled to free health and social care support. She was placed in a home to meet her needs, but the Health Trust, Clinical Commissioning Group and council were not clear about the funding arrangements for her care and charged the woman incorrectly.

We recommended the council should:

> Refund the charges the woman had paid. This was calculated by the council at £110,650,87.

Key Learning Points

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

> Property should not be taken into account when assessing a person’s ability to pay for the first 12 weeks of their stay in a care home.

> People should be offered clear information about the care choices available to them. Choices should include at least one ‘affordable’ option where a top up fee is not required.

> Clear procedures should be in place to guide staff on how to consider cases for deprivation of assets.

> There may be risks to commissioning models that rely on single or small numbers of care providers; steps to mitigate risks should be put in place.

> New financial assessments should take place when people’s circumstances change to avoid incorrect charges being made.

> Contracts should detail clearly how all care charges have been arrived at. We welcome the recent guidance from the Competition and Markets Authority on this issue.
The Value of an Investigation

The process of making a complaint is often daunting for people, especially about care they, or loved ones, rely on. However, this experience of someone who made a complaint to us after the death of their grandmother shows the impact resolving a complaint can have.

“We were obviously sceptical as to what result we could get after dealing with the council, but when we got the final report, where it was determined there were issues, it was a big relief for us. They actually listened and went through each part of our complaint. Until the ombudsman got in touch to say who was at fault, I couldn’t properly grieve. There were so many questions. It has brought closure, in that it has brought justice…If the complaint stops another family having to go through the same thing - and if the care home can be held accountable - it has done its job.”

SOURCE: Manchester Evening News article, published August 2018.
Complaint statistics and trends

Rather than focus solely on complaint volumes, we choose to focus on the outcomes of complaints we investigate, and the value an investigation by us can add through the recommendations we make to remedy fault. In 2010, new legislation allowed us to investigate complaints about privately funded care, bringing thousands of independent care providers into our jurisdiction, and giving us a view of complaints across the entire adult social care sector.

In 2017-18 we found fault in 62% of cases we investigated, almost a fifth more than in 2010-11. We made 1,274 recommendations to put things right. Our remedies included 274 recommendations to train staff or change policies or procedures, up by a fifth on the previous year. In total, 40% of complaints remedied included service improvements to tackle systemic problems and improve services for people in the future.

During 2017-18 the complaints and enquiries we received about adult social care rose by 1% on the previous year and is the second largest area of our work.

Complaints and enquiries about adult social care have increased by 169% since 2010-11. However, we are clear that complaint volumes alone do not tell us enough about the social care landscape, the quality of services, or people’s experience of them. Rising numbers of complaints may be a positive by-product of people feeling able to speak up and raise concerns because councils and care providers demonstrate to them a willingness to listen and learn from feedback. Equally, the increase may be indicative of poorer quality care and experiences.

Figure 1: recommendations to put things right for individuals and improve services for others

During 2017-18 the complaints and enquiries we received about adult social care rose by 1% on the previous year and is the second largest area of our work.
Figure 2: Number of adult social care complaints and enquiries received each year since 2010-11, and percentage of investigated cases upheld.
Arranging social care support

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

What we saw

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.

The number of complaints and enquiries we received about charging increased by 9% on the previous year. More significantly, we found fault in a larger proportion of charging complaints we investigated, with 67% of complaints upheld, 2% more than the previous year.

![Figure 3: complaints and enquiries received by category](image-url)
Figure 4: Proportion of complaints upheld after investigation
Providing social care

We have the power to investigate complaints about any social care provider who is, or can be, registered with the CQC. 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.

What we saw

Social care is provided in a range of settings. We categorise complaints about the most common types of provision. Residential care and home care are the two largest areas of complaints. 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.

![Figure 5: complaints and enquiries received by category](image-url)
Figure 6: Percentage of complaints upheld after an investigation
Complaints about care arranged and funded privately

We investigate complaints about independent social care providers from people who fund their own care without any involvement from a council. In 2017-18, we received 442 such complaints and enquiries, a similar number to last year.

The chart shows the increase in the number of complaints and enquiries we have received about independent care providers since we began operating this part of our role in 2011. We welcome the increase as a sign of growing awareness of our role in the independent care sector and as a reflection of the increasing value of complaints as a learning tool for care providers.

This year we upheld 69% of investigations about independent care providers, an increase of 7% on the previous year. Those complaints led to a wide range of remedies to resolve injustice for individuals and improve services for others. The chart below shows the outcomes we recorded last year.

**Figure 7: Number of complaints and enquiries received about care arranged and funded privately since 2010-11, and percentage of investigated cases upheld**

This year we upheld 69% of investigations about independent care providers, an increase of 7% on the previous year. Those complaints led to a wide range of remedies to resolve injustice for individuals and improve services for others. The chart below shows the outcomes we recorded last year.
Compliance with recommendations

Our recommendations are non-binding and we value the positive action taken by the vast majority of councils and care providers to accept and implement the recommendations we have made. This shows a willingness to put things right and to learn from complaints. The single outlier to this trend was a care provider, Peepal Care Limited, operating in Wembley, that refused to comply with our recommendations, which were simply to apologise and make a small payment for distress caused. In response we published an Adverse Findings Notice to hold the provider publicly to account for its actions.
Using our data

To access our full data for 2017-18, visit our website. We publish the numbers of adult social care complaints and enquiries received and the decisions made against care providers and councils. To be open and transparent we provide the full data sets in accessible spreadsheets that can be utilised by academics, researchers or anyone with an interest in our work.

Care providers and councils should use the data, alongside the range of other information sources they have, to review the effectiveness of their complaints processes.

Data about complaints is a valuable source of intelligence for organisations. Regular scrutiny, by care provider board members and owners and council elected members, can signal early warning signs of something going wrong in a service or with a new policy. We suggest some ways you could use complaints data to inform scrutiny of services.

> Look out for high volumes of complaints received about a service or function and explore further. Does it indicate a healthy culture of feedback or that there are problems with the quality of the service?

> Compare data with organisations of a similar size or service type to create a clearer picture of performance.

> Look closely at the number of complaints upheld; this is often the best measure for indicating problems with services. Our data shows the proportion of investigations in which we find some fault.

> Does your organisation have a mechanism in place to share the learning from complaints across care locations or council functions to prevent the same issues affecting others?

> When fault is found, how good is your organisation at putting things right? Accepting responsibility and providing a genuine apology is often the most important way to remedy a complaint. Our data includes the number of investigations where we found that, while the organisation had been at fault, they had followed the right steps to put things right in its response.

> Complaints often involve more than one organisation. Do you have processes in place with local partners to provide a single investigation and response to people with a complaint about multiple bodies?

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

Using our data to influence debate

Mark Lloyd, Chief Executive of the Local Government Association drew on our data to illustrate the impact of funding reductions in local government and how this was showing in falling levels of public satisfaction with local councils. Giving evidence to the Public Accounts Committee, he stated,

“The Ombudsman has seen a 140% increase in complaints about [council] social care between 2010 to 2017-18...The upheld complaints have increased significantly in that time, to a 64% uphold rate now. We are seeing public dissatisfaction increasing, and justifiably so...”
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.