Nottinghamshire County Council

Report to Governance and Ethics Committee

21 April 2022

Agenda Item: 5

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE AND HEALTH

LEARNING FROM COMPLAINTS IN ADULT SOCIAL CARE

Purpose of the Report

1. To inform the Committee about how information from complaints is used to inform a cycle of continuous improvement to address recurring themes or trends in the type or volume of issues raised.

Information

2. Members of this Committee have previously asked for information about how the Adult Social Care department learns from complaints and seeks to improve practice in the future to avoid repeating mistakes.

Departmental Context

3. Adult Social Care supports around 9000 people directly each year with formal care, has responsibility through different duties for around a further 20,000 people and shares many duties and responsibilities with others such as the NHS and social care providers.

4. Social care includes the Department's services of around 1500 staff as well as broader services of around 22,000 staff. Due to the Care Act duties for safeguarding and market shaping, the Council will often have some degree of responsibility in settings for which it has no direct control or management.

5. Contacts can be very simple from one off interactions for Information, Advice and Guidance to complex support which can take many years for one piece of work.

6. Many people have control of their care and are very clear about what they want for themselves or their family. On other occasions, people supported by adult social care services may not be in control of their affairs and have decisions made for them. It is very common for the Council to take decisions against the wishes of the person or their family.

7. In essence, it is a complex context where the voice of the person is crucial and enabling the person to express their views and concerns is an area that the Department invests in.

Statutory Context for Adult Social Care Complaints

8. The Care Act 2014 ('the Act'), supporting regulations and the Care and support statutory guidance ('the statutory guidance') were introduced in April 2015. This is the law on which adult social care in England is based and the local authority must adhere. The complaints regulations are based on the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 ('the complaints regulations'), made under the powers of the Health and Social Care (Community Health and Standards) Act 2003.

9. Steps for people to disagree with our decisions or raise concerns:

   - Try to resolve issue informally
   - Make a formal complaint and use all stages of the procedure
   - Complain to the Local Government and Social Care Ombudsman (LGSCO)
   - Legal challenge or Judicial review

10. The LGSCO is the last stage in the Statutory Complaints process. The LGSCO can look at complaints about:

    - care provided by a council
    - care arranged directly with a care provider by:
        - someone paying with their own or family money
        - someone using money provided by a council, via direct payment for example

11. The LGSCO only looks at complaints where they have first been considered by the Council and the complainant remains dissatisfied. The LGSCO cannot question a Council's decision or action solely on the basis that someone does not agree with it. However, if the Ombudsman finds that something has gone wrong, such as poor service, a service failure, delay, or bad advice and that a person has suffered as a result, the LGSCO aims to get the Council to put it right by recommending a suitable remedy. The Ombudsman requires the Council to provide evidence that it has carried out any recommended action.

12. Complaints and LGSCO processes are very important safety nets for people to be heard. The council encourages anyone who is dissatisfied to make a complaint" but do aim to resolve issues at an informal stage. The Department aims to resolve LGSCO complaints through the Council's own processes first, but given the operating context, the Department is often responsible for fault where it has no control over all of the services.

Performance and cycle of improvement

13. Adult social care staff and services do make mistakes and learning from complaints is essential as part of our continuous improvement journey. The Department encourages people who draw upon care and support services to tell us when they are not happy, and the goal is to resolve issues early. Complaint's learning is a key element to our Quality Assurance.

14. Many complaints are examples of where the service received just hasn't been good enough or met departmental standards. Some complaints are more complicated regarding decisions, policy, and relationships between parts of the system. All complaints are important in understanding how adult social care services improves practice.

15. In terms of numbers, there has been a significant reduction in the number of complaints relating to Adult Social Care received over the past 2 years, and the number of complainants in 2021/22 equates to around 3% of the total number of people that the Department works with.

    2019/20 420 Adult Social Care complaints
    2020/21 280 Adult Social Care complaints
    2021/22 271 Adult Social Care complaints (at period 11)

    Between 40 and 50% of the complaints received over the 3-year period were upheld or partially upheld.

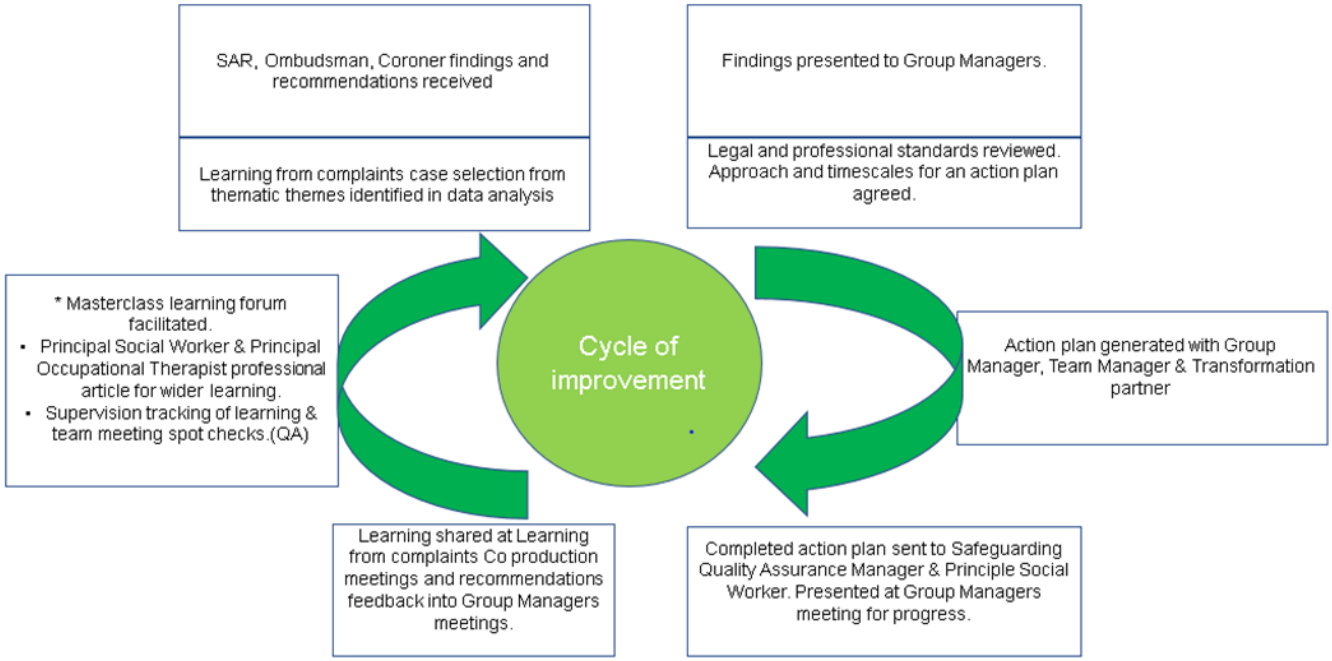
    74 of these complaints progressed to the Local Government Ombudsman and fault was found in 39 of these cases (0.4% of all Adult Social Care contacts/ cases).

16. The LGSCO Annual Review for 2021 confirms that for the period 1st April 2020 to 21, 54% of complaints against the Council and investigated by the LGSCO were upheld. This compares with an average of 71% in similar authorities and equates to 15 upheld decisions, 9 of which related to Adult Social Care. In the same period, there were 19 cases where the complaint was either not upheld, incomplete or invalid, closed after initial enquiries or referred back for local resolution.

17. Although the numbers are small, any case where fault is found or where the Department hasn't responded as well as it could have, is important. There are no national benchmarks for describing what a good level of complaints would be, so rather than setting quantitative complaints targets, the focus is on the following:

    - Trend analysis – understanding patterns of complaints
    - Hot spots – any service areas or topics
    - Timescale for resolution

18. There is a clear process and improvement cycle in place to ensure that recurring themes or trends in the type



or volume of issue raised are addressed, as described below.

- Data is collected from Safeguarding Adult Reviews (SAR), Ombudsman decisions, coroner decisions.
- Themes and trends are identified.
- Legal and professional standards are reviewed.
- Findings are presented to the relevant management team and action plans are developed, with oversight of progress by Safeguarding Quality Assurance Manager and Principal Social Worker.
- Learning is then shared through various forums including individual supervision meetings, team meetings, masterclasses, professional and departmental messages and/ or co-production (Committee approved framework for listening to people and involving them in shaping services).

19. Examples of where the Department has applied this improvement approach is as follows:

- An action required by the Ombudsman in relation to a recent case, was to undertake "*reflective learning with operational staff involved re: prompt communication of Safeguarding outcomes to people and their families in a timely manner to avoid any further distress*".

  In response to this, the responsible Service Director cascaded key messages to staff across the Department regarding lessons to be learned from the case and the need to communicate outcomes of safeguarding enquiries in a timely way.

  In addition, the Principal Social Worker has arranged a "Learning from Complaints" session with the social work team concerned to follow up on practice issues in more detail.

- The Learning Disability and Autism Partnership Board raised concerns about the accessibility of letters sent to people using social care services regarding changes to their financial contributions. Standard letters were being sent via bulk mail without considering

the communication needs of recipients and many people were unable to understand the content which caused worry and distress.

Through co-production, members of the partnership board wrote a guide called 'Letters Stop Think' to support organisations with accessible communication. Alongside this, they also helped to develop a one-page easy read summary, which the Adult Social Care Senior Leadership Team approved the inclusion of with any large mail out from the Department to people who use our services.

20. Alongside complaints, it is also important to take note of compliments and stories of difference where examples of good practice, feedback from our coproduction work and outcomes of nationally reported surveys feed into the cycle of continuous improvement.

Statutory and Policy Implications

21. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Data Protection and Information Governance

22. There are no direct data protection or information governance implications relating to the information contained in this report, however any learning arising from complaints is based on anonymised cases.

Financial Implications

23. There are no direct financial implications relating to the information contained in this report, although the Ombudsman can include financial remedies in the decision outcome.

Implications for Service Users

24. Complaints, Ombudsman decisions and Safeguarding Adult Reviews relate to people using adult social care services or their families.

RECOMMENDATION/S

That members note the contents of the report.

Melanie Brooks
Corporate Director – Adult Social Care and Health

For any enquiries about this report please contact:

Ainsley Macdonnell, Service Director – Community Services, Adult Social Care and Health

Constitutional Comments GR (08/04/22)

25. Pursuant to the County Councils' constitution this committee has the delegated authority to receive this report and make the recommendation contained within it.

Financial Comments KAS (08/4/22)

26. There are no direct financial implications relating to the information contained in this report, although Complaints and the Ombudsman can include financial remedies in the decision outcome on an individual basis.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Division(s) and Member(s) Affected

- All