From:	Clair Bell, Cabinet Member for Adult Social Care and Public Health Richard Smith, Corporate Director, Adult Social Care and Health
To:	Adult Social Care Cabinet Committee - 18 January 2022
Subject:	**ADULT SOCIAL CARE AND HEALTH ANNUAL COMPLAINT'S REPORT 2020/21**
Classification:	Unrestricted
Previous Pathway of Paper:	Adult Social Care and Health Directorate Management Team – 15 December 2021
Future Pathway of Paper:	None
Electoral Divisions:	All

Summary This report provides Members with information about the operation of the Adult Social Care and Health Complaints and Representations' Procedure between 1 April 2020 and 31 March 2021.

Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the content of this report

1. Introduction

1.1 This report provides an overview of the operation of the complaints and representations procedure for Adult Social Care and Health during 2020/21. The report includes summary data on the complaints, enquiries and compliments received during the year with additional information in Appendices 1-5. It also provides examples of the actions taken and improvements made from complaints which are used to inform future service delivery.

2. Policy Context and Procedures

2.1 The "Local Authority Social Services and National Health Service Complaints (England) Regulations 2009" places a duty on Local Authorities to have arrangements in place for dealing with complaints.

2.2 Associated with the Regulations, guidance was issued which outlines the three key principles of the procedure, **Listening** – establishing the facts and the required outcome; **Responding** – investigating and making a reasoned decision based on

the facts/information and **Improving** – using complaints data to improve services and inform the business planning and commissioning processes.

2.3 Complaints contain valuable feedback from the people we support and their representatives and create opportunities to review how services are working. Investigations into the concerns allow us to listen to the person's experience and to put things right if a mistake has occurred. All feedback is taken seriously and acted upon appropriately, recognising that Adult Social Care is often provided to vulnerable people during a time of crisis. It is important that we have a procedure that is flexible and puts the person at the heart of the investigation.

3. Total Representations received by Adult Social Care and Health (ASCH)

3.1 A total of **754 complaints** were received during 2020/21 about services delivered or commissioned in relation to ASCH. Appendix 1 contains information about the number and type of complaints.

3.2 The number of **complaints** received during 2020/21 has reduced by 30% from the previous year and the principal reason for this an exceptional high number of complaints relating to the Blue Badge Service during 2019/20 due to a change in eligibility criteria. Without this increase, the number of complaints received is fairly consistent with previous years:-

Year	**Complaints received**	% increase/ decrease on previous year	People receiving a service	% of people or their representative raising a complaint
2020/21	754	-30%	67,212*	1%
2019/20	1,072	+41%	36,455	3%
2018/19	780	+24%	35,385	2.2%

* *The figure of "people receiving a service" is much higher than that we have previously shown due to improved reporting capability on our new client database, Mosaic. The figure includes the total number of people that we have provided a service to throughout the year, rather than a snapshot of people receiving a service on a particular day which the previous figures related to. This is a more accurate number of people who had the opportunity to raise a complaint.*

3.3 A total of **381 Enquiries** were received in 2020/21 which is a very slight increase from the previous year. The majority of these Enquiries were from a MP or Member on behalf of a constituent about an aspect of the service they received. This represents a steady increase in the previous three years:-

Year	**Enquiries received**	% increase / decrease
2020/21	381	0%
2019/20	379	+10%
2018/19	345	+25%

3.4 In 2020/21, **512 compliments** were received which represents an 11% decrease from the previous year. The compliments provide useful feedback where people have written to ASCH with positive comments about their experience of using the service. Compliments are usually received via the operational teams and staff are encouraged to complete a form with details of the message and staff associated with the good work. A few examples from compliments received are found in Appendix 4.

Year	**Compliments received**	% increase / decrease
2020/21	512	- 1%
2019/20	518	+ 8%
2018/19	480	- 5%

3.5 In 2020/21**, 242 informal concerns** were received which represents an 18% decrease from 2019/20, which saw a significant increase from previous years. These are concerns that were locally resolved, within a short period of time, usually within 24 hours, by the Customer Care and Complaints Team, in consultation with the operational service. Someone raising an informal concern does not wish this to be logged as a formal complaint and is happy for their concern to be resolved via this route.

3.6 An example of an informal concern, was when someone called to chase up actions in respect of urgent adaptations to their home following an Occupational Therapist visit. The Occupational Therapist contacted the Borough Council to chase up the referral and then provided an update to the person to reassure them that progress was being made with the Disabled Facilities Grant.

Year	**Informal concerns**	% increase / decrease
2020/21	242	-18%
2019/20	298	+146%
2018/19	121	+17%

4. Coroner's Inquest Requests

4.1 From October 2020, the Customer Care and Complaints team started to manage and co-ordinate the requests from the Coroner's Office for reports or information to support the work they are taking forward with inquests. From October to end of March we managed **23** Coroner's requests.

4.2 A process was put in place to manage these requests and to ensure effective communication and sign off between the Coroner's Office, our operational teams and Invicta Law. There is continual learning taking place to ensure all staff are following the process and engaging the Customer Care and Complaints team in communication with the Coroner's Office to enable effective tracking and management of the requests.

4.3 A flow chart and guidance notes have been produced, in liaison with Invicta Law and a template report is to be used for the completion of the requests.

5. Performance against timeframes

5.1 KCC aims to respond to 85% of complaints within KCC's Key Performance target of 20 working days. ASCH complaints can be complex and therefore additional time is required to either meet with the complainant or liaise with other agencies; when this happens and with the agreement of the complainant, an extension to the deadline is agreed; 123 complaints had their timescales extended.

5.2 The response time achieved within target during 2020/21 for ASCH was 60%. To allow operational teams time to focus on the priorities of protecting vulnerable people during the first six months of the COVID-19 pandemic, complaints were triaged. This was supported by a Council wide temporary policy. This meant that in practice some complaints were responded to quicker, whilst other less urgent ones were not given the usual deadline of 20 days to respond. The Customer Care and Complaints Team managed this process with flexibility and liaised with the complainants to realistically manage expectations.

Year	Complaints closed	% responded to within 20 days
2020/21	783	60%
2019/20	1,063	60%
2018/19	746	61%

5.3 99% of complaints were acknowledged within three working days.

6. Complaint outcomes

6.1 An individually prepared response is provided for each complaint received following an investigation into the concerns raised. The response letter provides the opportunity to fully explain the findings from the investigation, detail what has been done to put things right and offer an apology, where appropriate. Some complaints lead to lessons being identified and these are also explained within the response so that the complainant is reassured that we are taking the issue seriously and have shared good practice as a result. A summary of the outcome of the complaints is recorded in the table below:-

Year	Complaints closed	Upheld and partially Upheld	Not upheld	Resolved upon receipt/ withdrawn/suspended/ another procedure
2020/21	783	48%	31%	21%
2019/20	1,063	66%	26%	8%
2018/19	716	66%	30%	4%

6.2 The number of complaints upheld or partially upheld has reduced from 66% to 48%. This pattern shows a steady decline over the years in the number of complaints upheld. This could indicate that recording has improved enabling us to defend and explain the actions taken in respect of complaints raised.

6.3 There is an increase in the percentage of those complaints “resolved upon receipt” which demonstrates that flexibility is applied if a complaint can easily be rectified upon receipt by liaising with operational teams to resolve the complaint quickly.

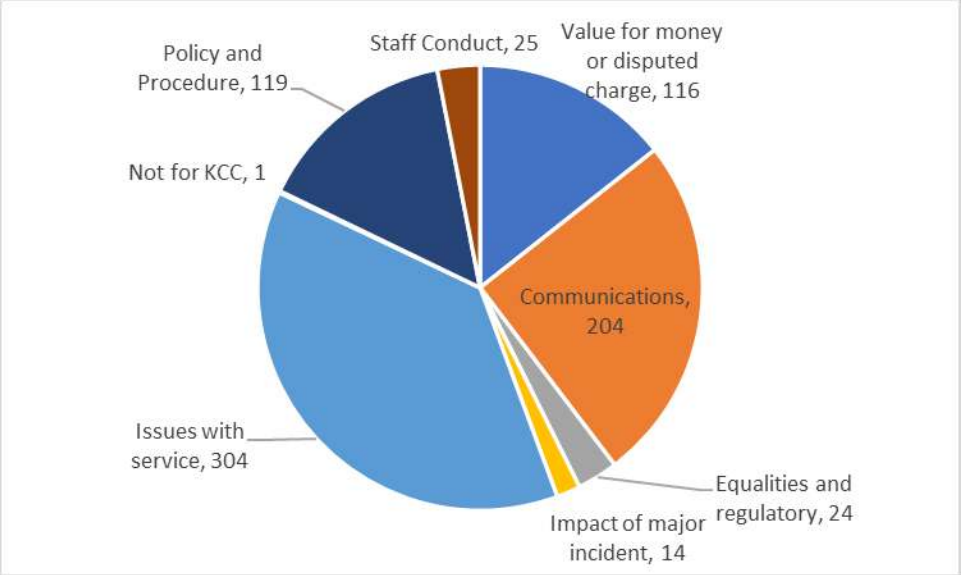
7. Methods of engagement

7.1 Communication, in whichever form is encouraged and accepted, so that people can complain in the way they feel most comfortable. There has been a further decline in the receipt of postal complaints with only 5% being received, with both email, 50% and telephone, 26%, being the most common forms of communication with the self-service via the website and online methods equating to 13% and the Contact Centre sending through 5% of complaints.

Method	Volume
Comment Card	3
Contact Centre	35
Email	379
Fax	1
Online	13
Post	39
Self service	89
Social Media	0
Telephone	194
Webchat	1
Total	754

8. Themes identified arising from complaints

8.1 The complaints are categorised under the following main corporate headings:



Policy and procedure	119
Staff Conduct	25
Value for money or disputed charge	116
Communications	204
Equalities and Regulatory	24
Impact of major incident	14
Issues with service	304
Not for KCC	1
Policy and Procedure	119
Staff Conduct	25

- **Covid-19** had a significant impact on how we deliver services during 2020/21. With some services needing to amend or suspend services following government guidance. Examples of complaints received include communications regarding day centres opening as well as disagreements with day centres being closed during lockdown, some felt these services should remain open, as the closure had an impact on wellbeing. Complaints were also received as services began to re-open with some service users expressing concerns. There were also several complaints about residential homes and visiting restrictions as well as staff not following the guidelines.

- **A delay in contacting the customer** is when someone we support perceives a delay in communicating with them. An example is that we have informed a someone that their Blue Badge application would be processed within 10 weeks, but they feel that this timescale is excessive or goes over that deadline. Another example is when someone requested an assessment for care or equipment had to chase for a response.

- People we support, or their representatives, who pay for all, or part of their care following a financial assessment sometimes **disagree with the charge received,** themes of these complaints include charges that are considered to be excessive, where we have not taken all of someone's circumstances into account or an invoice that the someone feels is incorrect as they have been charged for care that was not provided or was a poor standard.

- **Disagree with the decision**. Examples include when a person has completed a financial assessment and feels that a specific policy should apply, for instance someone may ask us to disregard a property they own from a financial assessment, but the criteria for this is not met. Another example is a someone requesting a care needs assessment, and they feel they either require more or less support than we have identified.

- **Failure to contact** example complaints include people we support who have not been informed of changes in care providers, not received contact from their case manager, or feel they have not been kept up to date with changes in the way in which a service is being delivered.

- **Failure to do something** is listed when an issue occurs which results in the service failing for some reason, for example is when a care provider is unable to provide care, which could be due to staff availability, or there has been a perceived miscommunication between parties. A further example of this could be the lack of alternative arrangements available whilst a day centre service has been suspended due to lockdown.

- **Incorrect/insufficient advice given** is selected when a person we support, or their representative, reports that they have not been provided with sufficient information regarding the services provided. For example, the provision of information regarding payment for care. In some cases, this information was provided but it may not have been understood, in these circumstances, we are working to make our correspondence clearer. Another example could be when someone feels that they were not asked sufficient questions regarding a care assessment to identify their needs.

- **Quality of communications**, this could be the way a decision has been communicated to someone using our service, whilst they might not disagree with the outcome, they feel that the information could have been made clearer. For example, a letter declining a Blue Badge that someone does not feel adequately explains the reason they were not eligible.

- Some complaints raise issues about the **quality of service** and these often relate to the quality of care provision by a third party. For example, when someone feels that the timings of their care calls are not consistent. Other examples would be of care that is commissioned and provided by private care homes not meeting the expected standard

- Complaints relating to **staff conduct** are taken seriously and where there is fault, these matters are addressed through supervision and training. Example complaints under this category could include people who feel that someone was not helpful, was dismissive of the issues raised or did not conduct a conversation in a professional manner.

9. Putting things right and improving– creating opportunities

9.1 A complaint investigation provides a vital source of insight about people's experiences of Adult Social Care and enables us to put things right. The outcome of an investigation can highlight practice issues to enable improvement and the sharing of experiences.

9.2 Lessons or corrective actions are identified when a complaint is upheld or partially upheld. These actions are tracked to ensure completion and sharing takes place with the relevant teams. The lessons are also shared with the Strategic Safeguarding, Practice and Quality Assurance team so that they are highlighted and linked with the good practice work taken forward by the team. Reminders are sent out to staff on issues identified where practice needs improving.

9.3 Many of the corrective actions recorded relate to communications, for example in respect of delays or in the accuracy and quality of communications experienced by the people we support, their representatives, and other agencies. A summary of corrective actions undertaken by Division is found in Appendix 2.

9.4 Examples of how we have put things right and shared the learning is contained in Appendix 5 and a summary of these are below:-

You said – we had let your son down by not providing sufficient support for his mental health

We did – we reviewed our processes to send assessment reports to GPs within 72 hours of completion and to ensure that the reports were clear and concise

You said – we did not keep you informed during your mother's assessment and did not engage with you in finding her a residential home

We did – we reviewed our procedures for continuity during staff changes and implemented a buddy system to ensure consistency around communicating with family members

You said – we did not progress your son's care plan because his worker was absent which caused a delay in the provision being arranged.

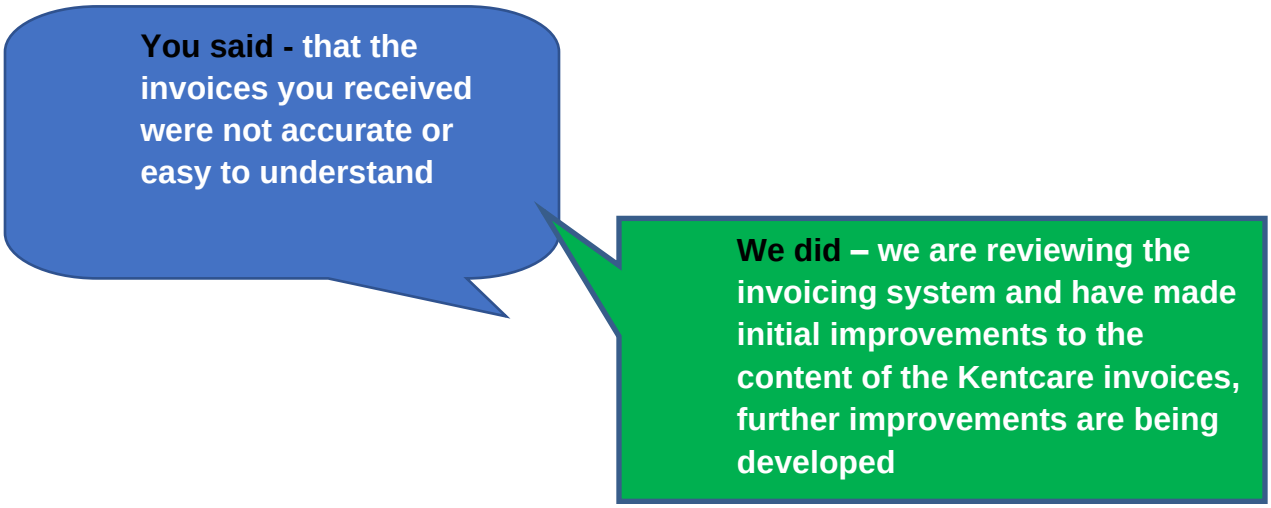
We did – we reviewed the process and the team now regularly reviews and re-allocates outstanding work when a member of staff is absent for a length of time

You said – that we did not tell you that your formal review was taking place during a telephone conversation in place of a face-to-face visit which left you uncertain if it had taken place

We did – we reminded staff to ensure people are clearly informed that a review is taking place over the telephone so that they could raise relevant queries

You said – we did not tell you when temporary government funding for residential care under Covid-19 had ceased

We did – we apologised and waived the charges and sent out letters to those affected to explain the changes to the charges



10. Financial

10.1 In 2020/21 a total of £60,887 was paid to complainants as gesture of goodwill payments, financial settlements or adjustments. Gesture of goodwill payments made up £3,300 which was paid in recognition of the impact of errors or where a delay had occurred that resulted in some injustice to the person we support or their family. The financial adjustments relate to where errors had occurred over charges, a lack of communication about a charge or an overpayment and it was considered appropriate to waive the charge as part of the resolution to the complaint.

10.2 This figure includes payments recommended as part of the Local Government and Social Care Ombudsman enquiries. Most of the gesture of goodwill payments are under £500 and are in line with the financial remedy guidance set out by the LGSCO as part of complaint resolution.

11. Complaints received via the Local Government and Social Care Ombudsman

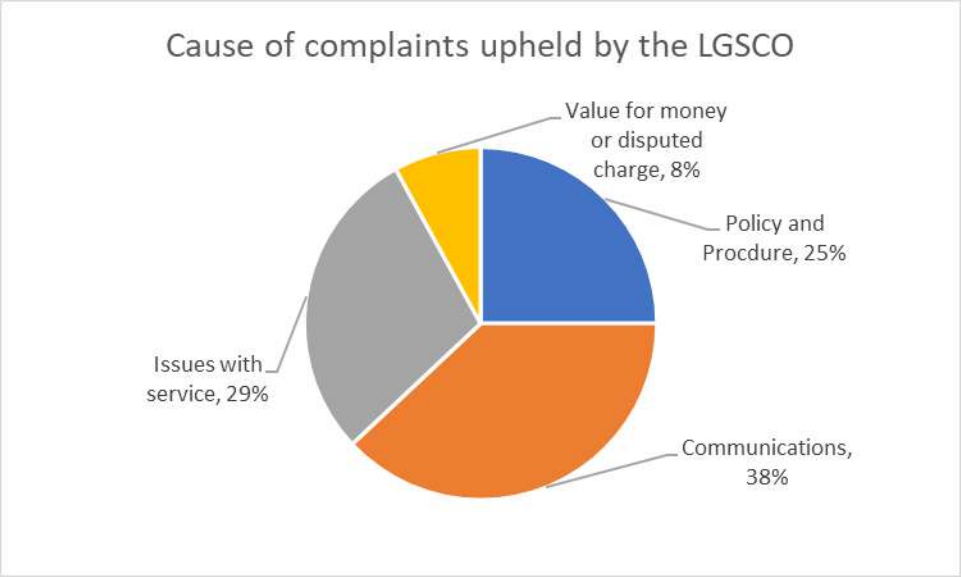
11.1 Responding to enquires from the Local Government and Social Care Ombudsman (LGSCO) is the second stage of the Adult Social Care process. Where a complainant is not satisfied with the response, they can contact the LGSCO to ask for their complaint to be independently investigated. The LGSCO will then request information and comments from the Council to enable them to conduct their investigation. The LGSCO gives the Council four weeks to respond to a full investigation request.

11.2 It should be noted that the LGSCO halted the progression of their investigations at the start of the Covid-19 pandemic and re-opened their investigations from the end of June 2020. There was an influx of new cases in the following nine months, which put additional pressure on teams to provide the information requested within the timescales.

11.3 The table below explains that the LGSCO raised an investigation on 45 cases during 2020/21. This represents 6% of complaints that progressed to the LGSCO. The LGSCO found fault and upheld the complaints in 19 of these cases which represents 42% and is an increase of 14% from the previous year:-

Year	Complaints received	**Complaints closed that progressed to LGSCO**	% of cases progressed	**Not upheld** (no further action / no maladmin.)	**Upheld** (maladmin./ injustice / no further action)	Other outcome (closed after enquiries/ premature/ withdrawn/	% of upheld against those cases investi-gated
2020/21	754	45	6%	6	19	20	42%
2019/20	1,072	53	5%	7	15	31	28%
2018/19	780	38	5%	7	16	15	69%

11.4 The diagram below demonstrates the main causes of the upheld complaints:-



Policy and Procedure	25%
Communications	38%
Issues with service	29%
Value for money or disputed charge	8%

11.5 Information about some of the cases are summarised in Appendix 3 and below are a few themes and highlights to consider:-

- 38% of complaints upheld related to communication issues, it is important to highlight that someone's specific communication and support needs must be considered. One case highlighted that expert advice should have been considered where someone was diagnosed with Autism and a hearing impairment. In another the LGSCO concluded that insufficient detail and explanation was provided to an applicant when their request for a Blue Badge was declined.

- The need to keep accurate and timely documentation was raised as an issue to improve. In one case a social worker was asked to join an informal hospital ward discussion but did not sufficiently record the discussion. Another investigation highlighted that a team had not chased up the hospital in respect of a Deprivation of Liberty application.

- We were able to defend our actions on one investigation with sufficiently robust record keeping and response when a long-term resident was required to be moved to safeguard her well-being as her needs had increased and the family disputed this was necessary.

11.6 Remedies are issued by the LGSCO that need to be taken forward and include sending apology letters to the person we support or their family, offering financial remedy, reviewing policies or procedures in recognition of the error and staff training. All recommendations have been taken forward in a timely manner.

12. Report Conclusion

12.1 It has been a challenging year however the team has continued to operate a robust and effective complaints procedure. Flexibility in our approach enabled the frontline operational teams to focus on the priorities that the Covid-19 pandemic presented. We successfully triaged the complaints that were received to allow this to happen. Throughout this time, we continued to respond to people's concerns and kept them informed to manage expectations from the beginning. Whilst we would have preferred our response times to be quicker the circumstances faced by services have been unprecedented. We have, however, improved the response times so far this year from April 2021 to 69% for the first six months, which we will continue to build upon.

13. Recommendations

13.1 Recommendations: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the content of this report

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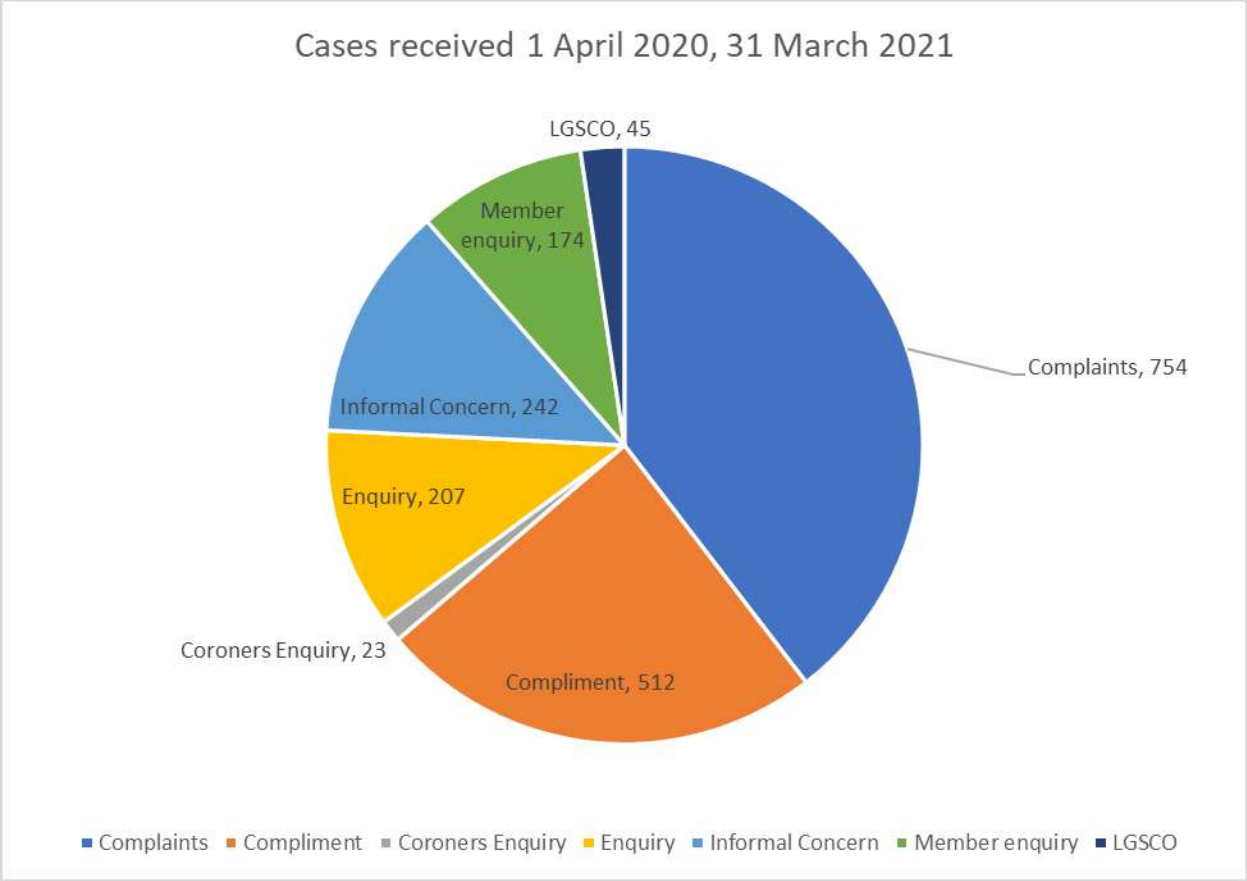
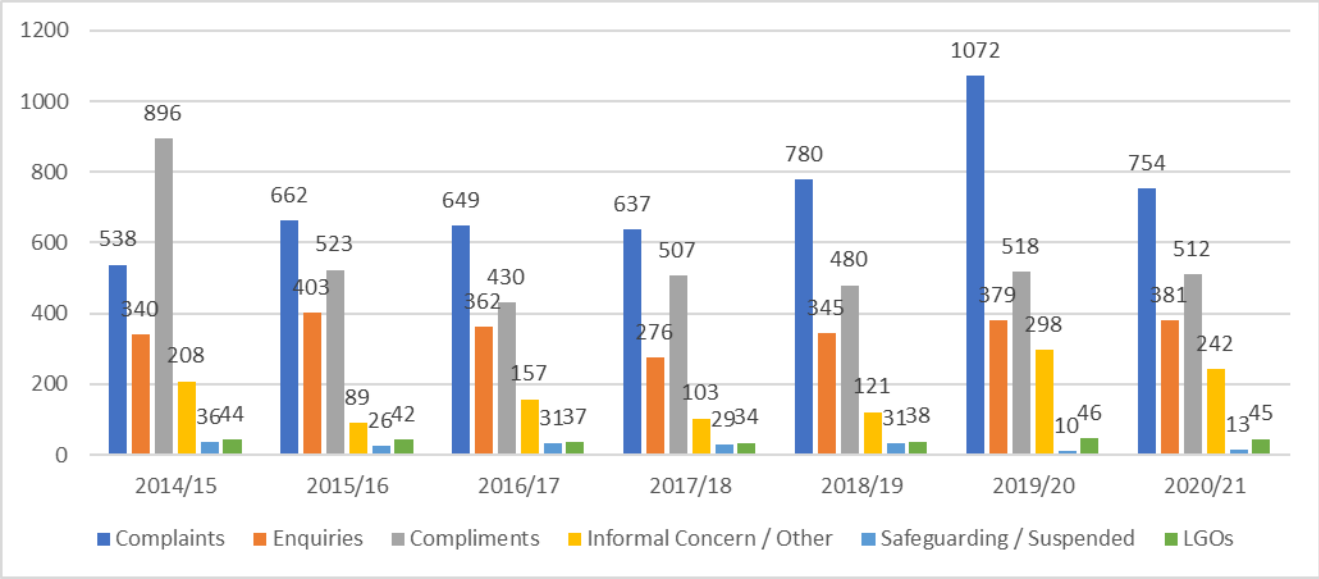
Appendix 1 – Statistical Data
for Annual Complaints Report 2020/21

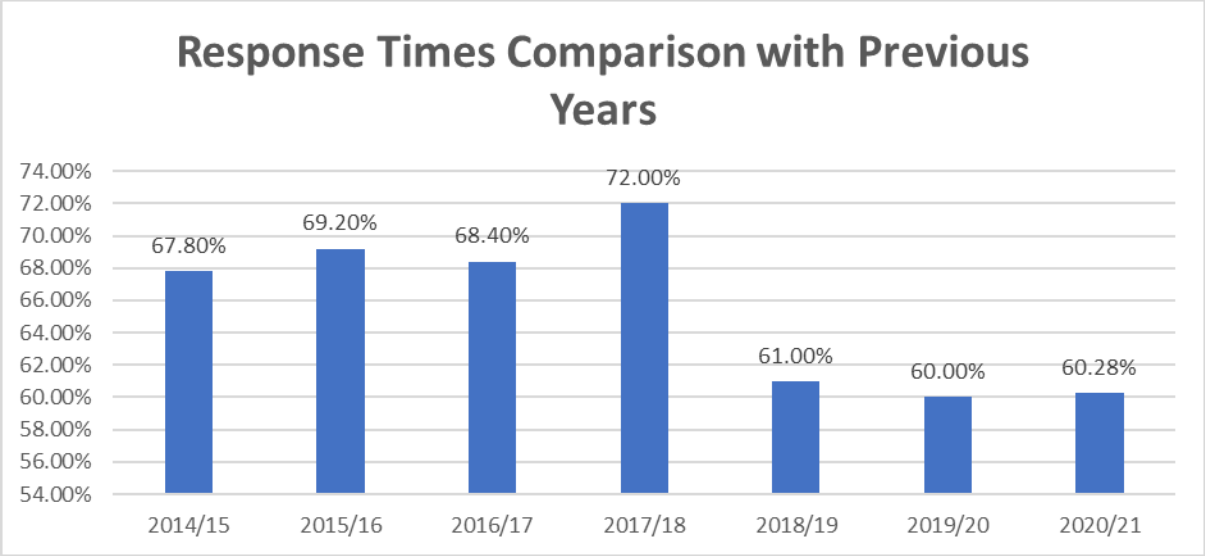


Case type	Total
Complaints	754
Compliment	512
Coroners Enquiry	23
Enquiry	207
Informal Concern	242
Member enquiry	174
LGSCO	45
Total	1905

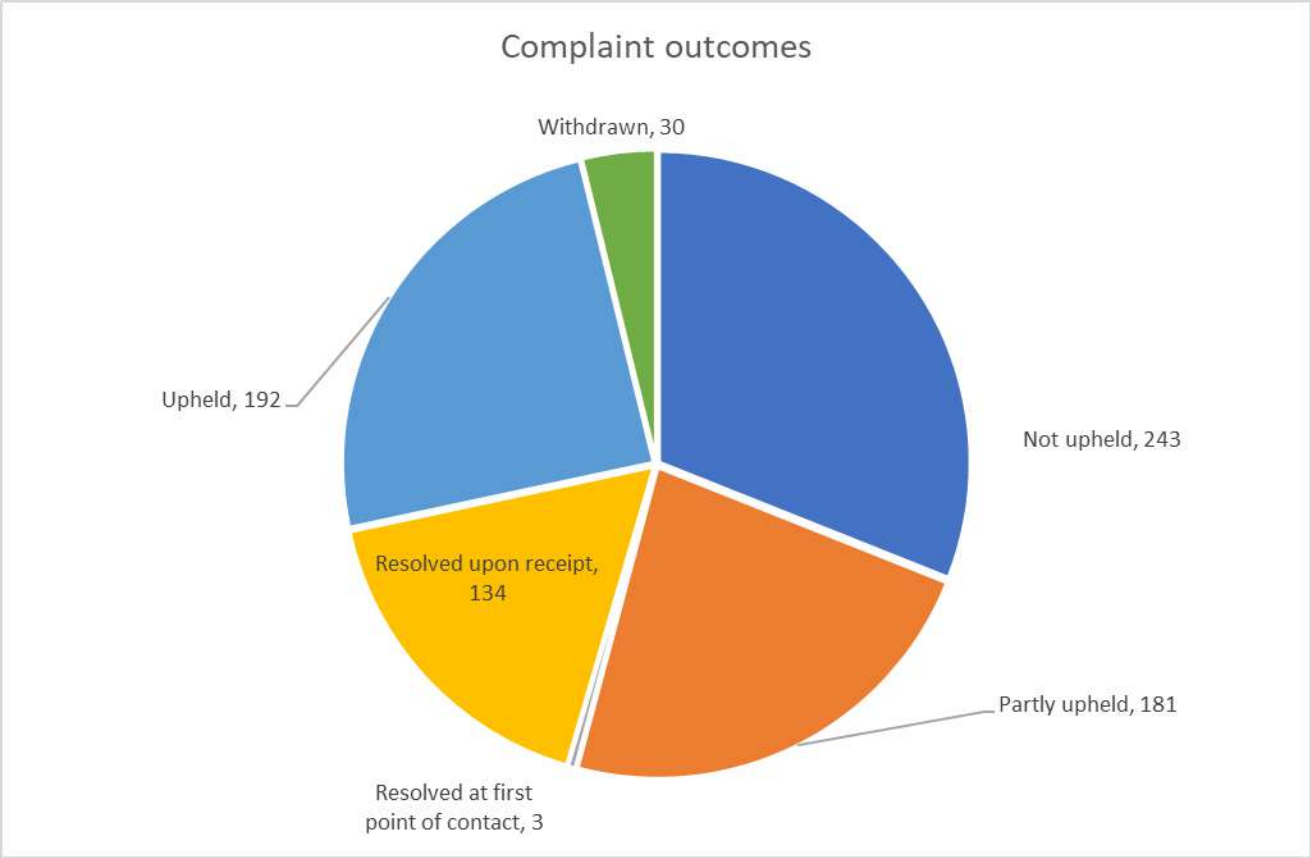


Year	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Complaints	538	662	649	637	780	1072	754
Enquiries	340	403	362	276	345	379	381
Compliments	896	523	430	507	480	518	512
Informal Concern / Other	208	89	157	103	121	298	242
Safeguarding / Suspended	36	26	31	29	31	10	13
LGOs	44	42	37	34	38	46	45

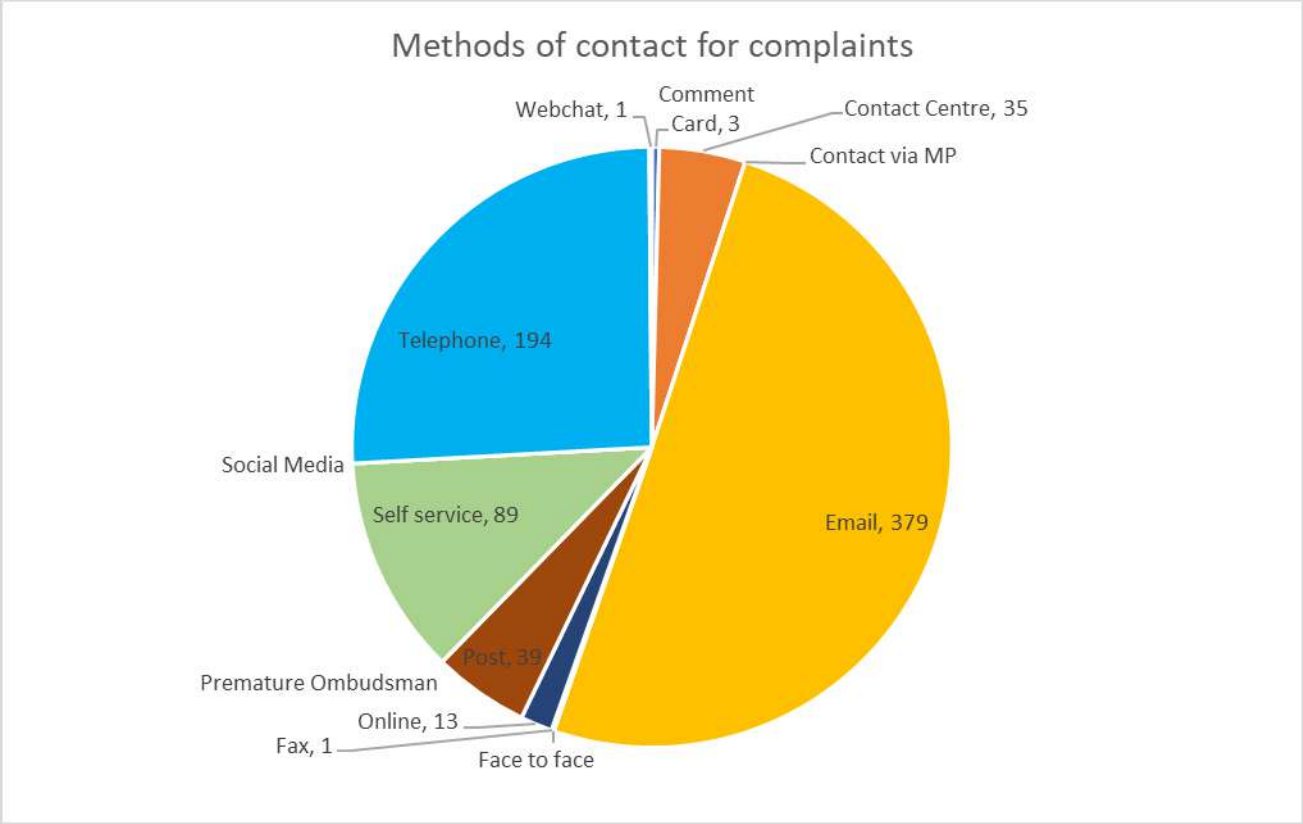
Responses for Closed Cases in 2020/21	Total
Response within target	472
Late Response	311
Open/Suspended	13
Total	783
Percentage Within Target	60%



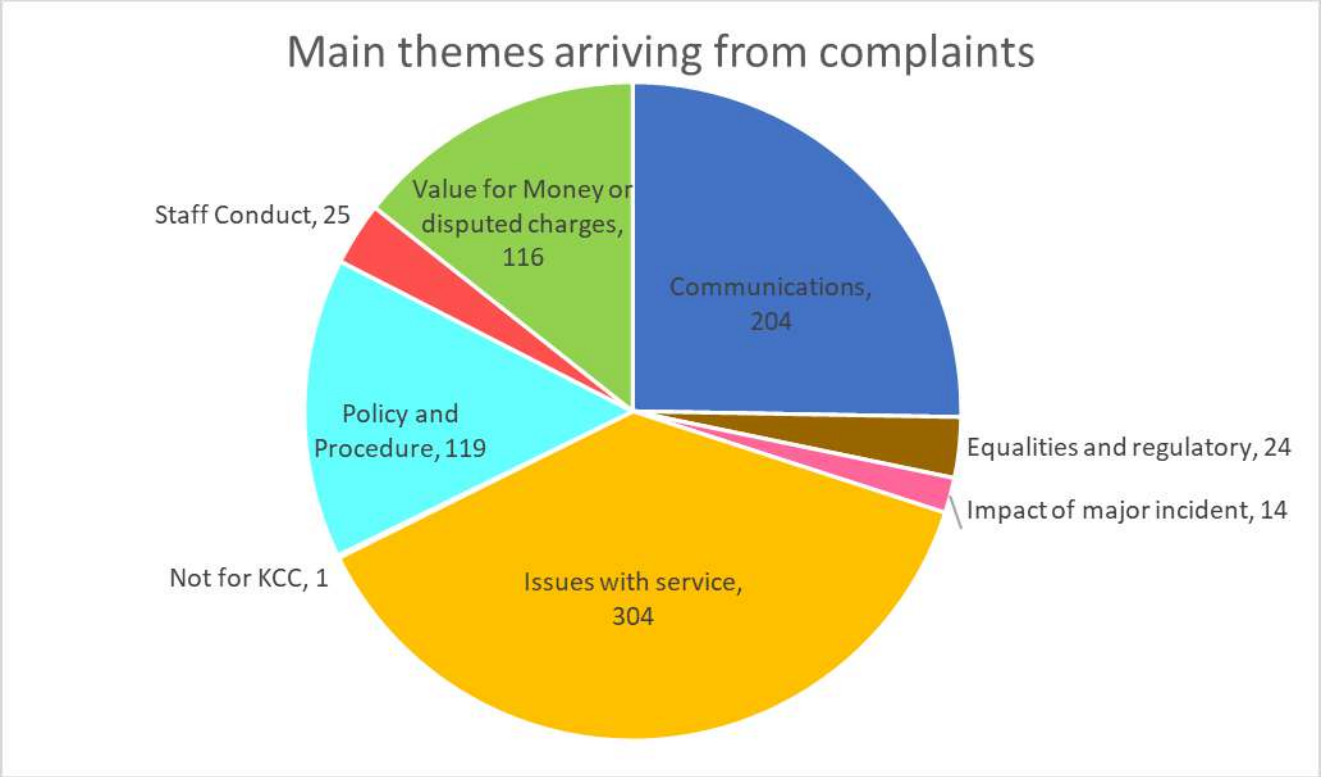
2014/15	**67.80%**
2015/16	**69.20%**
2016/17	**68.40%**
2017/18	**72.00%**
2018/19	**61.00%**
2019/20	**60.00%**
2020/21	**60.28%**



Decision	No of cases	%
Not upheld	243	31%
Partly upheld	181	23%
Resolved at first point of contact	3	0%
Resolved upon receipt	134	17%
Upheld	192	25%
Withdrawn	30	4%
Total	783	



Method	Volume
Comment Card	3
Contact Centre	35
Email	379
Fax	1
Online	13
Post	39
Self service	89
Social Media	0
Telephone	194
Webchat	1
Total	754



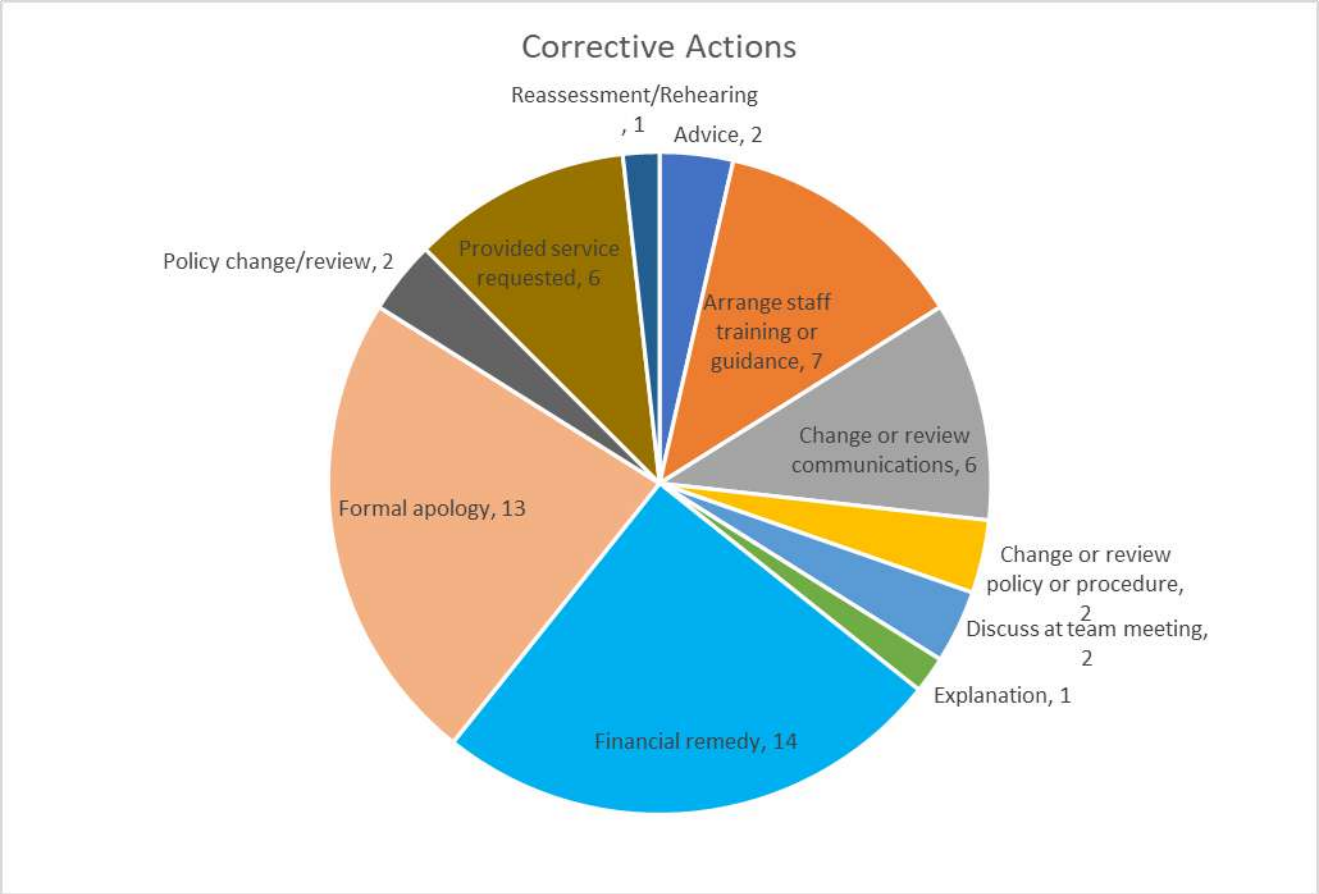
Problem category	Total	Upheld/ partly upheld	% Upheld/ partly upheld
Communications	204	103	50%
Equalities and regulatory	24	11	46%
Impact of major incident	14	5	36%
Issues with service	304	142	47%
Not for KCC	1	0	0%
Policy and Procedure	119	32	27%
Staff Conduct	25	11	44%
Value for Money or disputed charges	116	84	72%

*Some complaints have multiple problem categories.

Local Government and Social Care Ombudsman (LGSCO)

Details for Cases CLOSED in the 1 April 2020 to 31 March 2021

Decision	Cases
Closed after initial enquiries - no further action	16
Closed after initial enquiries - out of jurisdiction	2
Not upheld: No further action	2
Not upheld: No Maladministration	4
Referred back for local resolution	2
Upheld: Maladministration and Injustice	16
Upheld: Maladministration, No Injustice	1
Upheld: Maladministration, No further action	2
Total	**45**



Corrective Actions LGSCO	Cases
Advice	2
Arrange staff training or guidance	7
Change or review communications	6
Change or review policy or procedure	2
Discuss at team meeting	2
Explanation	1
Financial remedy	14
Formal apology	13
Policy change/review	2
Provided service requested	6
Reassessment/Rehearing	1
Total	56

*Please note some cases may record more than one corrective action.

Appendix 2 – Examples of Compliments received for Annual Complaints Report 2020/21

- **Area Referral Management Service**: Customer contacted us to let us know that they were grateful for the way the call was handled. They felt that the person they spoke to was patient and took time to make sure they understood what was going on. The call handler was polite and professional and recognised the complexity of the situation.

- **Promoting and Supporting Independence Team**: Member of the public called to say thank you for the way that the staff member dealt with their enquiries, they took the time to listen to what was going on and helped identify what they needed and also got them get in contact with other agencies who could also assist.

- **Safeguarding**: Family member calling to let us know that the member of staff was kind and caring, very professional and understanding of the situation.

- **Kent Enablement at Home**: Family member wants to thank the team as they felt we took into account their father's needs and have kept them updated with what was going on. Very grateful for the assistance provided at a difficult time.

- **Mental Health Team**: Family member wanting to thank her son's social worker for the support he has received. They understand that the case is complex, and he requires a lot of assistance. Has had bad experiences in the past but feels that Social Worker has taken the time to deal with him with compassion and has truly shown that she has his best interests at heart.

- **Short Term Pathways Team**: Family member reporting that her father was placed in a care home after being discharged from hospital. This was a very difficult time for the family, as he had previously been cared for at home. The Social worker was empathetic and understood how this was affecting the family. The social worker took the time to understand their father as a person, he is now settled in a home that meets his needs.

- **County Placement Team**: The team helped a family find a suitable placement during a very stressful period.

- **Sensory:** The person we support explained that they were now able to hear their son properly. The personal amplifier machine provided has been life changing. The person didn't realise how bad their hearing was until using the machine.

- **Lifespan Pathway 26+ Team**: Family grateful for the way Social Services have assisted the person we support to have a full and active life. Very thankful for the assistance provided by colleagues in the team.

- **Blue Badge team:** Person grateful for the way that their application was handled, although they found it challenging to complete the online form and also found it difficult describing their conditions without feeling upset. The assessor who they dealt with handled their call with empathy and put a smile on their face.

Appendix 3 – Corrective actions and improvements/lessons learnt for Annual Complaints Report 2020/21

Action	Total	%
Formal apology	203	30%
Change or review communications	156	23%
Arrange staff training or guidance	93	14%
Discuss at team meeting	57	8%
Financial remedy	46	7%
Change or review policy or procedure	36	5%
Review contract or partner arrangements	18	3%
Explanation	16	2%
Performance management - staff member	14	2%
Policy change/review	11	2%
Change or review service	8	1%
Procedure change	8	1%
Advice	2	0%
Provided service requested	3	0%
Reassessment/Rehearing	1	0%
Supervision discussion	2	0%
Total	674	

Corrective actions by Division 2020-21

Division	A & C	T & SKC	North Kent	West Kent	County	Provision	BDU	SSP QA	Finance	SC	Misc	Total
Advice	0	0	0	0	0	0	2	0	0	0	0	**2**
Arrange staff training or guidance	11	17	16	12	5	5	13	0	1	4	4	**88**
Change or review communications	12	36	16	29	12	21	19	0	8	6	0	**159**
Change or review policy or procedure	3	10	2	4	3	5	7	0	1	2	0	**37**
Change or review service	0	1	2	1	2	1	3	0	0	0	0	**10**
Discuss at team meeting	16	11	8	10	1	3	3	0	4	1	1	**58**
Explanation	1	2	2	3	0	0	3	0	2	2	0	**15**
Financial remedy	6	3	9	9	6	2	8	0	7	1	0	**51**
Formal apology	20	34	30	31	12	20	30	1	24	4	1	**207**
Performance management - staff member	3	2	3	4	0	1	0	0	1	0	0	**14**
Policy change/review	1	2	1	0	2	1	1	0	1	2	0	**11**
Procedure change	1	2	0	2	0	0	1	0	1	0	0	**7**
Provided service requested	0	0	1	0	0	0	0	0	0	0	0	**1**
Review contract or partner arrangements	2	5	3	1	2	2	1	0	1	4	0	**21**
Supervision discussion	0	1	1	0	0	0	0	0	0	0	0	**2**
Total	**76**	**126**	**94**	**106**	**45**	**61**	**91**	**1**	**51**	**26**	**6**	**683**

The Council has paid a total of £60,887 in financial remedies in 2020-21. Including £3,300 in goodwill payments to recognise the distress and inconvenience to complainants.

Many of the corrective actions recorded relate to communications, for example in respect of delays or in the accuracy and quality of communications experienced by service users, their representatives, and other agencies.

Appendix 4 – A few examples of complaints that have lead to KCC putting things right and improving our services for annual Complaints Report 2020/21

- A family member raised a complaint after a service user passed away and a joint investigation was instigated by KMPT to look into the circumstances. The complaint investigation by the Approved Mental Health Professionals (AMHP) Service concluded that there had been a delay in a record being shared with the service user's GP following an assessment. As a result, a corrective action to ensure that the AMHP team send reports to GP within 72 hours of completion was implemented. It was also agreed that the content of these reports would be reviewed to ensure that the information shared with GPs is clear, concise and accurate.

- A complaint investigation acknowledged that there was a breakdown in communications between the Promoting and Supporting Independence Team and the service user, in part because they had experienced a change of allocated worker three times over a relatively short period. The team reviewed their procedures in consideration of the need for service users to have continuity during the assessment and placement process. As a result, the team instigated a 'buddy' system for their social workers to ensure consistency, so if a member of staff is unavailable the client is able to speak with another team member who is familiar with their case.

- A complaint raised delays in progressing care plans due to the absence of the allocated worker and this absence resulted in a breakdown of communication and a delay in care provision being arranged. This led to the Lifespan Pathways 26+ Management Team being reminded to review and reallocate outstanding work when a member of staff is absent for a length of time.

- The restrictions instigated by the government as a result of the Covid-19 pandemic triggered a great many changes in the way in which Adult Social Care worked, particularly during the height of the restrictions during the summer of 2020. Many people we support and their families were understanding of the need for the changes, this ranged from staff working from home resulting in most care needs assessments and reviews being conducted virtually via telephone or video call, to the temporary restrictions and sometimes closure of services across the county. There were, however, a number of complaints received which, again, related to the communications people received, or did not receive, about these changes, which ultimately meant that they were not provided with realistic expectations or the information they required to make informed choices.

- In a complaint, a service user raised that they were not aware that a telephone call from the social care team was being conducted as a formal review of his care needs in place of a face-to-face visit. Following this complaint, staff were reminded to ensure that service users were made aware that a formal review was taking place, even if it is happening by telephone rather than in person.

- Many complaints and enquiries were received from the parents and carers of people with learning disabilities who usually attend day care centres. Under varying government guidelines, day services were at times closed and at others restricted, in order to comply with the guidance around social care 'bubbles' and to reduce the risk of infection to service users. The lack of communication was the principal issue within these complaints as service users and their families generally felt they were not informed of what was happening with their services and why.

- Alongside communication issues, disputed charges are one of the other main themes of complaints that are received by Adult Social Care. Communication often plays a part in these complaints also, both between the Council and service users, and with our partners. Several complaints during 2020-21 related to incorrect fees being applied to someone's accounts due to miscommunications between service providers and the Council when services were not supplied according to the usual schedule. For example, a break was not recorded on the client record system for a someone who was admitted to hospital, which led to them being charged in error for services they did not receive.

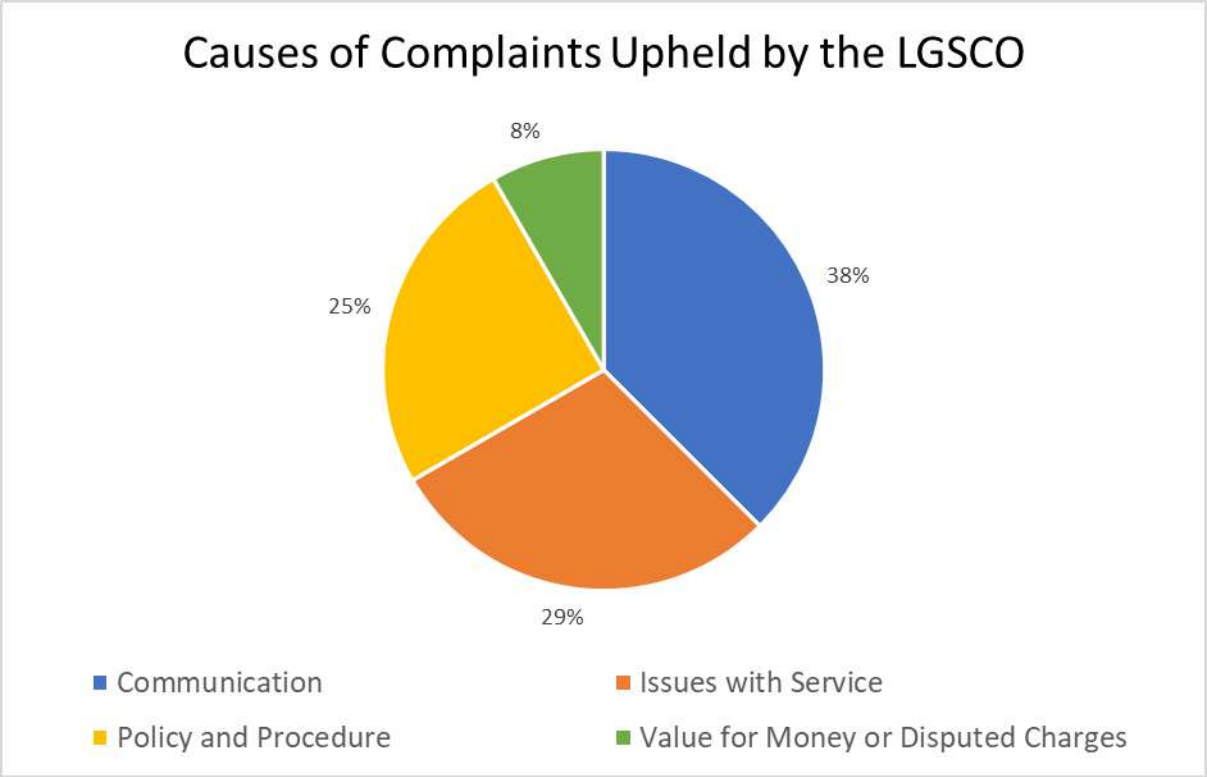
- There were also some cases where there was confusion around the temporary funding provided by the government under Covid-19 measures for residential care. One person was not informed that the funding had ceased until receiving a letter stating the charges would be backdated for nearly a month. The backdated charges were waived as a result of the complaint, which highlighted the need to ensure that charging letters were sent out in a timely way to ensure transparency.

- Numerous cases raising concerns about the way in which KentCare Invoices are presented led to a review of these which is still underway. A Governance Group meets on a regular basis to discuss the progress of the current changes. These include adding a current cost of care to the invoice to make this more transparent and providing a front summary sheet in a larger font. The team are also looking to work closely with a range of citizens in receipt of care over the next few months to better understand and develop the KentCare Invoice content further.

Appendix 5 – Local Government and Social Care Ombudsman information for annual Complaints Report 2020/21

Kent Adult Social Care and Health completed a total of 45 complaints which were escalated to the Local Government and Social Care Ombudsman (LGSCO) in 2020-21. Of these, 18 were closed following initial enquiries as no further action or because the complaint fell outside of the LGSCO's jurisdiction, and two were referred for local resolution as they had not previously been through the Council's own complaints process. A further six cases were closed with an outcome of Not Upheld, and 19 complaints assessed by the LGSCO were found to be Upheld.

Division	**Closed after initial enquiries**	**Referred back for local resolution**	**Not upheld: No Maladministration**	**Upheld: Maladministration**	**Upheld: No further action**	**Total**
Ashford & Canterbury	3	0	0	3	0	6
Thanet & South Kent Coast	3	2	2	2	0	9
North Kent	1	0	3	6	0	10
West Kent	4	0	1	2	0	7
County	3	0	0	1	0	4
BDU	4	0	0	2	1	7
Finance	0	0	0	1	1	2
Total	**18**	**2**	**6**	**17**	**2**	**45**



Problem category	Upheld Cases
Communication	9
Issues with Service	7
Policy and Procedure	6
Value for Money or Disputed Charges	2
Total	**24**

*Some complaints have multiple problem categories.
38% of complaints upheld by the LGSCO related to communications issues. Two of these cases were in relation to Blue Badge applications which had not been successful. The LGSCO found that the communications with the applicants lacked sufficient detail to explain why their applications, which related to 'hidden' disabilities, had been refused. As a result, the Blue Badge Team reviewed its communications and, in particular, the contents of refusal letters, to ensure that these are specific to the individual's circumstances and to enable the applicant to provide relevant additional information, if applicable, in support of their Blue Badge Appeal.

In order to communicate effectively with service users, it is important for practitioners to consider individuals' specific communication and support needs. In a case where the complainant was supported by an advocate to make their complaint the LGSCO found that the Council was at fault for failing to seek expert advise to inform the care needs assessment for the client, who was diagnosed with both autism and impaired hearing. Around the time that the complaint was raised by the LGSCO a new social worker was assigned to conduct a further assessment of the client's care and support needs. This social worker worked tirelessly with the client, his mother, and the independent advocate, to ensure that all of his eligible social care needs were fully met and that the entire process was transparent and understood by the client. This enabled a new and comprehensive care and support plan to be completed to the satisfaction of all parties, and the Council has since received the thanks of the client for this.

Another complaint upheld by the LGSCO related to concerns raised about the Deprivation of Liberty Safeguards (DOLS) procedure and record keeping. In this case, the client was admitted to hospital and the ward submitted an incomplete DOLS application, however the DOLS Team did not chase this up with the hospital in a timely to ensure that it had sufficient information to appropriately prioritise and progress the application. In addition, a social worker who was attending the hospital in relation to another client was asked on an ad hoc basis by the ward staff to attend the discharge meeting, and that social worker did not make any record about the meeting, which later led to some confusion over whether it was a member of Council or hospital staff that attended. This case highlighted the need to keep accurate records, to ensure that information is documented in a timely manner, and to maintain good communication with other organisations such as hospitals, to be able to provide the best service for clients and their families.

One case where the LGSCO found that the Council was not at fault related to an elderly lady who had been residing in Gravesham Place Care Centre for several years. She became a resident in the home at a time when long-term residents were accepted, and initially when the remit of the home changed it was decided that she would be allowed to remain, as long as her care needs did not significantly increase. However, when her needs began to increase significantly, Gravesham Place were unable to continue safely meeting her care and support needs, and therefore, following a care needs assessment, it was decided to make arrangements to move the client to a home where her higher needs could be met. Unfortunately, the client's family were concerned about this decision and escalated their complaint to the LGSCO, however following a robust response detailing all of the Council's actions to meet this lady's needs and safeguard her wellbeing, the LGSCO found that there was no evidence of fault.