

Annual Review of Adult Social Care Complaints 2023-24

September 2024



Ombudsman's foreword

I am pleased to present this annual review of adult social care complaints, my first since my appointment to the role of Local Government and Social Care Ombudsman in February 2024. It has been immediately clear that complaints about adult social care are a significant area of focus for our organisation, with 16% of the complaints we received during the year being about social care services and from adults of all ages. We know satisfaction with adult social care services is [reported to be](#) at an all-time low, and there are enormous demands on councils and care providers to provide the often complex care and support that people are entitled to, whilst managing the ongoing financial and staffing challenges faced by the sector.

The year saw us complete more than 900 investigations and uphold 80% of those complaints. These cases often reflect the complexity of the system, where there is extensive interaction between a range of organisations involved in providing care. Our casework highlights a range of concerns, specifically delays in the assessment of people's needs, processes that fail to put the individual at the centre, care that fits with the system's offer rather than the person's needs and preferences, and poor communication with people who use services and their families, where information is unclear or too complicated.

Indeed, poor communication is a key theme throughout our casework, with examples from each part of the care process and in all care settings. I urge all councils and care providers to focus on clear and timely communication. With effective communication channels, people feel well-informed and involved, and concerns are less likely to turn into complaints.

Our jurisdiction across adult social care is comprehensive, allowing us to look at complaints irrespective of how care has been funded or arranged. We received 15% fewer complaints from people who fund their own care than last year. In fact, we consistently receive far fewer complaints from people who fund their own

care than we would expect given their proportion in the care market. It is likely that low awareness of our role in privately funded and arranged care plays a part in creating this gap; independent care providers are not required by law to signpost users to our service. As a result, people are potentially missing out on their right to access our services, and providers are missing out on the opportunity to learn from mistakes and to improve their services. We want to close this gap and are calling for a legal requirement for all social care providers to signpost people to our service.

The data we publish today supports councils and care providers to better understand their complaint handling performance. Later in the report, you can find the range of complaint management resources we offer to care providers to help improve the complaints process.

Continuous review and improvement of our own performance is also a key focus for me. I encourage all care providers to complete [this survey](#) and share your view of our organisation. Your responses will help us to assess our impact and improve our offer to you.

I thank my predecessor, Interim Ombudsman, Paul Najsarek, for leading the organisation for most of this reporting year and look forward to working with colleagues across the adult social care sector to achieve our shared aims.



Amerdeep Somal
Local Government and
Social Care Ombudsman
September 2024

2023-24: Data headlines



2,982
complaints received
including 333 from people
who fund their own care



2,817
complaints
decided



926
complaints
investigated



742*
complaints
upheld



15%
satisfactory remedies**



99%
compliance with our
recommendations



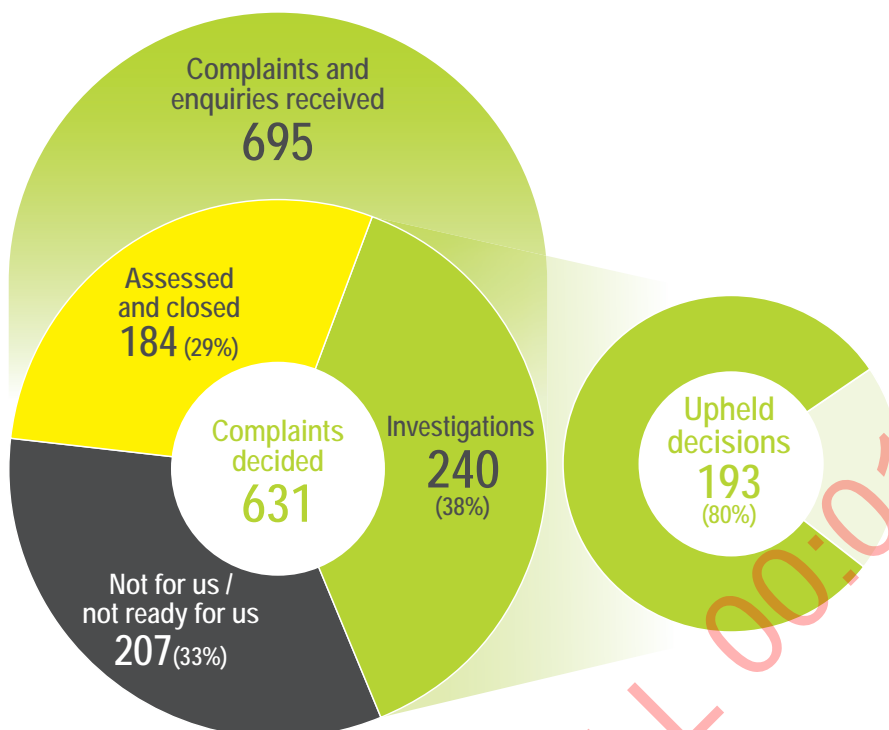
80%
uphold rate

* Includes cases where we found the organisation accepted fault early on.

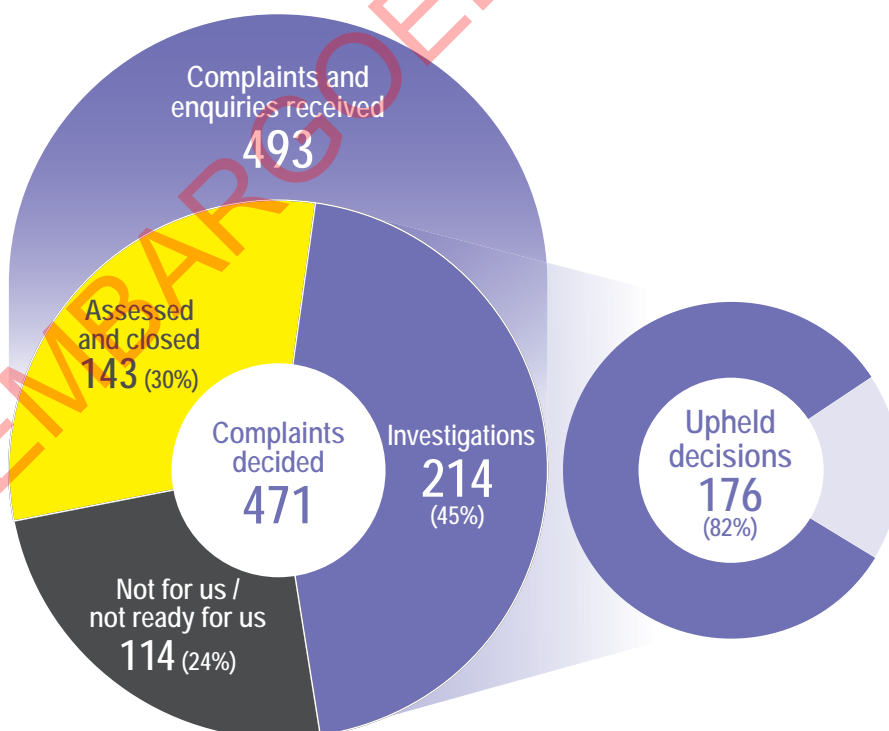
** We agreed with how the organisation had offered to put things right.

2023-24: Statistics by subcategory

Assessment & Care Planning



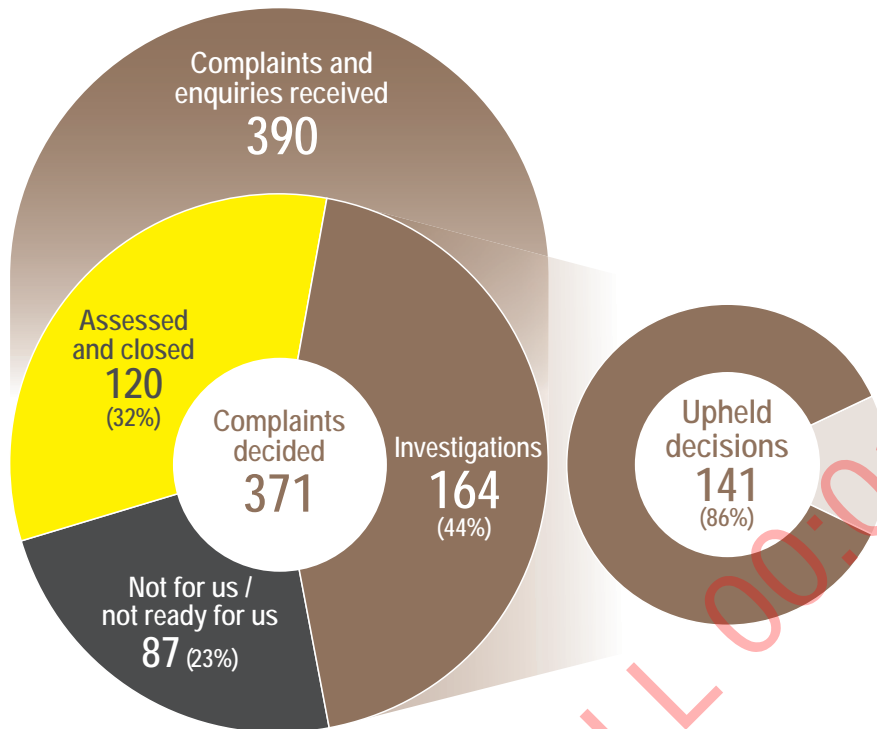
Charging



Note: percentages add to 99% due to rounding

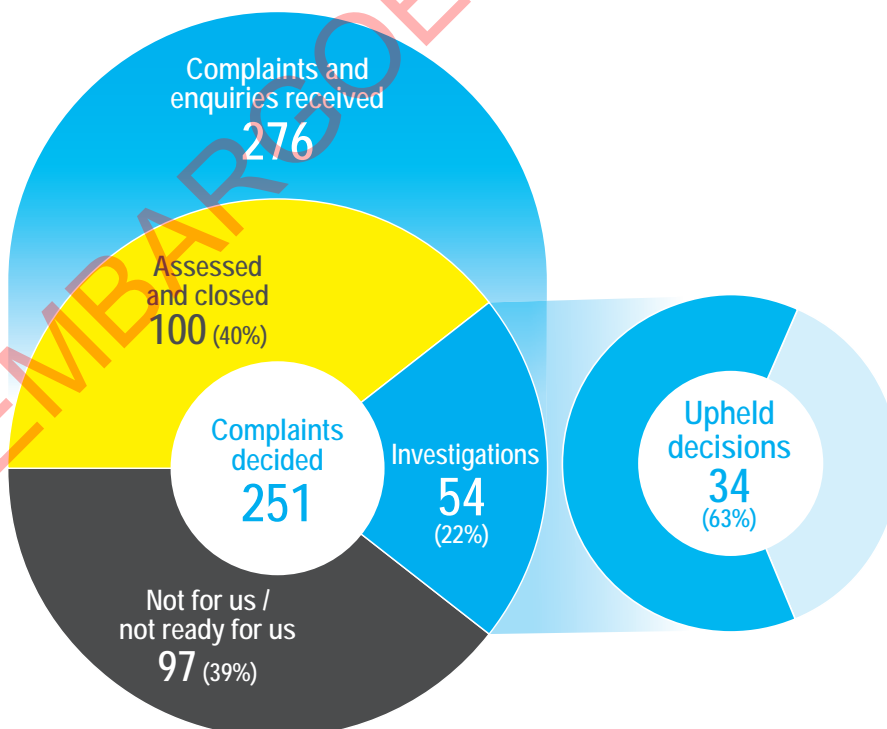
2023-24: Statistics by subcategory

Residential Care



Note: percentages add to 99% due to rounding

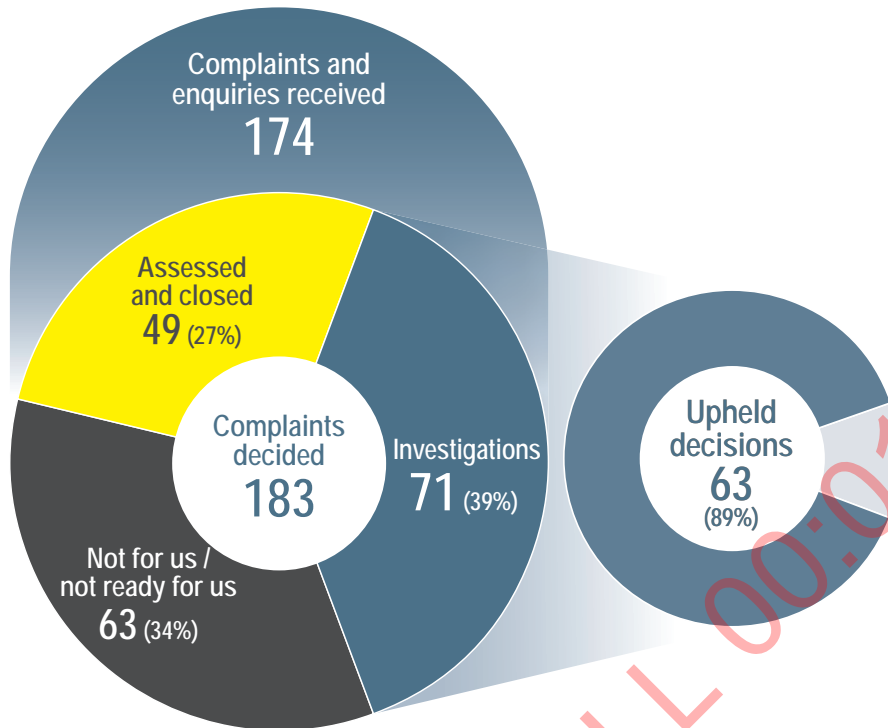
Safeguarding



Note: percentages add to 101% due to rounding

2023-24: Statistics by subcategory

Home Care



Best practice in complaint management

Putting things right when they go wrong

When we find fault we make recommendations to put things right. These recommendations are non-binding yet, in almost all cases, organisations agree to comply with them. We were satisfied with organisations' compliance with our recommendations in 99% of cases.

There were five cases in which we were not satisfied the organisation had complied with our recommendations. In response, we issued Adverse Findings Notices (AFNs) to four providers, highlighting their refusal to implement our recommendations satisfactorily. In the fifth case, we opened a new case to investigate the non-compliance.

We work with care providers and councils to agree a timescale for implementing the recommendations they have agreed to. It is therefore concerning that in more than a fifth of cases councils and care providers missed deadlines and **compliance with recommendations was late**.

We know there is significant strain on resources and pressure within the sector, but it is important that this final stage in the redress system is not undermined by unnecessary delay. Organisations should consider:

- The timescales proposed at our draft decision stage to ensure they are achievable
- Keeping track of agreed recommendations and informing us of delay
- Letting us know as soon as a recommendation is completed, and provide evidence
- Establishing simple processes that ensure apologies and payments to complainants are made promptly.

What are AFNs?

Where a provider fails to comply with recommendations to our satisfaction, we have the power to issue Adverse Findings Notices. These require the provider to publish the reasons for their non-compliance in the media.

We also publish the notice on our website alongside a press release. Should a provider fail to publish, we will do so and claim our costs back from the provider.

This year we issued notices to:

- [Farrington Care Homes Limited](#)
- [Mr M Mapara](#)
- [Pine View Care Homes Limited](#)
- [Wayside Care Limited](#)

Best practice: System and Oversight

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

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

Use these suggested questions to check the health of your organisation's approach to complaints:

- **Do you actively seek feedback about your services?**
- **Is your complaints procedure visible in care settings?**
People should be able to request information about complaints in a format that best suits them.
- **Does your organisation set out a timetable for responding to complaints and keep people informed if there are delays?**
Long delays and poor communication during the complaints process can cause additional distress for people making complaints.
- **Do contracts between commissioners and providers contain clear processes for handling complaints?**
- **Does your organisation work with local partners to provide a single investigation and response to people with a complaint about multiple bodies?**
- **Does your organisation's complaints procedure clearly signpost to the Ombudsman?**
If people have been through all stages of your complaints procedure and are still unhappy, they can ask us to review their complaint.
- **Do you regularly review your organisation's local complaints data and the outcomes of complaints?**
- **Do your elected members or board members regularly scrutinise complaints data and outcomes?**
- **How does your organisation ensure it shares the learning from complaints, across care locations or council functions to prevent the same issues affecting others?**

Learning and improvement

Public reports

We are one of the only Ombudsman schemes to publish the outcomes of our investigations. Our [decisions](#) can be easily searched and provide a useful resource for care providers and councils to see the approach we take in our investigations and the recommendations we make to put things right.

Cases about councils that raise serious issues or highlight matters of public interest are given extra prominence and issued as public interest reports.

We published four reports about Adult Social Care during the year, links to which can be found below.

Council	Category	Link
Calderdale MBC	Assessment and Care Planning	22 008 699
Cambridgeshire County Council	Medication prescribing	22 013 262
North Yorkshire Council (about former authority North Yorkshire County Council)	Charging	22 013 262
Sandwell MBC	Residential care	22 010 785

Guidance and support

We offer practical guides, tools and training to support care providers and councils with good complaint handling:

Focus reports and Good Practice Guides, including:

- [Good record keeping](#)
- [Practitioner guide: Deprivation of Capital](#)
- [Practitioner guide: Section 117 aftercare](#)

Care providers can use our revised and updated templates and guides:

- Template complaint procedure
- Template letters
- Writing a good decision letter
- Making an apology
- Complaint management checklists - handling individual complaints
- Written procedures
- Reporting performance

View our decisions

You can [sign up](#) to receive our regular Adult Social Care complaints decision newsletter.

Training

We offer [online and in-person training courses](#) to both councils and care providers, delivered by our experienced investigators. If you wish to discuss your training needs please contact our External Training and Relationship Lead, Cameron Black at c.black@lgo.org.uk

The role of the Ombudsman in 2024

The Local Government and Social Care Ombudsman has been putting problems right and improving public services for 50 years. We have a unique role in supporting people from all walks of life when the services they rely on from councils, social care support and a range of other organisations go wrong and have a real impact on their day to day lives.

The world is a very different place from when we were created in 1974 by the Local Government Act. In the last five decades we have evolved to become the efficient and focused organisation we are today. We help thousands of individuals to get justice every year and we increasingly change how organisations and whole systems deliver services, with a single decision often impacting hundreds or even thousands of people.

HOW WE WORK ACROSS THE HEALTH AND SOCIAL CARE SYSTEM

■ We carry out joint investigations with the Parliamentary and Health Service Ombudsman (PHSO), providing a seamless service to those people whose complaint involves both health and social care.

■ 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.

OUR SERVICE:

■ We conduct independent, impartial investigations of complaints about service failure and maladministration.

■ We look at individual complaints about councils, all adult social care providers and some other organisations providing local public services.

■ We are a free service and investigate complaints in a fair and independent way - we do not take sides.

■ Where we find fault, we make recommendations for remedy to redress injustice caused. Where the evidence supports it we also recommend changes to policy and practice to address wider systemic failures and to improve the local resolution of complaints and service provision.

EMBARGOED TILL 00:01, 26/09/24

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Care Ombudsman**

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