Sheffield City Council

Annual Report of Complaints Received About Adult Social Care Services

1 April 2020 – 31 March 2021

1. INTRODUCTION

1.1. This report provides information on the complaints received about Adult Social Care services between 1 April 2020 and 31 March 2021.

1.2. The provision of an annual Adult Health and Social Care complaints report is a requirement of the complaints procedures established through the NHS and Local Authority Social Services Complaints (England) Regulations 2009.

1.3. The report has been written by the Council's Complaints Manager (in the role of Complaints Manager as defined in the Regulations) on behalf of the Director of Human Resources and Customer Services and the Director of Adult Health and Social Care. The Director of Adult Health and Social Care has an accountability to provide a local offer in relation to provision of complaints.

1.4. Adult Health and Social Care services form part of the People Portfolio of Sheffield City Council. Services are delivered to people in need of social care under the Fair Access to Care Services criteria. Services are delivered to people with a learning disability, physical disability and/or sensory impairment, and to older people. Mental health services are provided by the Sheffield Health and Social Care Trust; complaints and feedback about mental health services are reported separately by the Trust.

2. WHAT IS A COMPLAINT?

2.1. Sheffield City Council defines a complaint as "any expression of dissatisfaction whether justified or not".

2.2. The aim of the Council is to resolve complaints to the satisfaction of the customers who have made them.

3. WHO CAN MAKE A COMPLAINT?

3.1. Anyone who uses Sheffield City Council services can make a complaint.

3.2. The Council's corporate complaints procedure provides a process for all customers to use.

3.3. If a complaint is about Adult Social Care, the statutory complaints process, as defined by the NHS and Local Authority Social Services Complaints (England) Regulations 2009, is used.

4. THE ADULT SOCIAL CARE STATUTORY COMPLAINTS PROCEDURE

4.1. The statutory complaints procedure is a single stage process designed to resolve matters at the earliest opportunity. However, Sheffield City Council has introduced an optional 'review stage', through which a customer who remains dissatisfied may request that a review of the investigation is carried out by a more senior officer. Where a complaint cannot be resolved, and the customer remains dissatisfied, they are informed of their right to raise this with the Local Government & Social Care Ombudsman.

4.2. A key characteristic of the statutory complaints process is the involvement of the customer in how their complaint will be resolved and how long this will take to investigate.

4.3. On receipt, the complaint is assessed against a set of criteria that determines the way it will be investigated. The majority of complaints are investigated and resolved by the service, but complaints can be investigated by independent investigators where this is judged appropriate. Independent investigators make recommendations to the Council's senior managers.

4.4. Complaints that are about both health services and social care services are investigated jointly with relevant NHS organisation/s. A single, coordinated response is made.

4.5. All complaint responses are approved and signed by the relevant Head of Service or, where appropriate, the Director of Adult Health and Social Care Services.

5. ANALYSIS OF COMPLAINTS AND FEEDBACK

Numbers received

5.1. A **total of 103 new complaints** were received about Adult Social Care services between 1 April 2020 and 31 March 2021. Of the new complaints, 23 complaints were problem solved by the service (56 in 2019/20); 71 were investigated under the statutory complaint procedure (95 in 2018/19) and 10 considered under the corporate complaint procedure.

5.2. The Adult Social Care service also received/formally recorded **a total of 17 compliments.** The service does receive a number of compliments that do not get formally recorded.

5.3. The table below shows the number of complaints dealt with through an investigation under both statutory and corporate complaints procedures broken down by service area:

Table 1: Complaints received by service area

Service area	2019/20 (total)	2020/21 (statutory)	2020/21 (corporate)
0-25/Future Options	-	-	-
Preparation for Adulthood	5	2	
Equipment & Adaptations	6	2	
Localities	36	17	3
Safeguarding	0	2	
Social Care Accounts Service	12	6	
Contracts/Strategic Commissioning & Partnership	31	22	6
City Wide Care Alarms	-	2	
STIT	5	4	1
First Contact Team	5	7	
Hospital & Out of Hours	5	7	
Totals	**105**	**71**	**10**

What the complaints were about

5.4. An analysis is made of each complaint on receipt. Therefore, the categorisation in the table below is based on the customer's perception on making the complaint and does not take into account the findings and conclusions following investigation.

5.5. It should be noted that complaints are categorised against multiple categories to capture all areas of dissatisfaction. Therefore, the totals in the table are greater than the total for the number of complaints received.

Table 2: Complaints by cause/problem category

	2018/19	2019/20	2020/21
Access	4	8	6
Policy/Legislation	5	6	9
Service Quality	147	77	58
Failure or refusal	95	68	67
Delay	38	45	19
Staff Conduct	41	43	50
Total	**330**	**247**	**209**

5.6. 'Failure or Refusal' is the highest overall headline cause of complaint (32%) followed by 'Service Quality' (28%). The highest more detailed causes of complaint were 'Failure or refusal to deliver a service' (13%) and 'Poor Customer Care" (12%).

Responding to complaints

5.7. During 2020/21, a total of 55 complaint responses were issued about Adult Social Care services through the statutory complaints process and 9 complaint responses about Adult Social Care services through the corporate complaints procedure.

5.8. The Department of Health has recognised the complexities of Adult Social Care complaints, and the difficulties in ensuring a quality response in a set timescale, and so took this into account when drafting the complaint Regulations.

5.9. The Regulations require that a timescale is agreed with the customer for each individual complaint, as opposed to their being a set response timescale. However, the Regulations expect all complaints to be resolved within six months.

5.10. Sheffield City Council has a corporate target for responding to complaints of 28 days but in line with the regulations expects the timescale for all statutory complaints to be agreed with the customer in each individual case.

The overall average response time in 2020/21 for the Adult Social Care service was 96 days which is an improvement on the 105 days reported in 2019/20. Clearer response times have been communicated in 2021.

The overall percentage of complaints responded to in 28 days was 16% the same as reported in 2019/20. The Covid-19 Pandemic did impact on Adult Health and Social Care response times to complaints due to conflicting demands on service.

5.11. The table below provides further detail on the investigation response time by specific service area in 2020/21.

Table 3: Complaint Investigation Response times by service area

Service Area	Number of responses	Average response time (calendar) days)	% within 28 calendar days
Localities	17	86	0%
Equipment & Adaptations	2	22	100%
STIT	3	62	33%
Hospital & Out of Hours	7	65	29%
First Contact Team	3	91	0%
Social Care Accounts Service	6	189	33%
Strategic Commissioning & Partnership	4	123	0%
Contracts	11	143	9%
Preparation for Adulthood (ASC Statutory complaints Procedure)	4	128	0%
City Wide Care Alarms	1	2	100%
Safeguarding	2	33	50%
Totals	**60**	**103**	**16%**

Complaint escalation

5.12. During 2020/21, 7% of complaints about adult social care services were escalated for review by a more senior manager (down from 9% in 2019/20).

5.13. There were 14 adult social care related complaints escalated to the ombudsman during 2020/21.

Outcomes

5.14. When a complaint is responded to, we record the complaint outcome. In 2020/21, we recorded the following complaint outcomes:

- Service failures identified – 34%
- Service agreed a way forward with customer – 26%
- Misunderstanding clarified – 19%
- No action necessary – 12%
- Complaints withdrawn by customer – 9%

5.15. The Council is committed to working together with customers to agree resolution. These figures demonstrate that in most cases the Council identified areas for action and improvement.

6. QUALITY ASSURANCE

6.1 The Complaints Team carries out quality assurance checks throughout the year on a sample of complaint responses. A total of 37 responses were sampled during 2020/21, and Adult Social Care services scored an overall quality score rating of 86% against a target of 80%.

One complaint response scored less than 70%. The main reasons for the lower score was a lack of evidence of personal contact; limited empathy/acknowledgment in the response around impact on complainant and service user and no explanation given for the delays. There was evidence of personal contact made in 77% of complaints but contact made within 3 days in only 10% of complaints.
A new Effective Complaints Handling Course has been designed in 2021 and all colleagues invited to join. A new Complaints Case Management system has also been introduced to support effective handling of complaints.

7. MULTI-AGENCY COMPLAINT HANDLING

7.1. The Adult Social Care Service has signed an inter-agency protocol with the local NHS organisations and aim to work together with local NHS organisations to provide single complaint responses to customer problems. This ensures the joint consideration of issues to assist in the improvement of services across health and social care boundaries**.**

7.2. Those NHS organisations that Adult Social Care services work with most frequently are:

- Sheffield Health and Social Care Trust (usually around health and social care joint services to learning disability and mental health service clients)
- Sheffield Teaching Hospitals NHS Foundation Trust (usually around discharge from hospital and health and social care services in the community)
- Sheffield Clinical Commissioning Group

7.3. During 2020/21 14 new complaints were the subject of a joint investigation with health partners (20% of all new statutory ASC complaints).

7.4 Of these complaints,10 complaints were investigated jointly with the Sheffield Teaching Hospitals Trust; 1 with the Clinical Commissioning Group; and 3 with the Sheffield Health and Social Care Trust.

7.5 The services involved were the Localities Service (3); Short Term Intervention Team (1); Hospital & Out of Hours (5); First Contact Team (1); Strategic Commissioning (2) and Contracts (2).

7.6 The Council led the investigation and response in respect of 1 complaint.

7.7 During 2020/21 we sent 11 joint complaint investigation responses with an average response time of 111 days.

8. REMEDIES AND SERVICE IMPROVEMENTS

8.1. A total of 73 remedies and/or service improvements were captured in respect of 30 individual adult social care related complaints that were responded to in 2020/21.

8.2. This demonstrates a positive and resolution focused approach to complaints by Adult Social Care services, and a willingness to learn from customer feedback to make continuous improvements for future service users and their families.

Table 4: Adult Social Care remedies and service improvements

	2018/19	2019/20	2020/21
Financial Remedy	2	5	11
Apology	76	51	33
Change, review or provide a service	17	12	5
Improve customer care	6	9	2
Provide or review employee training or guidance	6	11	6
Provide additional information or explanation	5	4	0
Review or change customer literature	2	2	0
Review or change policy or procedure	13	14	2
Take action or enforce a decision	24	13	14
Take action against contractor/partner	0	3	0
Change Carer	1	0	0
Change service criteria	1	0	0
Total	**153**	**124**	**73**

8.3. A number of complaints resulted in learning and improvements from an individual practice point of view, in particular around communication which fell below the standard expected.

Examples of areas of wider key learning and improvements for the Adult Social Care Service during 2020/21 are outlined below:

- As part of the Direct Payment Improvements Programme, SCC are enhancing the quality assurance protocol for money management companies. Complainants are invited to contribute and share thoughts/views *(Strategic Commissioning & Partnership).*
- Significant work carried out around improving service communication to ensure sufficient level of explanation of key decisions *(Social Care Accounts Service)*.
- Procedure around care workers alerting office if they will be late for a call has been re-enforced with all staff *(Contracts/Provider)*.
- SCC's Clinical Lead has now issued PPE and Covid safety guidance to company and offered support to them in terms of access to the PPE portal as well advice & support from Public Health. Confirmation received that all technicians and drivers now carry masks and gloves as a minimum. Commissioning Service now meeting company on a weekly basis to address making improvements to the service as a whole and are working closely with the newly appointed manager of the company (*Commissioning)*.
- Social work teams, contracts teams and all contracted home care providers have been reminded of process when care transferring to another provider *(Contracts)*.
- Process around handover of care between Short Term Intervention Team (STIT) and home care provider (including communication between STIT and Commissioning) reviewed to ensure effective handover and to ensure that all customers are clear what to expect and what is going to happen next *(Short Term Intervention Team).*
- Concerns raised/complaint findings shared with Contracts and Commissioning to monitor the home care provider more closely to ensure that good quality care is provided (*Localities)*.
- Reminder to staff to ensure that when planned hospital discharges do not go ahead to ensure all relevant parties are notified *(Hospital & Out of Hours Team).*
- Adult Social Care and CCG working hard to ensure that care is given by one care provider going forward to alleviate conflicting care times that would be of detriment to an individual (*Localities/Contracts).*
- Reminder issued to staff that approach is to always be inclusive and conduct positive conversations with patients and family (*Hospital & Out of Hours Team).*

9. COMPLAINTS TO THE LOCAL GOVERNMENT & SOCIAL CARE OMBUDSMAN

9.1. Complaints about Adult Social Care services received by the Ombudsman may become the subject of informal enquiry or formal investigation, or the Ombudsman may issue a decision without making any enquiries of the Council.

9.2. Occasionally, the Ombudsman will receive complaints that have not been considered by the Council, and in those cases may choose to refer the complaint to the Council to deal with first. These are known as ‘premature’.

9.3. In 2020/21 the Ombudsman received and referred 14 complaints about Sheffield City Council’s Adult Social Care Services, 9 of which were subject to formal investigation.

9.4. From an outcome perspective the Ombudsman closed 12 Adult Social Care complaints in 2020/21. Of these

- 6 complaints were upheld
- 2 were not upheld.
- 3 were closed after initial enquiries with no further action required
- 1 referred to council as premature

A summary of the 6 complaints upheld by the Ombudsman is provided at Appendix A.

9.5. Financial remedies totalling £2,500 (excluding reimbursements) were paid in 3 out of the 6 upheld complaints based on Ombudsman recommendations.

10. IMPROVEMENTS IN 2020/21 AND ONGOING/FUTURE DEVELOPMENTS FOR 2021/22

10.1 The following provides an update on actions and areas identified for improvement in 2020/21 and ongoing/future developments for 2021/22

- Complaints Manager appointed to vacant post in August 2020 and now leads on ASC statutory complaint handling.

- Complaints Manager/Assistant Complaints Manager regularly attend service level meetings to discuss and review status of open complaints.

- Recruitment to a dedicated Practice Development Officer (Complaints) to cascade and drive learning from complaints and compliments throughout adult health and social care.

- Statutory complaint handling has been maintained throughout 2020/2021 despite disruptions to service delivery and challenges of remote working due to Covid-19.

- A thorough review of the complaints process is included in the Council's One Year Plan 2021/22 and Adult Health and Social Care Change Programme so that customers are able to challenge and help us drive improvement in all our services.

- The ongoing complaints project focuses on the transformation of how we record and manage customer feedback and complaints across the organisation. It aims to improve the customer journey as well as our internal case management processes. The new Customer Relationship Management (CRM) system to improve recording and reporting of complaints, compliments and suggestions went live in November 2021.

- As part of the ongoing project all employees will be provided with the support and training needed to professionally manage complaints, by taking ownership and accountability from the day the complaint is received. Existing on-line and remote classroom training is being refreshed and relaunched. Complaint and feedback procedures; information/guidance available to all employees and managers around resolving, investigating, reviewing and responding to complaints; and letter templates are all being refreshed and information will be made available to all staff via a complaints and feedback SharePoint site.

Contact Us

If you would like to make a complaint, suggestion, or compliment, you can do this by completing an on-line form on Sheffield City Council's website:

https://www.sheffield.gov.uk/home/your-city-council/complaints

You can also telephone us on 0114 273 4567, or write to:

Customer Services
Sheffield City Council
Town Hall
Pinstone Street
Sheffield
S1 2HH

If you would like to comment on this report, or have any questions about Sheffield City Council's complaints procedure, please contact the Complaints Team at:

Email: complaintsmanagers@sheffield.gov.uk
Telephone 0114 273 4567 or write to the above address.

Appendix A – Breakdown of 6 Adult Social Care complaints - Upheld by Local Government and Social Care Ombudsman 2020/21

Complaint	Ombudsman Finding/Investigation Outcome	Agreed Remedy/Service Improvements	Remedy implementation detail and learning outcomes
Mr X complained for his wife Mrs X that the Council delayed in responding to his request in August 2018 for assistive technology and delayed in reviewing Mrs X's care and support plan.	LGSCO upheld Mr X's complaints about a delay in responding to his request for assistive technology (AT) for his wife Mrs X and a delay in reviewing her care and support plan and found the fault caused avoidable distress and financial loss. (Decision date 22/05/2020)	Council agreed (within two months) to apologise; fund the items set out in Mr X's original proposal for AT; reimburse Mr X for the items of AT he has already bought; pay Mr X £2000 in recognition of severe and long term impact; and identify and arrange suitable respite for Mrs X, consulting with Mr and Mrs X about the available options.	23/07/2020 - Apology letter sent to Mr and Mrs X. 24/07/2020 - £2000 payment raised 17/09/2020 - Further letter to Mr and Mrs X confirming verbal agreement that £775 reimbursement for assisted technology to be taken from surplus monies in the DP account. Copy of support plan hand delivered to Mr and Mrs X.
Mr Y complained the Council failed to meet his brother Mr X's needs due to the inadequacy of his current supported living accommodation and it failed to deal with the disruptive behaviour of another tenant.	The LGSCO concluded any concerns Mr Y has about the current accommodation are matters for the housing association and are outside the LGSCO's jurisdiction. The LGSCO found no fault in the way the Council is meeting Mr X's needs or in respect of the taken action to address the concerns about the other tenant's behaviour. The LGSCO did find fault for failing to review Mr X's care plan. (Decision date 30/07/2020)	The Council agreed (within three months of the final decision) to review Mr X's needs assessment and support plan.	Review of the support plan commenced 26/08/2020 and was completed/agreed 14/10/2020. Copy shared with LGSCO 29/10/2020.

Mr X complained the Council underfunded his mother-in-law's care between 2017 and 2019 and as a result the family had to pay more than £9,000 in top-up fees to the care provider. He complains the care provider failed to respond to his correspondence or assist with the refund and did not properly deal with his complaint.	The LGSCO found that in 2019 Mrs Y's social worker noticed the Council's error and informed Mr X. Mr X raised the matter with the Council and the care provider and while the Council acknowledged its error and agreed to reimburse the family the care provider did not respond to his correspondence or phone calls and maintained the family had not overpaid and were not due a refund. The LGSCO noted the Council had now issued Mr X a refund for the overpayment and agreed to pay more than £250 in interest and a further £300 for his time and trouble. (Decision date 15/09/2020)	No further action deemed necessary. Although Mr X remains unhappy with the care provider's handling of the matter and wants it to acknowledge its failures, improve its practices and apologise. The LGSCO will not investigate the complaint as the body commissioning Mrs Y's care the Council is responsible not only for its own actions but also for those of the care provider it commissioned to care for Mrs Y on its behalf. The Council acknowledges it failed to properly assess Mrs Y's care needs or to increase its funding for her care as required and it has provided a suitable remedy for this.	Not applicable

Mr B complained on behalf of his partner, Ms C, about the quality of care she received between August and November 2018. Care arranged by the Council and delivered by care provider.	On balance the LGSCO found the Care Provider failed to always meet standards expected in caring for Ms C including failure to keep appropriate records around visits and contacts; failure to investigate reported incidents and failure to take reasonable steps to ensure female carer attended. LGSCO also found failure by Council to follow basic good administrative practice when Mr B first made service aware of concerns including failure to ensure adequate investigation and failure to keep a record of key meeting, which was compounded by poor/delayed complaint handling. (Decision date 13/11/2020)	LGSCO gave credit to the Council for refunding to Ms C all fees paid for the care given by the Care Provider and writing off any balance due and because of this and given Mr B's own wishes did propose a financial remedy. The Council agreed (within 20 working days of decision) to provide a written apology to Mr B and Ms C accepting the findings of the investigation; Also (within three months) to write to LGSCO to clarify what further steps it has taken to assure itself the Care Provider: • has satisfactory procedures in place to ensure the safe administration of medication to users of its services; • has satisfactory training in place to ensure the safe moving, handling and transfers of users of its services; • keeps adequate records on its client files of such matters as the user of services' preference for care workers of a specific gender; how it records concerns or complaints from users of services including those brought to its attention by the Council;• undertakes prompt investigation into any concerns raised about the practice of individual care workers. Also (within three months) write to LGSCO to clarify what further steps it has taken: • to ensure that its social care staff ensure investigation of concerns raised by users of services; • to ensure that its social care staff maintain oversight where they have asked a Care Provider to look into a user of service's concern; • to ensure that officers asked to respond to complaints are reminded of the need to respond to the individual concerns around poor care raised by complainants; as well as considering broader questions of care provider's policy and practice; • to ensure timely responses to complaints and steps it has taken to avoid a repeat of the communication breakdown between its social care and contracts team that it says caused delay in replying to Mr B's complaint.	02/12/20 - Apology letter sent 31/03/21 - Chronology shared with LGSCO detailing contract monitoring and support visits undertaken and evidencing review of moving and handling training. 24/05/21 - Further evidence shared with LGSCO that various background documentation has been revisited and reviewed with Provider to ensure Provider aware of their responsibilities in completion of these documents and to also ensure compliance with the contract in place. This included: - Summary statement from Provider outlining their approach for Person Centred Care Plans and actions taken following concerns raised regarding a staff member. - Provider Complaints and Compliments Policy. - Incident Report Form - Investigation Disciplinary process - Person centred care plan (PCP) - Person centred medication plan (PCM) - Risk Assessment documents - Provider Service User Guide Provider confirms all Care workers are encouraged to read entire care plans to ensure important information is not missed for any client. Care plans are supported by additional documents such as risk assessments and if require, a medication care plan.

Mr X complained about distress caused to him and his wife because of errors the Council made with a care assessment. He also complained the Council commissioned care with a provider he had complained about previously.	The LGSCO found multiple errors in the assessment report the Council sent Mr and Mrs X. The issues with the assessment led to concern and anxiety and a loss of trust in the Council meeting Mrs X's needs and this took some time to resolve. There was further fault when a communication breakdown led to the Council commissioning care from Care Provider A. The Care Provider acknowledged due to an error when the Council cancelled the service, the visit still went ahead. The LGSCO concluded this would not have happened, had the Council clearly communicated Mr and Mrs X's wishes to the team organising her care. (Decision date 24/11/2020)	The Council had already apologised to Mr and Mrs X and taken steps to ensure the same problems are not repeated. However, to recognise the distress and anxiety caused by the failings set out above the Council agreed to make a payment of £100 to them (within four weeks of final decision).	11/12/20 - Email to Mr X to confirm that £100 payment (cheque) will be posted out on Wednesday 16th December - copy shared with LGSCO.

Ms B complained the Council failed to involve her as next of kin or take account of her father's wishes when placing him in a care home. Ms B complained the Council placed her father in an inappropriate placement, delayed meeting with her father to discuss his wishes, delayed completing a deprivation of liberty application, delayed completing a mental capacity assessment, failed to hold a best interests meeting, failed to carry out a safeguarding investigation and delayed completing an assessment when he was ready for discharge from hospital.	The LGSCO found the Council delayed meeting Ms B's father and in carrying out a mental capacity assessment and safeguarding investigation but no fault in the other parts of the complaint. The Council's delay caused Ms B distress and created some uncertainty about whether the outcome would have been different. (Decision date 15/01/2021)	The Council agreed (within one month of decision) to apologise to Ms B for the faults identified in this statement and pay her £400 to reflect her distress and the time and trouble she had to go to pursuing the complaint. Also (within two months) the Council agreed to draw up an action plan to address the faults identified (or provide evidence its practice development programme does so). That action plan to include: • consideration of how to keep the service user/vulnerable adult at the centre of the planning rather than being deflected by what the family's wishes are; • carrying out mental capacity assessments where a person's mental capacity is questioned and arranging a best interests meeting as soon as possible following that if the person is assessed as not having capacity; • the need to fully complete the record from the best interests meeting to show the options considered and the final decision reached; • consideration of the circumstances in which advocacy should be considered and/or some type of mediation where there is a difference of opinion or a person wants to return home and the partner disagrees; and • consideration of progressing a safeguarding referral where a family has requested it be put on hold.	11/02/2021 - Copy of apology letter sent to LGSCO alongside confirmation that £400 compensation payment will be made on the 16/02/2021. 19/03/2021 - Copy of updated Action Plan (with supporting documents) shared with LGSCO confirming following: - A series of practice development webinars have been developed to support staff in a number of different areas including Safeguarding, Financial conversations, Carers, Advocacy and the statutory assessment (Conversation 3). - Key messages around advocacy shared with staff and guidance around assessment (Conversation 3) circulated and discussed at team manager level, who are sharing with their staff. - Development of a legal literacy training course for staff covering the Mental Capacity Assessment and Best Interest processes. - Skills audit as part of the personal development review process will check individual training needs.