Complaints and Compliments
Annual Report

1 April 2019 – 31 March 2020

Adult Social Care Customer Services

Contents

Executive Summary

Executive Summary

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 combined the statutory complaints procedures for the NHS and Social Care under a single set of rules. This report, therefore, includes service user feedback in relation to Adult Social Care and Public Health.

Leeds City Council Adults & Health Directorate provides a range of services. Some services are provided by commissioned independent providers in residential care, supported living and commissioned home and day care. This annual reporting, therefore, includes services provided by commissioned independent providers.

This report provides information about compliments and complaints received during the twelve months between 1 April 2019 and 31 March 2020. As the reporting year came to a close in March 2020, the Council and care providers faced exceptional operational challenges because of the impact of COVID-19. This report, however, largely relates to the period prior to COVID-19. The full impact of COVID-19 on care users will be in the 2020-2021 financial year report.

In the 2019/20 reporting year 10,630 people received a service from Leeds City Council Adults & Health Directorate. When looking at a total number of complaints 651 therefore, 6% of service users or someone acting on their behalf raised a complaint about a service that they received and 1680, 16% of service users or their representative raised a compliment about the service that they received.

The focus for Leeds City Council Adults and Health has been to empower people to feedback about their social care service and to use the feedback to improve the quality of service provided. The service does not regard high numbers of complaints negatively, but rather as a positive indicator of service users, carers and family members being able to give feedback on the quality of service provided. The 6% increase is pleasing to note and is in line with our efforts to encourage more people to talk to us. As well as ensuring that this is included in the annual reporting, complaints are a valuable source of intelligence to help inform commissioning activities and service improvements.

This report highlights how various services within the Adults and Health Directorate have performed in line with key principles outlined in the complaints regulations and provides information about the nature of complaints, the compliments received and actions being taken to improve the quality of health and social care services.

Part of the year under review has been exceptional and challenging due to the COVID-19 pandemic. The aim for the Complaints Team has been to try and maintain a good customer service by focussing on keeping people informed. An update on some of the initiatives is as follows:-

- In this reporting year, we delivered face to face training to 214 staff. We delivered 8 sessions in total May, June, August 2019 and 2 in February 2020 before we paused our face-to-face training due to the COVID-19 pandemic. Arrangements are now in place to provide virtual classroom training, targeting Service Delivery Managers and Team Managers until March 2021 when we will re-assess the current circumstances.

- The Complaints Team has continued its close working and sharing of intelligence with the Working Age Adults Contracts Team, Homecare Contracts Team, the Residential and

Nursing Older People Contracts Team and the Quality Team to support commissioned providers to attain good or outstanding Care Quality Commission ratings.

- Continued to share key messages with operational teams by attending their management team meetings, these changed to virtual meetings when COVID-19 set in.

- Joint Working with our NHS Partners and the Voluntary Sector is good. The Leeds city wide complaints managers group meet on bi-monthly basis. In demonstrating learning from complaints individual organisations can evidence learning from complaints, however, there is no central mechanism to draw together and share lessons learned from mixed sector complaints. The next step has been to develop a system which should draw together lessons learned from people's experience of health and social care across the city. Initial discussions have taken place and arrangements are in place to develop a system which should allow the highlighting of lessons learned from mixed sector complaints.

- 1680 compliments were received in this reporting period compared with 1131 the previous year representing a 49% increase. The compliments received evidence how the Adults and Health Directorate is meeting the key qualities people expect from Health and Social care Services. Excellent examples of service users and/or their families thanking staff for being kind, respectful, treating them with dignity. Other professionals praising staff for effective joint working and how staff have promoted positive working relationships with partners. The Reablement service being praised for the service making people more independent and increasing their confidence and generally improving their quality of life which has aided their recovery. Overall excellent feedback across the board and most humbling.
- 651 complaints were recorded compared to 520 in the previous year, representing a 25% increase. The increase is positive as our ongoing strategy is to encourage more people to talk to us so that we can understand their experiences to help inform delivery of responsive quality services. The Complaints Team continues to work with service teams, contract and commissioning officers and commissioned provider staff in order to ensure that compliments and complaints information is shared with the complaints team. In addition to ensuring that the information is included in any reporting, complaints are a valuable source of intelligence to help inform commissioning activities and service improvements.
- 25 enquiries were made to the Local Government and Social Care Ombudsman compared to 27 the previous year. A breakdown of the 25 enquiries is detailed in Appendix 5 of the Report.
- Monitoring of our compliments and complaints procedure has again led to a number of actions and areas for development as set out in the report.

Judith Kasolo
Head of Complaints

1. Purpose of Report

The purpose of the annual report is to review the operation of the complaints procedure over a twelve month period and to provide information about complaints themes, the compliments received and actions being taken to improve the quality of social care services.

This report provides information about compliments and complaints received during the twelve months between 1 April 2019 and 31 March 2020.

2. Background

2.1 Local authorities and the National Health Service are legally required to establish complaints procedures to deal with complaints about their health and social care functions.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 applies to Adult Social Care. Similarly the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 applies to Public Health functions.

3. What is a complaint?

The Department of Health defines a complaint as:

'An expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a local authority's Adults Social Services and the National Health Service provision which requires a response'. The Adults and Health Directorate uses this definition.

In addition, it is important to note that service users or their representatives generally view complaints in its every day sense i.e. to mean any statement about a service or member of staff that has not met the standard that they can reasonably expect.

If it is possible to resolve the matter immediately, there is no need to engage the complaints procedure.

4. Who can make a complaint?

Anyone coming into contact with Leeds City Council can make a complaint. The Corporate Complaints Procedure provides a process for all service users to use. If the complaint is about Adult Social Care or Public Health functions, the statutory complaints procedure for Health and Social Care services must be used.

A person is eligible to make a complaint under the statutory complaints procedure where the Local Authority and the Health Service have a power or duty to provide or secure a service. This includes a service provided by an external provider acting on behalf of the Local Authority. In such a case service users or their representatives can either complain directly to the provider or to Leeds City Council, as commissioner of the service.

Commissioned providers are encouraged to attempt to resolve complaints at the first point of contact in line with good practice highlighted by the Local Government and Social Care Ombudsman, but are equally advised to direct service users or their representatives to commissioners of the service, where local resolution is not possible or appropriate, or where the complainant remains dissatisfied.

A complaint can be made by the representative of a service user who has been professionally defined (under the Mental Capacity Act 2005) as having no capacity to make decisions, as long as the representative is seen to be acting in the best interests of that service user.

Anyone can complain who is affected (or likely to be affected) by the actions, decisions or omissions of the service that is subject to a complaint.

5. The complaints procedure

The complaints procedure is a two-stage complaints system, focusing on local resolution and, if unresolved, an investigation by the Ombudsman.

The aim of the Local Authority Social Services and the National Health Service complaints regulations is to make the whole experience of making a complaint simpler, more user-friendly and more responsive to people's needs. The emphasis is to offer a more personal and flexible approach, which is effective and robust. Complaints are risk assessed. The investigation needed is informed by the level of risk and complexity and the wishes of the complainant.

Complaints Officers contact the complainant to agree the complaint and sought outcome. They then determine the level of risk and complexity. Options include mediation, resolution by the Service Manager or an independent investigation.

Each complaint is treated according to its individual nature and the wishes of the complainant.

In the reporting year 10,630 people received a service from Adult Social Care.

When looking at the total number of complaints of 651 therefore, 6% of service users or someone acting on their behalf raised a complaint about a service that they received and 1,680, 16% of service users or their representative were happy with the service that they had received from adult social care or public health.

6. Review of compliments received

Table 1 – Compliments Received by Service Area

Service area	**2019/20**	%	2018/19	%
Skills/Reablement	**392**	23.3%	**280**	24.8%
Blue Badge	**291**	17.3%	**443**	39.2%
In-house Older People Residential and Day Services	**257**	15.3%	**40**	3.5%
In-house Mental Health Residential and Day Services	**186**	11.1%	**51**	4.5%
Equipment and Adaptations	**117**	7%	**59**	5.2%
Area Social Work	**83**	4.9%	**64**	5.7%
Learning Disability Housing and Day Services	**75**	4.5%	**51**	4.5%
Physical Disability Residential & Day Services	**69**	4.1%	**2**	0.2%
Resources and Strategy	**64**	3.8%	**61**	5.4%
Independent Sector Other	**36**	2.1%	**15**	1.3%
Learning Disability Social Work	**31**	1.8%	**20**	1.8%
Independent Sector Home Care	**22**	1.3%	**14**	1.2%
Independent Sector Care Homes	**22**	1.3%	**1**	0.1%
Strategic Commissioning	**11**	0.7%	**3**	0.3
Hospital Social Work	**10**	0.6%	**8**	0.7%
Mental Health Social Work	**7**	0.4%	**6**	0.5%
Leeds Shared Lives	**5**	0.3%	**8**	0.7%
Meals	**2**	0.1%		
Public Health Healthy Living & Health Improvement	**-**	-	**3**	0.3%
Public Health Resource Centre	**-**	-	**1**	0.1%
Transformation and Innovation	**-**	-	**1**	0.1%
Total	**1680**	100%	**1131**	100%

6.1 1680 compliments have been received this reporting year, compared to 1131 in 2018/19. Compliments evidence how the Adults and Health Directorate are meeting the key qualities people expect from health and social care services i.e. being treated with dignity, respect, staff being caring, responsive to people's needs, being effective and well-led.

6.2 The increase in compliments is in response to the Adults and Health Complaints team and frontline staff efforts to try and increase the number of people talking to us and providing us with feedback either good or bad. The complaints leaflets which are provided to service users at assessment or at review encourage service users or their representatives to tell us what they think of the service. Service users are informed that learning is taken from compliments in the same way as complaints and are recorded and used to influence and promote best practice.

6.3 Service users or their families have made compliments in person or in writing through personal thank you letters, cards, using the feedback forms or by email. As

part of the continuing complaints training both Adults and Health staff and staff from commissioned providers are actively encouraged to forward any compliments to the Complaints Team in order to ensure that they are recorded.

6.4 The largest number of compliments were received by the Reablement Team, who received 392 compliments which was an increase from 280 the previous year. Service Users commented about how caring, kind and reliable the carers were. Some commented on how the service made them more independent, increased their confidence and improved their quality of life which aided their recovery. Some Service Users mentioned how patient and friendly the carers were which made them comfortable, one Service User mentioned they "*made you feel as if you had known them for years"*. A family member commented that "We have found the team reliable, friendly, professional and helpful. They responded quickly when mum began choking on her medication."

The Blue Badge Team received 291 compliments. Service users commented on how pleasant the assessors were that the assessment was carried out in a relaxed atmosphere. Service Users commented on how they were treated with respect whilst others commented on how well organised the process was. Service Users mentioned that the building was welcoming with good access and facilities which were comfortable and there was plenty of parking. Many commented on how kind and helpful the assessors were and how at ease they felt and how time was taken to explain the process and everything was very clear. The assessor "was brilliant to me in every way she could be to me and I am so grateful for her help and consideration it will make a huge difference to me".

Older People Residential and Day Services received 257 compliments. Family members commented on the care and compassion their loved ones received during their end of life care to ensure the final weeks were as comfortable as possible "Every single member of your team always treated us and Mum with great compassion and the end of life care that Mum received was fantastic". Service Users commented on the high standard of care they had received One Service User commented "Thanks for all your kind care and attention, it's a beautiful place and staff are wonderful. It is like a 5 star hotel." Many compliments were received for the Recovery Hubs which is an intermediate service between a hospital stay and being discharged home. Service Users commented on kind, cheerful and caring staff and a comfortable environment.

6.5 186 compliments were received for the In house Mental Health Residential and Day Service. Service Users commented on the support, understanding and encouragement they had received from staff. Mental Health Homeless Team received compliments for assisting them into accommodation and support with obtaining household furnishing and items such as carpets and kettles. One Service User thanked a worker for getting a food parcel after their freezer broke. A Service User commented "his support made all the difference for him and his family. The support allowed him to stay with his child when it was most important for him. It helped his child to feel safe and protected".

6.6 Equipment and Adaptation Service received 117 compliments clients thanked staff for their help and support and how they found the various aids a great help, this was an increase from 59 the previous year. Others commented on how the workers were patient and took time to explain everything and came up with ideas or

suggested aids that would be helpful and make people safe, comfortable and maintain independence. “I just wanted to say how amazing the team here in Leeds have been in recent months, they have quite honestly been my lifeline. It has been a rollercoaster of a decade dealing with both the physical and emotional challenges that come with a degenerative health condition and I've been genuinely astounded by their empathy, care and understanding of my situation. I really can't thank them enough and may this help and support continue for those out there like myself”.

6.7 83 Compliments were received for the Area Social Work Teams. Comments were received on Social Workers’ person centred approach and ensuring that the correct support services were available and client’s needs were met. Others commented on how compassionate and kind the Social Workers were and how their involvement has been invaluable, professional and how they have treated Service Users in a dignified manner. “May I take this opportunity to say a huge heartfelt thank you for ALL the help, support and guidance that you have been able to offer us during this difficult time, you have always answered my many silly questions rapidly and very professionally. Without your assistance I really don't think I could have got through this turbulent time. Knowing you were there to assist me made a huge difference”.

6.8 Learning Disabilities Housing and Day Services received 75 compliments. Comments were received from family members regarding how staff had built positive relationships with Service Users which aided a smooth transition into the service. The staff supported Service User in promoting their independence; one relative commented “this showed that everyone is actively thinking about new ways that the Service User can safely access and experience the outside world. ”Staff offered a flexible approach for example when assisting in emergency placements often with short notice. On one occasion this prevented an out of area placement.” Many complimented the excellent care their loved one had received and how caring and friendly staff were.

6.9 69 Compliments were received for Physical Disability Residential & Day Services. Service Users commented on how much they had enjoyed accessing the service and had enjoyed visits out to places such as Leeds Art Gallery and the Royal Armouries, one client commented “They worked really hard and it was one of the most enjoyable days I've had for a long time!". A few Service Users complimented staff for supporting them in accessing work placements or voluntary work. Other Service Users had thanked Staff for their support with chair based exercises or Hydrotherapy which they had found enjoyable and beneficial.

6.10 64 Resource and Strategy – of those 45 were received for the Complaints Service. Service users commented that workers they spoke to when dealing with complaints were patient, understanding and kept them updated. Compliments were also received from Managers and agencies thanking the Complaints Team for their advice and support. In addition compliments were received from professionals who had attended the complaints training course. A write up published by Healthwatch England commented on good practice case study about Leeds City Council, Adult Social Care Complaints Team and its positive approach to complaints.

6.11 The Adults and Health Finance Service received 19 compliments this year. Service users and their families commented on how patient, helpful and efficient staff have been and how they dealt with queries promptly and professional, some clients really

appreciated that staff took time to support them and assisted them in resolving issues.

6.12 31 Compliments were received for Learning Disability Social Work which was an increase from 10 last year. Compliments from family members thanking the Social Workers for their support and sensitivity through complex situations. Comments were received from other professionals complimenting Social Workers on their collaborative work. One professional complimented a Social Worker and her care and commitment to a Service User which they found inspiring. Family members thanked Social Workers for their support to find appropriate placements or activities and for supporting them as carers.

6.13 Independent Home Care received 22 compliments which was an increase from 14 the previous year. Compliments were made about reliability of the service and the friendliness and caring manner of the carers and their kindness and willingness to 'go the extra mile'.

6.14 Independent Care Homes received 22 compliments, an increase from 1 the previous year. Family members commented on the compassion and professionalism of the staff and how attentive the staff are with the residents. One family member commented that they have peace of mind that their loved one is safe and well cared for during the current Covid 19 pandemic and how incredibly grateful they are to the staff. Since their relative became a resident, the home has received an Outstanding CQC rating.

6.15 Commissioning Service received 11 compliments this year. Other professionals commented on effective joint working and how staff have promoted positive working relationships with partners.

6.16 Hospital Social Work received 10 compliments this year. Compliments were received from family members for the kindness and consideration shown to their relative. Compliments were also received from other professionals for work in assisting with reducing the length of patient's average stay in hospital and also in reducing the number of patients with the longest length of stay 'super stranded'.

7 Compliments were received for the Mental Health Social Work team. Relatives commented on the care and compassion shown to their relatives and for the level of support during challenging circumstances. Other professionals commented on the Social Worker's response in emergency situations. A judge praised a Social Worker for the detail of their report which aided the judge in their decision making.

Leeds Shared Lives received 5 compliments. Thank you cards were received thanking workers for their support and friendship.

2 Compliments were received for the meal service. Both mentioned that it was an excellent service and the meals were delivered on time.

7. Review of complaints received

Table 2 – Complaints received by service area

	2019/20		2018/19	
Service area	**Number of complaints**	% of total complaints	Number of complaints	% of total complaints
Total	**651**	100.0%	**520**	100.0%
Area Social Work	**129**	19.8%	**102**	19.6%
Blue Badge Applications	**78**	12%	**37**	7.1%
Independent Sector Home Care	**76**	11.7%	**76**	14.6%
Independent Sector LD supported/day services	**57**	8.8%	**6**	1.2%
Finance	**47**	7.2%	**47**	9%
Older People Direct Provision Residential Care	**42**	6.5%	**36**	6.9%
Learning Disability Social Work	**40**	6.1%	**36**	6.9%
Equipment and Adaptations	**33**	5.1%	**39**	7.5%
Independent Sector Other	**28**	4.3%	**18**	3.5%
Skills / Reablement	**23**	3.5%	**17**	3.3%
Mental Health Accommodation and Day Services	**21**	3.2%	**12**	2.3%
Learning Disability Commissioned Services	**17**	2.6%	**25**	4.8%
Hospital Social Work	**17**	2.6%	**16**	3.1%
Independent Sector Care Homes	**12**	1.8%	**19**	3.7%
Mental Health Social Work	**12**	1.8%	**11**	2.1%
Older People Direct Provision Day Services	**11**	1.7%	**5**	1%
Strategic Commissioning	**4**	0.6%	**8**	1.5%
Other Council Department	**1**	0.2%	**5**	1%
Support services	**1**	0.2%	**2**	0.4%
Public Health Localities, P Care, Capacity /Capability	**1**	0.2%	**-**	-
EDT	**1**	0.2%	**-**	-
Public Health Sexual Health Commissioning	**-**	-	**2**	0.4%
Safeguarding Unit	**-**	-	**1**	0.2%
Public Health Healthy Living Service	**-**	-	**0**	0

7.1 The Adults and Health Directorate provides a range of services in a range of settings and where the Council commissions care from the independent sector, the Ombudsman is very clear that the Council remains accountable for the actions of the commissioned service provider. It is usually best to tell the care provider and give it chance to put things right. However, if the problem cannot be sorted out there and then and the person continues to be unhappy, they have a right to complain to the Council, as commissioner of the service. In these circumstances,

service users or their representatives are advised to raise concerns with the Complaints Team. The Complaints Team recorded 651 complaints in this reporting year compared with 520 complaints the previous year.

The monitoring and oversight of complaints made directly to commissioned providers is in response to recommendations made by the Ombudsman in their Annual Review of Adult Social Care Reports. The Ombudsman has made it very clear that it will hold commissioners accountable for the commissioned service providers' failings and further that it is the commissioner who will be held accountable to remedy any identified failings. In view of this, Adults and Health Directorate has developed and implemented an Information Sharing Protocol with effect from October 2018 which should provide a framework for regular communication between the Council and its commissioned service providers in relation to any complaints and compliments relating to the Council's Adults and Health commissioned services. This should provide the Council an opportunity to gain an overview of compliments and complaints of commissioned services.

8. Nature of Complaints

The most common category of complaints are as follows:-

- 127 complaints about Challenging assessment outcome
- 122 complaints about Quality of service
- 105 complaints about Inconsistent Home Care Service
- 98 complaints about Staff Attitude Conduct
- 78 complaints about Lack of Social Work Support

8.1 Challenge Assessment Outcome. This was the most common cause for concern. 15.5% of complaints received were about this issue. Below is a summary of some of issues raised

Blue Badge Team. New legislation was introduced in 2019/2020 allowing hidden disabilities to be taken into consideration as eligibility for a blue badge. Complaints of people wishing to make a complaint increased from 37 the previous year to 78 this year. A summary of some of the key issues raised:

- Many of the Service Users challenging the assessment outcome felt that their condition did meet the criteria to be issued a blue badge
- Some Service Users who raised concerns felt that all of their conditions or all of their supporting evidence had not been taken into consideration
- Several Clients appealed that their incontinence issues did not meet the criteria to be issued with a Blue Badge.
- One complaint was received regarding their supporting information going missing which had been sent by Specialists to the Blue Badge Team.
- Many of the complaints received this year were from clients not meeting the criteria for the new hidden disabilities criteria and wishing to challenge this.
- A few complaints were received from parents of children with learning disabilities who feel their child meets the hidden disability criteria.

- Some Service Users, in particular with hidden disabilities were not in a position to provide sufficient supporting evidence from professionals but still feel their health conditions meet the criteria.

Finance. A summary of the key issues included the following:

- Some Service Users felt that either all of their information was not provided, accessible or taken into consideration.
- Many complaints received were from Service Users who felt they have less capital than they have been assessed as having or certain assets should be disregarded and not form part of the assessment. .
- Several complaints were where the Service User's contribution has increased due to a change in their circumstance but disagreed with the increase in their contribution
- Some family members who raised concerns felt that the services should not be chargeable or they should have a nil contribution.
- Several complaints were received from Service Users who felt some of their disability related expenditures should have been disregarded when taking into consideration their contribution and their assessed contribution should be reduced to reflect this.
- One Service User felt their assessed contribution was too high and did not leave them sufficient living expenses.
- A complaint was raised by a Service User who would usually give financial gifts to family members is no longer allowed to do so as it is seen as deprivation of assets. He was previously self-funding his care and now required Council funding for his care.

Area Social Work. Some of the key issues raised include the following:

- Many complaints were raised by family members who felt that their relative required more services than they were assessed to receive so were requesting an increase in service.
- Several family members disagree that their relative had been assessed as being able to remain in their own home and feel they should move into a full time residential placement.
- Some family members were challenging the 'third party top up' for the Service User's residential home placement and requested that the cost of the residential home be fully funded.
- A couple of complaints were received where relatives challenged that the Service Users did not meet the threshold for a Continuing Health Care Assessment and request their services were full funding.
- We received complaints where Service Users felt other items or services should form part of their care plan and requested a more person centre approach
- Three complaints were received from relatives who felt they were incorrectly advised about top up charges.

- Complaints were received that challenges that Service Users had been deemed to have capacity when the Complainant felt that they did not.
- Complaints were made which disagreed with the decision that the Authority act as appointee in dealing with finances both from relatives and Service Users.

8.2 **Quality of Service.** This was the second most common cause for concern with 14.8% of the total number of complaints received.

Older People Services. A summary of some of the issues raised included:-

- Complaints were received where there was a failure to identify that the Service User was suffering from a water infection or delay in arranging this to be tested when Service Users were displaying challenging behaviour.
- Many Complainants felt there was a lack of communication with family members which caused matters to escalate.
- Family members raised concerns concerning a poor level of care or service users having to wait for support to be administered.
- Complaints were made from family members who felt staff were abrupt with them or that they are an inconvenience when asking staff for updates or assistance.
- One complaint was received raising that family meetings were held through the week so some family members are unable to attend.
- Complaints were received from one family members who felt frustrated that the Service User was not making improvements, for example with their mobility and they felt that staff should be doing more. The Complainants felt there was a lack of rehabilitation.
- As part of their complaint two family members felt that staff members should have given them more detailed responses.
- Complaints were received from family members that personal care was not being delivered, for example teeth or hair not being brushed.
- Complaints were also received regarding a lack of recording or incorrect recording of care delivered.

Learning Disability Commissioned Services. A summary of some of the issues includes:

- Concerns were raised that there was a lack of staff training which made the Service User feel that they were not looked after.
- A family member raised that there are too many agency staff and no continuity of care. Workers were therefore unfamiliar with how to handle some Service User's challenging behaviours.
- Family members felt there was a lack of communication and a lack of feedback. Some family members felt that as a result of the lack of

communication progress was not made and support was not being implemented.

- Concerns over hygiene standards were raised. A Service User had not been cleaned property and was drinking out of a dirty glass. Another required their teeth to be brushed more regularly.
- A Service user commented that their weekly support was cancelled at short notice and no cover was provided.
- A member of the public was unhappy that a security light was shining into her bedroom
- Concerns were raised regarding staff members buying fizzy drinks for a Service User when he is discouraged from having them due to his health concerns.
- Complaints were raised regarding workers arriving late, which then in turn had an impact on the Service User's mood and behaviour.

Independent Home Care. A summary of some of the issues includes:

- Concerns were raised regarding inadequate personal care; Service Users were not being cleaned adequately, bedding not being changed and the Service User's home not being left tidy.
- A Service User complained that support staff were talking on the phone instead of assisting them and that carers were talking between themselves which made the Service User feel excluded.
- Two complaints were raised that carers were not wearing uniforms when they visited the Service Users to deliver care. This caused confusion to the Service User who suffered from dementia.
- Concerns were raised regarding lack of communication; this resulted in the family of the Service User being unsure what care had been delivered.
- A relative of a Service User raised a complaint that sugary drinks were being provided to a Service User who is diabetic.
- Complaints were raised regarding the lack of training in dealing with clients who suffer from dementia and dealing with their challenging behaviour.
- Other issues include carers taking the Service User's key so no one else could get into the Service User's home, meals not being heated thoroughly.
- Complaints were also raised regarding agreed tasks not being carried out such as opening and closing curtains and washing up.
- As part of complaints family members commented that when they had raised concerns they had not been provided with feedback or the outcome of the investigation from the care provider which made them feel ignored.

Disability Services. Some of the issues raised included:

- Complaint were raised about problems with adaptations and the family also challenging decisions within the assessment

- A family member was unhappy that decisions were being made about the Service User without her being present
- Incorrect equipment being provided. A Service User's replacement equipment was delivered but was not fit for purpose, several alternatives were supplied but were not ideal and a special order was required which should have been identified earlier.
- Complaints were received concerning equipment which was supplied for Service Users not being collected when it was no longer required.
- One complaint was received regarding staff members visiting houses without shoe coverings; the Complainant felt these should be provided.

8.3 **Inconsistent Home Care** was the third most common cause for complaint. A summary of the issues raised are as follows:-

Independent Home Care Providers.

- Many complaints were received regarding an inconsistent number of different carers attending to deliver care. A Service User commented that the care agency has a high turn-over of staff. Family members were particularly concerned about this where the Service User suffered from dementia.
- A number of complaints were raised regarding missed call visits; this caused great distress to one Service User who was unable to prepare their own meal.
- Complaints were raised regarding only one carer attending when there should have been two carers in attendance; two carers were required in order to safely transfer the Service User.
- A number of complaints were raised regarding inconsistent times of carers arriving either early or late for visits, this resulted in one Service User having their breakfast at 10.30 and lunch at 11.30, others had continence issues or health concerns for example where the client was diabetic and required consistency in meal and medication times.
- Dissatisfaction was expressed that carers were not staying for the duration of the care visits
- Insufficient length of visit. Complainants felt that there was not enough time for the carers to complete the tasks as the carers were not allocated enough time for the visit some elements of the care were not being delivered. Complainants felt a reassessment and an increase in the care package was required.
- Complaints were raised regarding care tasks being missed such as incontinent pads not being changed or medication being missed.
- Two family members complained that the carers had turned up in their casual clothes and not their uniform.
- Concerns were made regarding incorrect recording on the call log, such as being recorded that a meal had been given to the Service User but the Service User had only been given biscuits by the carers.

- Complaints were raised regarding the agreed call times, this was where the care agency only had capacity for times which were not convenient for the Service User. This meant in one case that the Service User would be going to bed at 20.00, the Service User preferred to go to bed much later.
- As the care provider's systems are now digital one family member commented that they can no longer see what care has been delivered.

Skils/Reablement.

- Complaints were raised regarding carers being late for their call times
- A Service user felt the carer was recording incorrect information on the care notes
- Several complaints were raised regarding the large number of different carers who were attending to deliver the care and there was no consistency.

8.4 **Staff Attitude/Conduct** was the fourth most common area of concern. The number of complaints received about this issue increased from 78 to 98 this reporting year. These complaints were sometimes raised as part of a larger complaint where the Complainant is challenging an assessment or a decision

Commissioned Learning Disability Services, some of these complaints were raised as a result of a Service User's frustration over other matters which had caused them distress.

- Clients with learning disabilities raised dissatisfaction by the way a worker had spoken to them or by a comment which was made which upset them or caused distress.
- Several complaints were made in which Service Users or their family members felt that a worker's were abrupt, unhelpful or disrespectful. Sometimes the family felt workers were not listening to them.
- One Service User was unhappy that their worker had to take emergency leave and the Service User had declined support from any other worker.
- Complaints were raised by Service Users following disputes with other Service Users and they were unhappy with the manner in which the staff member had spoken to them.

Area Social Work. Seventeen complaints related to Area Social Work.

- Several complaints were raised about the way in which workers spoke to Service Users or family members in particular during complex or stressful situations. One family member commented that they felt the worker was confrontational and a Service User felt the Social Worker lacked compassion.
- A family member felt their elderly relative was taken advantage of when they allowed a Reviewing Officer to view their sensitive information as part of a review.
- A family member felt that a worker had made a malicious accusation against them following a heated discussion.

- One family member made a complaint regarding lack of communication from the Social Worker, they complained that the Social Worker did not turn up to multi agency meetings or feed back to the family regarding the outcome of an investigation.
- A complaint was received from a Service User who felt their Social Worker was putting them under pressure to accept a service otherwise they may lose it. They felt the Social Worker was 'pushy' and they felt 'bullied'.

Disability Services. 15 complaints were made about Learning Disability social workers.

- One Service User raised concerns that they feel rushed by a carer when they were delivering care.
- Several Service Users raised complaints regarding comments made by workers which they felt were rude.
- Three complaints were raised by the family members of a Service User where they were unhappy that the carers informed the Service User directly that the service was going to end. The family members felt that this caused the Service Users distress.

Mental Health Residential and Day Services.

- Three complaints were raised where a Worker was heard making derogatory comments about a Service User when they thought the call had ended.
- Three complaints were raised by Service Users who did not like the manner in which a worker spoke to them.

8.5 **Lack of Social Work Support.** 9.5% of the complaints received were regarding this.

Area Social Work some of the concerns highlighted included:-

- Service User and family members raised dissatisfaction at the level of support provided and the level of contact with the Social worker. Others raised concerns regarding poor decisions made by the Social Worker; they feel this inaction or an incorrect decision led to delays in services being provided. Family members felt they were not involved with the assessment and this demonstrates a lack of understanding of the Service User's position.
- Friends of a Service User raised concerns as they felt a Service User required more support from the Social Worker when the Service User found themselves in a vulnerable situation or where their situation was deteriorating.
- Several complaints were received regarding lack of communication and feedback or involvement with family especially when waiting for availability within services. In one instance a Service User was moving into a care home and there weren't any discussions with the family around fees, in particular with the third party top up fee which the family would be required to pay.
- Many complaints were raised about Service Users or family members not being able to contact the Social Worker. One mentioned that the Social

Worker's Out of office and their voicemail did not reflect that the Social Worker was on leave for two weeks.

- We received complaints that Social Workers gave conflicting information about the level of care required or financial contribution required.

Learning Disability Assessment and Care Management

- Concerns were raised by the parents of a Service User who did not feel the Service User's dietary requirements were being met and felt the Social Worker ignored their opinion.
- One parent complained that they felt the Social Worker's support was intermittent.
- A Service User complained that they felt dominated by their Social Worker and she wanted more independence.
- A parent raised a complaint that a Service User required an increase in support and felt a fast tracked plan needed to be put in place
- A complaint was received from the parent and carer of a Service User regarding their lack of involvement into the Service User's support plan and information not being provided to them.
- Concerns were raised about meetings being cancelled and emergency support not being in place when the Service User was not able to stay at their placement

9. Outcome

The table below shows the outcome of complaints following an investigation. The three main categories for classifying the outcome of a complaint are "Upheld", "Partly Upheld" and "Not Upheld". Also included is a proportion that were "inconclusive" and those that were "Withdrawn". It will be noted from the table that 63% of complaints were either upheld or partially upheld.

Outcome	**2019/2020**	**%**	**2018/2019**	**%**
Upheld	**219**	33.6%	173	33.3%
Partially upheld	**193**	29.6%	165	31.7%
Not upheld	**181**	27.8%	149	28.7%
Inconclusive	**28**	4.3%	15	2.9%
Withdrawn	**17**	2.6%	9	1.7%
Ongoing	**13**	2%	9	1.7%
Total	**651**	100%	520	100%

10. Formal investigation

This reporting year 5 of the 651 complaints received were escalated to formal investigation by Independent Investigating Officers. In addition 1 independent investigations that began in the previous year was concluded in this reporting year.

As is standard practice, complaints requiring formal investigation are investigated by Investigating Officers who are independent of Leeds City Council. Independent investigation has proved effective in resolving complex complaints.

Appendix 7 of this report contains examples of action taken in response to investigation findings to improve the quality of services.

11. Mixed sector complaints – joint working across health and social care in Leeds

The Leeds Citywide Complaints group has continued to meet on a bi-monthly basis underpinned by a joint work programme. The group provides learning, expertise and sharing of good practice. It identifies information and processes that can be improved through joint working and reduces duplication through joint review of the required policies and national requirements.

In demonstrating learning from complaints there are frequent examples of practice improvement by individual organisations. This is through a range of methods to try and ensure that the lessons learned from people's experiences lead to service improvements. Examples of practices used include:-

- Managers acting on recommendations made after an investigation to avoid a similar situation arising for other people
- Developing action plans and sharing the lessons learnt with staff teams
- Sharing relevant learning as widely as possible within the organisation, owned by the relevant Heads of Service or equivalent.
- Incorporating lessons learned from customer feedback and discussing them with frontline staff as part of the organisations training offer.
- Sharing lessons learned from complaints in the Complaints Annual Report.

However, for lessons learned from mixed sector complaints, there is no central system of bringing all the learning together and/or sharing this widely across the city. This represents a missed opportunity to share learning about how to improve health and social care in Leeds. A system is in the process of being developed which should draw together lessons learned from people's experience of health and social care across the city.

Next Steps:

The group has highlighted a number of areas that will be focused on moving forward:

- Highlighting more clearly the trends in city wide complaints and develop a process to draw together and share lessons learned from the people's experience of health and social care across the city.

- To continue to challenge that learning is not done in 'silos'. This means greater drawing out of actions and recommendations for improvement which relate to improving systems across the city and a range of services. Whilst this happens already where individual cases are high profile it is not sufficiently consistent where system learning opportunities are present.

12. The Local Government & Social Care Ombudsman - update

The Ombudsman has statutory powers to carry out joint investigations with the Parliamentary and Health Service Ombudsman (PHSO). They operate a joint team of both health and social care investigators and undertake a single investigation which as previously stated in the report provides a more effective way of ensuring that complaints are resolved and lessons learned.

From 2010 the Ombudsman's role in providing independent redress was extended to all adult social care providers registered with the Care Quality Commission (CQC), the regulator for health and social care. This means that the Ombudsman investigate unresolved complaints about care arranged, funded and provided without the involvement of local authorities.

COVID-19: Handling of complaints – Key messages from the Local Government and Social Care Ombudsman

In order to support Councils and Care Providers during this difficult time, the Local Government and Social Care Ombudsman suspended all case work activity that demands information from or action by Local Authorities and care providers. During this period, they stated that they would not issue Final Decisions and cases still in progress would be frozen until they resumed normal operations.

Michael King, Local Government and Social Care Ombudsman, said:

"We need to do all we can to support the vital work local authorities and care providers are doing for the communities they serve in co-ordinating the response to the Covid-19 threat. By temporarily suspending our enquiries until government advice changes, we will allow care homes and councils the breathing space they need to deliver those frontline activities without distraction.

Councils and care providers are far better placed than we are to respond to any local complaints, particularly those that are the most serious and high risk. We still expect local authorities and care providers to respond appropriately to any complaints they receive during this time, but we understand this may look different to their normal arrangements. We will be picking this up with them once we are told normal service can resume."

The Adults and Health Complaints Team put arrangements in place to maintain the service during the COVID-19 outbreak whilst bearing in mind that there may be delays in responding to postal correspondence.

In June 2020 the Ombudsman informed the Council that it would re-start its casework activity, whilst being clear that if at all we are unable to meet deadlines and need more time to provide a response to inform the investigator as soon as

possible. These arrangements have worked well for the Adults and Health Complaints Team.

12.1 Summary of Ombudsman Cases

The Council is required by Law to inform people of their right to complain to the Ombudsman if for whatever reason they are unhappy with the way the Council has dealt with their complaint. The Adults and Health Directorate complaints leaflets, therefore, provides people with the Ombudsman contact details and informs people of their right to escalate their complaint to the Ombudsman. In addition, complainants are provided with the Ombudsman contact details as part of the response letter to their complaint.

In view of the above, it is envisaged that more service users will escalate their dissatisfaction to the Ombudsman either because they would have liked something more or a different outcome from the Council in response to their complaint.

In the reporting year, 25 complaints and enquiries in total were made to the Local Government & Social Care Ombudsman compared to 27 the previous year.

The 25 includes invalid/incomplete complaints/enquiries or from people who may not have initially contacted the council and, therefore, recorded as 'premature' and referred back to the Council. Below is the breakdown

- 2 were invalid or incomplete
- 1 had previously been investigated so was closed
- 6 were premature and referred to the council for investigation
- 3 were closed after initial enquiries
- 2 were not upheld
- 7 were upheld
- 1 investigation is ongoing
- 3 are awaiting investigation

In two of the cases that were upheld cases the Ombudsman noted that the Council had already accepted fault and offered a satisfactory remedy before the complainant had referred their complaint to the Ombudsman.

A breakdown of the Ombudsman enquiries and the findings are detailed in Appendix 5 of this report.

13. Local Settlements and Public Reports

Where the Ombudsman finds fault he may recommend a local settlement or issue a public report. In this reporting period none of the complaints resulted in a public report.

The Council agreed to pay financial remedies in local settlement of five complaints to the Ombudsman.

In one case the Leeds NHS Clinical Commissioning Group was asked to make a payment of £700 to a service user, and £500 to their family who had complained on her behalf. The payments were in recognition of the fact that at times not all the care and support needs had been fully met. The service user's care was fully funded by the NHS's Continuing Healthcare funding, hence the CCG was asked to pay the settlement. The case was managed by the Council's Learning Disability Social Work service on behalf of the CCG.

In one case the Council agreed to pay £500 to a person's whose care needs had not been met in full by a supported living provider, and £500 to his parent who had made up the short-fall in their care.

In one case a family member had refused to pay their parent's care fees because they felt the quality of home care had not been sufficient. The Council accepted there had been confusion over the timing of visits and agreed to reduce the person's debt for outstanding care fees by £200 and pay the complainant £100 in recognition of their time and trouble in making the complaint.

In one case the Council agreed to pay £250 to a relative in recognition of a delay in advertising their parent's house for sale (the Council was this person's financial deputy). This had not been done by the time the person died, at which point the Council ceased to be the deputy and the relative had to dispose of the person's assets.

In one case the Council agreed to make a payment of £250 in recognition of delays in completing a complaint investigation.

Therefore the total of financial remedies provided as a result of Ombudsman investigations was £3,000 compared to £5381.07 in the previous year.

14. Timescale Performance

14.1 The statutory timescale for acknowledging complaints is 3 working days. In 2019/20 performance against this timescale was 98.2%. Good performance in acknowledging complaints within timescale has been maintained.

14.2 Whilst the statutory timescale for fully resolving a complaint is now up to six months based on level of risk and complexity, the service aims to provide an initial response to complaints risk assessed as low within 20 working days. This year performance against this timescale improved from 96.4% to 98%.

15. Compensation Payments

Under Section 92 of the Local Government Act 2000, Local Authorities are empowered to remedy any injustice arising from a complaint. It is now practice to consider small *ex gratia* payments by way of recompense for costs incurred or compensation for a distress caused as a result of a matter complained about. In some cases it may be appropriate to waive care fees. The Local Government Ombudsman also has powers to direct the authority to pay compensation and to recommend the amount**.** As noted at paragraph 13, £3,000 was paid as a result of Ombudsman investigations.

Payments were also offered as a result of internal complaints investigations. Including payments made as a result of Ombudsman investigations, the Adults & Health Directorate provided financial remedies totalling £46,000.83 this year. This compares with £150,598.85 in the previous year.

The payments and/or waiving of fees fall into three main categories, as follows:-

- **Payments or Waivers made in recognition of fault / poor quality, or delay in the provision of services.**

  In total £13,587.41 was paid (or care fees waived) for this reason. Individual payments are usually modest and can reflect the reimbursing of care fees where isolated incidents have occurred, or a payment in recognition of distress, anxiety and inconvenience caused as a result of failings. Larger payments can be made where a problem has persisted for a long period of time.

- **Fees repaid due to people being incorrectly charged:-**

  £25,970.07 was paid to customers for this reason, comprising:

  - Where the service user had been charged for services that were either not provided (e.g. a home care provider had not turned up or stayed for the full duration) or were not required (e.g. where the service user had cancelled the service):

  - Where service users or their representatives had not been given adequate information about their contribution to the cost of their care. These payments are often substantial as they reflect the fact that the service user has received a backdated invoice for care fees which they were not expecting:

- **In some cases service users had overspent their personal budgets when their needs changed, but had not informed their social worker.**

  In these cases it was recognised that service users had got into genuine difficulty, so any debt they had accrued was written off and their care plan was reviewed. This totalled £6,443.35

16. Methods of notifying complaints

16.1 There is no requirement that a complaint must be written, although a person making a complaint is always encouraged to be as specific as possible. Consequently, complaints can be received via a number of different channels and the chosen channel of communication is recorded. Leaflets providing information on how service users or their representatives can send compliments and complaints are widely available across all service areas and the leaflet contains a simple form, which people can use.

16.2 This year most people (26%) chose to make their complaints by e-mail – this was a large increase as 171 people used this method compared to 101 last year. The numbers of people making complaints directly to a member of staff also increased significantly, with 169 (26%) people using this method compared to 129 last year, which is encouraging as it may indicate an open and welcoming culture in terms of seeking service user's feedback on the quality of service. As with last year, significant numbers of people made their complaints by telephone to the corporate complaints team (14%) and to workers (9%). The numbers of people writing letters

of complaint (10%) or completing the complaints forms included in our complaints leaflet (3%) remained the same in terms of numbers received but declined in percentage terms when compared to other methods. It is perhaps encouraging to note that there were noticeable increases in people using other channels, such as Healthwatch Leeds (up from zero to 12); the Care Opinion website (up from 6 to 13) and advocacy services (up from 2 to 4).

16.3 The number of service users making complaints increased slightly from 170 to 174, but the largest group were carers making complaints which increased significantly from 107 to 182. The numbers or complaints received from relatives also increased significantly from 128 to 172. There was also an increase in complaint received from members of the public, from 52 to 68.

17. Equality Monitoring

17.1 All complaints are subject to equality monitoring, which now includes all the equality characteristics protected through legislation (age, disability, gender, race, religion or belief, sexual orientation). Information is most frequently provided on ethnicity, gender and disability. No information has been provided about other characteristics. 37.3% of all complaints have ethnicity recorded, reflecting a decrease from 54% the previous year. 96.2% have gender recorded. 34.1% of complaints state whether the person was disabled or not. A breakdown of the equality related information provided by complainants is detailed in Appendix 6 of this report.

18. Lessons Learned

18.1 Where a complaint has been upheld, it is often the case that the manager undertaking the resolution of the complaint will make recommendations on how the service should be improved to avoid a similar situation arising for another service user. These actions will be brought to the attention of the complainant and there is a system in place for recording the action and the person with responsibility for implementing the action. Appendix 7 of this report contains some examples of the lessons learnt during the course of the reporting year and actions taken to improve the quality of service.

19. Service user Satisfaction surveys

19.1 The Complaints Service sends a satisfaction questionnaire to all complainants after they have received a response to their complaint. The purpose of the questionnaire is to seek complainants' views on how easy they found it to complain and how satisfied they are with key aspects of the process and outcome. The return rate in this reporting period was less than 3%. Of the satisfaction questionnaires which were returned 85% were either very satisfied or quite satisfied with the response to their complaint. The main reservations complainants had about returning the satisfaction questionnaire was that 'they were not sure it would do any good" or they "were unsure who to complain to". The Complaints Team is looking into how the satisfaction questionnaire return rate can be improved.

20. Developments / updates – 2019/20

2019/20 has been a challenging year for everyone. Some of the priorities set for 2019/2020 were paused due to the COVID-19 pandemic. During 2019/2020 the overall number of complaints increased by 25%. The increase is in line with our

efforts to encourage more social care service users to provide feedback about their experiences so that services know what they are doing well, as well as identify areas that needs to improve. The Complaints Team has experienced having to deal with increasingly more complex complaints and the challenge of operational managers who have had to support the front line – particularly affects ability to investigate locally resolved complaints. Commissioning Officers are supporting front line providers so have no capacity to investigate complaints and also Finance Officers who are involved in providing support payments to the sector to keep it afloat.

The focus, however, has been to maintain good customer service by focussing on good communication by keeping complainants informed of any progress.

21. Training

21.1 In this reporting year we delivered face to face training to 214 staff. We delivered 8 sessions in total May, June, August 2019 and 2 in February 2020 before we paused our face-to-face training due to the COVID-19 pandemic. Arrangements are now in place to provide virtual classroom training, targeting Service Delivery Managers and Team Managers. These will be delivered to end of March 2021 when we will re-assess the current circumstances.

Virtual classrooms will allow the training to mirror what happens on a face to face course. Delegates will be able to see the Trainer and the other delegates and there will be able to ask questions and have them answered.

22. Guidance for dealing with unreasonable behaviour from service users

Occasionally the behaviour or actions of some service users or their representatives has made it very difficult for staff to deal with them. In a small number of cases the actions of individuals become unreasonable and can be considered to be unacceptable because they involve abuse of staff and has a huge impact on Council resources.

In view of this, Adults and Health Directorate has Guidance for staff to guide them when dealing with customers whose behaviour is unacceptable or unreasonable and with action that can be taken.

Staff feed back to the effect that they find the Guidance helpful as it provides them with strategies they can adopt when dealing with difficult service users or their representatives.

23. Protocol on Complaints Handling with commissioned service providers

The Local Government and Social Care Ombudsman has made it clear that where a council commissions care from the independent sector, that the council remains accountable for the actions of the provider it has commissioned. In view of this, Leeds City Council, Adults and Health Directorate has a protocol with its commissioned service providers.

The purpose of the protocol is to provide a framework for collaboration in handling complaints and ensuring regular communication in relation to commissioned services between Leeds City Council, Adults and Health Directorate and its commissioned service providers. This should also allow the council to gain an overview of service user feedback in relation to commissioned services as well as provide an opportunity to collate information to ensure that learning points arising from compliments and complaints are used to inform contract monitoring and/or used to improve services and inform commissioning activities.

Unfortunately only a few providers are adhering to the protocol. The Complaints Team continue to remind providers to share information as requested in the protocol.

24. Review of information literature for service users and their representatives

24.1 Monitoring and review of information for service users or their representatives in order to try and ensure that the Complaints Procedure is accessible is one of ongoing monitoring, development and review. The action to review information literature was paused and has been carried forward to the 2020/21 reporting year. Information for people with a learning disability and the main generic complaints leaflet will be updated.

24.2 Deaf people using British Sign Language can contact the Complaints Team using mobile telephone number **07800005460.**

25. Complaints Handling – national developments

25.1 **Local Government and Social Care Ombudsman (LGSCO) Review of Adult Social Care Complaints 2019-20**: The Ombudsman published its Annual Review of Adult Social Care complaints on 16 September 2020. The Ombudsman reiterated its move away from a simplistic focus on complaint volumes and instead focussing on lessons that can be learned and the wider improvements that can be achieved through its recommendations from an individual complaint to improving care services for the many.

The Ombudsman has reported in its Annual Review Report that people who fund their own care are still under represented in the complaints they see and that the number has plateaued for the past couple of years. Further that this anomaly is notably out of step with trends in other parts of the Ombudsman's work.

The Ombudsman has reiterated that it is important that care users understand how to complain about the services they receive and that providers should use this feedback as an opportunity to identify and tackle the root causes of complaints and view each complaint as an opportunity to improve care services. The Ombudsman has reported that it is now calling for the government to use the planned social care reforms to require providers to tell people, if they are unhappy with the services they are receiving how to complain not only to the providers themselves but also how to escalate to the Ombudsman.

The Ombudsman's Complaints Annual Review Report has also highlighted that the Ombudsman works closely with partners across the social care landscape to share intelligence and experience of complaints. This includes sharing information about complaints investigations with the Care Quality Commission (CQC) in order to inform regulatory action.

It is also reported that the Local Government and Social Care Ombudsman are signatories of the Emerging Concerns Protocol. This is a mechanism for sharing information and intelligence that may indicate risks to people who use services, their carers, families or professionals.

As reported in previous years, it has reiterated that it will hold commissioners to account for their commissioned service providers' failings. It encourages all councils and care providers to have systems in place to ensure learning from complaints is shared widely. As stated above, Leeds City Council, Adults and Health Directorate has implemented an information sharing protocol with commissioned service providers. This provides clear arrangements for providers to share information about Leeds commissioned services i.e. compliments and complaints with the Adults and Health Complaints Team.

Included in the Ombudsman's Annual Review Report is data on how each local authority and/or independent care provider complied with its recommendations to remedy complaints about them. Leeds City Council, Adults and Health Directorate achieved a 100% compliance rate i.e. percentage of cases the Ombudsman were satisfied that it had successfully implemented the Ombudsman recommendations.

Lessons to be learnt from the Ombudsman's findings are shared with staff via the complaints training. The complaints training will be virtual until we jointly agree that we can go back into the classroom. The sessions have been 'redesigned' and will initially be delivered to Service Delivery Managers and Team Managers.

25.2 **Creating a learning culture in social care – what can we learn from Local Authority complaints reports? (work undertaken in the reporting year but published in August 2019)**

As part of Healthwatch England's commitment to Quality Matters (a sector-wide initiative aimed at improving social care) Healthwatch has committed to helping foster a culture of learning from feedback and complaints in care services.

To support this work, in early 2019 they began a project investigating what the 152 local authorities in England, who have responsibility for commissioning social care services are learning from feedback and complaints. As each local authority has a duty to produce a complaints annual report, they conducted a desk-based audit of statutory local authority annual complaints reports from 2017/18. The results were then compared with a previous study that looked at reports from 2015/16 to:-

- find out how many complaints councils are receiving and what they are about.
- establish to what extent councils are communicating the action they have taken to improve services in response to complaints.
- identify common themes which could be shared across the sector to help other councils learn and prevent problems occurring in the first place.

The outcome of the research was a report published in August 2019 and called for local authorities to shift focus away from complaint volumes to complaint outcomes and the lessons that can be learned and the service improvements that have been made as a result of those complaints.

Leeds City Council, Adult Social Care, Complaints Team was featured in this national report under Learning from complaints – positive examples of councils demonstrating learning under pages 8, 9 and 10 of the report.

26. Other priorities to be taken into account during 2019/2020 include:

- Contributing to gathering intelligence on the impact of COVID-19 on care users and their families and lessons that can be learned to inform improvements
- Contributing to the Best Council ambition to be efficient, enterprising and a healthy organisation and meeting this by ensuring that staff are effective and have the right knowledge and skills
- Contribution to the Council Climate strategy by adopting practice which contributes to addressing this emergency.
- Contributing to the Council achieving its vision of a more enterprising Council, working with partners and businesses who are more civic and a more engaged public.
- Evidencing how the Adults and Health Directorate is meeting its priorities of keeping people safe from harm, people feeling safe and people living with dignity and staying independent for as long as possible because the Complaints Service is a useful tool for indicating where services may need adjusting and/or were they are not working well.
- Continuing to work closely with operational and support services' teams, sharing lessons learned from service user feedback to inform commissioning activities and service improvements.
- Continuing with the Complaints training via virtual classroom on the statutory complaints procedure, incorporating learning from service user feedback.
- Continuing to provide briefings to voluntary sector organisations so that they understand the health and social care complaints procedure so that they can effectively support people who may wish to access the complaints process.
- We will continue to push forward a learning culture throughout the organisation. We will continue to do this by ensuring learning is followed up by simple action plans with the Heads of Service at the time the complaint is closed. Learning which has a wider impact will be shared widely with the relevant teams/partners.
- We will continue to monitor and evaluate information to ensure that the complaints procedure is accessible to all service user groups.
- Continuing to promote the complaints service across all Adults and Health operational teams by attending their management team meetings to share key messages, the national picture and the impact this will have on their practice.

27. Conclusion

The Council has continued to face financial challenges and enormous amount of pressure that necessitate tough decisions to deliver care services. Despite this, as

highlighted in the report, the Ombudsman has made it clear that when it comes to service delivery, no concessions will be made for the said financial pressures. In addition the Council, as commissioner, will be held accountable for the commissioned service provider's failings.

As noted in the report, service user expectation of what they can reasonably expect from the Council remains very high. Indeed service users feel more empowered to challenge assessment outcomes and to even escalate their complaints to the Ombudsman as evidenced by the number of complaints made to the Ombudsman.

It is, pleasing to note the high number of compliments received from service users and their families thanking staff for being kind; helpful; patient. Older people residential and day services being commended for being caring and compassionate and for providing a wonderful environment. Social work teams being commended for being person-centred and in ensuring that the correct support services are available to meet service user needs.

Complaints are a crucial early warning sign when something has gone wrong and the person complaining could be without a crucial service at a critical time. Their complaint, therefore, is an opportunity to put that right. Our strategy, therefore, is to encourage as many people as possible to provide us with this feedback so that issues can be resolved early and for these to drive service improvements.

The focus for the Complaints Team during these challenging times has been to ensure that we communicate clearly with complainants and keep them informed.

This reporting year has seen, through the collective efforts of staff at all levels of the organisation significant progress in respect of the key principles of the complaints process, such as the speed of response and listening to service users and focussing on treating service user feedback including complaints as a learning opportunity to improve the quality of services for all.

As in previous years, it is important that the Council takes even greater measures to evidence that lessons learned from complaints are used to improve and maintain the quality of the services it provides and commissions. Complaints continue to be a complex and difficult service area with both legal and insurance implications.

If you would like to comment on this report, or to receive it in large print, Braille or other format, please contact: complaints.socs@leeds.gov.uk

Complaints Service, Leeds City Council, Adult Social Care, PO Box 848, Leeds LS1 9PQ

Telephone: (0113) 2224405.

Email: Judith.kasolo@leeds.gov.uk

Complaints Team Members include:

Judith Kasolo, Head of Complaints

Dominic Wyatt, Complaints Manager

Tina Price, Senior Complaints Officer

Sarah Jones, Complaints Officer and

Complaints Co-ordinator – vacant

Appendix 1 - Compliments received by service area

Service area	**2019/2020**	%	2018/2019	%
Skills/Reablement	**392**	23.3%	**280**	24.8%
Blue Badge	**291**	17.3%	**443**	39.2%
Older People Residential and Day Services	**257**	15.3%	**40**	4.5%
Mental Health Residential and Day Services	**186**	11.1%	**51**	4.5%
Equipment and Adaptations	**117**	7%	**59**	5.2%
Community Social Work	**83**	4.9%	**64**	5.7%
Learning Disability Housing and Day Services	**75**	4.5%	**51**	4.5%
Physical Disability Residential & Day Services	**69**	4.1%	**2**	0.2%
Resources and Strategy	**64**	3.8%	**61**	5.4%
Independent Sector Other	**36**	2.1%	**15**	1.3%
Learning Disability Social Work	**31**	1.8%	**20**	1.8%
Independent Sector Home Care	**22**	1.3%	**14**	1.2%
Independent Sector Care Homes	**22**	1.3%	**1**	0.1%
Strategic Commissioning	**11**	0.7%	**3**	0.3%
Hospital Social Work	**10**	0.6%	**8**	0.7%
Mental Health Social Work	**7**	0.4%	**6**	0.5%
Leeds Shared Lives	**5**	0.3%	**8**	0.7%
Meals	**2**	0.1%	**-**	-
Public Health Living & Health Improvement	**-**	-	**3**	0.3%
Public Health Resource Centre	**-**	-	**1**	0.1%
Transformation and Innovation	**-**	-	**1**	0.1%
Total	**1680**	100%	**1131**	100%

Appendix 2 - Complaints by service area

	2019/20		2018/19	
Service area	**Number of complaints**	% of total complaints	Number of complaints	% of total complaints
Total		100.0%	**520**	100.0%
Community Social Work	**129**	19.8%	**102**	19.6%
Blue Badge Applications	**78**	12%	**37**	7.1%
Independent Sector Home Care	**76**	11.7%	**76**	14.6 %
Independent sector Learning Disability	**57**	8.8%	**6**	1.2%
Finance	**47**	7.2%	**47**	9%
Older People Direct Provision Residential Care	**42**	6.5%	**36**	6.9%
Learning Disability Social Work	**40**	6.1%	**36**	6.9%
Equipment and Adaptations	**33**	5.1%	**39**	7.5%
Independent Sector Other	**28**	4.3%	**18**	3.5%
Skills / Reablement	**23**	3.5%	**17**	3.3%
Mental Health Accommodation and Day Services	**21**	3.2%	**12**	2,3%
Learning Disability Commissioned Services	**17**	2.6%	**25**	4.8%
Hospital Social Work	**17**	2.6%	**16**	3.1%
Independent Sector Care Homes	**12**	1.8%	**19**	3.7%
Mental Health Social Work	**12**	1.8%	**11**	2.1%
Older People Direct Provision Day Services	**11**	1.7%	**5**	1%
Strategic Commissioning	**4**	0.6%	**8**	1.5%
Other Council Department	**1**	0.2%	**5**	1%
Support services	**1**	0.2%	**2**	0.4%
Public Health Localities, P Care, Capacity/Capability	**1**	0.2%		
EDT	**1**	0.2%		
Public Health Sexual Health Commissioning	**-**	-	**2**	0.4%
Safeguarding Unit			**1**	0.2%
Public Health Healthy Living Services	**-**	-	**-**	-

Appendix 3 - Complaints—how received

How received	2019/20	%	2018/19	%
Email	**171**	26.3%	**101**	19.4%
Via a Worker	**167**	25.7%	**129**	24.8%
Corporate call centre	**91**	14%	**108**	20.8%
Letter	**62**	9.5%	**65**	12.5%
Telephone	**60**	9.2%	**48**	9.2%
In Person	**28**	4.3%	**16**	3.1%
Form	**20**	3.1%	**19**	3.7%
Via an elected member	**15**	2.3%	**20**	3.8%
Care Opinion	**13**	2%	**6**	1.2%
Healthwatch	**12**	1.8%		
Via the Ombudsman	**7**	1.1%	**5**	1%
Via an Advocate	**4**	0.6%	**2**	0.4%
HCPC	**-**	-	**1**	0.2%
CQC	**1**	0.2%		
Total	651	100.0%	520	100.0%

Complaints—received from

Complainant—how involved	**2019/20**	2018/19
Carer	**182**	**107**
Service user	**174**	**170**
Relative	**172**	**128**
Member of Public	**68**	**52**
Other	**16**	**30**
Worker	**14**	**4**
Parent	**12**	**19**
Other agency	**11**	**6**
Advocate	**2**	**4**

Appendix 4 - Timescale performance

	Acknowledged within		Responded within	
	% within 3 days	% after 3 days	% within 20 days	% after 20 days
Resources	100%	0%	100%	0%
Social Work & Social Care Provision	98.6%	1.4%	98%	2%
Strategic Commissioning	96.4%	3.6%	96%	4%
Public Health	100%	0%	100%	0%
Total	**98.2%**	**1.8%**	**98%**	**2%**

Appendix 5 - Breakdown of Ombudsman complaints and enquiries received between 1 April 2019 and 31 March 2020

	Outcome								Total
	Upheld	Premature	Closed after Initial Enquiry	Awaiting Investigation	Not Upheld	Invalid or Incomplete	Previously Investigated	Ongoing	
Assessment and Care Planning	-	4	1	1	-	-	1	-	7
Charging	1	-	1	1	1	-	-	-	4
Blue Badge	1	-	-	-	1	-	-	-	2
Residential Care	2	-	1	1	-	-	-	-	4
Home Care	2	1	-	-	-	-	-	1	4
Supported Living	1	-	-	-	-	-	-	-	1
Other	-	1	-	-	-	2	-	-	3
Total	7	6	3	3	2	2	1	1	25

Appendix 6 - Complainants by ethnicity provided by complainants

Ethnicity	**2019/20 Number**	%	2018/19 Number	%
Not known	**408**	62.7%	240	46.2%
White British	**210**	32.3%	234	45%
Other	**15**	2.3%	21	4%
Black Caribbean	**10**	1.5%	11	2.1%
Indian	**4**	0.6%	2	0.4%
Black Other	**1**	0.2%	7	1.3%
Pakistani	**1**	0.2%	3	0.6%
Black African	**1**	0.2%	2	0.4%
Chinese	**1**	0.2%	-	0%
Total	**651**	100%	520	100.0%

Complainants by gender

Gender	**2019/20 Number**	%	2018/19 Number	%
Female	**385**	59.1%	299	57.5%
Male	**235**	36.1%	204	39.2%
Not known	**25**	3.8%	13	2.5%
Joint (married / partnership)	**6**	0.9%	4	0.8%
Total	**651**	100.0%	520	100.0%

Complainants by disability provided by the complaints

Disability	**2019/20 Number**	%	2018/19 Number	%
Not Known	**429**	65.9%	302	58.1%
Disabled	**164**	25.2%	126	24.2%
Non-disabled	**58**	8.9%	92	17.7%
Total	**651**	100.0%	520	100.0%

Appendix 7 – Examples of action taken in response to investigation findings to improve services

Independent Sector Supported Living	Lessons Learned
A relative of service user alleged staff are under-qualified, staffing is low, and that tenants did not feel well looked after or treated with dignity or respect.	The Council's Commissioning team recommended: • The service's complaints log is completed in greater detail including the outcome and if the complainant is satisfied; and lessons learned. • That all staff complete Acquired Brain Injury training. • That all staff complete complaints training. • That training is a mixture of face to face and e-learning rather than primarily e- learning. • That supervision sessions are more frequent. • That the manager keeps records of visits and calls to service users to monitor satisfaction and makes analysis of these for actions required.
The parent of service user sent a letter by recorded delivery to the provider's head office but hadn't received a reply. He was concerned about the violent behaviour of another tenant towards other tenants and members of staff. He felt nothing was being done to protect his daughter and her quality of life was being adversely affected by this behaviour.	The provider acknowledged that the letter had been delivered but had gone missing. The provider put a procedure in place with regards to signed and recorded post. All future signed and recorded post will be sent onwards as recorded or scanned to the relevant individual. The provider also drew up a plan for improving communication with family members: • All Managers to contact families and establish method and frequency of contact required and record this. • All family contact to be logged on the recording system. • Monthly reports to be drawn from the system by senior managers to monitor actions. • Senior Management to have contact with all families six

	monthly or at families' request.
The parent of a tenant complained that the provider was awaiting a washing machine to be fixed. In the meantime parents were being asked to do tenants' laundry which is difficult due to it being soiled etc.	The provider submitted a list of properties where a washing machine is an essential part of service delivery and this was shared with the landlords. Staff were made aware that family completing an individual's laundry is only appropriate if previously agreed as part of an individual's support plan.
A parent carer complained about a respite placement. An important meeting was chaired by a worker who the parent did not know. The keyworker had moved onto another role in without informing the parent. The new manager of the service has little or no knowledge of the service user. The parent was not given a copy of the care & support plan. Miscommunication over his being unable to attend the last respite due to illness.	Staff to ensure that they inform parents if any other professionals are arranging meetings/assessments whilst in respite. Management team to ensure that the City Wide Respite Manager is informed of any CHC assessments taking place for respite customers. The management team will arrange regular monthly contact with parents to share any updates and for the support plan to be updated so this can be shared with the team. Support plan to be reviewed by the City Wide Respite Manager. City Wide Respite Manager to be the first point of contact if Service Manager is on leave. The management team will ensure that requests for information are dealt with promptly in future. Management have been made aware that any information would always be hand delivered to parents. Staff to ensure that any concerns about health & wellbeing are relayed to parents. In future any medication errors will be communicated to the social worker and parents. Day care provider to be invited to future reviews. The management team shall compile more detailed short stay reports to ensure that it covers any changes in health, behaviour. City Wide Respite Manager to monitor communication within the

	service and deal with any concerns.
Parents complained that a service user had been raising complaints with the provider and her social worker for some time. The provider then gave notice that they were withdrawing all care and support, the reason given was that the service user's care needs had changed. However a worker disclosed that the provider was losing staff because of the service user's complaints. The provider told parents that the Council had refused to provide additional funding.	The Council's Commissioning team recommended that the provider do the following: • Identify lessons learned in relation to a specific incident complained about. • Ensure that where an individual experiences poor health the service keeps a log to be able to identify patterns. • Obtain a profile for each agency member of staff which provides a photo and an outline of their training and work experience, as well as details of their DBS check. • Ensure that all relevant documentation at indicate whether members of staff are employed or are agency staff. • Link Risk Assessments with Support Plans and ensure risk management strategies are identified within Support Plans. • Review the frequency of Risk Assessment reviews. • Review the format of tenant's meetings in order to ensure that any grievances are followed up 1:1 after the meeting rather than discussed during tenant's meetings. • Ensure staff record sufficient detail in case notes including times when support was provided, offered or declined. • Record evidence in new member of staff's personal record that they have completed shadow shifts as per policy. • Conduct a review of the night support needs of individuals. • Ensure that agency staff read service user's support plans and sign to indicate that they have understood the content. • Review use of agency staff and where possible the staff are used to limit the number of agency staff used. • Support plans should be detailed and clear, including support requirements in respect of eating and drinking.

	• Where an individual is prone to choking or has a diagnosis of Dysphagia, a choking risk assessment should be completed.
A relative raised concerns about a changes they observed in their sibling's behaviour following a visit and was worried about what this could signify.	The provider implemented measures to closely monitor and document this behaviour so as to identify a pattern behind it.
A service user complained about money going missing from their bag.	The provider acknowledged that large amounts of cash need to be kept in a locked safe and that the valuable items of the people they serve should not be left unattended.
The manager of a day centre complained to a supported living provider that a doctor's appointment made by the day centre had been cancelled without the day centre being informed, which meant a wasted visit was made to the surgery by the service user and a day centre worker. The surgery had cancelled the appointment, it was recorded in the house diary, but the supported living provider's staff presumed that the doctors had also told the day service.	Staff shall record conversations with professionals and place it in the house manager's in-tray, this will ensure that the manager is aware and will ensure that the issue is communicated to the relevant professionals.
Area Social Work	**Lessons Learned**
A relative complained that they had not been given clear advice about how to request a Care Act Assessment or a Financial Assessment, which caused confusion and anxiety.	Changes were made to the advice to social workers regarding financial thresholds, and to Contact Centre staff, so that clear advice could be given to customers.
A relative had raised concerns about their parent being potentially abused by another member of their family but had not received a response.	EDT manager identified that the referral was received but was not referred onto the correct area social work duty team. This was raised with the EDT social worker in question and all EDT staff were made aware of the correct procedure. The referral was redirected to the correct team.
Complaint from a relative regarding a recent decision made without any input from family members or the service user.	The Team Manager discussed with the team the need to improve communication particularly ensuring that any changes to service provision are discussed directly with family members.

A family carer complained about travel restrictions imposed due to a sports event in Roundhay which meant that their relative's scheduled care visit was unable to take place at the usual time.	It was acknowledged that we need to be clearer next year in the information we send out to the public and caring services. This year approximately 170 individual route plans were in place, but not in relation to the complainant's relative. • Blue Light services have controllers in the event control room and emergency movements are managed either around the closures or, when necessary, across the route in a controlled manner using stewards and moto-marshals. • Health visitors, homecare provides etc are expected to plan around the route but will be permitted to cross the route, but only in exceptional circumstances. • Managed access is possible where a route crossing is pre-determined and resources are put in place to manage it. This is dependent on location, time and agreement with the race route manager.
A relative of a person who had a severe stroke complained that a social worker had not followed up a medical referral for ongoing physiotherapy following discharge from hospital into residential care.	The Team Manager instructed social workers to ensure routine telephone contact with service users and their families prior to the reviews of care and support plans.
A relative complained about a lack of response to telephone calls from the social work team during the period when plans were being made to discharge their relative from hospital.	The social work team were reminded about the importance of returning calls and keeping residents and families fully involved in the discharge arrangements

Finance	Lessons Learned
Two complaints were received from relatives about delays in completing financial assessments, and poor communication (including being asked to send the same documents twice).	Apologies were provided and it was explained that, following a review of the service, it was recruiting more staff to assist with completing financial assessments more efficiently in future. This has been completed and assessments are now taking less time.
The complainant is a carer who was managing their relative's care & support using a Direct Payment. The complainant had been asked to return some overpaid funds following an audit of the DP bank account. The complainant said they had spent them on the relative's care so the funds were gone. The complainant described many challenges faced and how the system had not been supportive. The complainant described the letter received from the DP Auditor as threatening and unclear.	The complainant met with the Area social work manager and the Senior Finance Manager. It was agreed that the funds had been spent on the relative's care so the repayment was cancelled. The tone and content of letters from the DP Audit team was reviewed.
A service user complained to the Ombudsman about their care and support. The complainant alleged the Council is discriminatory as it will not cover their full hair care costs, which are higher because of their specific needs. The complainant was unhappy with the quality of care received from the Council's commissioned care provider. They complained about the Council's actions.	The Council agreed to complete the following action: • make an apology for the distress, time and trouble for the missed, late and shorter care visits and the handling of the complainant's hair care needs; • commence monthly monitoring of the care provider's performance. The Council will review performance with the complainant after three months and continue to monthly monitoring if necessary; • issue a reminder to staff in the financial assessment team about the Council's complaints procedure for dealing with complaints of discrimination; • consider whether the complainant's child needs to be assessed as a young carer and child in need. • reimburse the family's hair care costs; • commence the review of the care and support plan.

Leeds Community Equipment Service - Telecare	Lessons learned
A relative complained that they had tried to cancel the service following their relative's admission to a care home. They had left a voicemail message but had not received an acknowledgement two days later.	The service changed its processes and nominated a dedicated member of staff to just deal with telephone queries ensuring that all calls are dealt with quickly and effectively.
Mental Health Provider Services (In-house)	**Lessons Learned**
A service user of the Mental Health Homeless Team was unhappy with the level of support provided following a regular worker leaving the service. They said their support needs are not met within the time allocated and this was affecting their mental health.	The service acknowledged that better handover of clients needed to take place when staff know they are going on leave, ensuring cases are covered properly.
A service user complained that a member of staff had left a voicemail in which they could hear the member of staff making a derogatory comment about them after completing the message but failing to terminate the call.	The Service Manager met the complainant alongside with the staff member who made the derogatory comment. The staff member apologised and this was accepted by the complainant. Discussed within the staff team meeting conduct within the office, and the impact that this could have on tenants.
Independent Sector Residential Care	**Lessons Learned**
A relative had raised numerous concerns about their parent's care and requested an update on the outcome of the subsequent safeguarding investigation.	The following required improvements had been identified: • Better recording of care interventions, and staff being more mindful to not just accept refusals for care - but to be more proactive in gaining patient cooperation. • Enhanced quality improvement plan. There has been input from the Leeds NHS CCG & Adult Social Care in effecting improvement to standards of care within the home. This has been monitored over a 6 month period and has included input by skilled professionals to address specific areas of care, including pressure care, medications, safeguarding, dignity.

	• Training was rolled out to all staff from domestic to senior manager level. • CCG quality monitoring input, specific to pressure care: Pressure Evidence that all care staff have completed the e-learning module on pressure area care; evidence that all staff have attended face to face training on pressure ulcer prevention and management or a plan to do so; evidence that all patients with identified wounds or pressure ulcers have a completed incident report; evidence that all reports of Pressure Damage have been kept open and identified on DATIX system; provide evidence that a weekly review of Datix by the manager or trained senior staff has taken place on all identified pressure ulcers. • Evidence that this has included a review of care plans, risk assessments, positional change records, wound management records, GP / TVN involvement. The DATIX report will contain evidence of the findings from the weekly review. • Evidence that a Wound analysis has been completed for all wounds, monthly and reviewed by the Regional Manager during the monthly visit and a Wound TRaCA completed • NHS CCG took the lead role - all staff within the care home were involved, the actions were completed and now remain under routine monitoring.

A relative complained about the time taken to investigate a safeguarding referral made about their parent's respite care at a residential care home. 7 weeks had passed and they had not been informed of the outcome of the safeguarding investigation.	The investigation was concluded and led to improvements in the care home's procedure for completing body maps for new residents on arrival and on leaving.
A resident and their relative complained about the way another resident spoke to them. The relative had been visiting and sitting in the rear garden and when they came back into the home they inadvertently disturbed an activity taking place in the Conservatory – one of the residents taking part was very rude and made them feel like a second class citizen.	Do not Disturb' signs will be displayed on the conservatory door should the apartment clients be having a private event. A memo has been sent round to all staff (outreach and residential) reiterating that all residents have access to the back garden. The home manager checked the terms and conditions for the residents and confirmed that it does include a section about communal facilities and that all gardens are accessible for all clients. It also mentions how clients should behave within the home and that unwanted behaviour is not tolerable.
Recovery Hubs	**Lessons Learned**
A complaint from a relative who was recorded as the second next of kin regarding: 1. Around service information / welcome pack not communicated to service user and family. 2. Regarding progress reports of parent's rehab progress to relatives. 3. Regarding the complainant not being notified of relative's discharge from the Hub.	A contingency plan has been implemented to ensure that new residents and relatives are given sufficient and appropriate induction information when they are welcomed to the Hub. A review of the Hubs advertised telephone number online was completed. The Customers' welcome pack was updated to include information around what happens following unplanned discharge from the hub. Lessons learned were shared with the staff team.
A service user complained about their recent stay at the Hub. The complainant said staff didn't know what to do; cleaning of their room was not done until requested (when they were advised it would be done on a regular basis); food was never hot or edible.	The manager discussed the concerns with the cleaning supervisor. To comply with infection control standards, all bedrooms are deep cleaned when customers are discharged and bedrooms are checked to ensure high standards. The manager promised to undertake a quality audit on the meals

	service and checking quality, service, quantity and menus and to report the findings to the catering officer. The manager will monitor the length of time it takes for staff to respond to the nurse calls to ensure they are answered in timely fashion. The management team shall make regular observational checks of agency staff for standards and addresses any shortfalls in practice
A relative complained about the service provided by the LGI and the Hub. Their relative, who has Alzheimer's, had a broken ankle and had acquired infections in hospital. The complaint was wide ranging and related to communication with the complainant; a failure of Hub staff to accompany the patient to hospital appointments; a lack of stimulation and rehabilitation at the Hub; and of meetings where the complainant felt workers were not fully informed about their relative and therefore unable to make appropriate plans for rehabilitation and future care.	The manager of the Hub undertook to arrange a multi-disciplinary lessons learned meeting with all professionals involved in this person's care. The purpose of this meeting was to share and use the knowledge derived from this complaint to prevent future occurrence. As a result quality conversations now take place with customers and their families upon admission. Information regarding appointments is clearly communicated. Email responses in complex cases will ensure clarity and prevent delays. Qualified social worker's shall be requested, rather than wellbeing workers, for complex cases. Clear communication shall be provided around discharge once therapy stops.
Independent Sector – Home Care	**Lessons Learned**
A relative complained about workers not staying the agreed length of time and the quality of care provided.	The Council's commissioning officer recommended: • Dementia training for the care team. • Call time monitoring data to be checked by the office staff. • Care notes - ensure there is a quality audit system put in place to address care note quality. • Priority given to this service user for care quality auditing. • Regular spot checks to ensure staff are turning up in uniform and rectify the reasons behind this. • Care workers to detail exactly where they have applied

	topical medication. • Ensure type of food is logged to ensure nutritional intake is recorded. • Ensure service users and families have full access to the complaints and escalation process.
A relative complained about: • The time taken for a care plan to be drafted following the first visit. • How quickly the service user was changed to be taken to their bedroom to sleep, and whether there was time to wash. • Care worker asked a lot of questions about what should be done. • Some personal care tasks not being carried out. • Care worker did not document time of arrival and departure, nor note the care provided. • Problems with preparation of drinks (the service user is diabetic).	The Director of the provider undertook to closely monitor and oversee how his visits are going and to ensure care standards were met. The provider reviewed how it would work with relatives/next of kin more closely from the start of a service users care to ensure that families have a full understanding of the care provided and how the provider documents and monitors care plans. The provider reviewed the information service users receive about their right to complain or raise concerns to ensure that they know that doing so will not negatively impact their care whatsoever. It was felt that in this case care workers were doing as the service user wished, but this was not in line with the complainant's expectations, so the provider undertook to review how this is discussed with relatives. It said it was already in the process of developing more robust audits for communication and visit logs and have established a system which means they will be checked more regularly, which will allow it to identify any missing information/issues in the entries filled out by workers. The provider undertook to make sure that service users and their families are provided with information about quality control systems should they wish to consult them.
A relative complained that a care worker was leaving early from care and support visits.	New procedure implemented to ensure care and support staff call office if, for any reason, they leave a care call early. Communicated to all staff.
A relative complained about a medication incident where one	The provider has ensured that the storage of medication is checked

parent was given medication which belonged to their other parent. Their parent had a seizure and paramedics were only able to save their life because they which medication they had taken. The parent had to spend 4 weeks in hospital.	in more detail and is all in its packaging when field supervisors complete assessments. A discussion now takes place with the service user about safe storage and old medication when completing routine quality assurance checks. Detailed medication themed supervision with workers now takes place to discuss the importance of reporting and acting more quickly to reduce risk. Written instructions have been sent to all carers detailing the importance of reporting any concerns/risks identified around medication and to ask them to contact the branch manager to report if any service users have old medication so safe disposal can be completed. The provider refunded over £500 of care fees.
A relative raised issues relating to: • Inconsistent time of visits; • Carers not trained in removal/fitting of Stoma bag; • Stoma bags left all over property; • Curtains left closed all day; • Washing up not done; • Not leaving water for service user.	The provider had taken on the package as an emergency. In such cases the provider now visits the next day to allow for extra time to introduce the company and the key workers, and to document what the service user expects from the service. Managers will carry out regular spot checks. Stoma refresher training was arranged for all staff
Learning Disability Social Work	**Lessons Learned**
A parent complained because a service user had been asked to leave a day centre. When the service user joined this day centre it was explained that the service user had to leave their last day centre because of climbing on things and grabbing cables. Family was reassured that this would not be a problem at the new day centre, but they have now been asked to leave.	The provider's Operations Director has ensured that, in addition to Area Managers completing a comprehensive needs and risk assessment for all new customers, they also provide a separate summary of the key decision making points as to whether or not the provider can offer a service (with or without additional support). This shall ensure that, when it accepts a person into the service, everyone shall have a clear understanding of how their needs shall be met.

The Member of Parliament raised a case where an IQ test which was carried out by the NHS which was, in the family's view, unethical and reached faulty conclusions. The Learning Disability Social Work service now believes this person may have to transfer to a generic area team for social work support.	An investigation was carried out by the Service Manager of the Learning Disabilities Services in Leeds & York Partnership Foundation NHS Trust. Suggested improvements that can be made are improved clarity within appointment letters as to the purpose of the appointment; and an appropriate method and timing of sharing assessment outcomes to be agreed with the LD social work service.
Mental Health Social Work	**Lessons Learned**
A complainant who had suffered a mental health crisis had started a user led support group due to a lack of community based support in their area. The group has run into problems and cannot find a suitable location to meet. The complainant was also finding running the group alone to be too much pressure. The complainant asked for help from Adults & Health to run the group which had become a well attended and vital service.	The Live Well Leeds project took over the running of this group so as to give the complainant and its members the required support.
Hospital Social Work	**Lessons Learned**
A partner complained that they had not been informed of their partner's planned discharge from hospital to residential care. The complainant thought their partner was coming home and bought a special chair for the purpose.	The team manager spoke to the complainant and apologised that this was not explained properly and for any distress caused. The team manager has discussed this with the social work team and stressed the need to make it clear what kind of placement people are moving into, why and if there is a charge for that placement. As a gesture of goodwill the cost of the chair was reimbursed.
A relative was unhappy with the attitude of the social worker. They feel some of the case notes are factually inaccurate. There is no documentation from a care planning meeting. The complainant doesn't feel the social worker's input has met their relative's needs now that they have been discharged from hospital.	This was a mixed sector complaint involving the NHS Neighbourhood Team. Planned actions to ensure the situation does not occur again included: • LCH NHS Trust will work with our partners and colleagues in health and social care to remind them of the need to wait

	until the Neighbourhood Team has completed their assessment before discussing the care that can be provided in the community. • By ensuring the assessments are completed before the discussions occur we should minimise the risk of other families being promised something a Neighbourhood Team cannot deliver. It was apparent that professionals on the hospital ward lacked understanding what these various service provided. • Please accept our sincere apologies that this occurred, the Trust have recognised the need for education with wards regarding the most appropriate pathway from hospital and there is now a new pathway guide which has been introduced which explains all the various services and how they can meet the different needs of individuals on discharge. It is felt that this will help reduce confusion and misinterpretation going forward.
The Leeds Teaching Hospitals NHS Trust received a complaint from a family that was unhappy with level of care provided to a relative. The family was also unhappy with the social worker.	LTHT reported that a multi-disciplinary team meeting is held once a week when all patients are discussed by senior members of staff to plan for a positive discharge. After the meeting any discharge plans that are agreed are discussed with family members and patients to improve discharge communication and planning. All staff have been informed that if there are any changes in a patient's treatment then these are discussed with family members. A free clothes shop is being created for patients to use so that they feel comfortable when sitting out of bed to eat their food. All patients have a food and fluid chart to monitor their intake. The Matron has spoken to staff about the way staff communicate with patients and relatives.

Complaints and Compliments
Adults & Health Directorate
Merrion House
4th Floor East
110 Merrion Centre
Leeds City Council LS2 8BB

Telephone: 0113 3783080
Mobile: 07800005460
Textphone: 0113 222 4410

Email: complaints.socs@leeds.gov.uk