ADULTS & HEALTH SELECT COMMITTEE
23 JUNE 2022
ADULT SOCIAL CARE COMPLAINTS OCTOBER 2021 – MARCH 2022

Purpose of report: To provide a detailed summary of complaints, Ombudsman investigations and compliments in Adult Social Care for the period October 2021 – March 2022.

Introduction

1. This report details all Adult Social Care complaints, Ombudsman investigations and compliments in the period October 2021 – March 2022 (Q3 and Q4). The report is provided to Select Committee on a six-monthly basis.

2. Surrey's Adult Social Care complaints are managed in accordance with the Statutory Social Care Complaints Procedure, which is governed by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Any complaint which does not fall within these regulations will usually be considered in accordance with the Council's corporate complaints procedure.

3. When a complaint has completed the Adult statutory complaints procedure, a person can take their complaint to the Local Government & Social Care Ombudsman (LGSCO) for their advice and assistance.

Executive Summary

4. There has been an upward trend in the number of complaints received by Adult Social Care over the last few years. The Directorate received 27% more complaints during Q3 and Q4 2021/22 (153) than the same six-month period in 2020/21 (120). It should of course be noted that the Council was facing unprecedented challenges in response to the Covid pandemic during 2020/21 and the number of complaints dropped significantly.

5. During Q3 and Q4, Adult Social Care received 153 complaints and investigated and responded to 107 complaints. 96% of all completed complaints were responded to within the agreed timescale. 40% of the complaints were upheld in full or partially, 33% were not upheld and 21% were resolved outside the complaint process.

6. The most common issues raised in complaints related to staff attitude/conduct, poor communication and the assessment process.

7. The key learning themes from complaints for this reporting period were:

- Communication
- Timeliness.
- Adhering to correct processes.
- Staff training.
- Process/policy/guidance review.

8. During Q3 and Q4, 8 complaints were investigated by the Ombudsman, of which 6 were upheld.

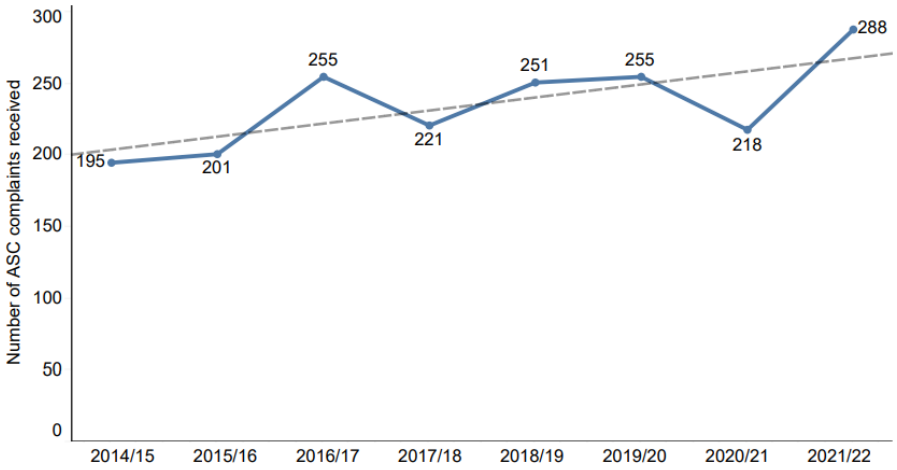
9. Going forward, the focus remains on ensuring complaints are addressed effectively with good quality responses and using the learning from complaints for continued service improvement.

Complaints received

10. Complaints are a valuable source of data and help us improve services. Figure 1 provides a yearly comparison of the number of complaints received by Adult Social Care. This upward trend could reflect the increasing complexity of need of many of the people we support, on-going workforce recruitment and retention challenges as well as the pandemic and subsequent recovery. Over time we have also made it easier for people to complain with the introduction of the Council's on-line web portal which accounted for 31% of Adult Social Care complaints in 2021/22, the publication of the new Listening to Your Views leaflet and making it easy to navigate to 'how to make a complaint about adult social care' on the Council's website .

11. The upward trend is likely to continue as the rising cost of living impacts many of the people we support and as the government's proposed Adult Social Care charging reforms are implemented and we come into contact with many more Surrey residents with expectations of what the reforms will mean for them.

Figure 1 – Number of complaints received by year in Adult Social Care



12. During Q3 and Q4, Adult Social Care received 153 new complaints, responded to 107 complaints and ended 39 complaints. The largest number of complaints were received by the North West Surrey and Surrey Heath Area (33) and the Learning Disability, Autism and Transition Service (31). These teams have large caseloads – North West Surrey and Surrey Heath has a caseload of 4,276 (20% of the total ASC caseload of 21,054[1]) and received 21% of complaints, whilst Learning Disability, Autism and Transition Service has a caseload of 5,411 (26%) and received 20% of complaints - so the higher number of complaints in these service areas is representative of their caseload. A detailed breakdown of the complaints received by the Learning Disability, Autism and Transition Service in Q3 and Q4 is included in Appendix 1.

Figure 2 – Number of complaints received and responded to in Q3 and Q4 2021/22

	Number of complaints received in the period	Responded* to	Responded to within deadline	Responses Within Deadline (%)	Number of complaints ended** in the period
East Surrey	20	15	15	100%	5
Guildford & Waverley	19	12	12	100%	4
Mid Surrey	17	14	13	93%	1
NWS & SH	33	22	20	91%	10
PLD, Autism & Transition	31	23	22	96%	8
Mental Health	7	7	7	100%	1
Countywide	22	11	11	100%	10
Service Delivery	4	3	3	100%	0
Total	153	107	103	96%	39

[1] LAS 1 March 2022

*Countywide complaints include Commissioning, Continuing Health Care, Emergency Duty, Financial Assessment & Income Collection, MASH and the support teams.

13. There were some peaks and troughs in the numbers of complaints received each month during Q3 and Q4. Figure 3 shows a dip in complaints received in January and an uplift in March when Mid Surrey (7), the PLD Autism and Transition service (11) and countywide service (6) received more complaints. The uplift in March appears to have been driven by:

- Mid - The timeliness of the assessment process.
- PLD Autism and Transition - Staffing providing incorrect information and not being supportive.
- Countywide Finance Assessment & Income Collection (FAIC) - Annual review of assessed charges in line with benefit increases and notification in writing which offers an opportunity for a review if people feel anything is incorrect.

Figure 3 – Complaints received by month and service in Q3 and Q4 2021/22

	2021/22 Q3				2021/22 Q4				Period total
	Oct 21	Nov 21	Dec 21	Quarter Total	Jan 22	Feb 22	Mar 22	Quarter Total	
East Surrey	2	2	6	10	2	6	2	10	20
Guildford & Waverley	3	2	6	11	2	2	4	8	19
Mid Surrey	1	4	1	6	3	1	7	11	17
NWS & SH	5	6	6	17	6	5	5	16	33
PLD, Autism & Transition	9	2	3	14	2	4	11	17	31
Mental Health	1	2	0	3	0	1	3	4	7
Countywide	1	7	4	12	2	2	6	10	22
Service Delivery	0	0	1	1	1	1	1	3	4
Total	22	25	27	74	18	22	39	79	153

14. Of the 153 new complaints received in Q3 and Q4, 10 related to commissioned home-based care and 6 to commissioned residential/nursing care - these are included in 'countywide' figures. A detailed breakdown of the complaints received by commissioned providers in Q3 and Q4 is set out in Appendix 2.

15. We received most complaints via e-mail, although use of the Council's on-line web portal is growing.

Figure 4 - How complaints were received

How received	Q1	Q2	Q3	Q4

Email	31	30	38	47
Letter	5	2	3	0
Telephone	13	13	8	8
Web	23	18	25	24
Total	**72**	**63**	**74**	**79**

16. Figure 5 shows the themes raised in complaints received in Q3 and Q4, with the most frequently raised being:

- Communication - quality of information and advice provided to people who use services and their families, together with the timeliness of responses to queries and concerns.
- Staff attitude or conduct - dissatisfaction with a worker's involvement and decision making in the case.
- Assessment process – timeliness of the assessment.

Figure 5 - Theme of complaints received in Q3 and Q4 2021/22*

	Staff	Communication	Financial	Assessment process	Service provision	Safeguarding	Decision making	Policy/Procedures	Information Governance/Legal	Communicaion	Number of complaints received
East Surrey	7	6	4	8	5	3	6	1	0	0	20
Guildford & Waverley	7	9	5	3	4	4	3	1	0	0	19
Mid Surrey	3	4	7	7	5	0	5	0	0	0	17
NWS & SH	13	14	8	7	6	6	7	3	0	0	33
PLD, Autism & Transition	12	10	2	14	3	0	9	2	0	0	31
Mental Health	3	4	0	1	2	2	0	1	2	0	7
Countywide	3	5	11	4	2	0	2	2	3	1	22
Service Delivery	3	0	0	1	1	0	1	0	0	0	4
Total	51	52	37	45	28	15	33	10	5	1	153

* Complaints may be about more than one issue, so the numbers recorded in the above table will be higher than the number of complaints received.

17. We understand some residents may be fearful to complain believing it may affect the care and support services they receive. We try to make it as easy as possible for residents to make a complaint by offering a variety of channels through which they can make their complaint, as well as accepting complaints made on their behalf by another party or anonymously. Residents are also able to approach Healthwatch Surrey and our network of user and carer groups who can raise issues on their behalf. Adult Social Care welcomes complaints as a learning opportunity.

Complaint responses and outcomes

18. There is no statutory timescale for responding to a complaint within the Statutory Social Care Complaints Procedure, although a complaint should be fully completed within six months. This enables a more customer centred and flexible approach to addressing complaints, including those that are complex or require multi-agency involvement with external agencies such as health. The focus is on establishing a consistent approach to getting it right and putting things right. The Council and Adult Social Care has adopted 20 working days as a response target.

19. Under the Statutory Procedure, Adult Social Care operates a single stage complaint procedure - there is no formal escalation stage as in Children's Services. This means that in our response to a complaint, we will explain that if the complainant is dissatisfied with any aspects of the response, they can contact the investigating manager or the Customer Relations Team who will ask the service to look again at their areas of dissatisfaction. This allows for more flexibility to respond to a complaint and timescales can be extended if required. Residents can also ask the Local Government and Social Care Ombudsman to review their complaint once it has been closed if they remain dissatisfied.

20. Adult Social Care has a performance target of 90% for responding to complaints on time. Whilst the Council has adopted a timescale of 20 working days as an initial response timeframe, this can be extended depending on the circumstances of the issues being investigated, which can often be complex and/or involve partners.

21. The response times are detailed in Figure 2 and show that of the 107 complaints that were investigated and received a response during Q3 and Q4, 103 (96%) complaints were within the deadline date.

22. Figure 6 sets out the outcomes of the 146 complaints investigated and responded to or ended in Q3 and Q4. It shows that 40% of the complaints were upheld in full or partially (22 upheld and 37 partially upheld complaints) and 33% were not upheld.

Figure 6 - Outcomes of complaints responded to and ended in Q3 and Q4 2021/22

	Responded			Ended			Total
	Not upheld	Partial upheld	Upheld	Resolved outside the process	Withdrawn	Not applicable	
East Surrey	8	2	5	4	1	0	20
Guildford & Waverley	3	6	3	4	0	0	16
Mid Surrey	7	6	1	1	0	0	15
NWS & SH	10	9	3	8	2	0	32
PLD, Autism & Transition	9	9	5	7	1	0	31
Mental Health	3	2	2	1	0	0	8
Countywide	7	3	1	5	4	1	21
Service Delivery	1	0	2	0	0	0	3
Total	48	37	22	30	8	1	146
% Total	33%	25%	15%	21%	5%	1%	100%

23. A further 30 (21%) complaints were resolved outside the complaint procedure. This will often be where a relatively simple complaint has been made verbally and can be resolved within one day to the resident's satisfaction. Complaints resolved outside of the procedure are still tracked but will not have a formal investigation. This approach is supported by the statutory procedure[2] and the Ombudsman also actively encourages early resolution.

Ombudsman complaints

24. Where a complainant remains dissatisfied following completion of their complaint under the Adult Social Care complaint process, they can refer their complaint to the Ombudsman, and it may result in an investigation. Figure 7 shows the number of Ombudsman investigations completed in Q3 and Q4.

[2] The Statutory Social Care Complaints Procedure, para 8 (1) 'complaints are not required to be dealt with in accordance with the Regulations where … (c) a complaint which— (i) is made orally; and (ii) is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made'.

Figure 7 - Ombudsman investigations completed in Q3 and Q4

	2021/22 Q3	2021/22 Q4	Total	% Total
Completed - Not upheld	1	1	2	25%
Completed - Upheld	2	4	6	75%
Closed - Out of jurisdiction				
Closed - No further action				
Grand Total	3	5	8	100%

25. Of the 8 Adult Social Care complaint investigations in Q3 and Q4, the Ombudsman upheld 6 as follows:

Figure 8 – Ombudsman investigations upheld in Q3 and Q4 and financial remedy

LGSCO Investigation Upheld	**Financial Remedy**
Mid Surrey: Q3 (Upheld: Maladministration & Injustice) Fault found, the care provider agreed to pay £300, to remedy the distress, client's daughter suffered at the home's failure to properly manage her late father's pressure sores.	
Total	£300
PLD Autism Team: Q3 (Upheld: Maladministration & Injustice) Fault found, delay in remedying complaint and back dating of care payments. Pay £100 in recognition of distress and time taken to bring the complaint to the Ombudsman.	
Total	£100
PLD Autism Team: Q4 (Upheld: Maladministration & Injustice) Fault found, with the Council not being able to find a care agency since July 2020. Background – Ms X continued to receive personal care but was left without outreach support when the provider withdrew during the pandemic. The Council has since offered Ms X Occupational Therapy, specialist reablement and reablement but this has been declined as Ms X believes her assessment isn't correct. Ms X has declined care and support until a reassessment is completed. Apologise, and pay £5,400 for the loss of support services and the impact this had.	
Total	£5,400
Transition: Q4 (Upheld: Maladministration & Injustice)	

Fault found, the Council failed to inform when the respite provider gave notice. Also failed to inform that responsibility for son's support was being transferred to the CCG. Pay £300 to mother in recognition of the distress caused. Pay £1,000 to individual in recognition of the distress caused by the loss of respite provision.	
Total	£1,300
PLD Autism Team: Q4 (Upheld: Maladministration & Injustice) Fault found, assessments contained inaccurate information about the source of a medical diagnosis. Pay £250 to reflect the avoidable distress.	
Total	£250
PLD Autism Team: Q4 (Upheld: Maladministration & Injustice) Found fault in record keeping and handling sensitive data. Pay £500 to reflect the avoidable distress.	
Total	£500
Total for Q3 and Q4	**£7,850**

26. Nationally, the Ombudsman is finding fault more often by local authorities and care providers and the percentage of all adult social care complaints upheld nationally was 72% in 2020/21, an increase on the previous year. The Ombudsman upheld 64% (9 out of 14 complaints) of Surrey Adult Social Care complaints in 2021/22.

27. The Ombudsman will recommend a remedy where there has been fault resulting in an injustice to the individual. A financial remedy is recommended only when the complaint has resulted in a quantifiable financial loss as a reimbursement and/or to acknowledge identified distress, time and trouble. The Ombudsman's focus is to put things right when a fault is identified and improve services. This aligns with the direction being taken by Adult Social Care, to ensure complaint learning is implemented in a timely manner.

28. Figure 9 presents the trend of Ombudsman complaints with a financial remedy. Remedies are mainly reimbursement of care payments and backdated direct payments.

Figure 9 - Ombudsman financial remedies by year

	2017/18	2018/19	2019/20	2020/21	2021/22
Financial remedies as recommended by the LGSCO	£7,775 [3]	£1,200	£6,695 [4]	£28,069 [5]	£14,085

[3] £2,475 direct payments refund

[4] £3,769 refund of incorrect charges for residential care and paid directly by the provider

[5] £11,000 reimbursement for unofficial third-party top up paid to a care provider and £9,603 w as a backdated direct payment

Learning from complaints

29. Adult Social Care continues to focus on putting things right in response to complaints and ensuring services are improved. The Customer Relations Team works closely with teams to ensure learning from complaints is successfully implemented and this will continue to be a key objective going forward.

30. The main learning themes from complaints during Q3 and Q4 were:

- Communication – Improving the quality of information shared with people who use services/ carers/ Deputyship Team and keeping individuals informed and updated.
- Timeliness - Avoiding unnecessary delays in completing assessments/ reviews, responses and implementing services.
- Adhering to correct processes - Working in line with legislation and policies.
- Staff training - Training staff to ensure they keep timely records of decision making and relevant policies in future.
- Process/policy/guidance review - When new or adapted approaches are introduced, ensure frontline staff are clear about any new expectations so they can give the right advice to people who use services.

31. Examples of complaints upheld with learning in Q3 and Q4 are summarised in Appendix 3.

32. Members of the Adult Leadership Team receive a monthly update on complaints in their area of responsibility together with learning identified for action.

33. The Customer Relations Team will resume regular drop-in sessions on lessons learnt from complaints from August onwards. These sessions which are open to all Adult Social Care staff have been paused while the new Customer Relations Manager gets established in post. These sessions will be part of the 'Learning Space' being delivered by the Quality Improvement Group. Sessions held earlier in 2021/22 looked at learning from a complex complaint investigated by the Ombudsman, the broader theme of poor communication and how delays in service delivery impact upon service users.

34. The Customer Relations Manager meets with the leads from the Quality Assurance and Commissioning services to review issues in relation to provider complaints on a quarterly basis.

35. A Quality of Practice dashboard has been implemented in Adult Social Care to promotes a culture of continuous improvement, learning and sharing. It brings together qualitative and quantitative measures including complaints and compliments, case file audits and reflective practice.

36. The Customer Relations team will try to obtain performance data from other comparable local authorities, so we are able to compare and contrast our performance and identify any learning opportunities. This will be included in future reports to Select Committee.

Equality, Diversion and Inclusion

37. We have analysed the protected characteristics of people from whom we received complaints/on their behalf in Q3 and Q4 relative to the number of open cases. The analysis is included in Appendix 4 and shows that:

- Age – Adult Social Care received more complaints from/on behalf of people aged 85+, and fewer from/on behalf of people aged 55-64 and 65-74, relative to the number of open cases for these age groups.
- Race - The profile of complaints received appears representative of the race profile of open cases.
- Disability - Adult Social Care received more complaints from/on behalf of older people and people with a learning/physical disability, but significantly fewer from carers, relative to the number of open cases for these disability groups. Carers made up 13.5% of open cases in Q3 and Q4 but only submitted 1.4% of complaints in their own right as a carer.

38. These results suggest that whilst our complaints process is accessible, carers perhaps don't feel confident or know how to make complaints, or indeed may not wish to do so. In response to this finding we will:

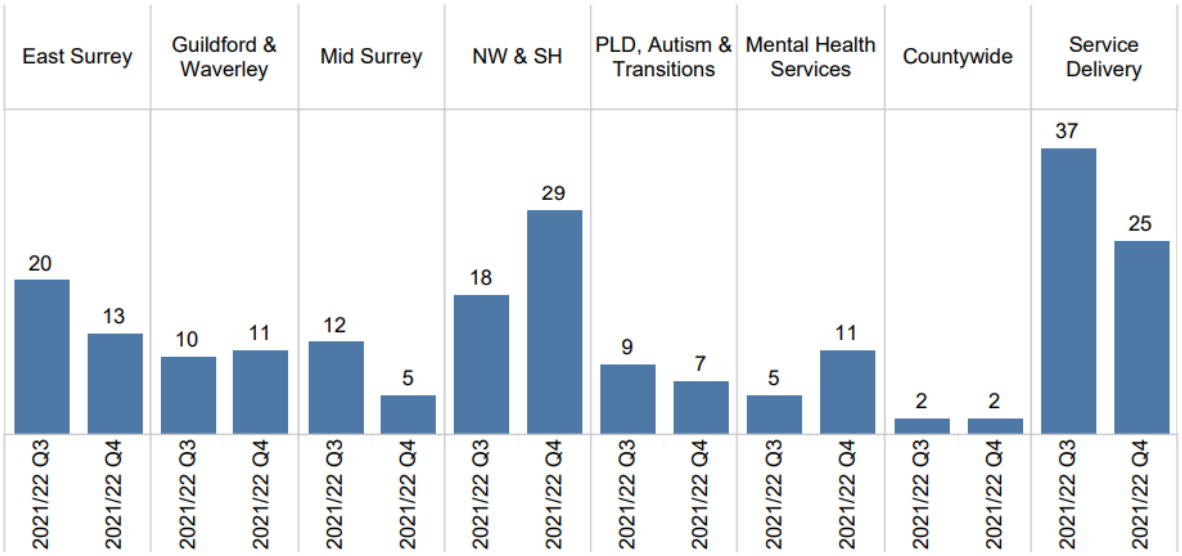
- Ensure the carers services we commission are aware of, and able to signpost carers to our complaints process.
- Brief our social care practitioners to ensure they are confidence to advise and signpost carers wishing to make a complaint.
- Arrange for our carers dashboard, which is reported regularly to the Carers Partnership Board, includes reporting on the number of complaints from carers received across the system and themes.
- Raise our concerns about how representative the complaints data is with our 'Giving Carers a Voice' provider HealthWatch to scrutinise and make recommendations.

Compliments

39. Compliments provide an insight into what's working well in services and a measure of customer satisfaction. Figure 10 shows the 216 compliments received by team across Adult Social Care during Q3 and Q4.

40. Adult Social Care generally receives good feedback and staff are encouraged to report and share their compliments within their teams. Compliments are published in Adult Social Care E-Brief each month to celebrate good feedback from residents.

Figure 10 – Number of compliments received in Q3 and Q4 2021/22



41. In Q4 we started to classify the nature of the compliments received so teams can understand the areas where they are doing well and share best practice. Figure 11 shows we received 103 compliments during Q4 with the most popular themes being people wanting to say thank you and complimenting teams on their communication.

Figure 11 – Nature of compliments received in Q4 2021/22*

	Communicati..	Decision Making	Placement	Service Quality	Staff behaviour/ competence	Thank you	Timeliness of response/ service	Grand Total
East Surrey	2	2		1	1	7		13
Guildford & Waverley	4	2		1	1	3		11
Mid Surrey	4				1			5
North West Surrey & Surrey Heath	8	3	1	1	6	10		29
Central PLD, Autism & Transitions	3	2	1			1		7
Mental Health Services	4	1	1	1		4		11
Countywide							2	2
Service Delivery				9	1	15		25
Grand Total	25	10	3	13	10	40	2	103

Issues of concern

42. Select Committee has expressed an interest in understanding more about 'issues of concern' raised by residents which don't get treated as a complaint. For example, patterns of unfavourable comments about a member of staff or process, recurring errors, where people are unhappy but don't use the language of 'complaint'.

43. Our aim is to be a responsive Council, open to feedback and resolving any concerns as close to the point of service as possible, because that delivers the best outcomes for residents and staff. We also recognise that people may not always want to use the complaints procedure to make us aware of issues or concerns they might have. Any 'issue of concern' will always be addressed by members of staff at the time it is raised by a resident and recorded in a case note as appropriate.

44. Adult Social Care doesn't have a means of formally monitoring and reporting 'issues of concern'. We have thousands of contacts with residents every day through a range of channels including face-to-face, telephone, e-mail, online and social media. Given the scale of the service it is not possible to capture all the comments made. However, we will be making significant changes to how we interact with the public in preparation for the forthcoming Adult Social Care charging reforms and will investigate how we might be able to capture issues of concern as part of that process, without introducing a resource intensive process.

Conclusions

45. The Customer Relations Team continues to work closely with teams to ensure effective complaints handling and that learning from complaints is implemented across all teams.

Recommendations:

46. The report to be noted by all Members of the Select Committee.

Next steps:

47. Adult Social Care will continue to ensure people making complaints receive high quality and timely responses and implement learning to help shape future service improvement.

48. We will continue to review provider complaints with the Commissioning and Quality Assurance teams, to ensure effective monitoring of issues and learning.

49. The Customer Relations Manager will offer regular drop-in sessions on lessons learnt from complaints from August onwards as part of the 'Learning Space' being delivered by the Quality Improvement Group.

50. Training for managers on complaint handling will continue to run virtually through the year to ensure staff are equipped and feel confident to manage any complaints.

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Sources:

- LGSCO Annual Review of Adult Social Care Complaints 2020-2021
- Adult Social Care Complaints and Compliments Annual Report (2020-2021)

Complaints Received by the Learning Disability, Autism and Transition Service in Q3 and Q4

	Area	Root Cause	Date	Outcome	Action	Complaint received
1.	LD West	Assessment process and Staff	Oct 2021	Partial upheld	Apology	Complaint regarding staff member and how they conducted the Mental Capacity Assessment
2.	LD East	Decision making and Staff	Oct 2021	Partial upheld	Advice/ Information Given	Client's mother complains that not enough is being done to return her adult autistic son back to Surrey
3.	LD West	Assessment process, Communication and Staff	Oct 2021	Not upheld	None required	Client complained that he wasted his time to attend a crisis planning meeting, when no crisis plan was put in place.
4.	Transition	Assessment process, Policy/Procedures and Staff	Oct 2021	Not upheld	Advice/ Information Given	Father of service user does not want his sone to undergo a mental capacity assessment until the team have reached agreement as to its necessity and terms of the decision with him.
5.	LD East	Assessment process	Oct 2021	Upheld	Staff training	Client complained that she did not receive a copy of her assessment, and the reduction in hours had only been agreed as a temporary measure.
6.	Transition	Assessment process and Decision making	Oct 2021	Resolved outside the process	None required	Prior's Court wrote to parents, social care and education stating that in order to be considered for a placement in the post 19 young adult provision, a representative from the local authority must submit a formal request in writing to request assessment. This assessment is free and non-binding. Despite this, no such request has been made.

7.	LD West	Decision making	Oct 2021	Upheld	Apology	I was transferred from the adult team to the LD and autistic team. My care plan was wrong and has been amended. The LD team are refusing to review my care, they did not have a care plan despite numerous requests and ASC are providing no support whatsoever.
8.	LD Targeted Review and Provider	Service provision	Oct 2021	Upheld	Communication improved internally	Complaint from client's brother that there had been a drastic deterioration in his brother's mobility, which he believes was largely caused by lack of regular, supervised, monitored walking movement sessions at Heathlands.
9.	LD West	Staff	Nov 2021	Not upheld	Advice/ Information Given	Complaint from client that he didn't think his keyworker acted very professionally or values his opinion. She keeps doing things behind his back without taking the time to get to know him.
10.	LD West	Communication	Nov 2021	Not upheld	None required	Complaint from independent living scheme housing provider that the client placed by ASC has caused incidents of anti-social behaviour towards staff and residents, and that as his housing provider they feel out of the loop and their worries and concerns are being ignored.
11.	LD West	Communication and Policy/Procedures	Dec 2021	Not upheld	Advice/ Information Given	Client complained the council cancelled a meeting on the day it was due to take place and promised him it would be rescheduled, but this did not happen.
12.	LD East	Staff	Dec 2021	Not upheld	Advice /Information Given	Complaint from client that the key worker had fraudulently completed the assessment without his input.
13.	LD East	Assessment process, Communication and Staff	Dec 2021	Upheld	Apology	Client complained of a lack of response to emails, and the assessor lacked the understanding, as per the Care Act.

14.	LD West	Assessment process, Communication, Safeguarding and Staff	Jan 2022	Upheld	Financial redress of £250 (LGSCO investigation)	Mr x complains a social care assessment in October 2020 wrongly said he had PTSD and incorrectly stated the source of this information was his GP medical history.
15.	LD West	Communication and Staff	Jan 2022	Upheld	Financial redress of £500 (LGSCO investigation)	Alleges that a care agency was incorrectly informed that he had sexual behaviour problems when he did not.
16.	Transition	Communication and Financial	Jan 2022	Partial upheld	Advice/ Information Given	Parents challenging care provision in place for their son and wanting an explanation for services being retracted
17.	Transition	Staff	Feb 2022	Not upheld	None required	Parents of service user complain their son is at a residential college for special needs and the social worker stated that they would lose the mobility car if they did not pay more, and that they felt threatened and bullied.
18.	Transition	Assessment process and Communication	Feb 2022	Upheld	Staff training	Complaint from client's mother wanting to know why nobody had informed her when Adult Social Care would complete a Transition assessment to consider support for her son's post 18 support?
19.	LD East	Service provision	Feb 2022	Partial upheld	Support plan reviewed	Mum alleges that son has not been in receipt of care since the beginning of the pandemic, due to a refusal to consider his other living costs.
20.	LD East	Decision making	Feb 2022	Resolved outside the process	None required	Complaint from client that they wanted to end their services and return to living on the streets.
21.	Home Care and LD West	Service provision and Staff	Mar 2022	Partial upheld	Advice/ Information Given	Brother raised concerns about being messed about by his current care provider and would like us to source a care provider who will provide the agreed level of care.

22.	LD West	Staff	Mar 2022	Partial upheld	Apology	Alleged a staff member demonstrated a poor level of empathy and understanding and an equally poor attitude.
23.	LD East	Assessment process, Communication and Decision making	Mar 2022	Resolved outside the process	Communication improved externally	Complaint from provider on behalf of their client that they had not been included in the best interest decision or kept informed of the process in moving the service user.
24.	LD East	Assessment process, Communication and Decision making	Mar 2022	Partial upheld	Advice/ Information Given	Allegation that the needs assessment had been completed without involvement or knowledge.
25.	LD West	Staff	Mar 2022	Upheld	Advice/ Information Given	This case involves staff using language to communicate with xxx that has caused offense to her.
26.	Transition	Staff	Mar 2022	Not upheld	Advice/ Information Given	Mother raised concerns that the social worker is not providing sufficient support for her son as he transitions to adulthood.
27.	Transition	Assessment process and Decision making	Mar 2022	Partial upheld	Agreement with person using service or carer	Issues raised about the handling of Mr x care needs in relation to Mr x long-term and alleged ongoing under payment of his awarded direct payment.
28.	LD West and provider	Decision making	Mar 2022	Not upheld	Service Provided	Changing the internal doors to fire doors at xxx has created a number of ongoing issues since they were fitted
29.	Transition	Assessment process	Mar 2022	In Progress	In Progress	Mother raised concerns that there is a lack of effective joint working to facilitate proactive planning. Her son is turning 18 imminently and is without a social worker.

30.	Financial Assessment & Income Collection and LD West	Assessment process and Financial	Mar 2022	Upheld	Service improved	Not knowing Social worker allocated to case and lack of assessment to establish financial position, instead it is alleged that SCC simply looked at government guidance to then claim a "debt".
31.	Transition	Assessment process and Communication	Mar 2022	Partial upheld	Advice/ Information Given	Mother raised concerns regarding negligible involvement by the Transition Team because Mr X reacts badly to uncertainty about his future

Complaints received by commissioned providers in Q3 and Q4

	Provider	Date	Complaint	Outcome
	Home Based Care			
1.	(redacted): Runnymede Locality Team	Oct-21	Charges incorrect for services received. Homecare provider: (redacted) not doing what was agreed. Overall concerns of neglect.	Closed case within time, not upheld. Advice and information were given, together with offers of continued support.
2.	(redacted): Guildford Locality Team	Oct-21	Daughter alleged her father passed away six days after this agency was put in place owing to the unnecessary stress and lack of care he received in his last week of care.	Closed case following safeguarding. It was partially upheld. (redacted) confirmed that the live in carer, in question is no longer working in their service and a referral to the Disclosure and Barring Service was made. The outcome of the safeguarding enquiry was shared with Surrey Police for their information.
3.	(redacted): Elmbridge Locality Team	Nov-21	Wife of service user query over financial assessment and costs they are being asked to pay. Client's condition is progressive, and wife raised concerns that the support in accessing the wider community and requested assistance with transport costs	Closed case within time, not upheld. Team Manager explained that because Mr X receives PIP the Personal Independence Payment includes the mobility component benefit as follows: lower rate £23.70 per week and higher rate £62.55 per week
4.	(redacted): Guildford Locality Team	Dec-21	Daughter complains the domiciliary care company who provided the care for her mum was unsatisfactory and resulted in neglect of her mum's general hygiene with bed sores, and skin which was so red and sore that she was crying in pain if she moved or touched it.	Team Manager responded partially upheld case with learning including a recommendation for staff at (redacted) to undertake safeguarding training

5. (redacted): Woking Locality	Feb-22	Unhappy with care agency service. Serious concerns raised regarding care worker who advised family their mother was eating and drinking independently but upon admission to hospital, mother was found to be seriously ill with severe chest infection, dehydration and was severely underweight.	Paused for safeguarding - to review on 11/05/2022
6. (redacted): LD West Team	Mar-22	Brother Mr X raised concerns about being messed about by his current care provider and would like us to source a care provider who will provide the agreed level of care.	Closed - Partially Upheld with service looking for an alternative care provider as a resolution.
7. (redacted): Surrey Heath Locality	Mar-22	Lack of contingency planning by (redacted) who failed to meet Mr X needs and assist him getting to bed that meant that Mr X was placed at risk of an accident.	Extended to 09.05.22
8. (redacted): Reigate and Banstead Locality Team	Mar-22	The Home Care provider said that 30 minutes is not enough time to mobilise Mrs X in the morning. This information was not shared with the family and the App provided by the provider to reassure the family that visits have taken place is not showing accurate information and is misleading	Case extended 28.4.22
9. (redacted): Epsom & Ewell Locality Team	Mar-22	Regarding ASC staff and the bridging care agency care workers not having adequate information on the people they are visiting	Case closed - Council provided a contribution

10. (redacted): Elmbridge Locality Team	Mar-22	Concerns raised by daughter about various aspects of the domiciliary care being provided by (redacted)	Closed case late - Upheld. Follow up actions include ramps allowing access to property and to advise our Commissioners about the poor standard of care our service user received from (redacted)
Residential/Nursing			
11. (redacted): Reigate and Banstead Locality Team	Oct-21	Lack of staff due to many leaving and the care home use agency staff. Many of them don't meet Ms X communication needs. Ms X would prefer regular staff to support her who can communicate in British Sign Language	Closed case within extended time frame, not upheld. Team Manager confirmed that Ms X needs will be continued to be met and that they are responsive to any changes and continue to review regularly
12. redacted): Elmbridge Locality Team	Dec-21	Granddaughter raised serious concerns regarding care home practices, including an allegation that her grandmother was assaulted by a care worker	In hand with Manger who is chasing home for information to enable closure of the enquiry
13. (redacted): PLD & Autism Team	Oct-21	Brother alleged staff at home administered wrong medication which could have caused detrimental impact on Mr X, poor food provision and neglect	Case closed on time partially upheld. Information to be shared between care providers. This is in process with oversight from the PLD and Autism Team this will help to improve external communication.
14. (redacted): Guildford & Waverley	Mar-22	Daughter alleges her mother's being kept in hospital due to malnutrition, as a direct consequence of the lack of appropriate care received in (redacted) over the 4-week respite period.	Closed case - not upheld. Having reviewed notes and actions there is nothing to indicate there were any concerns with the level and standard of care provided, and nothing to correlate the care provided by (redacted) with a significant decline in Ms X health and wellbeing
15. (redacted): Woking Locality Team	Mar-22	Respite care recently used for father at (redacted) was below expected standards including continence care and visiting	Section 42 only with the Woking team. Complaint cannot be considered as respite was privately funded.

16. (redacted): Spelthorne Locality Team	Mar-22	Lack of information being supplied to the family, impacting the care. Daughter couldn't get a district nurse sent out, as her mother was still showing her residence as (redacted), that was used for respite	Complaint closed outside of the process with a telephone call from key worker, offering information and advice as case was centred around the fact that the Mother had changed GP without her knowledge.

Complaints upheld with learning during Q3 and Q4

Area	Root Cause	Date	Complaint received	Learning Outcome
1. Countywide	Service provision	Mar 2022	Concerns over daughter's Relevant Person's Representative (RPR) actions including preventing mother being updated.	Reminder to their Relevant Person's Representative that if they have any queries about their remit or advice they are being asked to give, they should discuss these with their supervisor and / or the DOLS Team who are commissioning their services.
2. East Surrey	Assessment process, Communication and Decision making	Jan 2022	Granddaughter shared her poor experience her 87-year-old nan faced due to the NHS & Council not being able to decide between them who will take on the responsibility of my nan's health needs	A meeting was arranged between Senior Management from the Adult Social Care Team, West Sussex CCG and Surrey Heartlands, in order to discuss how to prevent and avoid future delays during the discharge of patients through the D2A pathway.
3. East Surrey	Communication and Decision making	Feb 2022	Daughter concerned mum moved to another care home without her consent or knowledge. Care home didn't have 121 carer's she needed for Mum who was at risk of falls.	Team advised they are putting in robust measures to ensure that handovers take place efficiently and there should have been better communication between the Care Homes and SCC. This would have led to us being able to provide Ms X daughter with clear updates concerning her mum's move to a new care home.
4. East Surrey	Decision making	Feb 2022	Discharge planning concern. Lack of communication with relative, patient, and ward staff. Also, appears to be complete lack of care and compassion.	The manager was in complete agreement about the poor communication the complainant received and apologised. As part of our reflective practice to identify lessons learned, the staff member concerned recognised that had she made the follow up call to the Ward and contacted the relative and the other professionals involved, then

				this would have been a more positive experience for them.
5. East Surrey	Safeguarding	Feb 2022	Concern safeguarding investigation not concluded after five months, and decision for supported living application to be reconsidered and proper explanation as to why this was declined in the first instance.	The initial worker left, meaning there was a delay whilst Mr x was reallocated. The complex support needs and behaviours that Mr X presented, included not engaging with support, had proven difficult for the provider to manage but there was an acceptance of this behaviour without fully exploring alternative support. A new care provider has been commissioned and the number of hours of support substantially increased with added flexibility. This has shown a marked improvement in the effectiveness of the support given to Mr X
6. East Surrey	Assessment process	Mar 2022	Since discharge from hospital concerns raised by son that mother has had no assessments and been given no advice from re: financial or care plans.	The manager has raised concerns with the lead person at Surrey and Sussex Healthcare Trust to ensure that information is accurate to enable the Social Care team to support with discharges from hospital going forward.
7. Guildford & Waverley	Staff	Dec 2021	Senior Social Care Assistant was accused of “stepping out of line” during email communication with a GP surgery	Further training and supervision for staff members when working jointly with other professionals to ensure means of communication are appropriate and advantageous to all involved
8. Guildford & Waverley	Safeguarding and Service provision	Mar 2022	Daughter complains the domiciliary care company who provided the care for her mum was unsatisfactory and	A recommendation was made by the Manager of the service for staff at Care Art to undertake safeguarding training

			resulted in neglect of her mum's general hygiene with bed sores, and skin which was so red and sore that she was crying in pain if she moved or touched it.	
9	Guildford & Waverley	Communication, Financial and Staff	Jan 2022	Family agreed they could contribute to the cost of care for Ms X. The assessment documents recorded that as a weekly contribution. Despite countless telephone calls to the social worker 3 months, they were told something different nearly every time. Family asked for a response to this in writing with the exact plan regarding the financial support package.	An apology was provided, and we advised that staff training would be undertaken on capital thresholds to prevent this happening again and to enhance the knowledge of the team.
1	Mental Health	Communication	Oct 2021	A relative raised complaint about poor communications during the pandemic about funding decisions that occurred before the pandemic began and request for review of a section 117 decision that he wasn't consulted on	Social Workers will be reminded of the importance of including family/ carers in assessments and/or reviews. The case highlighted the need to provide alternative opportunities for family/carers to feedback their views should they not be able to attend a specific meeting.

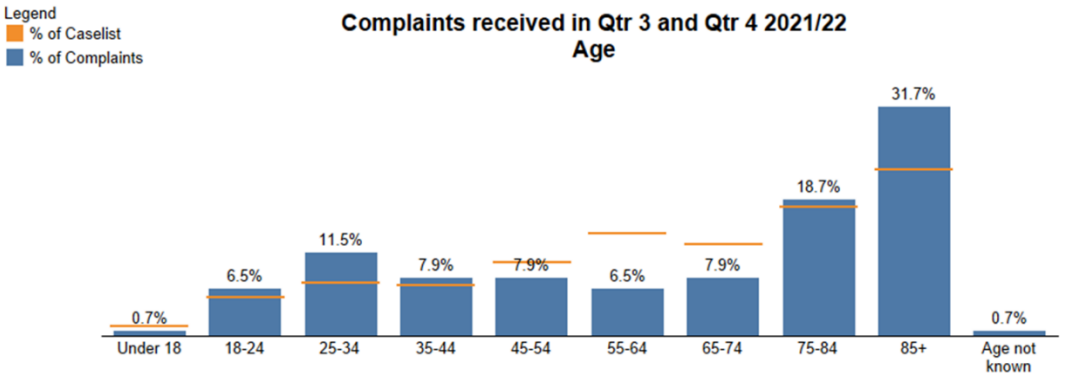
1	Mental Health	Communication and Staff	Nov 2021	A disabled (deaf) service user complained about the delay in being discharged from hospital due to lack of response from key worker	We apologised to Ms X for not being kept up to date regarding the progress in finding her independent supported accommodation. We acknowledged the stressed it caused and how important it is for staff who can sign and communicate with Ms X, as she felt that the hearing loss was not considered in the past.
1	Mid Surrey	Financial	Feb 2022	Ms X mother complains that her daughter is being wrongly invoiced and paying more than she should.	Apology regarding the direct payment being left open when Ms x was not receiving a service. Service breaks were found but there were periods not actioned, the team went through all the invoices and identified dates where no care was delivered. Service breaks charge would be reflected in the next statement from the Financial Assessment and Income Team.
1	NWS & SH	Communication and Staff	Oct 2021	Carer to a disabled husband complained about the lack of communication received regarding her husband, she had made several calls and was expecting to be updated as promised but this never happened.	The manager responded to the complaint and wrote a separate letter of apology for their failure to keep their promise to the complainant and provide the update Ms X required.
1	NWS & SH	Communication and Financial	Jan 2022	Concerns raised around paying care home fees until the brother could become legal power of attorney for health and finance	We agreed the problem was with the interface between adult social care and the customer. The team identified that once the assessment was completed, we could have put forward the case for funding at that point. This would have meant less delays and could have prevented the negative experience.

1	NWS & SH	Assessment process and Communication	Feb 2022	Specific care needs were discussed at the Care Plan Review but virtually nothing was included in the subsequent plan and care plan not shared	The issues regarding the specific member of staff will be raised with them in supervision and appropriate retraining will be implemented and a new practitioner will be instructed to make contact to arrange the reassessment.
1	PLD, Autism & Transition	Assessment process	Nov 2021	Removal of support for adult son, who is under the remit of the Learning Disability and Autism team. Up until the beginning of the pandemic (March 2020) he was in receipt of 7.5 hours of support. We were not kept updated that the support would be removed as the lockdown restrictions were lifted and the decision needed to be challenged.	The manager responded to apologise if the options around the care were not explained in a clear way to Mr X or his family who complained on his behalf. The team reinstated some hours to meet the need for him to attend football training and offered further reassurance by reviewing how these hours are working after a period of time, alongside how the handi calendar and reablement intervention are working to ensure that these are meeting Mr X needs.
1	PLD, Autism & Transition	Service provision	Dec 2021	Brother alleged staff at supporting housing accommodation where he resides, gave his brother the wrong medication in error which could have caused detrimental impact on Mr X health, alongside poor food provision and neglect	Information to be better shared between care providers. This is in progress with oversight from the PLD and Autism Team to improve external communication and provide a more person-centred approach.

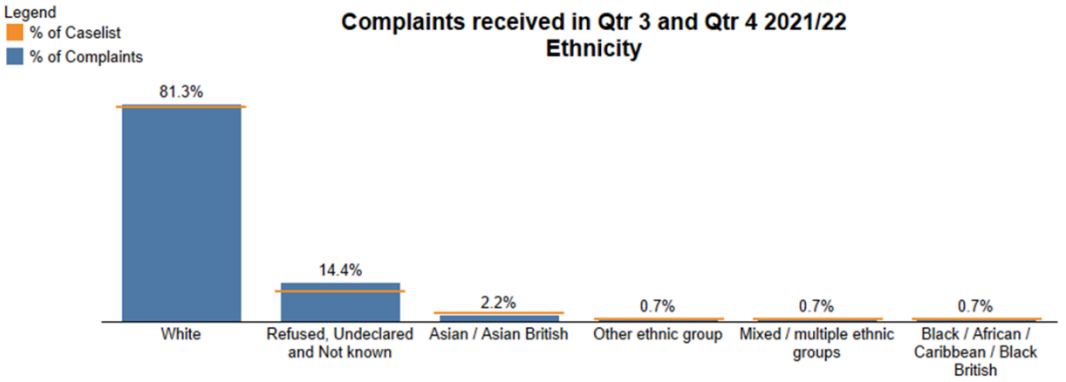
1	PLD, Autism & Transition	Decision making	Nov 2021	Ms X told us that her care plan was wrong and had been amended. She informed us that the team are refusing to review this care plan despite numerous requests and failing to provide support due to her complex needs	The remedy offered to the complainant was a review and an apology for the delay in arranging the meeting to conduct the review.
1	PLD, Autism & Transition	Assessment process, Communication and Staff	Jan 2022	Lack of response to emails, conflicting information given regarding Epsom Community Mental Health Team and the assessor lacked the understanding they should have, as per the Care Act. Overall needs are not being met.	The team accepted that they could have been clearer about what services they can and cannot offer and why. Several services were involved and it became confusing to Ms X . Reablement were to offer support with personal care and maintaining nutrition and working on any skills based identified goals. A referral to social prescribing was also offered as a result of this complaint.
2	PLD, Autism & Transition	Assessment process and Communication	Feb 2022	Failure to advise when Adult Social Care would complete a Transition assessment to consider support for xxx for post 18 support and the lack of involvement from Adult Social Care in the Special Educational Needs annual reviews.	Learning including making staff aware of the need to follow procedures to ensure service users receive effective updates when moving from Children's to Adult care provision. Better overall collaboration would have prevented the complaint.
2	Service Delivery	Service provision and Staff	Jan 2022	Staff member visiting Ms X on Christmas Day did not leave accurate notes following medication administered in error.	Followed up with the staff member concerned and documented in a supervision assessment. As a result of this complaint and to ensure improvement of record keeping in Extra Care services, all staff will be reassigned to complete reporting and recording training as a priority.

2	Service Delivery	Staff	Feb 2022	Son was extremely upset about what happened with his mother's medication and he is very concerned that the outcome could have been much worse. He wanted this reported to ensure a similar incident doesn't happen again to his mother or to anyone else	Although the right protocols were followed after the wrong medication was given, we didn't follow up with the family who were concerned. As a result of this complaint, we will improve our service by ensuring any communication with relatives are followed up without delays.

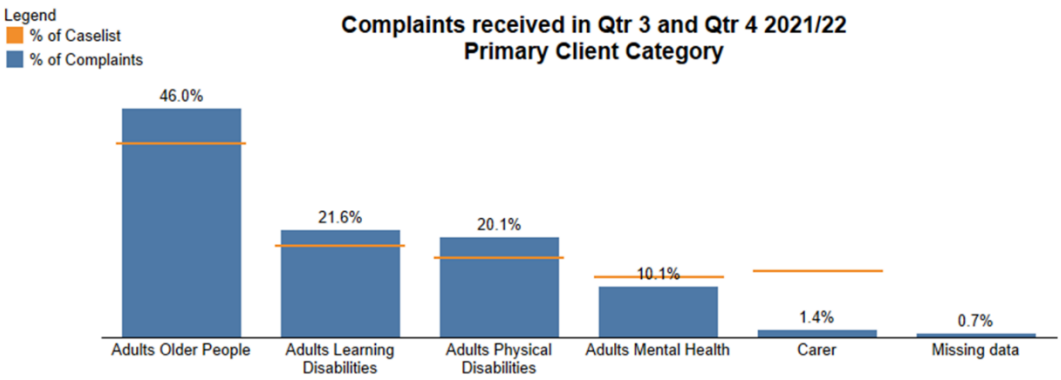
Complaints received analysed by protected characteristics in Q3 and Q4



Age	Number of complaints	Number of people with complaints	% of Complaints	Number of open cases	% of Caselist	Difference in %
Under 18	1	1	0.7%	316	1.5%	-0.8%
18-24	10	9	6.5%	1,148	5.4%	1.0%
25-34	18	16	11.5%	1,591	7.5%	4.0%
35-44	15	11	7.9%	1,522	7.2%	0.7%
45-54	16	11	7.9%	2,159	10.2%	-2.3%
55-64	9	9	6.5%	3,005	14.2%	-7.8%
65-74	11	11	7.9%	2,694	12.8%	-4.8%
75-84	27	26	18.7%	3,804	18.0%	0.7%
85+	46	44	31.7%	4,871	23.1%	8.6%
Age not known	1	1	0.7%	1	0.0%	0.7%



Ethnicity	Number of complaints	Number of people with complaints	% of Complaints - Ethnicity	Number of open cases	% of Caselist - Ethnicity	Difference in % - Ethnicity
White	128	113	81.3%	17,109	81.0%	0.3%
Refused, Undeclared and Not known	20	20	14.4%	2,502	11.9%	2.5%
Asian / Asian British	3	3	2.2%	729	3.5%	-1.3%
Mixed / multiple ethnic groups	1	1	0.7%	278	1.3%	-0.6%
Black / African / Caribbean / Black British	1	1	0.7%	246	1.2%	-0.4%
Other ethnic group	1	1	0.7%	247	1.2%	-0.5%



Primary Client Category	Number of complaints	Number of people with complaints	% of Complaints - PCC	Number of open cases	% of Caselist - PCC	Difference in % - PCC
Adults Older People	67	64	46.0%	8,283	39.2%	6.8%
Adults Learning Disabilities	35	30	21.6%	3,946	18.7%	2.9%
Adults Physical Disabilities	30	28	20.1%	3,394	16.1%	4.1%
Carer	2	2	1.4%	2,860	13.5%	-12.1%
Adults Mental Health	19	14	10.1%	2,626	12.4%	-2.4%
Missing data	1	1	0.7%	2	0.0%	0.7%