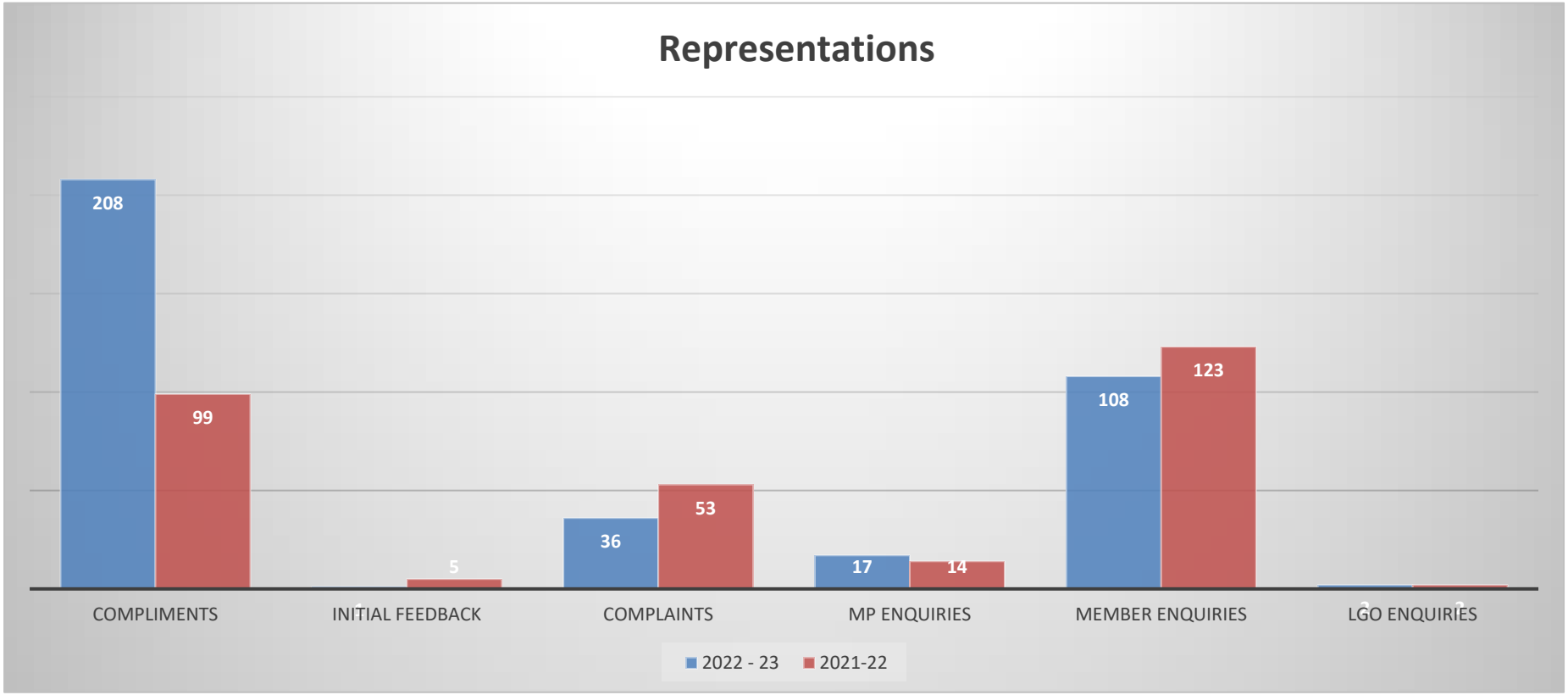
Appendix 2 – 2022/23 Adult Social Care Complaints & Representations Report

1.Volume of Representations 2022/23 vs 2021/22

Below is a comparison of representations received for both years. During **2022/23**, **372** representations were received, compared with **296** for **2021/22**.



2.Complaints – 2022/23 vs 2021/22

Below is the comparison between the two years broken down into more specific detail including those complaints involving both internal and external providers.

Feedback:	Initial Feedback	Complaints	No. withdrawn / Cancelled	Total to be investigated	Cases closed in period*	% of complaints upheld in period	% timeliness of response for those due in period
2022/23	1	36	2	34	37	66%	85%
2021/22	5	53	1	52	44	66%	84%
Difference	-4	-17	+1	-18	7	0%	+1%

For 2022/23:

- 36 complaints were received in the reporting period. Of these 36 received 2 were cancelled. These are shown within section 4.
- 33 complaints were due a response in this period. 28 of 33 (85%) were responded to within timeframe.
- 35 complaints were responded to within this period. These are shown in section 5.
- 23 of 35 complaints responded to (66%) were upheld. These are shown in section 5 and the learning is detailed within section 3

Key Note for 2022/23:

Complaints volumes are low, when taking into consideration that there are 4148 services commissioned across Adult Social Care for 2192 service users.

3.Learning and/or outcomes from upheld complaints:

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	Complaint 1 Concerns that care visits are not completed at requested times and pads used during care visits are not disposed of correctly (Extra Care) **Learning and/or outcome** • Monitoring will be introduced to ensure calls/visits are at the agreed times going forward • Care Staff have been reminded of the need to dispose of pads correctly and to ensure they follow infection control procedures **Complaint 2** Concerns regarding the poor level of care provided (Ronti Care) **Learning and/or outcome**	**Complaint 4** – Concerns regarding a financial form being issued with incorrect details included (Older People Mental Health) **Learning and/or outcome** Discussions held with the member of staff responsible for issuing the financial form and further training has been provided on data protection **Complaint 5** The service provider missed a visit (Clarity Homecare) **Learning and/or outcome** Staff involved did not communicate with one another	**Complaint 10** Concerns that waste within the home was poorly managed (Grays Court Care Home) **Learning and/or outcome** The Home now has an extra clinical waste bin to avoid overflow and housekeeping and maintenance staff also monitor the waste area on a daily basis. **Complaint 19** Concerns that another service user was verbally abusive. (AK Supported Living) **Learning and/or outcome** The service user was spoken to, and a letter was sent to the family to apologise.

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	An action plan has been put in place to ensure the concerns regarding quality of care are addressed. This will be monitored via visits to the provider and service users, to obtain their feedback and views **Complaint 3** Concerns that the service provider staff did not stay for the full 30 minutes and there was a lack of consistency in the carers attending (Clarity Homecare) **Learning and/or outcome** The service provider returned the package of care to the council as they were unable to meet the expectations of the service user. Since then, the package of care has been allocated to Pineapple Care and they are now providing support to the service user. **Complaint 9** Concerns that the service user was not supported when getting off the	clearly to ensure that the visit was carried out. Training in relation to the expected standards of communication has been provided **Complaint 6** Concerns received regarding the level and quality of communication with the service user and their family. This included delays and disruption in scheduled meetings and/or family requests for contact not being addressed. (Community Led Support Team 1) **Learning and/or outcome** Staff to update case recordings of all contact made in a timely manner, and on the relevant systems. Teams to have a system in place to enable them to respond to queries in the absence of staff members.	

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	council minibus and as a result suffered an injury (Day Care) **Learning and/or outcome** Disciplinary investigation completed and further training provided to all staff. **Complaint 11** Complaint regarding service user's items going missing (Leatherland lodge) **Learning and/or outcome** Items were located following the hospital returning a bag to the home. Therefore, in the event of any concerns regarding missing items, full checks must be completed to ensure any items are located. **Complaint 12** Concern as to how a relative fell from bed whilst being assisted by 2 care staff (Merrie Loots Farm) **Learning and/or outcome**	Staff not to be late when attending meetings. If staff are running late, the Chair of the meeting must be informed. Staff to ensure they are familiar with cases when attending meetings. **Complaint 7** A request for a meeting, to discuss the family's concerns regarding the care of service user was refused (Hospital team) **Learning and/or outcome** It was noted that while a meeting would not have resulted in the outcome of the service user returning home, it was acknowledged that a meeting would have allowed the family to feel heard. Due to this, a recommendation was made to the Hospital team that	

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	High needs/dependency service users to only be assisted by familiar, experienced staff. Additional risk assessments and visual prompts to be incorporated/undertaken **Complaint 13** Concerns regarding human waste in a tissue box. (Willow Lodge Care) **Learning and/or outcome** Staff to ensure that they check the environment for every service user during all interventions with them. **Complaint 14** Concerns regarding a change in care users' needs regarding assistance with mobility and meal times as well as infection control issues. (Willow Lodge care) **Learning and/or outcome** To ensure effective communication with families to keep them up to date	in future if a request for a meeting is received from a family, then it should be fully considered. **Complaint 8 Note: The complaint and outcome are the same as complaint 7, as the issues were the same, however this was a separate complaint received from different family members** A request for a meeting, to discuss the family's concerns regarding the care of service user was refused (Hospital team) **Learning and/or outcome** It was noted that while a meeting would not have resulted in the outcome of the service user returning home, it was acknowledged that a meeting would have allowed the family to feel heard. Due to this, a recommendation was made to the Hospital team that	

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	on service users' needs. In addition to this robust documentation must be held to detail any changing needs of the service user **Complaint 15** Concerns in relation to how personal care was delivered as the service user was wet after a pad change (Willow Lodge Care) **Learning and/or outcome** Members of staff who carried out the care were spoken to, and additional training was provided **Complaint 16** Concerns regarding a delay in replacing a fall pendant/alarm. (Careline) **Learning and/or outcome** At the point the council were informed that a replacement pendant was required it was replaced the following day. The learning in this case is to	in future if a request for a meeting is received from a family then it should be fully considered. **Complaint 21** Concerns regarding lack of communication with regards to a hospital admission for a service user. (Willow Lodge) **Learning and/or outcome** Additional training was provided to members of staff regarding effective customer service/communication	

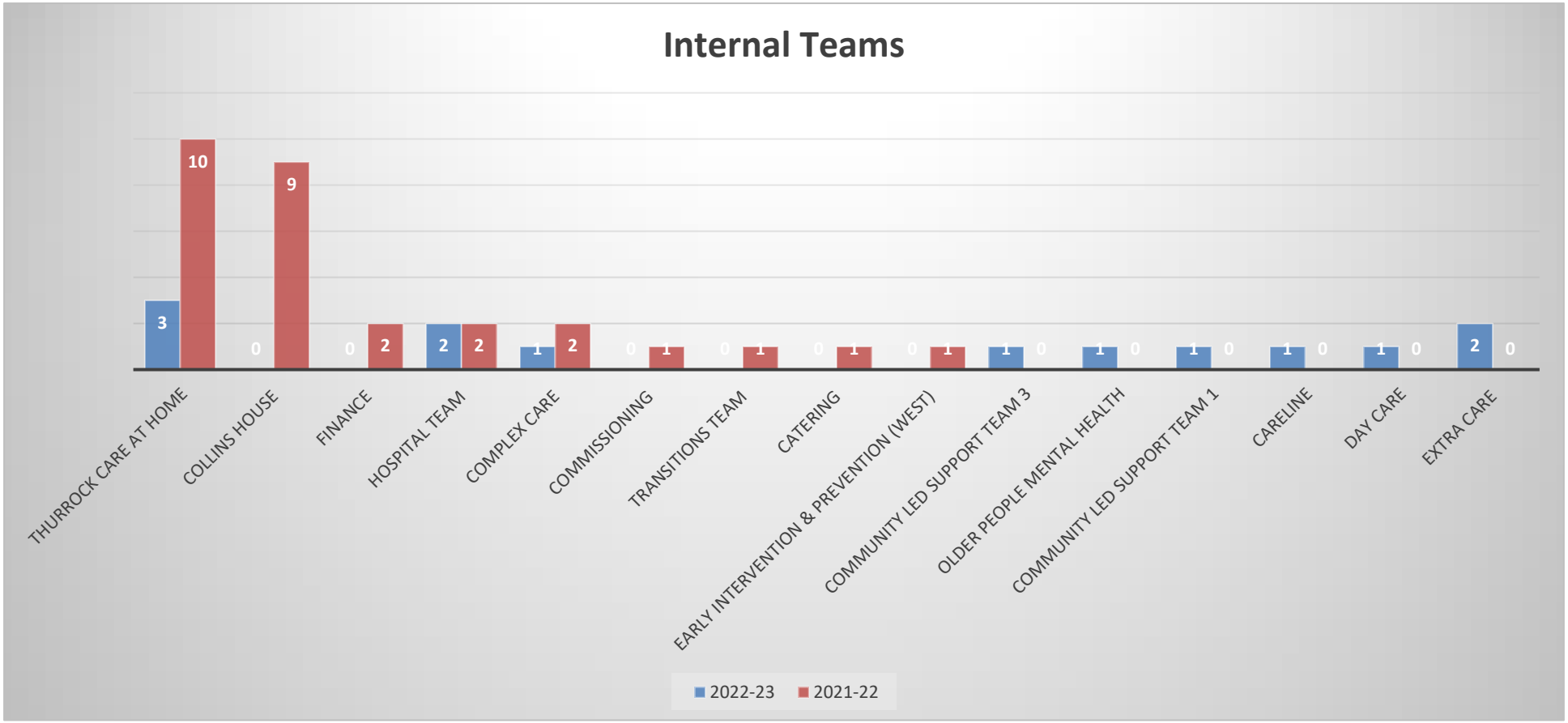
Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	explore localised options for fall pendant stock so that going forward these devices can be replaced sooner if required. **Complaint 17** Concerns regarding a missed telephone call and missed medication. (Thurrock Care at Home) **Learning and/or outcome** Members of staff responsible were spoken to and further training was provided. Medication Support Workers will also complete medication competency spot checks on staff **Complaint 18** Service user had raised concerns that he was feeling unwell. However, this was not raised as a concern or escalated for action. (Thurrock Care at Home) **Learning and/or outcome**		

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	Care workers who carried out visits have been spoken to and were required to complete refresher training on duty of care awareness, safeguarding adults and the role of the carer **Complaint 20** Concerns that the service user had been given continence pads when they were not needed. Concerns that the service user was not wearing dentures or being showered. (Leatherland Lodge) **Learning and/or Outcome** • Ensure that staff are fully aware of any new residents needs • Staff to ensure that family members are made aware immediately of any changes to care process. • Staff to ensure that any care related tasks or information is		

Root cause analysis and learning from upheld complaints:	Root Cause 1 and associated learning Standard of Care	Root Cause 2 and associated learning Communication	Root Cause 3 and associated learning Concerns regarding care home
	documented for future reference. **Complaint 22** Concerns regarding the texture of food that was provided, and a lack of assistance provided for cleanliness within the bedroom. (Willow Lodge) **Learning and/or outcome** Additional training provided to staff regarding nutrition and hydration. Planned care actions also implemented to address concerns regarding lack of assistance. **Complaint 23** Lack of empathy or compassion shown by member of staff whilst dealing with a service user (Willow Lodge) **Learning and/or outcome** Additional training provided to the relevant member of staff		

4A. Breakdown of complaints received - Internal teams and staff:
This may be different to figures shown within the upheld complaints section below, as the upheld section is based on closed complaints (not complaints received). The figures shown below will also exclude cancelled complaints.

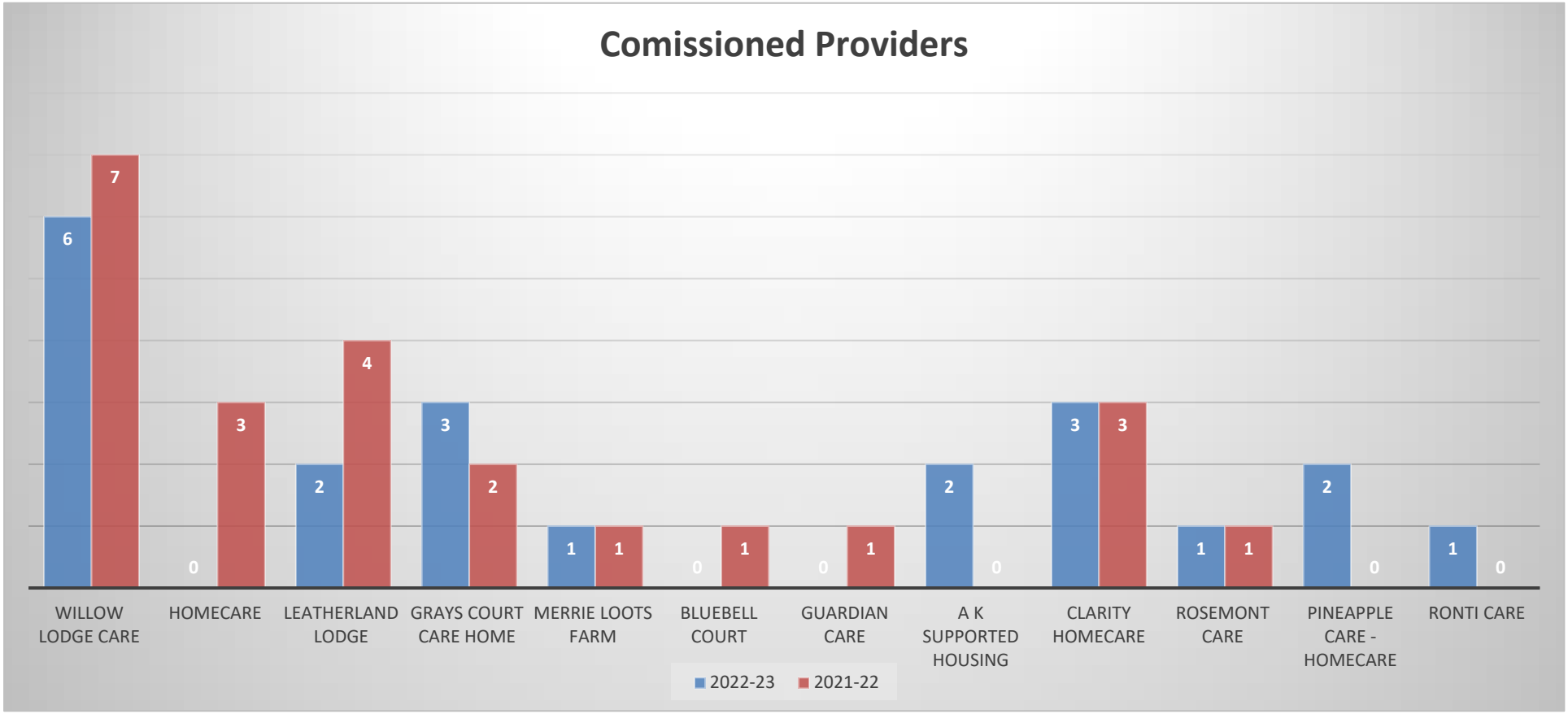
14 of 36 complaints received within this period are for internal teams/services (**1** was cancelled and this related to Community Led Support Team 3). This compares with **30 of 53** during 2021/22.



4B. Breakdown of complaints received - Commissioned Providers:

This may be different to figures shown within the upheld complaints section below, as the upheld section is based on closed complaints (not complaints received). The figures shown below will also exclude cancelled complaints.

22 of 36 complaints responded to within this period are for commissioned providers services (**1** was cancelled and this related to Willow Lodge Care). This compares with **23 of 53** during 2021/22.



5.Upheld Complaints:

This may be different to figures shown above within the complaints received section, as the figures below are based on closed complaints (not complaints received).

Complaint Area	Volume Closed 2022/23	Upheld	Volume Closed 2021/22	Upheld
Thurrock Care at Home	2	2	10	10
Collins House	0	0	8	3
Willow Lodge Care	6	6	6	2
Homecare	0	0	3	3
Leatherland Lodge	2	2	3	3
Clarity Homecare	3	2	3	2
Careline	1	1		
Finance	0	0	2	2
Hospital Team	2	2	2	1
Rosemont Care	1	0	1	0
Commissioning	0	0	1	0
Complex Care	2	0	1	0

Bluebell Court	0	0	1	0
Grays Court Care Home	3	1	1	1
Guardian Care	0	0	1	1
Merrie Loots Farm	1	1	1	1
Community Led Support Team 3	1	0	0	0
A K Supported Living	2	1	0	0
Extra Care	2	1	0	0
Ronti Care	1	1	0	0
Older People Mental Health	1	1	0	0
Day Care	1	1	0	0
Pineapple Care - Homecare	2	0	0	0
Community Led Support Team 1	1	1	0	0
Transitions Team	1	0	0	0

6.Local Government and Social Care Ombudsman (LGSCO) Complaints:

There were **2** enquiries from the Local Government and Social Care Ombudsman (LGSCO), where they reached a final decision on any cases within the reporting period.

Area	Issue Nature	LGSCO Findings	Financial Remedy	Learning where relevant	Did the council respond to the LGSCO timeframes
Hospital Team	Complaint regarding the handing of discharge from hospital by the council and the NHS Trust	Closed after initial enquiries - No further action	N/A	N/A	Yes
Early Intervention & Prevention (West)	Complaint regarding how the council dealt with matters relating to social care between 2013 and 2018	Closed after initial enquiries - Out of jurisdiction	N/A	N/A	Yes

7.Enquiries:

In the reporting period the following was received:

- **17** MP Enquiries
- **108** Member Enquiries

MP Enquiries	Feedback total
Complex Care	**4**
Disabled Facilities Grant	**3**
Finance	**2**
Public Health	**2**
Thurrock Care at Home	**1**
Preparing for Adulthood	**1**
Blue Badges	**1**
Community Led Support Team 1	**1**
Community Led Support Team 2	**1**
Collins House	**1**

Member enquiries	Feedback total
Thurrock First	**30**
Public Health	**22**
Community Development	**20**
Local Area Coordination	**9**
Safeguarding	**5**
Finance	**3**
Blue Badges	**2**
Contract Compliance	**2**
Commissioning	**2**
Older People Mental Health	**2**
Grays Court Care Home	**2**
Complex Care	**2**
Hospital Team	**1**
Thurrock Care at Home	**1**
Community Led Support Team 2	**1**
Disabled Facilities Grant	**1**
Hollywood Rest Home	**1**
Pineapple Care - Homecare	**1**
Day care	**1**

8.External Compliments:

A total of **208** compliments have been received during this period compared to **99** within the same period last year. A breakdown of the areas that these relate to is shown below.

Note – These relate to compliments that have been sent to the Complaints Team to record on the complaints system.

Service Area 2022/23	Number of Compliments	Service Area 2021/22	Number of Compliments
Community Led Support Team 1	**53**	Thurrock First	**26**
Thurrock First	**32**	Joint Reablement Team	**20**
Thurrock Care at Home	**17**	Disabled Facilities Grant	**10**
Older People Mental Health	**15**	Blue Badges	**6**
Hospital Team	**14**	Community Led Support Team 1	**6**
Rapid Response Assessment Service	**12**	Community Development	**5**
Collins House	**10**	Hospital Team	**3**
Extra Care	**7**	Local Area Coordination	**3**
Day Care	**6**	Community Led Support Team 3	**3**
Disabled Facilities Grant	**5**	Thurrock Care at Home	**3**
Thurrock Healthy Lifestyle	**4**	Careline	**3**
Careline	**4**	Community Led Support Team 2	**2**
Community Led Support Team 3	**4**	Collins House	**2**
Blue Badges	**4**	Rapid Assessment Service	**2**
Local Area Coordination	**3**	Safeguarding	**2**
Contract Compliance	**3**	Extra Care	**1**
Community Development	**3**	Complex Care	**1**
Preparing for Adulthood	**2**	Preparing for Adulthood	**1**

Community Led Support Team 2	**2**		
Grays Court Care Home	**1**		
Meadowview	**1**		
Complex Care	**1**		
Barn & Coach House	**1**		
Joint Reablement Team	**1**		
Community Led Support Team 4	**1**		
The Whitecroft	**1**		
Leatherland Lodge	**1**		

9.Examples of External Compliments

Thurrock First

I would like to comment how helpful your member of staff was during my call to Thurrock First this morning.

Not only did she listen and give helpful feedback, she asked relevant questions and gave useful information about services that may be available. She seemed to genuinely care. She has arranged for call backs from appropriate services.

This member of staff is very professional and good at her job and is an asset to Thurrock First.

Rapid Response Assessment Team

Thank you for the amount of time you spent with xxx and myself over the last couple of days. Your understanding, empathy, efficiency and knowledge was so reassuring. Learning that some of xxx actions are ‘normal’ for people with dementia has given me a better understanding of how to cope better with caring for him. Also thank-you for our conversations about everyday life.

Community Led Support Team 1

Service user confirmed all the staff are very polite and good at their job, no complaints, all very helpful.

The service user would like to thank the member of staff for all she did when xxx was taken into hospital. She stayed with me all the way through.