

## HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL

<b>DATE</b>	24 <sup>th</sup> November 2021
<b>REPORT OF</b>	Bev Compton Director of Adult Social Care
<b>SUBJECT</b>	Adult Social Care and Health Statutory Annual Complaints Report 2020/2021
<b>STATUS</b>	Open

### CONTRIBUTION TO OUR AIM

Service user or patient feedback about the services we commission, are viewed as a window into their experience of our services. Encouraging and responding to feedback strengthens the community's input into service design and helps to improve services for users, contributing to the council's and Clinical Commissioning Group's (CCG) aim to develop stronger communities.

### EXECUTIVE SUMMARY

It is a requirement of the Local Authority Social Services and National Health Service Complaints (England) regulations 2009 to produce an annual report regarding all representations made about social care and health services. The purpose of the attached report is to fulfil this obligation and to provide insight on the effectiveness of the statutory complaints service.

### MATTER(S) FOR CONSIDERATION

#### 1. BACKGROUND AND ISSUES

The purpose of this report is to provide an overview of the complaints received by North East Lincolnshire Clinical Commissioning Group (NELCCG) during the period 1 April 2020 to 31 March 2021, in line with the NHS and Adult Social Care (Complaints) Regulations 2009. Under these regulations, complainants can raise a complaint to either the provider of the service or to the commissioner of the service, in other words the CCG.

The report also details the trends and themes from feedback from the public received during this period, which includes contacts from the public via other routes such as enquiries received from MPs, Patient Advice and Liaison Service (PALS) contacts (signposting and informal contacts) and compliments. NELCCG recognises that patients have a range of experiences when using local healthcare services. Where possible where things have gone wrong, the CCG takes immediate action to put things right for service users. Where this is not possible, the CCG has a robust complaints process. The data collated through complaints, MP enquiries, PALS and compliments play a significant role in improving the quality of care and service experience of patients and their families, which continues to be a priority for the CCG.

During 2020/21 there were 1,269 contacts made to the Customer Care team

and these are broken down and analysed in the attached report.

It is acknowledged that 2020/21 was an unprecedented year for health and social care due to the COVID-19 Pandemic. In line with all CCG staff, the Customer Care team adopted a working from home model and through this demonstrated both adaptability and an excellent multi-disciplinary approach to team work, stepping in to offer support to other areas of the CCG as needed to help with the response to COVID-19, together with offering a seamless service to the public. The Pandemic led to increased enquiries from MPs and patients alike, particularly in relation to primary care services. Additionally, once the vaccination roll-out programme was launched, the number for enquiries rose significantly with members of the public contacting the CCG with queries about the programme, in particular regarding eligibility and timing of vaccinations. Each contact had to be dealt with on an individual basis in order to provide the person with the most accurate response due to the ever-changing landscape during the pandemic; this added significant pressures to the customer care teams workload. A review of the CCG's complaints handling arrangements is currently underway, with a view to improving response times and due diligence surrounding the learning from complaints.

## **2. RISKS AND OPPORTUNITIES**

Managing complaints effectively allows organisations to learn from feedback and improve services as a result, reducing the risk to patients and service users of poor quality or ineffective services and reducing the risk to both organisations of regulatory and Ombudsman intervention. Receipt of service user feedback concerning our services is a significant opportunity for us to understand and learn from the public's experience of using our services, this customer care functions are essential to help us effectively deliver our commissioning responsibilities.

## **3. REPUTATION AND COMMUNICATIONS CONSIDERATIONS**

Under the current complaint's regulations, there is a requirement for an annual report of complaints to be produced and made available to the public. By doing this we can demonstrate our compliance with the regulations and provide an overview of what we have learnt and the actions we have taken to respond to the feedback we have received.

The information supplied in this report has been presented to maintain confidentiality.

## **4. FINANCIAL CONSIDERATIONS**

Effective and timely complaints handling reduces the risk of complaints being escalated to the Ombudsmen and potential findings of maladministration and the requirement to pay redress to complainants.

Learning from service users' experiences helps to improve future care delivery and can be a positive contribution to preventing future costs.

## **5. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS**

The report will not have any impact on climate change or environmental implications.

## **6. MONITORING COMMENTS**

In the opinion of the author, this report does not contain recommended changes to policy or resources (people, finance or physical assets). As a result, no monitoring comments have been sought from the Council's Monitoring Officer (Chief Legal Officer), Section 151 Officer (Director of Finance) or Strategic Workforce Lead.

## **7. WARD IMPLICATIONS**

All wards affected

## **8. BACKGROUND PAPERS**

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

## **9. CONTACT OFFICER(S)**

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**Director of Adult Social Care**

**STATUTORY**

**ADULT SOCIAL CARE AND NATIONAL  
HEALTH SERVICE**

**COMPLAINTS ANNUAL REPORT**

**2020-2021**

**Author: Zoë Wray**  
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## 1.0 Executive Summary

The purpose of this report is to provide an overview of the complaints received by North East Lincolnshire Clinical Commissioning Group (NELCCG) during the period 1 April 2020 to 31 March 2021.

Under the NHS and Adult Social Care (Complaints) Regulations 2009, complainants can raise a complaint to either the provider of the service or to the commissioner of the service, in other words the CCG, and this is particularly so if there are multiple agencies involved, when it is considered good practice for the commissioner to lead.

The same Regulations state that the CCGs have a statutory duty to record and report:

- **The number of complaints received**, see section 2 of the report.
- **The number that were well founded**, see section 5 of the report.
- **The number referred to the Ombudsman (Parliamentary and Health Service Ombudsman (PHSO) and the Local Government and Social Care Ombudsman (LGSCO))**, see section 11 of the report.
- **The subject matter of complaints**, see section 3 and appendix A of the report.
- **Matters of importance arising from the complaints or handling thereof**, these are addressed throughout the report and include complaints handling and learning from complaints.
- **Action taken, or being taken, to improve services as a result of complaints received**, see section 2c and appendix B of the report.

This report also details the trends and themes from feedback from the public received during this period, which includes contacts from the public via other routes such as enquiries received from MPs, Patient Advice and Liaison Service (PALS) contacts (signposting and informal contacts) and compliments.

NELCCG recognises that patients have a range of experiences when using local healthcare services. It is essential that the CCG provides service users with a mechanism to tell us about both positive and negative experiences. Where possible, the CCG takes immediate action to put things right for service users. Where this is not possible, the CCG has a robust complaints process. The data collated through complaints, MP enquiries, PALS and compliments play a significant role in improving the quality of care and service experience of patients and their families, which continues to be a priority for the CCG.

During 2020/21 there were **1,269** contacts made to the Customer Care team and these are broken down by function in the table over leaf. Also included is the same data for the past three reporting years for comparison and an indication of the direction of travel when comparing this year's contacts with the number of contacts received in the previous year (2019/2020).

The table below shows the contacts by function over the last four reporting years.

Function	Total Number 2017/18	Total Number 2018/19	Total Number 2019/2020	Total Number 2020/2021	Direction of Travel from 19/20 to 20/21
Number of PALS contacts	726	679	799	1119	↑
Number of complaints	111	72	76	45	↓
Number of MP Enquiries	7	2	5	22	↑
Number of Compliments	147	86	86	82	↓
Ombudsman requests	9	6	6	1	↓
<b>Total contacts</b>	<b>1,000</b>	<b>845</b>	<b>972</b>	<b>1,269</b>	↑

It is acknowledged that 2020/21 was an unprecedented year for health and social care due to the COVID-19 Pandemic. In line with all CCG staff, the Customer Care team adopted a working from home model and through this demonstrated both adaptability and an excellent multi-disciplinary approach to team work, stepping in to offer support to other areas of the CCG as needed to help with the response to COVID-19, together with offering a seamless service to the public.

In response to the emerging Pandemic, a national pause on complaints was mandated by NHS England/Improvement (NHSE/I) for 3 months to allow front line services to focus on responding to the Pandemic. Both the PHSO and LGSCO followed suit. Details of what NELCCG actioned to mitigate this pause is included in section 2 of this report.

The Pandemic led to increased enquiries from MPs and patients alike, particularly in relation to primary care services. Additionally, once the vaccination roll-out programme was launched, the number for enquiries rose significantly with members of the public contacting the CCG with queries about the programme, in particular regarding eligibility and timing of vaccinations. Each contact had to be dealt with on an individual basis in order to provide the person with the most accurate response due to the ever-changing landscape during the pandemic; this added significant pressures to the customer care teams workload.

However, despite the additional challenges brought by the Pandemic, the Customer Care team recognised the importance of aligning the CCG IT systems with intelligence received to capture data more efficiently. It was decided to progress with the planned, April 2020 launch of going live with the new 'RESPOND' system. This has allowed the Quality team to have all intelligence received into the CCG categorised by both provider and issue, logged centrally, allowing more opportunity to analyse data received in a more transparent way, identifying trends and any necessary service improvements which we can share wider for learning and service development

## 1.1 Definitions

**Complaint:** When a person makes a statement that something is unsatisfactory or unacceptable. This can be about any aspect of the CCG and its commissioned service, and a formal investigation and response is required.

**PALS:** The Patient Advice and Liaison Service (PALS) is about listening and working with patients/service users to improve their health and social care services. Contacts with PALS can be broken down into 2 types:

- **PALS Enquiry:** A light touch contact with patient/service user to signpost them to services/contacts within North East Lincolnshire.
- **PALS Concern:** Where a concern is raised and managed informally, with the agreement of all parties and usually within three working days. A person may also be asking for information, advice or making a constructive suggestion. An enquiry may escalate into a formal complaint should the enquirer remain dissatisfied or require deeper investigation.

**Appeals:** These are made by persons in receipt of social care who wish to challenge the process or outcome of their assessment including the contributions they pay towards their care, or a clinician appealing the decision made the CCG’s Individual Funding Request Panel (IFR).

**Compliments:** A verbal or written expression of praise or thanks.



**MP Enquiry:** General enquiries from MPs about CCG related matters. Where a patient/service user goes to their local MP to raise concerns about an issue and the MP then raises the matter with the CCG on the patient’s behalf, these are categorised and progressed as a formal complaint.

## 2.0 Complaints Activity

In managing complaints, the CCG works in accordance with our complaints policy that complies with the requirements laid out by the NHS (Complaints) Regulations 2009, the PHSO Principles of Good Complaint Handling (2009) and the NHS England / Improvement (NHSE/I) Complaints Handling for CCGs (2013).

During 2020/21 there were **45** complaints received by NELCCG, a fall of **41%** on the previous year. A breakdown of these into complaints about healthcare (including the CCG commissioning) and social care can be seen below.

**The table below shows a breakdown of the complaints received by the CCG into health and social care complaints over the past four reporting years and the direction of travel of this year’s figures compared with 2019/2020**

Type of complaint	Total Number 2017/18	Total Number 2018/19	Total Number 2019/2020	Total Number 2020/2021	Direction of Travel from 19/20 to 20/21
Adult Social Care complaints	53	35	37	23	
CCG/health Complaint	58	37	39	22	

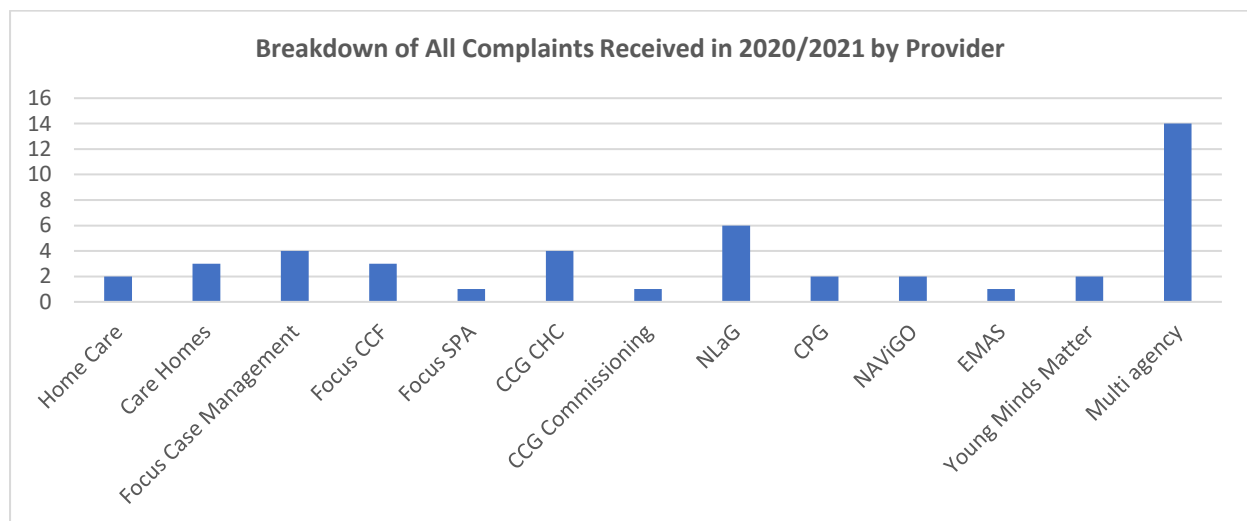


As advised within the executive summary, there was a national pause in the handling of complaints between 26 March 2020 and 30 June 2020 to support the pandemic work.

The Customer Care team recognised that this would have impacted patient experience and as such introduced a triage system of all new complaints it received to mitigate any potential patient experience delays. As a result, two complaints received during the paused period were resolved through the alternative informal PALS route. This was supported by and in agreement with the complainant.

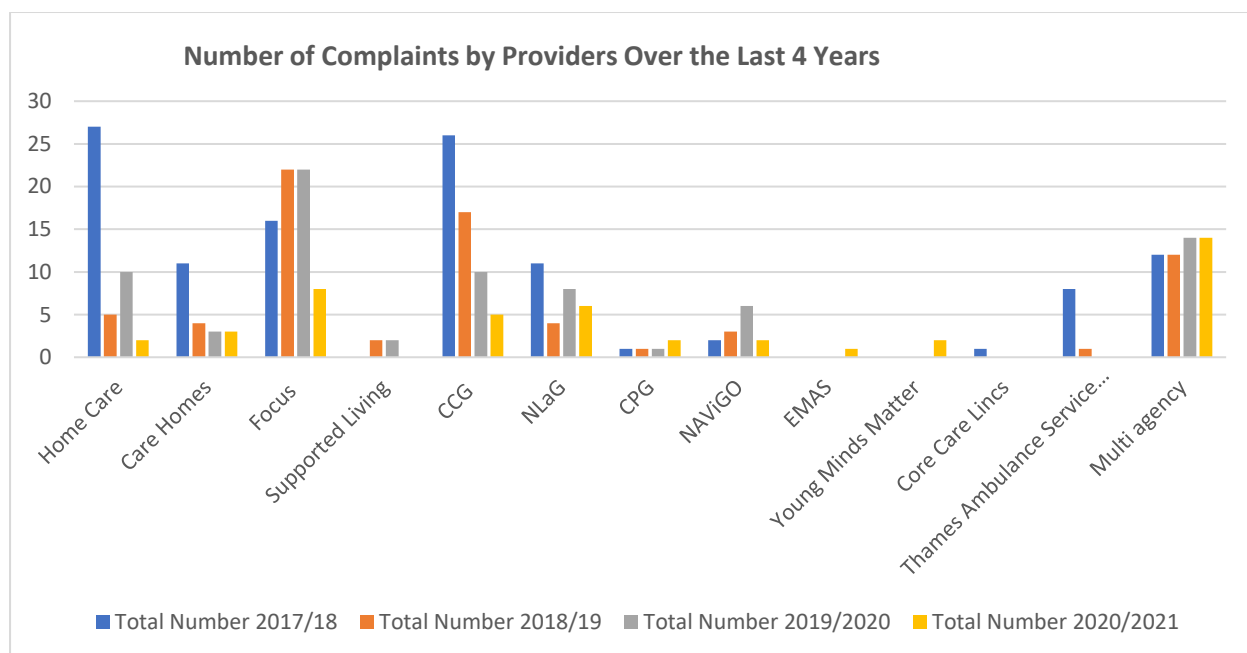
Looking now at a breakdown of complaints by provider:

**The chart below shows an overall breakdown of the complaints received during 2020/2021.**



Below the data is further analysed, with year-on-year trend comparisons.

**The chart below shows the number of complaints by provider over the last four years.**



In summary the overall provider complaints data has remained, in large, static since 2019/2020 with some noted reductions. The Quality team, work with all providers to identify and process complaints.. There are no reportable changes in process or care delivery to justify a drop in complaints received.

The global pandemic saw many patients receiving care in different ways the Quality team has continued to align the incident review process, alongside the complaints process, to triangulate or identify any trends in care delivery, not captured as a result of the reduced complaints received. No trends have been identified.

## 2.1 Acknowledgement of complaints

During 2020/21 100% of complaints received into the Customer Care Team were acknowledged within three working days as required by the NHS and Adult Social Care (Complaints) Regulations 2009.

## 2.2 Responding to complaints

There is no definitive timeframe set out in the Regulations for responding to complaints. However, it is position of NELCCG that complainants are provided with a response after a thorough investigation by the provider and a review of the investigation findings by the Quality Team. Complainants are updated regularly as to progress and are kept informed as to delays as they occur.

During 2020/21 the average response time for a complaint made to the CCG was **125** working days. This is an increase on the average length of time to respond last year, which was 80 working days. This increase can be accounted for by the pause in the complaints process during the first quarter of the year.

It is acknowledged that there are delays within the current NELCCG complaints process. These delays are as a result of a combination of factors. Therefore, the complaints process is currently under review. This review will identify the influencing factors of delay in more detail, and the changes made will focus on improving transparency, ownership, and accountability of delays within the complaints process. It is the hope that next year's annual complaint report will have a better understanding of the delays within the complaint process for sharing.

## 2.3 Actions associated with complaints

Where a complaint is either upheld or partially upheld, the provider(s) are asked to develop action plans to address the learning and these action plans are monitored by the Quality team until all the actions are completed.

During 2020/2021 **23** complaints were either upheld or partially upheld. Due to the pressures of the Pandemic, not all the action plans were followed up as rigorously as they have been in the past, but assurances are being sought from providers that the actions have been implemented and the learning is embedded.

From the 23 complaints, **17** action plans were received from the providers concerned, equating to **48** actions undertaken.

A refresh of the action plan follow up process is being included in the complaints review.

### 3.0 Themes

A complaint can relate to more than one service and contain a number of themes. During 2020/21 the highest number of complaints were in relation to the local acute trust, the Northern Lincolnshire and Goole NHS Trust, the local social work provider, Focus, and the CCG. Issues relating to discharge from hospital, Continuing Healthcare (CHC) funding, and questions about social care charges (which can also be appealed through the charging appeal process), were the most common themes.

Within the past twelve months complainants have identified a wide range of concerns, with the key ones being:

- Discharge from hospital, including poor planning, poor communication with patients and their families, issues with medication and poor coordination between the hospital discharge team and social care providers.
- CHC concerns, mainly relating to the outcomes of assessments.
- The application of retrospective social care charges and disregards of disability related expenditure (DRE).
- Late/missed calls from home care staff and poor quality or rushed care.
- Lack of support from mental health services.
- Lack of support from social worker.

Please see appendix A for an exhaustive list of complaint themes during 2020/21.

### 4.0 Serious Incidents

NHS England’s Serious Incident Framework (supporting learning to prevent recurrence) 2015, defines a Serious Incident (SI) as follows:

“In broad terms serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare.”

The Customer Care team are trained to identify potential SIs, and should a complaint contain such an event, they are reported to the quality officer for reporting or, if it relates to a provider, the provider is informed and told to report it as an SI through the national reporting system.

Of the complaints received during 2020/21, there were none identified as potentially involving an SI.

### 5.0 Outcome of Complaints

In line with the Ombudsmen’s approach to categorising the outcome of complaints, the CCGs record complaints as either ‘upheld’, ‘partially upheld’ or ‘not upheld’. This is the CCG’s equivalent of ‘well founded’ complaints as referred to in the Regulations.

The PHSO’s definitions of these are as follows:

**Upheld:** This could mean we found that:

- The organisations made mistakes or provided a poor service that amounted to maladministration or service failure, and
- This has had a negative impact on an individual that has not yet been put right.

**Partially upheld:** We might partly uphold a complaint if:

- We found that the organisations got some things wrong, but not all the issues that were complained about, or
- The mistakes made did not have a negative effect on anyone.

**Not upheld:** This could mean we found:

- The organisations acted correctly in the first place, or
- The organisations made mistakes but have already taken action to put things right for the person or people affected.

During 2020/2021 the number of the complaints that after investigation NELCCG found to be ‘well founded’, in other words, those that were found to be either upheld or partially upheld, were **23**.

**The table below illustrates the outcomes attributed to complaints completed during 2020/21**

Complaint outcome	Total for 2020/2021
Upheld	5
Partially upheld	18
Not upheld	10
Withdrawn*	10
Progressed through PALS due to complaints pause	2

\*Withdrawn complaints are cases that were initially complaints but were the complainant later changed their mind and did not want to progress the matter.

As per the table above, of the **45** complaints closed in 2020/21, **48%** were upheld or partially upheld and **22%** were not upheld; the remaining **30%** were either withdrawn or resolved informally through PALS with agreement of the complainant due to swift action being required during the pause of the complaints process due to the national pause mandate.

Please see section 11 for details of cases referred to the two ombudsmen during the last year.

## 6.0 Lessons Learnt – Turning intelligence into improvement

Robert Francis QC highlighted the importance of complaints in enabling NHS organisations to develop and sustain a culture in which the patient is at the heart of service design and delivery. “Complaints, their source, their handling, and their outcome provide an insight into the effectiveness of an organisation’s ability to uphold both the fundamental standards and the culture of caring. They are a source of information that has hitherto been undervalued as a source of accountability and a basis for improvement.”

NELCCG welcomes feedback, whether adverse or complimentary, as it enables learning from the experiences of patients, carers, and service users, and allows measures to be put in place to improve services for everyone. Whilst the majority of learning comes as a result of complaints, PALS concerns in particular can also generate learning in order to improve services.

All outcomes of investigations are reviewed by the relevant Head of Service. There are clear expectations that actions will be undertaken when complaints are upheld or partially upheld. As

advised earlier, the Customer Care team follows up on the progress of these actions in order to ensure that service improvements are made and to hold responsible providers to account.

Please see appendix B for further detail regarding lessons learnt during 2020/2021. This appendix shows examples of the upheld/partially upheld complaints that led to changes being implemented as a result of the concerns raised. The majority related to changes to procedures to facilitate better communication or improve service/care provision.

## 7.0 PALS – Informal Enquiries and Concerns

The Customer Care team also provides a Patient Advice and Liaison Service (PALS) dealing with informal enquiries and signposting. Contacts with PALS are divided into two types:

- **PALS enquiries:** A light touch contact with patient/service user to signpost them to services/contacts within North East Lincolnshire.
- **PALS Concern:** Where a concern is raised and managed informally, with the agreement of all parties and usually within three working days.

These informal enquiries provide the CCG with another valuable insight into patient and public experience of local health and adult social care services.

During this reporting period, the Customer Care Team handled **1,119** PALS contacts, an increase of 15% on last year.

**The table below shows the number of PALS contacts received by NELCCG during 2020/2021**

Type of PALS contact	Number of Contacts
PALS concerns	201
PALS enquiries	918
Total	1,119

Whilst the PALS team endeavours to resolve all informal enquiries quickly for the patient/service user and to limit any further escalation to becoming a formal complaint. However, on occasion, some of the informal enquiries the CCG receive are time consuming, complex and require the involvement of multiple organisations and departments.

If enquiries cannot be resolved in a satisfactory way, the patient can escalate their concern as a formal complaint. During 2020/2021, 4 PALS concerns were escalated into a formal complaint. This equates to just 2% of the total number of PALS concerns received.

**The table below shows the five most common issues raised as a PALS contact with the Customer Care team during 2020/2021:**

	Issue
1	Requests for information on health and social care services
2	COVID-19 related queries
3	Care related queries
4	Medication related queries
5	GP related queries

The table below shows the top 10 organisations the PALS contacts were about:

	Organisation
1	NELCGG*
2	NELC (including Children's Services)
3	GP Practices
4	Focus
5	NLaG
6	Home care agencies
7	CPG
8	Care home (nursing/residential)
9	TASL
10	NAVIGO

\* NELCCG received the highest number of PALS contacts as they were related the COVID-19 pandemic and in particular the national vaccination roll out programme.

## 8.0 Feedback from complainants on their experience of the CCG's handling of their complaints

As advised in last year's annual report, the CCG appointed a community lead for quality, which is a lay representative appointment. Part of their role is to undertake satisfaction surveys with complainants over the telephone once the investigation is concluded. The survey focuses on the handling of the complaint and the results are reviewed to look at how the CCG's complaints handling could be improved. Feedback received by this process has demonstrated that on the whole complainants are happy with the handling of their complaint but often remain dissatisfied with the outcome of their complaint.

Due to the break in the satisfaction surveys during the pause in the complaints process and a number of complainants declining to be telephoned for their feedback, this has resulted in feedback from only **27%** of the completed complaints.

Number of completed surveys carried out **12**.

Of those 12 responses:

**58%** were very satisfied with the way their complaint has been handled.

**42%** were satisfied with how their complaint had been handled.

**0%** were dissatisfied with how their complaint had been handled.

The satisfaction survey focuses primarily on the handling of the complaint, but complainants do have an opportunity to make comments at the end. These are recorded and reviewed, and action taken as appropriate.

The table below shows the main themes of any general feedback, and action taken as a result.

Main themes of free text feedback received	Action taken as a result of the feedback
5% were not happy with the length of time taken to investigate and respond	A review of the CCG's complaints procedure to commence in June 2021 looking at improving the timeliness of responses.
40% were unhappy with the response from the provider.	CCG response format was revised to explain how the CCG quality checks the provider's responses and to include personal comments on the overall complaint by the person signing the letter.

One of the developments this year is to develop an electronic survey with the aim of improving uptake during 2021/2022.

## 9.0 MP Enquiries

During 2020/2021 there have been **22** enquiries from our local MPs, Lia Nici and Martin Vickers.

The themes of these MP enquiries were:

- Care related issues. These included CHC issues and individual funding requests (IFR).
- COVID-19 related issues including extremely clinically vulnerable designation, access to the vaccine early on in the roll out programme for care staff and the provision of vaccinations to the housebound.
- Other medication related issues.
- GP practice related issues.

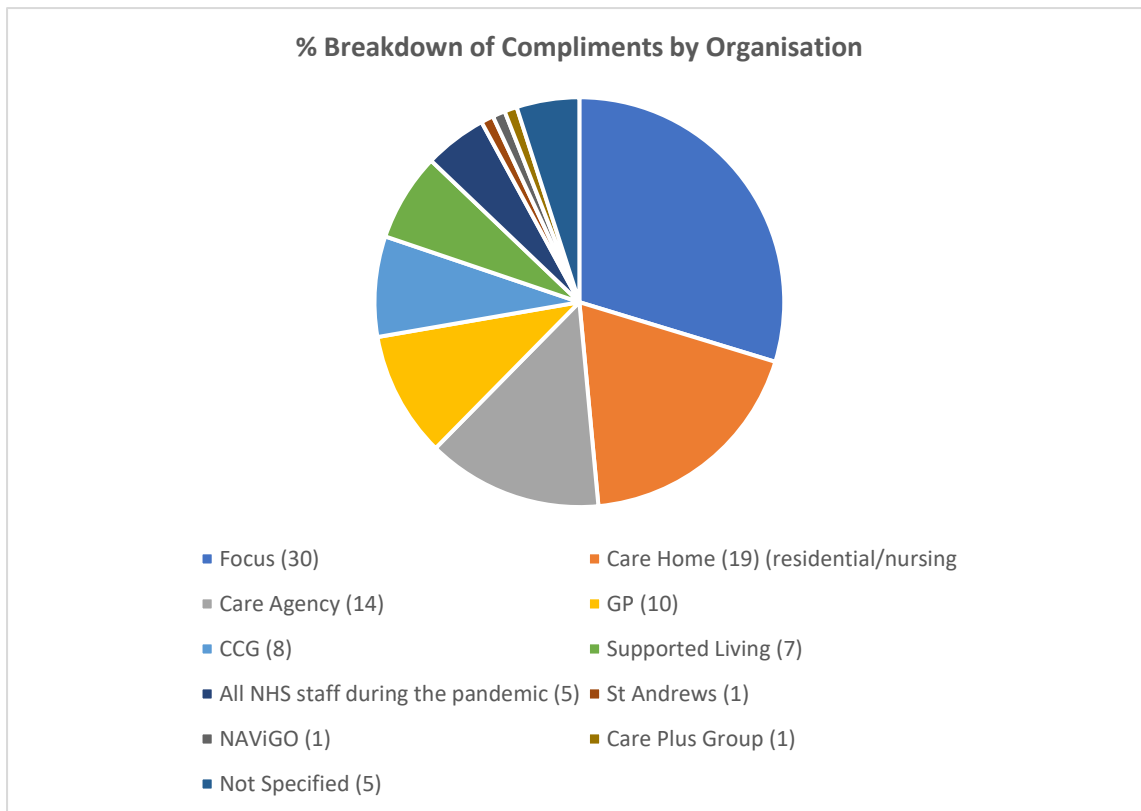
All of the cases were investigated and responded to the satisfaction of the MP involved.

## 10.0 Compliments - Learning from excellence

A compliment is recorded when a member of the public or another staff member from another organisation expresses their gratitude for a member of staff performing well, often above the person's expectations. Most of these compliments are received in writing, but a few are relayed through a line manager or to the customer care team verbally. Adult social care compliments are also received via comments left when a service user completes a survey at the end of a call to the Single Point of Access (SPA) and occasionally these are shared with the Customer Care team. The team also note when there have been compliments related to CCG functions and to other providers that have been incorporated within a complaint letter. The team ensures that these are acknowledged and that they are shared with the relevant teams to recognise and celebrate best practice.

During 2020/2021 **82** compliments were received. This amount has been static for the past three reporting years and a reminder has been issued to both CCG and provider staff of the value of reporting and sharing compliments.

The chart below shows the percentage breakdown compliments by organisation:



Some examples of the compliments received can be seen below:

**To a social worker:**

*“My sister and I do want to say how much we appreciate the care, support and advice you have provided over what has been and continues to be a very stressful time. You have answered my ‘daft’ questions and listened to my concerns, when I didn’t know who else to ask, I just wanted to acknowledge that and to say thank you.”*

**About a care agency:**

“Both the client and the family member wanted to express how excellent the support from X has been to date. The family member told me that she was particularly impressed by one carer’s actions who had noticed a pressure sore to which she contacted the family member and the district nurse directly for support. The district nurse visited the same day and the sore healed within a week as a direct result to the carers timely actions. Family member has also reported that communication between agency and family has been excellent also.”

**To a PALS officer:**

*“Thank you very much for all of your help with this. I can’t even begin to tell you what it means to me. I could not have managed it without you, and I am unbelievably grateful for all of your support.”*



### About a care home:

*“The information sent into hospital with the patient was really thorough and identified all of the gentleman’s care needs, preferences and important things to him. It was so detailed and allowed to us continue care in hospital whilst he was in his last few days of life.*

*If you could feed that back to the care home - it’s great to hear of somewhere that clearly cares about its residents and ensures everything is in place to ensure care at the end of life.”*

### To all members of the NHS:

“I write with greetings and deep heartfelt appreciation for all your hard work and especially during the last 10 months.

Many of you have gone over and above what you have been asked to do. Whether in the hospitals, GP practices, medical centres, ambulance, and paramedic services, you have not failed to aid the people who need you. We cannot thank you all by name, but please know this is for you, in whatever role you hold, and this of course includes those valiant volunteers.

We understand that there is still a long way to go and want to assure you of our continued prayers.”

## 11. Parliamentary and Health Service Ombudsman (PHSO) and Local Government and Social Care Ombudsman (LGSCO)

During 2020/21 there was only one case investigated by the LGSCO.

This concerned the level of housing costs disregarded in a financial assessment. The Ombudsman did not find fault with the CCG’s charging policy or financial assessment.

The complaint was not upheld and there was no learning for the CCG.

No cases were investigated by the PHSO which is considered a reflection on the quality of the responses provided.

## 12.0 Horizon Scanning: 2021/2022

As with other CCG teams, the Customer Care team is anticipating a period of significant change and challenges going forward into 2021/2022 financial year following the publication of the white paper ‘Integration and innovation: working together to improve health and social care for all’. This proposes to establish statutory integrated care systems who will be responsible for developing a plan to meet the health needs of their population; developing a capital plan for providers within their geography; and securing provision of health services to meet the needs of the system’s population. The Customer Care team therefore expects to see potential changes in the way complaints are managed and in particular those about GP, Opticians, Pharmacists and Dentists, together with potentially some specialised commissioned services.

During 2020 the PHSO launched a public consultation on the Complaints Standards Framework and the LGSCO also published revised guidance for Effective Complaints Handling for Local Authorities (including adult social care) for comments. Comments were fed into both consultations through local and national forums and the recommendations will be actioned within the 2021/2022 financial year. No significant themes were identified for immediate action.

A review of the CCG's complaints handling is being undertaken during the first half of 2021/2022 with its main focus being improving the timeliness of complaint responses; in addition, a refresh of the CCG's due diligence process for following up on lessons identified from complaints will also be included. One early change identified as part of the review, is that the equality and diversity survey sent to complainants at the end of the process is being reintroduced in an electronic format and it is hoped that the data from this will be included in the 2021/2022 annual report.

There continues to be a significant number of enquiries and concerns regarding the COVID-19 vaccination programme, and the Customer Care team would like to take this opportunity to express our gratitude to our NELCCG Primary Care colleagues who have worked very closely with our team in relation to COVID enquiries. They have worked tirelessly and have been of great assistance in responding to queries during the pandemic.

Health and wellbeing of workforce is being reviewed by the NELCCG in its entirety. The team are continuing with home working, supported with a daily catch up over MS Teams. The reintroduction of more formal team meetings is being set up to allow the learning from the handling of complaints and PALS to be discussed in person as a team and for any necessary training to be provided.

Finally, it is anticipated that there may be an increase in enquiries and complaints relating to delayed procedures, in relation to the restoration and recovery programme. The Customer Care Team will continue to work closely with the Commissioning and Communications teams to ensure responses are provided for general enquiries and individual concerns to address these enquiries.

## Appendix A: Complaints themes by provider for both health and social care

The table below shows the complaint themes for each of the main providers and how many complaints had the same theme. Complaints about discharge arrangements and CHC funding, including the assessment process, were the most common themes during 2020/2021.

The table below shows the complaint themes by provider

Complaint Type and Numbers	Themes	
<b>Care agency</b>	Quality of care	3
	Late/missed calls	2
<b>Care home (residential/nursing)</b>	Poor communication with family	3
	Quality of care	2
<b>Care Plus group</b>	Removal of a key safe	1
	Missing blood test	1
	Lack of planning and coordination of a discharge	2
	Rapid Response Team	1
	Health Triage at the SPA	1
<b>EMAS</b>	Poor communication by call handler	1
<b>Focus</b>	Lack of support from social worker	4
	Charging issues	3
	Poor discharge arrangements	1
	Inaccurate advice provided by SPA	1
<b>GP</b>	Delays in arranging investigations re Long COVID	1
	Concerns re assertive outreach team	1
<b>NAViGO</b>	Lack of support by Crisis team	1
	Lack of support from Older Peoples services	1
<b>NELCCG</b>	CHC funding	6
	ADHD (attention deficit hyperactivity disorder) diagnostic service	1
<b>NLaG</b>	Lack of follow up for an MS patient	1
	Delay in arranging investigations for Long COVID	1
	Poorly fitting orthotic boots	1
	Missed cancer referral	1
	Infection control re COVID-19	1
	Lack of communication with relatives re dental treatment for a patient with learning disabilities	1
	Quality of care of brain injury patient	1
	Poor treatment and communication in A&E	1
	Poor communication re test results	1
	Poor planning and communication re discharge	4
<b>Virgin Care</b>	Late cancellation of a procedure	1
<b>Young Minds Matter</b>	Outcome of ADHD assessment	1

## Appendix B: Examples of learning and actions taken from Complaints and PALS for both health and social care

### Appendix B: Lessons Learnt

Whilst the CCG would expect the majority of learning to be informed via complaints, it does not underestimate the value of PALS cases that have also demonstrated actions and learning. Two examples of this have been included in the selection below.

Learning identified is monitored by the development of an action plan by the provider to address the learning and the action plan is monitored by the CCG until all the actions are completed.

The table below shows examples of the lessons learnt and actions taken from upheld and partially upheld complaints and PALS concerns.

Complaint summary	Outcome and learning identified	Action taken
Patient journey from a fall at home into hospital and subsequent discharge.	Upheld: It was accepted that the discharge planning and process could have been better, and it was exacerbated by poor communication between the hospital staff and the family, which could have been clearer and timelier.	<p>The hospital discharge pathway for hip patients is now clearly explained to patients and families, including a clear explanation of the differences between services offered in the community post discharge.</p> <p>In addition, a transfer sheet has been developed for use when a patient is ready to be discharged to prevent miscommunication between the ward and the discharge lounge at busy times.</p> <p>Details of the complaint have been shared so staff can learn from the patient's experience in how they can improve their process for co-ordinating with a number of family members.</p> <p>The issue of record keeping has been raised with staff as this investigation identified poor records and inadequate records of communications and discussions.</p>
Having been referred for the removal of a lump, the patient did not	Upheld. Having been seen, the patient should have been recalled in 6 months. Initially there	The service concerned has undertaken a project to reduce their waiting times to improve the follow up position and to ensure they manage patients within the requested time frames.

<p>receive a follow up appointment having been told she would receive one in 6 months.</p>	<p>was a backlog of cases, which meant the patient would have been at a later date; but in the meantime, the patient was incorrectly discharged from the clinic.</p>	<p>However, should the time limit for follow up be exceeded, a communication will be sent to the patient.</p> <p>The Trust apologised that an administrative error caused the episode of care to be closed.</p> <p>Details of the complaint were shared with the relevant teams as part of their learning lessons process.</p>
<p>The chasing of an outstanding invoice for adult social care charges from 5 years ago.</p>	<p>Partially upheld. The chaser letter was triggered following the death of the service user when the account was being closed off. It was accepted that the outstanding invoice should have been chased up sooner and apologies offered.</p>	<p>It is now practise that outstanding amounts must be checked as part of the annual reassessment process and outstanding balances be addressed as soon as possible.</p>
<p>Cancellation of a minor procedure 2 hours before it was due to be carried out. The patient was told the procedure could not be carried out in Grimsby and was not offered a follow up appointment.</p>	<p>Upheld. The procedure in question could not be carried out at Grimsby and it required supervision from a different specialty, which is only available on a different. The theatre list was only reviewed on the day of the procedure, which is when the error was highlighted. It was accepted that a new appointment should have been offered at the time and apologies were offered for the inconvenience and upset caused.</p>	<p>All staff were initially reminded that certain procedures cannot be carried out at Grimsby, but now premises have been located within the Grimsby area, so these clinical procedures have been recommenced.</p> <p>Theatre lists are now being reviewed earlier in the week.</p> <p>Training has undertaken to confirm the process for rebooking appointments following a cancellation, which should be carried out at the time of cancellation, where possible, to avoid delays in rebooking.</p>
<p>Delays in communicating the results of a CT scan.</p>	<p>Partially upheld. The patient was referred for a CT scan to rule out any sinister pathology and this was addressed and communicated to her. However, additional findings relating to a different specialty were communicated later and these were passed to her GP to arrange follow up.</p>	<p>To prevent delays with the CT and MRI reporting process, the Trust has now implemented strict quality control measures with regard to reports of scans from external companies, resulting in improved CT and MRI reporting.</p>

<p>The removal of a resident from her home following a safeguarding alert.</p>	<p>Partially upheld. The resident was removed from the family home following a safeguarding alert and placed in a care home, but in doing so Focus failed to consider other options to keep her safe, which may well have been less upsetting and would have complied with her wishes when she had capacity.</p>	<p>An anonymised case study has been developed for training purposes based on this case to enable staff to reflect on their practise and identify the least restrictive options when faced with emergencies.</p>
<p>Poor level of care provided by a home care agency, there was no paperwork at the property so family could not see what was happening and service user was not being showered.</p>	<p>Partially upheld: There was a lack of documentation at the service users house due to a change over to an electronic system and this should have been explained. Following a meeting to discuss concerns, no ongoing monitoring and feedback to the family was arranged. Personal care was offered but was often refused by the service user. This was not documented in the notes.</p>	<p>All care coordinators were reminded of the importance of accountability and to ensure that in a review meeting clear actions are identified, along with agreed timescales for completion and an appropriate follow up meeting to be arranged if agreed.</p> <p>All staff reminded of the importance of recording and reporting any issues, concerns, refusals, or changes in care needs.</p>
<p>A safeguarding concern was raised via an advocate, but no one involved the service user in the investigation and the outcome was only fed back to the advocate.</p>	<p>Partially upheld: It was accepted that service users should be kept informed on the progress of their enquiry and they are asked if they are satisfied with the outcome when the enquiry is closed, and an apology was offered.</p>	<p>Safeguarding practitioners have been reminded to take a person-centred approach and record the desired outcomes that have been expressed by the individual for all enquiries.</p> <p>At the end of the enquiry, the practitioner is to record whether or not the individual believes that their desired outcomes have been met, and this forms part of the performance feedback to the Safeguarding Adults Board.</p>
<p>Poor pressure ulcer care during a stay in hospital.</p>	<p>Partially upheld: It was acknowledged that the repositioning of the patient was inconsistent during their stay.</p>	<p>Staff were reminded of the following;</p> <p>To ensure that patients are repositioned in a timely manner and that the Trust's specific pressure area management guidelines are followed.</p> <p>To fully document the nursing care they provide.</p> <p>To ensure that wound care is prioritised throughout the patient's admission, including as part of the discharge</p>

		arrangements, ensuring that patient's skin wounds are dressed prior to discharge where necessary.
Late calls by a home care agency and failure to act on informal concerns raised.	Partially upheld: It was accepted that some calls were provide outside the agreed window and the service users concerns were not escalated.	<p>Staff reminded to attend within agreed window unless they are dealing with an emergency situation and if they are running late, to update the service user.</p> <p>A remind issued to service users on how to escalate any concerns they have about the service provided and the complaints process.</p>
Poor after care provided following a CT scan.	Partially upheld: It was accepted that staff should have checked to see if the patient was experiencing pain and discomfort following the CT.	<p>Staff were reminded of the importance of ensuring all patients are made aware of the emergency pull cord in the toilets and regular checks are carried out when patients feel unwell that after a procedure.</p> <p>The feedback from the patient to be considered when a review of the patient leaflet given to patients prior to their procedure is undertaken to ensure information is as clear as possible in the future.</p>
Poor discharge planning and communication with family meant that they were unaware a relative had been discharged and were therefore unable to help her settle in.	Upheld: it was acknowledged that staff should have kept the family updated when the discharge was being planned and notified them of the date it was take place.	Key lessons for the hospital discharge team have shared. These included the need to provide regular communication and that it is crucial that key personnel are involved in discharge plans and advised when this will be taking place and where to, in accordance with the wishes of the individual concerned.
Via PALS - a person had been advised by 3 GP practices that they were not registering new patients due to the pandemic.	PALS found the person a practice to register with.	GP practices were confused of the rules around registering patients during the pandemic and a reminder was sent to all GP practices of the registration expectations.

<p>Via PALS – bloods taken by a district nurse were handed to a receptionist to be sent for testing by the Path lab.</p>	<p>The bloods had to be retaken and were sent off correctly. An apology was given to the patient for the error and any inconvenience caused.</p>	<p>A reminder was issued to the district nurses and health centre staff of the need to be aware of correct processes, and to be more vigilant with samples.</p>
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## Appendix C Glossary of abbreviations used

Table 12 a glossary of abbreviations used within the report.

Abbreviation	Full Description
ADHD	Attention deficit hyperactivity disorder
Adult Social Care	Home care agency providers, care home (nursing/residential) and Focus (independent adult social work)
CHC	Continuing Healthcare
CPG	Care Plus Group
DRE	Disability Related Expenditure
EMAS	East Midlands Ambulance Service
IFR	Individual Funding Request
LGSCO	Local Government and Social Care Ombudsman
MS	Multiple Sclerosis
NELC	North East Lincolnshire Council
NELCCG/CCG	North East Lincolnshire Clinical Commissioning Group
NHSE/I	NHS England/NHS Improvement
NLaG	Northern Lincolnshire & Goole NHS Foundation Trust
PHSO	Parliamentary and Health Service Ombudsman
PALS	Patient Liaison and Advice Service
SI	Serious incident
SPA	Single of Point of Access
TASL	Thames Ambulance Service Ltd