



Working together to investigate health and social care complaints

Focus report: learning lessons from complaints

December 2016

Foreword

This review offers an overview of the first year's activity of our Joint Working Team, which was set up in 2015 as a response to the challenges of investigating and remedying complaints which span services delivered by both the health and social care sectors.

The fragmentation within these sectors and the complexity of the way in which services are often delivered, has been well-documented. It follows that bringing a complaint when such services fail can be both confusing and time-consuming for individuals, who may already be suffering considerable stress as a result of the injustice they believe they have suffered.

The Joint Working Team is made up of investigators from both the Parliamentary and Health Service Ombudsman (PHSO) and the Local Government Ombudsman (LGO). They are trained to work on both health and social care investigations, rather than in only one sector as they would have done previously. This enables a more streamlined investigative approach which provides a single point of contact for both the complainant and the organisation being complained about.

The results, to date, have been encouraging. These cases are often complex and can involve a number of different organisations. They require thorough investigation and can take some time to complete. Even so, we are also starting to see a reduction in the overall time taken to resolve complaints. The team has now been made permanent so we can continue to learn from these new ways of working and ensure the benefits of this approach are fully realised.

This report illustrates those benefits and provides examples of some of the cases we have investigated throughout that year. It is clear that they would have been more difficult to conclude effectively if we had adopted a more traditional 'one investigator for one sector' approach.

The Joint Working Team has, therefore, succeeded in making it simpler to bring and investigate a complaint within the health and social care sector. However, we recognise this approach has its limitations and can only be a sticking plaster response to patching up a system in which the cracks are visible. Wholesale reform is needed to enable us to operate in a way that reflects the increasing integration between health and social care services.

Legislation is the only option. We are delighted, therefore, that it is now Government policy to integrate LGO and PHSO into a new, single Public Service Ombudsman and draft legislation was published on December 5. We have been working with the Cabinet Office to ensure that our many years of experience of investigating and remedying complaints informs the development of legislation and we shall continue to do so.

Of course, this is only one step on the journey towards creating a Public Service Ombudsman. It remains to be seen when legislation will be introduced formally in Parliament and a bill finally becomes law. However, we are optimistic that this will be achieved, as a clear and simple route to redress is what the public rightly deserves.

Dr Jane Martin
Local Government
Ombudsman

Dame Julie Mellor
Parliamentary and Health
Service Ombudsman

The Joint Working Team: an innovative approach to investigating complaints

Health and social care services provide vital support for some of our most vulnerable citizens. When things go wrong, the impact can be life-changing, so it is essential that there is a clear route to achieving redress when this is required.

Our role is to provide that redress and remedy the injustice that people experience when services fail. This is, inevitably, more challenging when we are investigating complaints about services which are provided by a number of different organisations. This can be the case in health and social care in particular, where pressure on budgets and the fragmentation of providers have led to increasing complexity in the way in which services are offered.

It is for this reason that, in April 2015, the Local Government Ombudsman (LGO) and Parliamentary and Health Service Ombudsman (PHSO) set up a joint working team to trial an innovative approach to investigating complaints spanning both these sectors. The team is managed by LGO but comprises investigators from both ombudsmen, who are trained to investigate both health and social care complaints, rather than focusing on just one sector as they would have done previously.

In the first year we completed 180 investigations. Although these investigations can take considerable time to conclude due to their complexity, we have seen visible improvements through the two organisations working together through a single team. The team has been made permanent and we are currently looking at ways in which we can expand its capacity and integrate it into mainstream working. This will also help to ensure we have the resource to deal with the increasing numbers of these types of complaints that we are seeing.

The benefits to the public of joint working include:

- > One investigator with an overview of the whole case, who is able to investigate all aspects of the complaint
- > Clearer, more focused investigations
- > Speedier investigation process
- > Single point of contact for both complainants and the organisation under investigation.

Most of the complaints we looked at would have been significantly more difficult to investigate without one single investigator being able to consider all the issues together. The new approach enables us to look at the full picture, rather than fragmented parts, which helps to keep the complainant at the centre of our investigations. We believe the outcomes speak for themselves.

This review provides an overview of our work so far: the types of complaint we have investigated; how we handle these complaints; the kind of fault found and the key themes which have emerged from our investigations. Mindful that our key goal is to remedy injustice caused by fault in the delivery of local services, we also highlight our recommendations within each case study. In almost every case the recommendations we make are accepted by the organisations involved.

Key themes in the complaints we investigated

The complaints we have looked at range from the assessment of mental capacity to the failure of organisations to communicate properly, either with each other or with complainants and their families. Investigations can take from six months to a year to complete, depending on their complexity. All are characterised by a potential failure to deliver a service

that should be provided by a combination of health and social care organisations. This may include social services, health trusts, clinical care commissioning groups or care agencies.

The key themes we have seen are:

- > Delays in assessments, meaning that people have to wait longer to get the care they need
- > Poor care or failure to provide services altogether
- > Failure to deal with safeguarding issues
- > Lack of appropriate aftercare following discharge from hospital for those sectioned under the Mental Health Act.

The problems we see

The law says that if an organisation becomes aware of a complaint that affects another organisation, it should contact that other organisation and work on the complaint jointly. They should also provide a joint response to enquiries from the Ombudsman. In practice, we see problems with collaboration as many organisations fail to do this. As a result, some of the confusion and lack of communication that may have caused the complaint in the first place is perpetuated during the complaints process. If we find this happening, we will criticise the organisations for it in our decision.

Some of the problems we see arise because of the fragmented way in which health and social care are provided. There are moves throughout the country to address this, with some local authorities being given a budget which includes both health and social care. The aim of this is to encourage more joined-up services and better communication between the different aspects of the overall service for service users. But meanwhile, we see many complaints where the division of labour

and poor communication cause problems for service users.

Joint working cases comprise some of the most complex complaints investigated by either LGO or PHSO. They often involve a range of different services, provided by a number of organisations. Shared responsibilities can cause problems when organisations are not clear where their individual responsibilities begin and end. Sometimes these organisations will be aware of each others' roles and will work together smoothly. In other cases, the first task of the Joint Working Team will be to identify who the different organisations are and what their roles were. This is not as straightforward as it might sound – sometimes health and social care providers are not clear about their responsibilities. In some cases a person will move house or be placed out of area; several providers will then argue that someone else is responsible for providing the care. We also have cases where the identity of the bodies we need to investigate is in dispute.

How we investigate

The Joint Working Team comprises investigators from both organisations. These individuals have been trained to deal with complaints into both health and social care provision, rather than specialising in only one of these areas, as they would formerly have done. Investigators are sited in three offices: London, York and Manchester.

Cases for the team are selected by means of an assessment process. Joint working allows us to look at the full picture of what has happened across the organisations involved. One investigator assesses the complaint as a whole using our Assessment Code. This sets out a number of issues that we must consider before deciding to do a full investigation. Crucially, these involve finding out whether there is a nexus of joint activity or responsibility between the

organisations. This can occur, for example, if more than one organisation was involved in decision-making that affected a person. It could also occur if there is an agreement between the bodies to work together or for one to perform the functions of another.

We then need to ascertain whether we have the remit to investigate the case. Very often, joint cases are brought by a relative or friend of the person affected. We need to check whether the person affected actually wants the complaint to come to us and whether they agree that the relative or friend is the right person to represent their interests. We then have to decide whether the events complained of really involved a number of organisations together. We also look at how long ago the events took place and whether the person has already had a remedy, say, through the courts.

Both LGO and PHSO expect organisations complained about to go through their complaints process before investigating. In the Joint Working Team, even if only one organisation has been through a local process, we will often take the case, rather than returning it to the organisation for them to look at first. This ensures we can move the whole case forward at the same time. If we decide that we can investigate, one investigator will be assigned to investigate all health and social care aspects and all of the organisations involved. This could be up to six organisations for any one investigation, so it can be a time-consuming and complex process. The investigator will be required to obtain and read copious amounts of information; work out exactly what each of the organisations' responsibilities were and how well they have discharged them. Very often, investigators find that organisations blame each other, or claim that something is someone else's responsibility, not theirs. The investigator will need to work out who should have provided what services and whether they did so appropriately.

For many long-running issues, where the positions of the organisations involved have become entrenched, it is unlikely the matter will be resolved without an independent investigation by the Ombudsman. There are also times when organisations agree to recommendations that they have adamantly resisted until that point. This is often because the issues and who is responsible for them, simply do not become clear until the investigation considers the role of all providers and reaches a considered view. Sometimes we find fault and sometimes we do not, but in either case we do clarify the issues for the complainant and make evidence-based decisions.

We do this without the complainant needing to go to court or pay for services. We are completely independent of the organisations we investigate and have the same powers as the High Court to ensure that they co-operate with our investigations. This means we can ensure that we obtain all the information the organisations hold that relates to the investigation.

If we find fault causing injustice, we will recommend remedies to try to put the person affected back in the position they would have been in had the injustice not occurred. Again, as we are able to see across the whole complaint, we are normally able to identify which organisation is responsible for which part of the injustice. If organisations share the blame, we will ask them each to contribute to the remedy. Our remedies sometimes include small payments, but we also ask organisations to ensure the same problem doesn't occur again. This could involve asking them to review their practices or train staff, for example.

There is no denying that, for the individuals experiencing delays and failures in getting access to services they may desperately need, the experience can have a serious impact on their lives.

The complainant's experience

Michael lodged a complaint after his brother-in-law, who suffers from Huntington's disease, remained in a care home for 15 months, against his wishes, due to failures to agree funding for a home care package following a stay in hospital.

Michael provides informal care for both his brother-in-law and sister-in-law, who live separately in the same house. Both suffer from the same condition. His wife is also a sufferer and he is now her full-time carer.

He said he came close to cracking under the pressure of trying to get funding agreed.

“ This caused me so much stress, I nearly ended up in hospital myself. No-one talked to each other, all they seemed to do was push the blame backwards and forwards and nothing was ever resolved. I was in despair. It seemed that no-one wanted to help me.

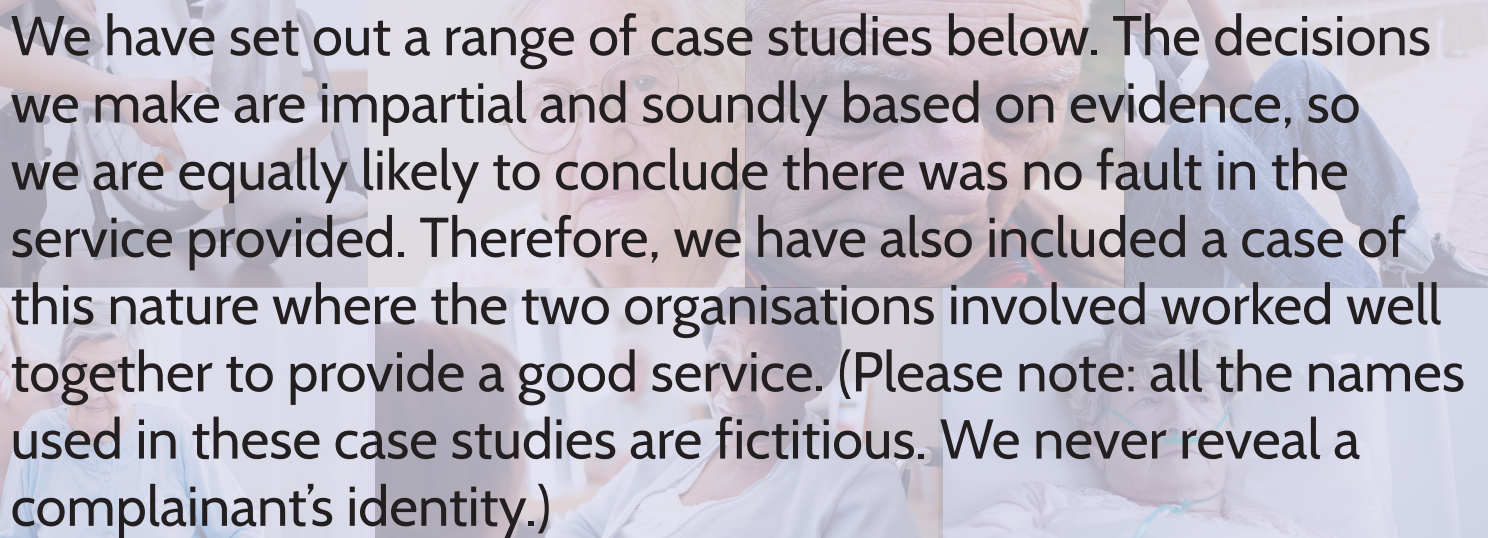
Sometimes I felt it was just too much trouble, people were saying I should put my brother-in-law and sister-in-law in a care home, but I knew it wasn't what they wanted, so I persisted. All I wanted was an answer. If I'd done something wrong I'd have said OK and dealt with it, but I was just passed from one person to another.

The investigator (from the JW team) was the only one who listened to me, it was so good to have one point of contact at last. I'm very happy with the way my complaint was dealt with.

I wasn't worried about getting any money, all I wanted was to make it easier to help my brother-in-law.

If I learned one thing from this experience it was that health and social care providers need to work together better. It was this which caused a lot of my problems.

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We have set out a range of case studies below. The decisions we make are impartial and soundly based on evidence, so we are equally likely to conclude there was no fault in the service provided. Therefore, we have also included a case of this nature where the two organisations involved worked well together to provide a good service. (Please note: all the names used in these case studies are fictitious. We never reveal a complainant's identity.)

Removal from home without proper assessment: A council did not properly check whether a woman with Parkinson's disease had capacity to make her own decisions before forcibly removing her from her family home.

Winnie's story

Background

Winnie lived in her own property with her adult son, ex-husband and privately arranged live-in carers. She had mobility and communication difficulties due to advanced Parkinson's disease. Her communication difficulties meant that sometimes it was hard for people to understand what she was trying to say. However, Winnie's daughter knew and understood how her mother communicated.

The records of the community nurses that used to visit Winnie show they had concerns for a long time about whether she was safely cared for at home. They felt Winnie was at risk of unintentional harm. However, she wanted to remain at home and was considered to have capacity to decide this.

When a community nurse and a council officer visited Winnie they found her in bed, soaked in urine, and were concerned she was not getting enough to eat and drink. The council officer returned the next day and remained



concerned. Winnie's ability to communicate fluctuated because of her condition, and she was not able to communicate that day. The officer decided she did not have capacity to make decisions about her care needs. When he discussed this with colleagues they decided that she needed to go to hospital, as a place of safety, and informed the community nurse. When the community nurse went to Winnie's house that evening, Winnie said she did not want to go to hospital. Nevertheless, in the presence of the police, she was put in an ambulance and taken to hospital. She became highly distressed and her son and ex-husband also became distressed and agitated. At the hospital she was found not to be dehydrated or malnourished and the notes say there was no medical need for her to be there.

Winnie's daughter said that she should have been contacted directly. She said her mother may have slept for long periods and could access food and drinks herself. She said Winnie had the capacity to decide to stay in her own home, the admission to hospital was against her will and had scared, distressed and traumatised her. Her daughter said she should have been asked to be present at the capacity assessment since she understood how her mother communicated.

Which organisations we investigated

We investigated the council, a GP surgery and a community nursing service to find out what happened.

What we found

We found no fault with the community nursing service or GP surgery, but concluded that the council had failed to ensure Winnie's capacity was assessed properly; and did not give her sufficient opportunity to make her own decision about whether to go to hospital. Less restrictive options were not considered. The council should also have consulted Winnie's daughter prior to making a decision. As a consequence of these faults, we found that a vulnerable adult was forcibly removed from home in the evening with no prior warning, without consent and in the presence of police.

Our recommendation

We recommended the council apologise and explain how it will ensure such events do not happen again. We recommended it pay Winnie £1,000 and her son and ex-partner £500 for their distress. The council has complied with our recommendations.

Lack of support services: Failure by a council and a Clinical Commissioning Group (CCG) to provide sufficient support services to a young man assessed as needing full-time support over a period of six years.

Ben's story

Background

Ben is a young man with a brain disorder, severe epilepsy and severe learning disability. He was entitled to joint funding from the council and the CCG and was assessed as needing full-time (five days a week) support at a day centre. His mother complained to the council in 2010 because she was concerned that her son had not been provided with day services since leaving school the previous year. He was finally able to start attending services in January 2011. He attended one placement for three days and another for two days a week. In July 2011, the council stopped the two-day placement because it decided it did not meet his needs. From that point until 2015, he attended a placement for three days a week only, despite the fact that he had been assessed as entitled to full-time services.

Which organisations we investigated

We investigated the council and the CCG to see what had happened.

What we found

We found Ben did not receive the full-time support services that he had been assessed as needing over a period spanning six years. We found that Ben's needs should have been met by the CCG as he was entitled to full healthcare funding. We believe these failings had a significant impact on both Ben and his parents, who were also his informal carers.

Our recommendations

In practice, both the council and CCG were involved in this case, even though he was entitled to full healthcare funding. Our decision, therefore, was to hold both accountable for the period. We asked both organisations to apologise to Ben. We also recommended a payment of £4,200 to Ben for the lack of services and £2,000 each to his parents for failure to provide them with carers' support. Each organisation paid 50% of our recommendations.



Loss of education and lack of nursing care: Failure by a trust and council to provide full-time education to a disabled child for nine months and failure to provide respite nursing care at school.

Dan's story

Background

This complaint was about loss of education and access to hydrotherapy (water-based exercise to improve muscle tone) for Dan, who is a profoundly disabled child, with a statement of special educational needs. He attends a special school and is dependent on others for all his needs. He has severe cerebral palsy, learning difficulties and visual impairment. In 2011 Dan turned nine. During the first part of the year, he was in hospital several times owing to severe spasms and sudden build-ups of fluid secretions in his airways.

In July 2011 the council agreed to allow Dan to attend a school with access to hydrotherapy facilities. He began school in early October 2011 for two half-days a week. In December 2011, he was admitted to hospital. When he was discharged, the plan was for him to have a staged return to school, with full-time attendance within a month. This did not happen. In March 2012, he was offered one day a week at school and his parents asked for this to be increased to two. This was refused, as the trust had insufficient nursing staff. In April, they agreed to increase the provision to two days a week, but adequate transport could not be provided. Provision was increased to three days a week from May half term. Dan finally began full-time education at the start of October 2012. His parents complained about the loss of education, but the council said its policy for providing education for children medically unfit to attend school did not apply to children who attended special school, whose cases were dealt with individually.

Meanwhile, Dan had not received the amount of hydrotherapy that he was entitled to in the first half of 2012. There had been mechanical faults with the pool during this period. In addition, the trust had required his parents to use their hours of respite care to provide nursing support at school, instead of arranging nurses to do this. This meant the family lost out on a significant amount of respite at home.



Which organisations we investigated

We investigated the council and the trust.

What we found

We found Dan had been out of education for around nine months and had lost the hydrotherapy he should have been given, but this was mitigated by times when he was in hospital and would not have been able to attend. We also found the family had lost the use of their own respite provision for over 18 months because the trust had failed to provide respite nurses.

Recommendations

We considered both the council and trust should bear responsibility for the faults we identified. We also recommended both agencies apologise to the family. We recommended each pay Dan's family £2,325 for these faults (a total of £4,650). This included £3,150 for loss of education over nine months and £1,500 for loss of respite. The council should also review its policy on access to education for children in special schools to explain how its legal duty to provide access to education will be met for children who attend special schools. The organisations accepted our recommendations.

Failure to provide medication: A trust and council should have ensured that a lady who was dying from leukaemia received appropriate pain killers during the last few days of her life.

Gail's story

Background

Gail was diagnosed with leukaemia in early 2015 and admitted to a care home. A district nurse visited her and, on the same day, told her GP she needed stronger painkillers than the ones she was being given. Her GP prescribed her morphine, based on the district nurse's request. Six days later, the morphine had still not arrived. Gail was then admitted to hospital and passed away the same day.

Which organisations we investigated

We investigated the council (which was responsible for the care provided through a council-funded care home), a GP surgery, a health trust and a pharmacy.

What we found

We found no fault on the part of the pharmacy, as there was no evidence that they ever received a prescription. We also found no fault with the GP surgery. However, we concluded that the council and trust should have followed up on the prescription and made sure Gail received her painkillers in a timely way.

We were concerned about the responses we received from the trust and council on this issue. Both asserted it was someone else's responsibility to ensure the prescription was dispensed and administered. This indicated a lack of co-ordinated service. As a result it is likely that Gail, who was a vulnerable elderly service user, suffered unnecessary pain for approximately six days before she died.

Our recommendations

If a person has died and there is clear financial loss, we can suggest it is remedied by a payment to the person's estate. If the loss is not so easy to quantify, as in this case, we generally do not ask for a payment to the estate. However, we consider if the person who has brought the complaint on behalf of the person affected by the events, has suffered any injustice.

In this case, we felt that Gail's daughter, who brought the complaint, was affected. We asked the trust and council to apologise to her for the distress it caused her to think that her mother may have been in unnecessary pain during the last few days of her life. The trust and council accepted our recommendations.



Poor care in a nursing home and delay in considering safeguarding: A nursing home failed to care for a lady properly and she developed a serious pressure sore. The council failed to take timely action to safeguard her.

Edna's story

Background

Edna, aged 80, was admitted to a nursing home in August 2013. She had a number of health conditions, including vascular dementia and diabetes. She had very poor mobility and regularly slept in her recliner chair. Edna often refused personal care and would not allow staff to measure her blood sugar level or take insulin. She was also often aggressive towards staff.

Over time, she developed a sore on her skin. This became a grade 2 sore (an abrasion or blister involving partial thinning of the skin); which developed into a grade 3 pressure sore a week later (grade 3 involves full loss of skin thickness with damage to, or death of, the underlying tissue). The nursing home made a statutory notification to the Care Quality Commission about this the following day, and referred her to a tissue viability nurse. Three days later, after Edna had been admitted to hospital, ward staff recorded that she had a grade 4 pressure sore (the most serious level, involving severe pressure damage and often a deep wound down to the bone, with the death of underlying tissue). In the end, Edna spent three and a half months in hospital being treated for various conditions, including the grade 4 pressure sore and dehydration.

Edna's daughter complained to us that staff at the nursing home did not provide her mother with adequate care; and the council and trust should have intervened and made sure her mother was properly safeguarded. She felt that lack of appropriate care caused her mother to deteriorate more than she would have done and led directly to her hospital admission.

Which organisations we investigated

We investigated the council, trust and nursing home.

What we found

Edna often resisted care at the nursing home and law and guidance says that nurses need to respect a patient's right to decline care. However, the law also says that staff need to be aware if somebody repeatedly makes unwise decisions and thereby exposes themselves to significant risk of harm. They must also consider whether the person has capacity to make decisions about particular elements of their care, rather than whether they have mental capacity in a general sense.

We found that although the situation was very challenging for the nursing home because of Edna's refusal of care, it had a duty to provide adequate care for her and make its own assessments of her mental capacity. It failed to do so. The sore developed over about six weeks and there were many occasions when staff could have taken action. It also should have made a safeguarding referral sooner. We believe the nursing home's failure had a significant impact on Edna's well-being.

We found the nursing home's failings were compounded by fault by the council. It failed to take proper control over the safeguarding process or to ensure Edna's needs were assessed in a timely way. This meant Edna's condition continued to deteriorate. We found the trust performed its role adequately.

Our recommendations

We recommended the nursing home should provide a written apology to Edna's daughter and pay Edna £500 in recognition of the pain and distress she suffered. It should also pay Edna's daughter £250 for her distress; and produce an action plan to address its failure to complete a mental capacity assessment. We also asked the council to apologise and pay £250 for distress and £100 for time and trouble to Edna's daughter. Both organisations accepted our recommendations.



Delay in assessment and unfair charges: Fault by a council, a health trust and a Clinical Commissioning Group (CCG) which meant that a man with Huntington's disease was kept in a residential care home for too long before being allowed to return home.

Duncan's story

Background

Duncan has Huntington's disease, a condition that damages nerve cells in the brain. The disease can affect movement, cognition and behaviour. Duncan shared a house with his disabled sister, who has the same disease. Duncan lived upstairs in the property and his sister downstairs. His brother-in-law provided informal care to both him and his sister. Duncan received a care package from the council consisting of three 30-minute support calls daily.

He was admitted to hospital in October one year and he stayed until December when he was moved to a step-down bed in a residential care home so that his needs could be properly assessed for continuing healthcare (CHC). Duncan wanted to be allowed to return home as soon as possible but, in the end, his placement in the home lasted 15 months. His brother-in-law complained that this was far too long.

Which organisations we investigated

We investigated the actions of the council, trust and the Clinical Commissioning Group (CCG).

What we found

We found that Duncan's stay in the step-down placement lasted far longer than it should have done because of faults and delays by the council, trust and CCG in assessing him. There were long periods when no progress was made with the assessment; and others when incomplete information was sent from one body to another. When it was finally produced, it was not 'person-centred' and did not consider some of the information available. Nor did it take into account Duncan's desire to return home to live with his sister or how his needs would be managed at home. He was also required to pay fees for the home, even though he would not have had to be there so long if he had been assessed sooner.

These faults had a significant impact on Duncan's independence. While it is reasonable for an assessment to take a little time, we think he spent over a year longer than necessary in the care home. He found this highly distressing. His brother-in-law was also affected, suffering carer's strain and distress as a result.

Our recommendations

We recommended the three bodies apologise collectively in writing to Duncan for the delays in the assessment process. We also asked the council to waive the charges for the residential care home, which were around £8,500. We asked each body to pay Duncan £350 (a total of £1,050) to acknowledge the impact the delays in the CHC assessment process had on his independence and wish to return home.

In addition, we recommended each body pay Duncan's brother-in-law £150 (a total of £450) to recognise the injustice he also suffered.

We also asked the CCG to review its CHC eligibility processes within three months of our decision and consider whether it needed to provide any training to practitioners working within the community to ensure quality standards are met. As a result, the CCG invited the organisations involved in the case to a case review and training event. They also revised their processes and template letters to improve clarity. They took steps to ensure the 28-day CHC timescale is adhered to. They also revised their training on CHC for staff and made it mandatory; and now ensure that all staff complete record-keeping training annually.



An example of good joint working: In many cases, organisations do work well together. In a case of a severely disabled child, we found that two organisations had worked jointly to provide a good service.

Tom's story

Background

Tom was seven and severely disabled. He needed 24-hour ventilation via a tube in his throat and feeding through a tube into his stomach. He used a wheelchair and was at high risk of bone fractures. Tom had been receiving support from the council's children's social care department and the Clinical Commissioning Group (CCG) since September 2009. This included specialist care support and adaptations to the family home. Tom was admitted to hospital in mid-2015. His discharge from hospital did not take place until 2016 because the new care provider, contracted to provide his home care package, required time to ensure staff were fully trained to support the package.

His mother complained that the council and CCG failed to arrange a care package to meet his needs adequately and that this led to his admission to hospital. She also complained that the council failed to provide suitable education for him whilst in hospital; and that there was a failure to reassess his needs and arrange appropriate care to enable his discharge home at an earlier date.

Which organisations we investigated

We investigated the council and the CCG.

What we found

There was evidence that the council and CCG had properly arranged a care package for Tom. Evidence also showed that he was admitted to hospital because his ventilator needed to be changed, not because of a breakdown in the home care package. We found some shortcomings in nursing, but there was no evidence that this caused a direct injustice to Tom.

We also found that the council made proper arrangements for educational provision for Tom while in hospital. This took account of his health conditions and his special educational needs. In addition, the council arranged a phased return to school once Tom was medically stable and sufficient care services were in place to ensure a safe transition. Throughout the process the CCG and council provided close oversight of the process, arranged home visits for Tom, held regular discharge planning meetings, and conducted assessments and reviews of his needs. They also took account of his mother's preferences about his care.

Overall, we found that the way the two bodies worked together was evidence of effective joint working.



The Ombudsmen's expectations

In 2014 the Local Government Ombudsman, the Parliamentary and Health Service Ombudsman, and Healthwatch England published [My Expectations](#). This report set the Ombudsmen's expectations of what good practice looks like from the user perspective when raising concerns and complaints about health and social care.

We expect organisations to provide an accessible and visible complaints process which provides people with confidence to speak up when they have concerns and complaints about services; which makes reasonable adjustments for people with additional needs; and which assures people that pursuing a complaint will not compromise the services being provided.

Local Government OMBUDSMAN healthwatch Parliamentary and Health Service Ombudsman

My expectations for raising concerns and complaints



We expect the process of making a complaint to be as simple as possible. We expect organisations to make people feel that they are being listened to and understood; to offer support to help people make a complaint; and to explain what steps will be taken to respond to the complaint.

We expect organisations to ensure that people are kept informed on the progress of their complaints; to provide personalised responses which reflect the specific nature of the complaint; and to ensure that staff dealing with

complaints are empowered to provide a resolution.

We expect organisations to provide a resolution within a time period which is proportionate to the complaint. We expect the outcome of complaints to be communicated in an appropriate manner, in an appropriate place, and by an appropriate person. We expect organisations to show that people's views have been taken into account, even if they might not agree with the overall outcome.

Finally, we expect organisations to reflect and learn from the complaints experience. We expect people to be left with the confidence to make future complaints if they feel it necessary, and to understand how their complaints are used to improve services.

Getting things right - good practice

Complaint handling duties

The Ombudsmen expect health and social care providers to be aware of their legal duties with respect to complaint handling.

The law says all health and adult social care providers must make arrangements to ensure that complainants are treated with respect and courtesy, that complainants are supported in making complaints where necessary, that complaints are dealt with in a timely and efficient manner, and that appropriate action is taken in light of the outcome of the complaints process¹.

The law also requires health and adult social care providers to co-operate and provide a joined-up and seamless response to complaints which span their services. Complainants should never be expected to make individual complaints to separate bodies about jointly arranged services². Similarly, good practice dictates that children's social care, and health providers should work together to identify and jointly respond to complaints which cross their respective boundaries³.

The Care Quality Commission's fundamental standards

The Ombudsmen expect health and adult social care providers to understand their legal duty to act openly and transparently and be aware of the fundamental standards which their services are expected to meet⁴.

The Care Quality Commission expects all registered services to meet the fundamental standards, which are the minimum standards below which a person's care should never fall. The Ombudsmen will take account of these standards when investigating complaints about health and social care providers.

Of particular relevance to the Ombudsmen's work is the duty of candour placed on health and social care providers. This duty means that where things go wrong with a person's care and treatment, then health and social care providers are legally obliged to inform the person/s concerned as soon as reasonably practicable, to take appropriate steps to investigate the incident, arrange support for the affected person/s, report on the lessons learned from the incident, and provide an apology to the affected parties⁵.

[1 The Local Authority Social Services and National Health Service Complaints \(England\) Regulations 2009, Regulation 3](#)

[2 The Local Authority Social Services and National Health Service Complaints \(England\) Regulations 2009, Regulation 9](#)

[3 Getting the Best from Complaints. Social Care Complaints and Representations for Children, Young People and Others, part 7.5](#)

[4 Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014, Care Quality Commission \(Registration\) Regulations 2009 \(Part 4\)](#)

[5 Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014: Regulation 20](#)

Getting things right - good practice

Understanding mental capacity

The Ombudsmen expect professionals to be aware of their duties surrounding the Mental Capacity Act 2005.

The law states that it should be assumed that everyone has capacity to make decisions for themselves, unless it has been proved otherwise through a formal capacity assessment. It is therefore important that health and social care providers arrange appropriate support for people who have difficulty in communicating their views, or who struggle to understand information provided to them. Professionals should never assume that such difficulties mean the person lacks mental capacity to make decisions relating to their health and social care services.

In situations where an assessment has established that a person lacks capacity to make a decision about their care and treatment, it is important that professionals take account of the legal safeguards in the Mental Capacity Act to ensure that any decision made on someone else's behalf is made in their best interests.

Transition between services

The Ombudsmen expect health and social care providers to have robust arrangements to ensure that mistakes are not made when a person moves between services.

The Ombudsmen find that things often go wrong when people move between services. This could be when a person is discharged from a hospital into a community setting, but could also happen when a child moves into adult services, or where a person moves from a community setting into a residential setting.

It is important that health and social care providers maintain effective channels of communication, so that a person's needs are properly understood by all parties when they move into a new service area, to ensure that appropriate services are in place at the point of transition, and to safeguard against people losing out on services if mistakes are made in the transition process.

The Ombudsmen also consider it good practice for the original service to provide ongoing oversight, or a follow-up, after a person moves into a new service area, so it can ensure that the person's needs are being properly met by the new service.

Record keeping

The Ombudsmen expect health and social care providers to ensure that full and accurate records are maintained for people using their services.

It is a legal requirement for health and social care providers to maintain proper records of the care and treatment they provide. Among other things, this includes records of decisions, assessments, care plans, day-to-day provision, reviews and complaints. Maintaining proper records ensures a person's care and treatment can be properly reviewed by other professionals, and ensures proper scrutiny can take place when mistakes are made or when complaints are raised.

The Ombudsmen will generally uphold any complaint when proper records have not been maintained. This is because a failure to maintain proper records impedes our ability to investigate complaints effectively.

Scrutiny - the role of councillors and board directors for NHS trusts and care providers

Bodies providing local public services should be accountable to the people who use them. The LGO and PHSO were established by Parliament to support this.

Councillors and board directors of NHS trusts and care providers have a mandate to scrutinise the way their organisations carry out their functions. We recommend they ask the following questions when scrutinising their services.

Does your council, NHS trust, or care provider:

- > follow the good practice advice in the previous section?
- > ensure complaint handling staff are fully trained on the legal requirements of [*The Local Authority Social Services and National Health Service Complaints \(England\) Regulations 2009*](#)?
- > ensure that operational staff are fully trained on the statutory duty of CQC's fundamental standards^{6?}
- > have robust links with partner agencies to ensure that complaints which span boundaries receive a seamless response?
- > have effective mechanisms to ensure that learning points from complaints are acted upon?
- > ensure that record keeping practices are fit for purpose?
- > publish information about complaints it receives, which is easily accessible to the public, including the outcomes and how the organisations uses them to improve services?

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