LONDON BOROUGH OF RICHMOND UPON THAMES

Annual Complaints Report
Adult Social Care, Richmond
2025-26

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1. Introduction

1.1 The production of a complaints report is a statutory requirement for Adult Social Care, to provide an overview of the complaints received and handled through the Local Authority's statutory complaints procedure. This report is designed to meet this requirement of Adult Social Care and is a public document.

1.2 Complaints are counted in the year in which they were responded to or closed: 2025-26 complaint figures include complaints that will have been initiated in the previous year (2024-25) but then closed in this reporting year.

1.3 The Local Authority has a duty to ensure that any individual (or appropriate person acting on their behalf with their consent or Power of Attorney) who wishes to make a complaint about the actions, decisions or apparent failings of a local authority's social care provision have access to the Adults Statutory Complaints Procedure.

1.4 The Complaints Team sits within the remit of the Resident Engagement Service. There is a statutory requirement to have a complaints manager in post. The Complaints Team is led by the Corporate and Statutory Complaints Service Manager who reports to the Head of Resident Engagement. The Complaints Team comprises two operational managers: an Adult and Children's Complaints Manager and a Corporate and Ombudsman Complaints Manager, and five complaint officers.

1.5 The Complaints Team provides an important corporate function within Richmond and Wandsworth Councils' Chief Executive's directorate. Its role is to support the service partnership to ensure that both Councils have effective and efficient complaints procedures, harmonised across the two councils in line with best practice and statutory requirements. The Complaints Team also trains and support Council officers to respond effectively to complaints and ensure learning from complaints feeds directly into service improvement.

2. Executive Summary

2. Learning from Richmond complaints this year highlights three key themes: the need for clear and timely communication with people who draw on care and support, families and carers; the need for efficient processes and strong case coordination to minimise delays, address unclear ownership, and inconsistent handovers; and continued focus on holistic, person-centred practice. Complaints show the importance of accurate recording in assessments, clear care planning, and transparent explanations, particularly about eligibility, support arrangements or financial matters.

2.1 50 complaints were responded to this year, which is an increase from 32 complaints last year. This is felt to be linked to better reporting of complaints, alongside tighter adherence to policy and procedures within teams. Alongside the 50 formal complaints, in liaison with Adult Social Care teams, the Complaints Team swiftly resolved 17 low level concerns that had the potential to become formal complaints without this intervention. The Complaints

Team also handled 68 enquiries/representations which were mainly matters that fall outside the formal complaints procedure.

2.2 More teams received complaints this year, although the overall numbers remain low across services. The largest increases were seen in Mental Health Social Care, Learning Disabilities, Teddington and Twickenham Locality, and Financial Assessments.

2.3 Analysis of principal complaint issues for 2025/26 shows that the most frequently raised issue was the perceived quality of social care assessment, which accounted for 14 complaints. This highlights the importance people who draw on care and support place on clear, well-explained assessment decisions and provides valuable insight into where clear communication and evidenced explanations of outcomes can continue to be strengthened.

2.4 23 complaints were partly upheld (compared to 9 last year), 14 were not upheld (compared to 11 last year) and 13 were fully upheld (compared to 12 last year).

2.5 Five formal complaints raised issues about external care providers compared to four last year. However, the Quality Assurance and Contract Monitoring Team successfully managed 146 service concerns which had the potential to escalate to formal complaints.

2.6 72% of complaints were responded to within the local ambitious internal 25-day target, although the complaint regulations allow six months to resolve complaints. This is higher than the 66% of complaints within this time last year.

2.7 Data on equalities and the type of support provided to people who draw on care and support services is detailed in Section 11 of the report.

2.8 Adult Social Care do not receive many corporate complaints as most complaints are investigated through the statutory complaints process. This year Adult Social Care completed four Stage 1 corporate complaints compared to six last year and three Stage 2 complaints, which is the same as last year.

2.9 During 2025/26 a total of five LGSCO enquiries and/or investigations were completed for Adult Social Care compared to six completed in 2024-25; only one of the complaints resulted in a full investigation after assessment by the LGSCO. This is set out in Section 13.

2.10 Adult Social Care regularly receives compliments from people who draw on care and support, their representatives and professionals from partner organisations. Section 14 provides examples of these compliments which evidence the good quality services that are being provided.

2.11 Section 15 of this report sets out key achievements this year.

3. Legislation

3.1 There is a legal requirement for the Local Authority to have in place a complaints procedure, in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 for the management of social care complaints.

3.2 The Regulations cover Adult Social Care and Health services and/or any of its commissioned services and/or independent services.

4. Overview of the Statutory Adults Complaints Procedure

4.1 The complaints procedure is a single stage process for both Health and Social Care services. The Local Authority has a total of six months to resolve a complaint from start to finish. Within this single stage, a complainant may receive a further investigation if not satisfied with the initial response or be offered the opportunity to meet to discuss their complaint.

4.2 Internal performance targets aim to provide the complainant with a first response within 25 working days. Any further response must be completed by the six-month statutory timescale. The complaint can be progressed to the Local Government and Social Care Ombudsman (LGSCO) following the final response from the Local Authority or at any time.

4.3 Complaints are recorded and monitored by the Complaints Team. All complainants are offered the opportunity to discuss their complaint with a complaints officer and are assessed for risk by the complaints team in liaison with the relevant social care team. Complaints that are deemed very high risk will be referred to the appropriate investigation route such as invoking safeguarding procedures.

4.4 A complaint is defined as “an expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a local authority’s adult social services provision that requires a response”.

4.5 Complaints can be made by a resident or carer receiving a direct service from Adult Social Care or by a person on their behalf such as an advocate or family member where the person has provided their written consent, and they are deemed to be acting in the person’s best interests.

4.6 Where a service is provided by a contractor on behalf of the Council, a complaint can either be made directly to the provider service or to the complaints team at Richmond Council. Whilst the complaints team will encourage a provider to firstly attempt resolution through its own procedures, if this is not possible, the Quality Assurance and Contract Monitoring Team will investigate.

4.7 Residents who self-fund their care for services that are regulated by the Care Quality Commission do not fall under this procedure but can complain about the adult social care teams if they have been involved in assessing their level of care need and helping to arrange placements.

4.8 Complaints will be considered if they are made within 12 months of an incident although the Council can apply their discretion to waive this time limit.

4.9 Complaints are counted in the year in which they were responded to or closed: 2025-26 complaint figures include complaints that will have been initiated in the previous year (2024-25) but then closed in this reporting year.

5. Approach to learning from complaints/quality assurance

5.1 Learning from the experience of people drawing on care and support helps identify where services, policies and procedures can be improved or developed, keeps senior management informed of issues that are important to people, improves communication, and strengthens relationships and trust.

5.2 Adult Social Care continuously explores innovative methods to enhance service delivery, to ensure people's needs are met effectively whilst while working to reduce pressure on services and improve overall outcomes.

5.3 The Complaints Manager holds quarterly meetings with the Adult Social Care Professional Standards team led by the Principal Social Worker. These meetings are an opportunity to triangulate learning from complaints with practice improvement being undertaken by the Professional Standards Team. Training and briefings on complaints, including learning from complaints, are delivered to social care teams on a regular basis throughout the year.

5.4 Learning from Richmond complaints this year reinforces the importance of clear, timely and compassionate communication with people who draw on care and support, families and carers. Complaint responses provided valuable insight into how advice, decision-making and expectations should be explained clearly, how preferred methods of contact can be confirmed, and how people should be kept informed when cases are delayed or transferred. The learning supports a continued focus on respectful, consistent and proactive communication, particularly where individuals may be under stress or where several teams or agencies are involved.

5.5 A second strong theme was the value of efficient and effective processes and coordinated case management in supporting good outcomes for people who draw on care and support. Complaints provided helpful insight into where allocation, follow-up, reassessment, provider actions and information-sharing between teams can be further strengthened. Learning from these cases will support more consistent handovers, clearer ownership of actions, resilient contingency arrangements when staff are absent, and timely follow-through once commitments have been made. This will also strengthen

partnership working, helping people drawing on care and support and their families experience a more joined-up service, with clearer responsibilities and less need to repeat information.

5.6 The complaints also highlighted the importance of holistic, person-centred assessments. Learning points referred to improving the quality of recording in assessments, considering the full context of a person's circumstances, and making sure care planning, referral decisions and written responses reflect the individual's needs accurately, although there may be differences of opinion. Staff were also reminded to offer carers assessments at an early stage, including during hospital admissions. In several cases, learning also related to clearer recording, more robust documentation and more transparent explanations where support arrangements, service eligibility, provider issues or financial matters needed to be understood by those affected.

Case Study: Improving transition to adult services for care leavers

Background

The complainant, a care leaver, raised concerns about their transition from a Staying Put arrangement, alongside wider concerns about care planning, communication and continuity of support. Key concerns included uncertainty about future accommodation, limited involvement in planning, changes in allocated workers, and whether mental health, disability and trauma had been fully considered. The case involved a complex transition between Children's Services and Adult Social Care. Although planning had taken place over time, changes in circumstances meant alternative arrangements had to be developed quickly.

Outcome

The investigation found no fault in how the end of the Staying Put arrangement had been communicated, as records showed this had been discussed on several occasions. However, both services acknowledged the distress caused by the uncertainty and complexity of the transition. Children's Services and Adult Social Care accepted that, despite attempts to involve the complainant, they felt excluded and insufficiently supported. Both services apologised and accepted that communication about accommodation options and contingency planning could have been clearer.

Actions included progressing a housing application, exploring supported living options, and reviewing the care and support plan. Adult Social Care confirmed that ongoing support would continue and that future planning would reflect the complainant's needs and preferences.

Learning

This complaint has strengthened early joint working between Children's Services and Adult Social Care. Dual pathway planning will now ensure alternative options are considered earlier and reviewed regularly.

Services will discuss contingency planning earlier, including realistic housing options, timescales and service responsibilities, to reduce uncertainty and manage expectations.

There will be a stronger focus on ensuring young people are meaningfully involved in decisions about their future, including improved participation in meetings and care planning. Communication and coordination between teams will continue to be strengthened, with clearer handovers where worker changes are unavoidable.

Learning from this complaint has been shared through team discussions and staff training to improve support for other young people moving between children's and adult services.

6. Statutory complaint numbers

6.1 This year Adult Social Care completed 50[1] complaints, a 56% increase on last year. Alongside the 50 formal complaints, in liaison with Adult Social Care teams, the Complaints Team swiftly resolved 16 low-level complaints that had the potential to become formal complaints without this intervention.

6.2 Adult Social Care welcomes complaints and feedback as an important way of understanding residents' experiences, identifying where services can improve, and ensuring that concerns are responded to fairly and transparently. The increase in complaints this year should be seen in the context of the Council's commitment to accessible complaints processes, which make it easy for people who draw on care and support, families, and representatives to raise concerns when they are dissatisfied. It is also likely that wider changes in how people access information and draft complaints, including the increased use of AI, have contributed to more detailed and more readily submitted complaints.

Chart 1: Completed complaints by year 2022/23 – 2025/26

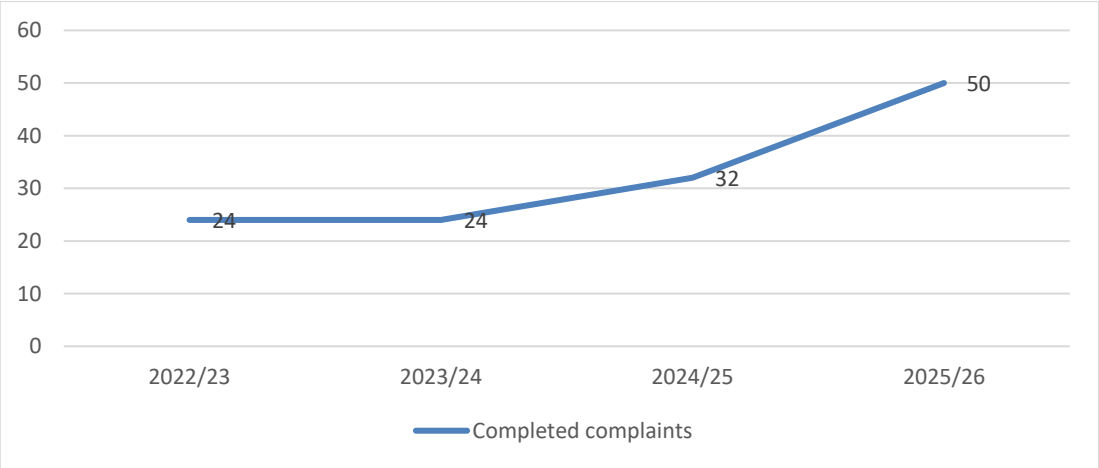


Table 1: Richmond Adult Social Care complaints by year.

2022/23 received	2022/23 completed	2023/24 received	2023/24 completed	2024/25 received	2024/25 completed	2025/26 received	2025/26 completed
22	24	23	24	32	32	53	50

6.3 Richmond is a small borough with a population of around 195,200 - 195,300[2] and the volume of complaints should be set in context by looking at the overall level of contact and interaction Adult Social Care has with its residents and people who draw on care and support. The rise in complaints reflects the broader increased demand and activity across Adult Social Care. During 2025/26, the department handled a significant volume of contacts and supported a

[1] Three of the complaints completed in the first quarter of this year were carried over from the previous year (2024-25). In total 53 new complaints were received during the year. One of these will be carried over and completed in the first quarter of next year. The 53 new complaints received is a 65% increase on the number of complaints received last year (24).

[2] Based on March 2021 census

large number of residents, including through assessments, reviews and financial assessments. Higher levels of activity, particularly at the front door and in assessment-related services, naturally increase the likelihood of dissatisfaction being raised, especially where people are navigating complex needs, eligibility decisions or financial arrangements.

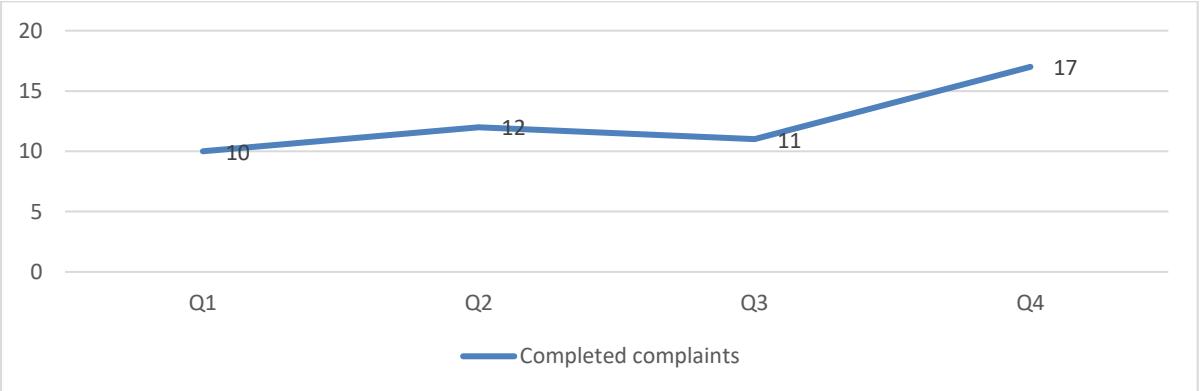
6.4 While complaint numbers have increased, they remain low when viewed against the overall level of contact and service delivery; the department handled approximately 27,781 contacts (calls and emails) and provided short-term and long-term social care support to 3,456 people during the year. Also, whilst the Financial Assessments Team led on six complaints in 2025-26, they completed 1,815 financial assessments this year[3].

6.5 The Quality Assurance and Contract Management team dealt with 146 service concerns about adult social care external providers which is 15% higher than the 127 service concerns last year. These were quickly resolved by contract officers, which is likely to have reduced the number of formal complaints.

6.6 Richmond Adult Social Care and Public Health Directorate responded to 174[4] Member enquiries this year in addition to the formal complaints. Member enquiries, either through local MPs or councillors are a way for residents and members to raise questions or concerns with the Council about local services or the community and in particular for this Department, for the welfare of neighbours. The Complaints Team works closely with Adult Social Care to identify Member enquiries that raise issues that require a response through established complaint procedures.

6.7 **Chart 2** details the complaints received for each quarterly period.

Chart 2: Number of Adult Social Care Complaints completed by quarterly period 2025/26



6.8 Adult Social Care encourages feedback and complaints. The team addresses issues promptly, reducing formal complaints.

[3] Last year the department handled 21,754 contacts, supported 2,022 long-term people during the year and undertook 1,590 financial assessments.

[4] The 174 Member Enquiries is 49% more than the 117 Member Enquiries in 2024-25

6.9 In addition to the 50 formal complaints, the Statutory Complaints Team addressed an additional 68 enquiries/issues throughout the year. These involved various low-level complaints or concerns that did not fall under the Statutory Complaints procedure. Altogether, including formal complaints, the Complaints Team managed 118 issues for Richmond Adult Social Care.

6.10 Low-level complaints are quickly resolved informally to prevent escalation. Issues or concerns are sent directly to the Complaints Team for triaging, signposting, or redirecting, such as housing complaints or safeguarding issues. These numbers are included in **Table 2** below to demonstrate the breadth of the work undertaken by the Complaints Team.

Table 2: Representations, issues or concerns handled by the Complaints Team in 2025-26

Type of case	Number
Formal statutory complaints.	50
Non-statutory complaints/issues directed to other Council services or directorates.	22
Low level complaints sent to Adult teams for quick resolution.	17
Issues directed to external partners/agencies.	8
Statutory complaint requests rejected (redirected) or no consent.	7
Safeguarding concerns directed to Adult Safeguarding procedures.	6
Data Protection/FOI requests/right to rectification, redirected to information governance processes.	3
Insufficient information to progress.	3
Issues directed to the Council's legal/insurance services.	1
Complainants disengaged from the process	1
Restrictions under the Unreasonable Complainant Behaviour Policy	0
TOTAL	**118**

Case Study: Strengthening Person-Centred Assessment and Placement Planning

Background

A family member raised concerns about Adult Social Care support for a young adult, including the level of updates provided, the time taken to complete the assessment and agree funding, and the suitability of a proposed supported living option. The complaint sought clear information about the support offer and the options being explored for the future.

Outcome

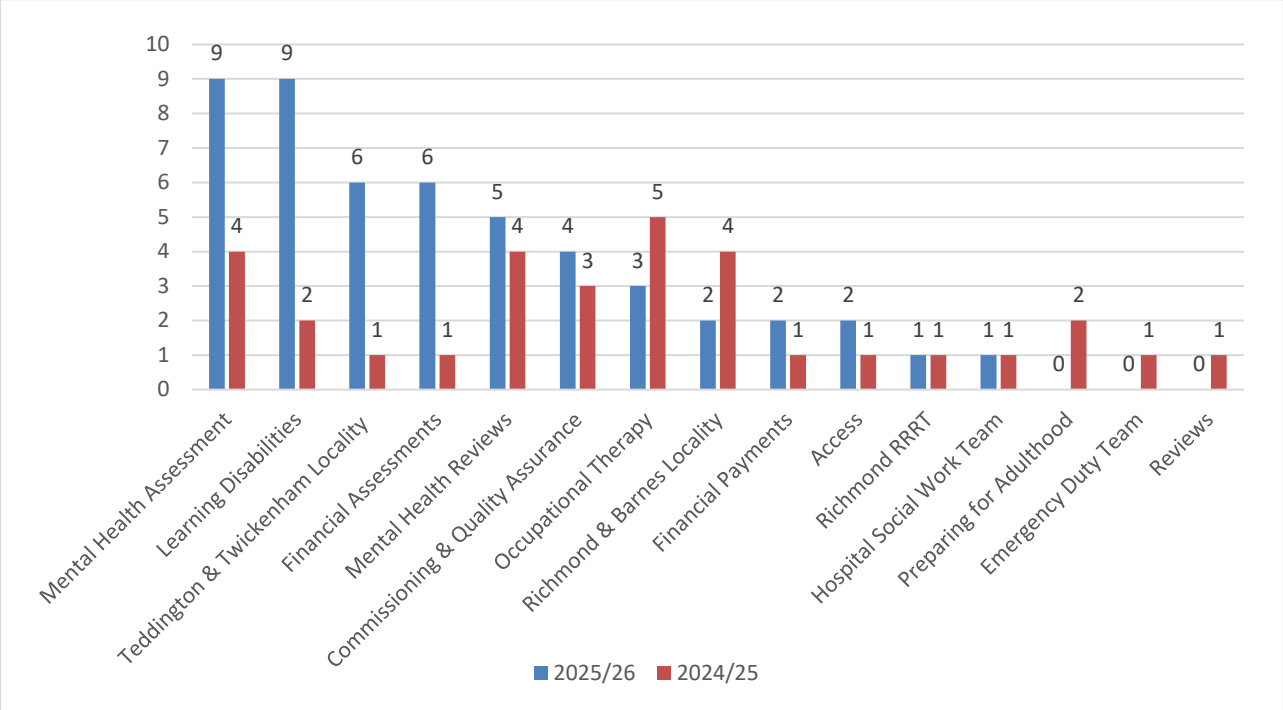
The servicel recognised the family's concerns and partially upheld the complaint. The investigation found that whilst the service had remained in communication with the family, fuller updates were not always provided whilst they were waiting for funding agreement. The service accepted that there had been delays in progressing the assessment and funding decision linked to unexpected staff absence and reduced decision making panel availability over the festive period. The service reflected on the proposed placement and recognised that options should be considered holistically, including the person's age, mental health and autism-related needs, local links, and whether support at home should be explored first as part of a strengths-based approach. The service apologised for the distress caused and confirmed that a range of options were being explored, including support at home and providers with greater experience of supporting younger adults with complex needs.

Learning

Adult Social Care will strengthen person-centred planning for adults with complex needs. Staff will be reminded to consider each person's circumstances holistically, including their age, preferred location, independence, mental health needs, autism-related needs and the suitability of the setting. Where a placement is being explored, officers will ensure families understand that options remain proposals until funding has been confirmed, so expectations are clear throughout the process. The service will also ensure funding decisions continue to be made in a timely way during holiday periods. This learning will help improve communication with families, promote strengths-based support planning, and ensure placement options are considered in a balanced, transparent and person-centred way.

7. Statutory complaints by team

Chart 3: Number of complaints by lead teams 2025/26 compared to 2024/25



7.1 **Chart 3** presents the number of complaints received by teams throughout the year in comparison to the previous year. It should be noted the number of residents served varies widely between teams. Despite the increase, the overall number of formal complaints for these services is still low when taken in the context of the number of people supported.

7.2 The increase in complaints within Mental Health Assessments, Learning Disabilities and Financial Assessments reflects the wider demand pressures across Adult Social Care. Overall complaints rose from 32 to 50 this year, alongside increased demand and activity. Higher volumes of assessments and reviews being completed inevitably increases the likelihood of dissatisfaction being raised, particularly in complex or high-need cases. Practitioners are also adhering closely to council policies and procedures and meeting eligible needs effectively in a strengths-based way that promotes independence, is proportionate and best value.

7.3 Assessment content and outcomes have become the most frequently raised issues, increasing significantly compared with the previous year. This is particularly relevant to Mental Health and Learning Disability services, where assessments are often complex, involve multi-agency input, require careful professional judgement and can be contested. Greater scrutiny of eligibility decisions, outcomes and agreed support is likely to have contributed to the rise in complaints. This can result in difficult conversations where residents or families expect services, or higher levels of services, to be provided than that recommended by the assessing practitioner to meet their eligible social care needs.

7.4 For Financial Assessments, complaints about charging and assessment outcomes have increased but remain relatively low in volume and are less frequently upheld. This suggests that concerns often arise from disagreement with, or misunderstanding of, statutory charging frameworks rather than service failure.

7.5 The increase in complaints within Teddington and Twickenham Locality, from 1 to 6 complaints, reflects similar themes seen across other service areas rather than indicating a specific issue within the locality. As with Mental Health Assessments, Learning Disabilities and Financial Assessments, complaints are largely driven by demand pressures, complexity of cases and the quality and clarity of communication, particularly in relation to assessments, care planning and decision-making. While Teddington and Twickenham show 6 complaints compared to Richmond and Barnes Locality 2 this year, this should be viewed in context of the team serving a larger volume of residents and the very small overall numbers and does not indicate a higher level of dissatisfaction.

Table 3: Number of Adult Social Care complaints by quarter 2025-26

Team	Q1	Q2	Q3	Q4	Total
Mental Health Assessments	2	3	0	4	**9**
Learning Disabilities	1	1	2	5	**9**
Teddington & Twickenham	3	0	3	0	**6**
Mental Health Reviews	0	1	2	2	**5**
Financial Assessments	0	2	0	4	**6**
Commissioning & Quality Assurance	0	3	1	0	**4**
Occupational Therapy	2	1	0	0	**3**
Richmond and Barnes Locality	0	1	1	0	**2**
Financial Payments	0	0	2	0	**2**
Access	1	0	0	1	**2**
Richmond RRRT	0	0	0	1	**1**
Hospital Social Work Team	1	0	0	0	**1**
	10	**12**	**11**	**17**	**50**

8. Complaints by issues and outcome

8.1 Complaints related to adult social care can be intricate and often involve multiple issues, occasionally spanning across different teams or service areas. Each complaint has been categorised by a single principal issue, representing the overarching theme or trigger of the complaint. To enable a more comprehensive analysis, data has been provided for every issue raised in all formal complaints resolved this year.

8.2 **Chart 4** sets out complaints by principal issue this year and **Chart 5** sets out complaints by principal issue in 2024-25. Analysis of principal complaint issues shows that the **quality of social care assessment** was the most frequently raised issue, accounting for 14 complaints. This reflects the importance people who draw on care and support, and their representatives, place on clear, well-evidenced assessments and accessible explanations of assessment outcomes. It also shows that assessment judgements can sometimes be contested. Complaints provided valuable insight into where assessment practice, recording, communication and the explanation of decisions can be further strengthened. The fact that 12 of the 14 complaints in this category were upheld or partially upheld demonstrates that the complaints process is helping to identify practical opportunities for learning and service improvement.

Chart 4: Number of Complaints completed by principal issue 2025-26

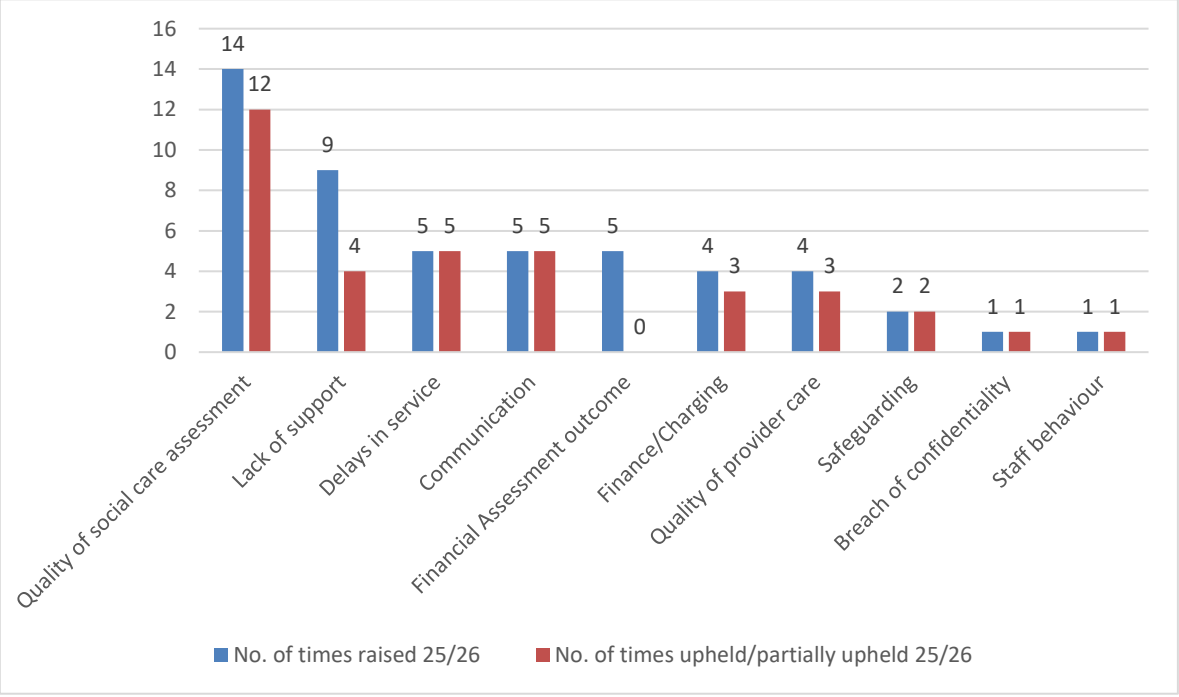
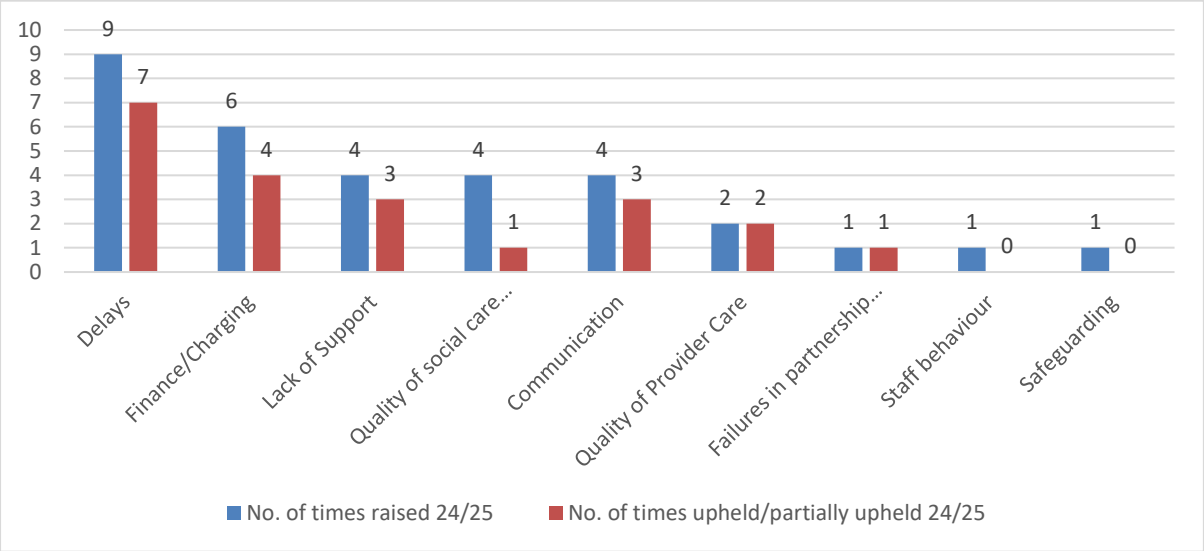


Chart 5: Number of Complaints completed by principal issue 2024-25



8.3 The second most frequently raised principal issue was **lack of support**, with nine complaints. These complaints are likely to reflect concerns where people who draw on care and support, or families felt that needs had not been fully recognised, that support offered was insufficient, or that expectations about the role of Adult Social Care had not been met. However, fewer than half of these complaints were upheld or partially upheld, which indicates that while people who draw on care and support may be dissatisfied with the level or type of support provided, this does not mean that there has been fault in the service's decision-making. This highlights the importance of clear communication, early expectation management and ensuring that care planning decisions are explained compassionately in a way that people who draw on care and support, and families, can understand (**Chart 4**).

8.4 In contrast, complaints relating to **delays** have decreased slightly as a principal issue (from nine to five), although they continue to feature prominently across complaints more broadly. Notably, all delay-related complaints raised this year were upheld or partially upheld, indicating that when delays do occur, they have a clear and demonstrable impact on service users. This suggests that, while delays may be less frequently identified as the primary issue, they remain a significant contributing factor to dissatisfaction.

8.5 Similarly, **communication** continues to be a theme across both years, with a slight increase in the number of principal complaints (from four to five). All communication complaints this year were upheld or partially upheld, reinforcing that the quality, clarity and timeliness of communication remain critical to the overall experience of people who draw on services. As demonstrated elsewhere in the report, communication issues often underpin wider concerns, even where they are not the primary reason for the complaint.

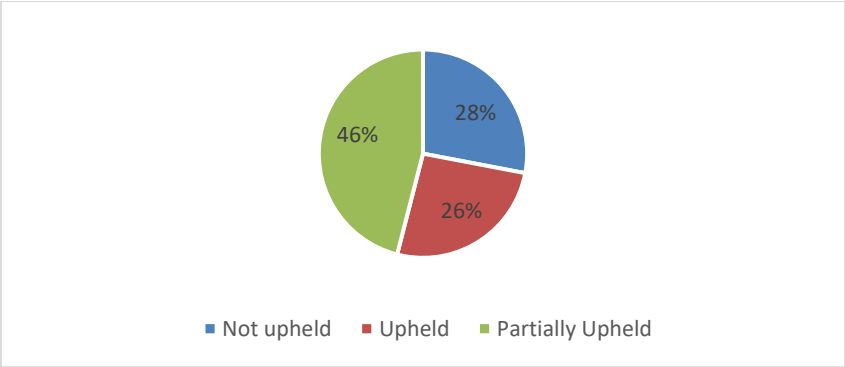
8.6 Complaints relating to **financial assessment outcomes** and **charging** have shown some increase in volume but remain relatively low in comparison to other issues. However, the data indicates that these complaints are less likely to be upheld compared to other

categories, suggesting that disputes in this area are more likely to arise from a lack of understanding or disagreement with statutory charging frameworks rather than service failure.

8.7 Overall, while the number of complaints has increased this year, the profile of issues remains broadly consistent with previous years. The data provides helpful insight into the areas that matter most to residents and their representatives, with communication, timeliness and clarity of professional decision-making continuing to be important themes. The high proportion of complaints that were partially upheld reflects the complexity of Adult Social Care complaints, where many aspects of service delivery are working well, but there are still opportunities to strengthen communication, coordination or expectation management. This supports the continued focus on improving practice, making decisions easier to understand, and ensuring people who draw on care and support feel informed and supported throughout their care journey.

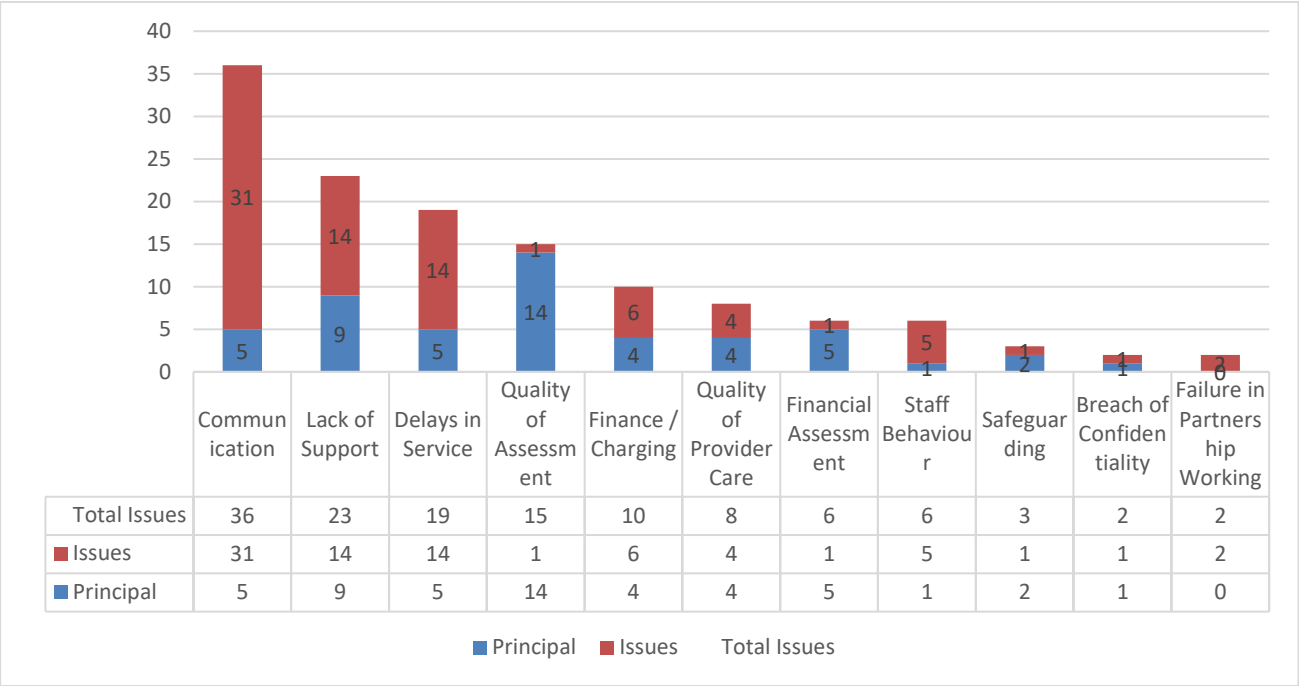
8.8 23 complaints were partly upheld (compared to 9 last year), 14 were not upheld (compared to 11 last year) and 13 were fully upheld (compared to 12 last year). **Chart 6** below illustrates that most complaints were partially upheld (46%). Where complaints are partially upheld, this means that some mistakes were made but not all the issues or complaints were substantiated.

Chart 6: Number of closed complaints by overall outcomes 2025/26



8.8 While **Chart 4** shows the principal issue for each complaint, **Chart 7** sets out every issue raised across the 50 complaints. Together, these complaints involved a total of 130 issues, highlighting the complexity of adult statutory complaints. This can make it difficult to identify the main reason for a complaint, as themes such as communication and delays often run throughout a case, even when the complainant's main aim is to challenge an assessment or a professional decision. For example, **Chart 7** shows that communication was raised 36 times, but it was the principal issue in only 5 complaints.

Chart 7: Number of Adult Social Care Complaints completed by issues 2025-26



	Communication	Lack of Support	Delays in Service	Quality of Assessment	Finance / Charging	Quality of Provider Care	Financial Assessment	Staff Behaviour	Safeguarding	Breach of Confidentiality	Failure in Partnership Working
Total Issues	36	23	19	15	10	8	6	6	3	2	2
Issues	31	14	14	1	6	4	1	5	1	1	2
Principal	5	9	5	14	4	4	5	1	2	1	0

Case Study: From Hospital to Home: Strengthening Partnership Working in Care Planning and Discharge Decisions

Background
A family member complained about the reduction in their mother's care after discharge from hospital, from live-in care to four daily double-handed calls. They questioned whether this was safe given her dementia and night-time needs, and also raised concerns about physiotherapy, assessment records, funding changes and continuity of care. The investigation found that the reduction had been decided by the Integrated Care Board following a Continuing Health Care assessment and that the Council's care planning reflected that decision. However, there was uncertainty about night-time needs and communication with the family was not always clear.

Outcome
The complaint was partially upheld. The Council accepted that there had been a lack of clarity about night-time care needs, which caused distress for the family. An apology was given and a Care Act review was prioritised to reassess needs and consider whether changes to the care package were needed. Other concerns, including physiotherapy and continuity of care, were not upheld, although communication about these issues could have been clearer.

Learning
Following this complaint, the service has taken steps to ensure that care needs are assessed more holistically, particularly where there is reliance on information provided by partner agencies such as the Integrated Care Board. Staff are expected to apply increased professional curiosity when reviewing external assessments, ensuring that all aspects of an individual's needs, including night-time support and emotional wellbeing, are fully explored and clearly evidenced within care planning.

The service has also strengthened communication with service users and their families, particularly during complex transitions between NHS Continuing Healthcare and local authority funding. Greater emphasis has been placed on providing clear, timely explanations of decisions, processes and next steps, so that individuals and their families are better able to understand how care arrangements are determined and what to expect throughout the process.

In addition, the service has reinforced the importance of effective partnership working with external organisations, including the Integrated Care Board and care providers, to minimise the risk of confusion during funding transitions. Processes will also be reviewed to improve coordination and ensure that information is consistently shared across agencies, reducing uncertainty and improving the overall experience for service users and their families.

9. External Care Provider complaints

9.1 The Quality Assurance and Contract Monitoring Team, which sits within the Commissioning Service, investigate complaints about care providers for Adult Social Care. This includes care homes and domiciliary care services. Complaints regarding a commissioned provider service, received directly by the Complaints Team, will be logged and processed in accordance with the Statutory Complaints Procedure and referred to the Quality Assurance and Contract Monitoring Team to investigate and monitor as required. Some complaints that raise issues about external providers are led by other teams if there are other aspects to the complaint, such as financial issues or care planning. In these complaints, social care teams liaise with the Contract Monitoring Teams to ensure that issues relating to quality of care are addressed.

9.2 If the care provider has not had the opportunity to investigate the complaint through its own process, the complaints team may ask the complainant if they agree to firstly attempt local resolution with the care provider. If the complainant does not feel local resolution is possible, or they have attempted to resolve their complaint with the provider, the Council will investigate.

9.3 This does not include complaints by 'self-funders' who are able to complain directly to the care provider and/or the Local Government and Social Care Ombudsman (LGSCO). Whilst complaints received by self-funders will be signposted to the relevant provider and/or LGSCO, information received by self-funders about the quality of provider services will be passed to the Quality Assurance and Contract Monitoring Team to inform the wider quality monitoring of services.

9.4 For this reporting year only five complaints raised concerns about care providers compared to four last year, and two the year before. Of the five complaints, four were investigated by the Quality Assurance and Contract Monitoring Team as the quality of provider care was the principal issue of complaint.

9.5 Complaints relating to commissioned care providers focused on concerns about the quality and reliability of care, including late or missed visits, poor communication, standards of care, and safeguarding or security issues. Some complainants expressed dissatisfaction with the care provided and the way concerns were responded to by the provider. Other issues included disputes regarding care charges and invoices, lack of awareness about the cost of care, delays in progressing individuals to appropriate supported living or care placements, concerns about decision-making by care providers, and allegations of discrimination. Complaints also highlighted communication and coordination issues, including lack of case ownership, delays in assessment and discharge processes, limited family involvement in decision-making, and concerns about responses to incidents occurring within care settings.

9.6 These low numbers should be set in the context of the number of service concerns that have been dealt with by the Quality Assurance and Contract Monitoring Teams. This year, 146 service concerns were processed by the Quality Assurance and Contract Monitoring Team which is 15% higher than the 127 service concerns last year.

9.7 Service concerns are a quick and effective way of dealing with issues as an informal complaint and prevent issues escalating. The Quality Assurance and Contract Monitoring Team aim to provide an outcome on these concerns within seven working days. People who draw on care and support are always provided with information about the formal complaints process, but the benefits of the service concerns process are that it provides a rapid response for the resident and intelligence to the Quality Assurance and Contract Monitoring team about the performance of external providers.

Case Study: Getting the Basics Right in Home Care Delivery

Background

This complaint was made by a family member about the domiciliary care provided to their father by an external agency. Concerns included late visits, poor communication, care standards, safeguarding issues about property access, and the handling of earlier complaints. The family said they had to step in because of inconsistent service and had lost confidence in the provider.

The investigation reviewed call monitoring data, care records, care plans and information from the provider. It found no missed visits, though there were some punctuality issues. More significant faults were identified in communication, record-keeping, and the alignment between the Council's support plan and the provider's care plan. Earlier recommendations had also not been fully embedded.

Outcome

Concerns about missed visits were not upheld, as records showed visits took place, although there were some minor timing issues. However, complaints about poor communication, inadequate care standards, and a lack of action were upheld, as the family was not consistently informed of carer changes, communication about care needs and medication was insufficient, and records did not always evidence the care provided.

The investigation also found that the provider's care plan did not fully reflect the agreed support plan, creating uncertainty for staff and the family. Although no significant safeguarding concerns were identified about property access, the provider was asked to reinforce staff protocols. The Council also agreed to improve recording, align care plans more clearly, and consider whether a change of provider was appropriate.

Learning

This case highlights the need for care plans to be clear and aligned. Going forward, providers will ensure their care plans accurately reflect the Council's support plan so staff have clear instructions and care delivery can be properly evidenced.

Communication with families will be strengthened, particularly where relatives are closely involved. Providers will ensure families are told promptly about changes to care arrangements and other important issues.

Care records will be improved so they clearly evidence the support provided, supported by regular spot checks and monitoring of record quality.

There will also be stronger oversight to ensure learning from previous complaints is implemented, monitored and sustained through contract management.

Where concerns continue, earlier consideration will be given to changing provider to maintain safe, effective and responsive care.

10. Response Times

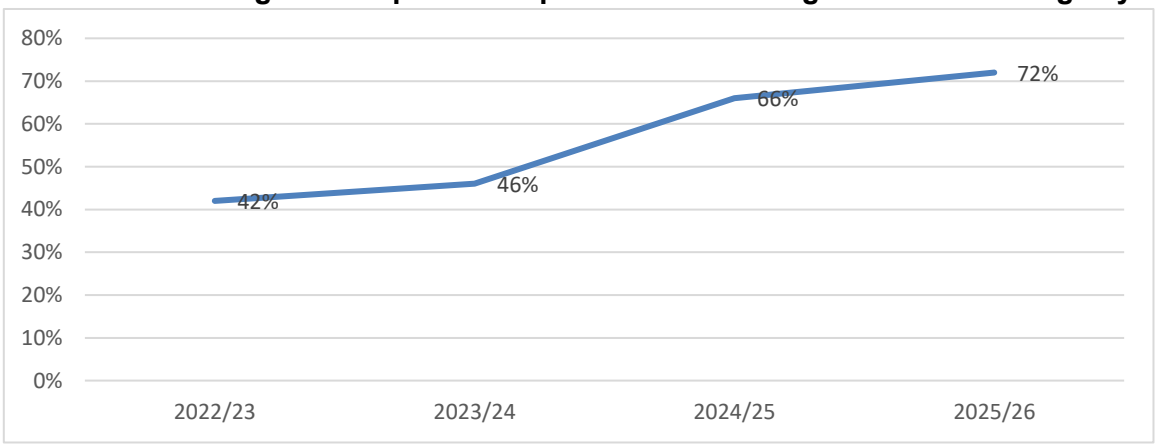
10.1 Adult Social Care teams work towards a local target of 25 working days to respond in writing to formal complaints. As the complaint regulations allow flexibility within the six-month statutory timeframe, this local target can be changed with the agreement of the complainant who is always kept fully informed. Whilst we measure against 25 working days to manage our internal performance, no complaints breached the statutory six-month timescale[5]. Also, where complaints have been extended past 25 days, complainants have been consulted throughout and have not raised concerns about delays.

10.2 For this reporting period, Richmond received 53 new complaints but also completed 50 complaints. Timescales were measured for the 50 complaints closed during this year within the 25-day local target.

10.3 Of those, 36 (72%) were closed within 25 working days and 14 complaints (28%) exceeded this timeframe. This is higher than the 66% of complaints on time last year. **Chart 8** details response times for the last four years.

10.4 Of the 28% complaints that exceeded 25 days, the average resolution time was 33 days, and well within the statutory timeframe. Adult Social Care complaints often involve multiple teams, requiring additional time for a thorough investigation.

Chart 8: Percentage of complaints responded to in writing within 25 working days



[5] Six months is calculated as 182.5 days although this includes non-working days.

Case Study: Improving Support Through Better Coordination

Background

This complaint was made by a family member about the support, communication, and decision-making relating to their brother, who has complex needs including blindness, older age, and learning disabilities. Concerns included repeated requests for information, unclear advice about care and housing options, poor communication about key decisions, delays with an Extra Care Housing application, inappropriate safeguarding advice, lack of welfare support, and no information about appeal rights after a housing application was declined.

The investigation found several service failings, including poor communication, delays, failure to follow the correct Extra Care Housing referral process, limited information about eligibility and appeal routes, and weak coordination across teams and partner agencies.

Outcome

The investigation found delays and confusion caused by failure to follow the correct Extra Care Housing process, alongside poor assessment, unclear communication, and limited information about eligibility, support, and appeal rights. The complainant was also required to repeat information to multiple professionals, adding to the family's distress.

To resolve this, a review of care and support needs was completed, additional support was arranged, and a new housing application was progressed. The service apologised and confirmed action had been taken to address the failings identified.

Learning

This case has highlighted the importance of clear, coordinated communication with individuals and their families, especially where multiple teams and agencies are involved. Services now ensure that service users and their representatives are not required to repeat the same information, and that effective systems are in place to share key information across professionals.

There has been a renewed focus on ensuring referral processes are understood and consistently followed. Improved staff awareness and oversight has helped reduce avoidable delays, confusion, and missed opportunities for timely assessment and support. Early informal discussions between teams before referral has also been encouraged to help manage expectations and confirm suitability.

The service has strengthened transparency in decision-making. Individuals and their families will be given clear information about eligibility criteria, the reasons for decisions, and the options available to challenge or appeal outcomes.

Finally, staff will ensure that advice is appropriate to the individual's specific needs, particularly in safeguarding contexts. Signposting and support to access services such as welfare advice will be improved, and management oversight has been strengthened to help ensure accurate, timely, and person-centred information and embed learning from complaints into practice.

11. Equalities data and categories of support

11.1 This year 35 complaints were from, or on behalf of, people who draw on care and support of working age; between the ages of 18 and 64. A further 15 complaints related to complaints made from, or on behalf of, older adults (65 and over)[6].

11.2 27 complaints concerned females, and 23 complaints concerned males.

11.3 For the 35 complaints from, or on behalf of, residents of working age (18-64), where known:

- 29% were in receipt of support from mental health services.
- 26% were in receipt of support from learning disability services.
- 11% were in receipt of mental health support, social, substance misuse support and access and mobility.
- 11% were in receipt of support for physical support and access and mobility only.
- 6% were in receipt of social support and substance misuse support.
- 6% were in receipt of support for visual impairment.
- 3% were in receipt of physical support.
- 3% were in receipt of personal care support.
- 3% were in receipt of social support for social isolation
- 3% were in receipt of Support with Memory and Cognition

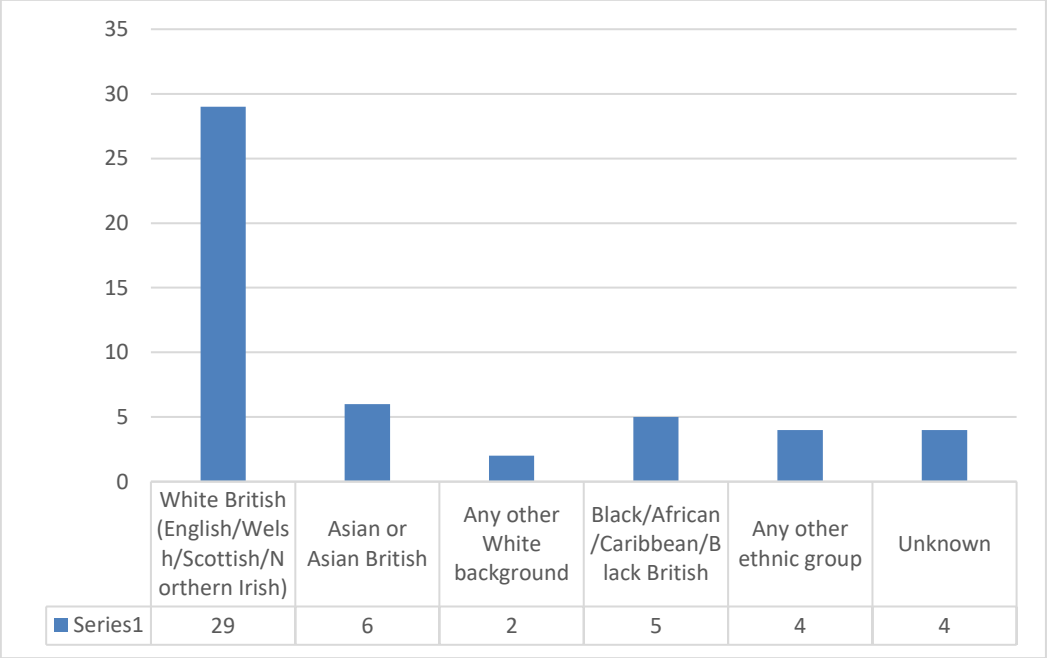
11.4 For the 15 complaints from, or on behalf of, people who draw on care and support in the older adults category (65 plus):

- 33% were in receipt of physical support for personal care, support with memory and cognition or visual impairment
- 33% were in receipt of physical support for access & mobility only or personal care Support
- 13% were in receipt of personal care support.
- 7% were in receipt of services from learning disability services.
- 7% were in receipt of support from mental health services.
- 7% were in receipt of social support for social isolation.

11.5 **Chart 9** provides ethnicity data for people who draw on care and support and made complaints (or had complaints made on their behalf). The majority were from a White background (62% or 31 people). In Richmond, 86% of people who draw on care and support are from a White background. Black, Asian and Minority Ethnic Groups represent 14% of people.

[6] 3 complaints include two people crossing both age categories

Chart 9: Richmond Adult Social Care Ethnicity Data 2025-26



12. Corporate complaints

12.1 This report provides a brief overview of Corporate Complaints closed by Adult Social Care. Detailed reporting on Corporate Complaints is within Richmond Council's Corporate Complaints Report 2025-26.

12.2 Adult Social Care does not receive many corporate complaints. The Corporate Complaints process handles complaints from individuals who have interacted with Adult Social Care but are not receiving, or been assessed for, statutory services. Often, these are relatives making complaints about communication or information sharing for themselves, rather than on behalf of a person drawing on care and support.

12.3 This year Adult Social Care completed four Stage 1 corporate complaints compared to six last year and three Stage 2 complaints, which is the same as last year.

12.4 Corporate complaints for Richmond Council are analysed in more detail within the Richmond Annual Corporate Complaints Report 2025-26.

13. Ombudsman Cases

13.1 This report provides a brief overview of Local Government and Social Care Ombudsman (LGSCO) cases closed by Adult Services. Detailed reporting on Corporate and Ombudsman Complaints is within Richmond Council's Corporate Complaints Report 2025-26.

13.2 A complainant has the right to refer their complaint to the LGSCO at any time. Generally, the Ombudsman will seek to ensure that the Local Authority has been provided with the opportunity to first respond to the complaint in accordance with the Council's own statutory complaints process.

13.3 During 2025/26 a total of five LGSCO enquiries and/or investigations were completed for Adult Social Care compared to six completed in 2024-25. The LGSCO decided an additional two enquiries regarding Richmond Adult Social Care, but they were not passed to the Council as they were deemed by the Ombudsman to be either incomplete or invalid. Only one of the complaints resulted in a full investigation after assessment by the LGSCO. Information on each enquiry is set out in **Table 4** after the case study.

13.4 The outcomes ff the five Adult Social Care complaints were as follows:

Table 4: Ombudsman cases by team and outcome

Service Area	Subject	Decision
Mental Health	Complaint regarding responsibility for rent and associated accommodation costs under S.117 Aftercare[7]	Upheld. Adult Social Care agreed to meet the full cost of rent and associated accommodation costs that the complainant had paid privately whilst under S.117 and provided an apology.
Mental Health	Complaint about care, treatment, accommodation under S.117 aftercare	Closed after initial enquiries due to lack of consent for third party representative to take forward the complaint
Occupational Therapy	Complaint that the Council has not supported bathroom adaptations or provided an OT assessment	Closed after initial enquiries as insufficient evidence of fault to justify an investigation.
Mental Health and Payments	Complaint about delays in completing a Care Act Assessment and subsequent decision not to backdate Direct Payments	Closed after initial enquiries as the complaint was passed the time limit without good justification.
Mental Health	Complaint about unhappiness with how a S.117 Aftercare meeting was conducted.	Referred back for local resolution

[7] Section 117 aftercare is a free package of health and social care provided to individuals leaving hospital after being detained under specific sections of the Mental Health Act (such as Section 3 or 37). It is a legal duty designed to help patients recover, prevent relapse, and reduce the risk of being readmitted.

14. Compliments

14.1 Positive feedback regarding staff or service delivery is another way in which the department can learn how well services are being delivered. Compliments remind us of the excellent practice within services and reinforce that the promises made to learn from complaints are sincere. Staff are reminded to report compliments they receive so the Complaints Team can record as much positive feedback as possible to evidence the commitment to good social care practice.

14.2 Examples of compliments received are outlined below:

- “I’m full of gratitude for all the support you have provided in making sure [name] and his family have the best quality of life possible. It was always such a pleasure to see you, and nothing ever seemed like too much trouble”. (Occupational Therapy)

- “I'm so very grateful for all your help, I was really at my wits end until you got involved”. (RRRT)

- “Thank you for your support and keep up the good work! We need people who genuinely care about others and who don’t expect or want anything in return”. (Teddington and Twickenham Locality)

- “They said that [name] is like a breath of fresh air in KITE and he is such a positive, kind caring person. She said this had set her up for the day and she would be smiling all day now as she felt so much appreciation for all of her hard work”. (KITE)

- “I want to extend a personal thank you. You’ve been by far the most effective social worker that I’ve so far dealt with in my 36 years. We will miss you, your diligence and ingenuity”. (Mental Health Reviews)

- “Just wanted to say a big thank you for all your support in the last few years. It’s fair to say it’s been life changing!”. (Learning Disabilities)

- “Thank you very much for your help this morning, your professionalism and thoughtfulness and patience to explain everything carefully to me to understand to apply for Richmond council for an OT for assessment”. (Front Door)

- “I just wanted to feedback to you that I thought you chaired the safeguarding meeting on Monday for [name] very well. It was a difficult meeting all round and you managed the situation calmly and sensibly”. (Richmond and Barnes locality).

- "We just want to thank you so much for giving us so much help in May. We have now been accepted for Attendance Allowance. The first help came through today. This will make such a difference to our budgeting in our circumstances". (Sensory Service).
- "You are one amazing person I know, thank you for everything you do for me, you should get a pay rise, I don't say this lot but I'm so grateful for you to be in my life". (Financial Payments)

- "I would be grateful if you could kindly share the following note of thanks. It feels important that she knows how much her team member, [name], is appreciated for his acknowledgement and support". (Financial Assessments).

15. Key achievements 2025/26

15.1 During 2025/26, the Complaints Service has continued to strengthen its role as a central corporate function, providing strategic oversight of both statutory and corporate complaints. We have maintained a clear focus on statutory compliance while using complaints insight to drive service improvement, strengthen governance, and provide assurance to senior leadership and external regulators.

15.2 A key achievement this year has been the further development of the Council's approach to statutory complaints, ensuring processes remain compliant, proportionate and responsive to the complexity of adult and children's social care cases. We have provided oversight and guidance on complex and high-risk complaints, supported multi-agency coordination, and ensured that investigation outcomes are robust, evidenced and aligned with statutory requirements.

15.3 We have also strengthened our approach to learning from statutory complaints, ensuring that themes arising from investigations are translated into meaningful service improvements. Through detailed case studies and engagement with practice leads, this has supported improvements in communication, transition planning, partnership working and decision-making, reinforcing the value of complaints as a driver for improvement, particularly in complex and sensitive cases.

15.4 A significant achievement this year has been our role in supporting housing services during a period of heightened regulatory scrutiny and a significant rise in complaint volumes. Acting as the Council's central point of contact and link officers with the Ombudsman, we have led on liaison with the Ombudsman, coordinated responses to enquiries and investigations, and ensured that submissions are clear, robust and compliant with the Complaint Handling Code.

15.5 This has included supporting the Council's response to Section 49 investigations and wider regulatory requirements, working closely with Housing and senior leadership to strengthen governance, improve oversight and embed more consistent complaint handling practices. We have provided direction and constructive challenge, supporting

housing services to respond effectively to complex and high-profile complaints in line with regulatory expectations.

15.6 We have also provided targeted support during periods of acute operational pressure, including in relation to fire-related incidents and other sensitive cases. This has ensured that complaint handling approaches are appropriate to the circumstances, that responses are coordinated across services, and communication with residents remained clear, proportionate and empathetic.

15.7 Alongside this, we have continued to build organisational capability across both statutory and corporate complaints through training, guidance and ongoing engagement with services. This has strengthened the quality and consistency of responses, with a particular focus on clarity, empathy and transparency in complex cases.

15.8 We have also enhanced our governance and assurance role, improving oversight of complaint handling across the organisation. This has included supporting improved data quality and strengthening reporting processes to provide a reliable picture of performance, risk and learning.

15.9 Finally, the Complaints Service has supported improved partnership working, particularly where complaints span multiple services or external organisations. By coordinating responses and supporting escalation where required, the service has ensured that complex complaints are managed effectively and outcomes remain fair and resident-focused.

15.10 Overall, the work undertaken during 2025/26 reflects the continued development of the Complaints Service as both a statutory function and a strategic enabler of improvement. Through its leadership on complex complaints, regulatory compliance, and organisational learning, the service has supported Richmond Council to deliver more consistent, transparent and resident-focused services in an increasingly demanding regulatory environment.