LONDON BOROUGH OF RICHMOND UPON THAMES

Annual Complaints Report Adult Social Care, Richmond 2024-25

Nancy Kurisa

Corporate and Statutory Complaints Manager

Table of Contents

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: 2024-25 complaint figures include complaints that will have been initiated in the previous year (2023-24) 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 of 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 train and support Council officers to respond effectively to complaints and ensure learning from complaints feeds directly into service improvement.

2. Executive Summary

2.1 This year, learning from complaints has focused on improving communication to ensure it is timely and accurate, ensuring advocacy is provided when an individual lacks capacity to make informed decisions about their care or welfare and there is no other appropriate person to support and represent them, undertaking refresher training with social care teams on effective complaints handling, and the development of a new policy on access to records of deceased service users.

2.2 32 complaints were responded to this year which is an increase from 24 complaints last year. Alongside the 32 formal complaints, in liaison with Adult Social Care teams, the Complaints Team swiftly resolved 7 low level concerns that had the potential to become formal complaints without this intervention. The Complaints Team also handled 45 enquires/representations which were mainly matters that fall outside the formal complaints procedure.

2.3 Principal issues of complaint ranged from perceptions of lack of support, delays, communication, to quality of assessments, but overall while formal complaint numbers have increased they remain relatively low, so no concerning trends have been drawn from complaints this year.

2.4 9 complaints were partly upheld, 11 were not upheld and 12 were fully upheld.

2.5 4 formal complaints raised issues about external care providers compared to 2 last year. However, the Quality Assurance and Contract Monitoring Team successfully managed 127 service concerns which had the potential to escalate to formal complaints.

2.6 66% of complaints were responded to within the local ambitious internal 25-day target, although the complaint regulations allow six months to resolve complaints. For the 34% complaints that exceed 25 days, the average resolution time was 35 days.

2.7 Data on equalities and the type of support provided to residents who draw on 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. Richmond teams responded to 5 stage 1 corporate complaints compared to 6 last year. No complaints escalated to stage 2.

2.9 Whilst 6 complaints were raised with the Local Government and Social Care Ombudsman (LGSCO) this year none resulted in a full investigation. This is set out in Section 13.

2.10 Adult Social Care regularly receives compliments from residents who draw on services or their family members 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 including the Complaints Team winning Team of the Year for ‘Leading by Example’ at the annual Staff Awards.

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 Adults 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: 2024-25 complaint figures include complaints that will have been initiated in the previous year (2023-24) 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 services helps identify where services, policies and procedures can be improved, keeps senior management informed of issues that are important to people, improves communication, and strengthens relationships.

5.2 Adult Social Care continuously explores innovative methods to enhance service delivery, to ensure people's needs are met effectively whilst working tirelessly to reduce the pressure on services and improving 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 Examples of key learning this year is set out below:

Delays

- Delays in sending out assessments and reviews were acknowledged, with commitments to monitor and address these through supervision and team meetings.
- Staff sickness and its impact on case progression were identified as a cause of delay, prompting discussions on better monitoring of outstanding tasks during absences.

Finance/Charging

- Staff were reminded to inform residents drawing on services and families early about financial assessment contributions and to provide written information.
- Teams are reminded to clarify rent and benefit costs early, especially during transitions from Children's to Adult Services.

Lack of Support

- The need for a more holistic approach when multiple teams are involved with family members was highlighted.
- A commitment was made to improve how services consider the emotional and practical impact of their processes on families, particularly during hospital admissions and discharges.
- The importance of ensuring agreed support (e.g., carers support and direct payments) is in place before annual reviews was reinforced.

Quality of Assessment

- Staff were reminded to ensure assessments are shared promptly and documented properly.
- Teams were instructed to explore and record advanced decisions and LPAs (Lasting Power of Attorney) during assessments and reviews.

- A factsheet will be developed to explain the Section 117 Panel's role in discharge planning, improving transparency in assessment processes (Mental Health discharge aftercare).

Communication

- Clear, respectful, and timely communication with residents and families is a recurring theme and regularly discussed with teams and embedded in reflective supervisions.
- Staff were reminded to explain decisions clearly and ensure communication is appropriate, especially when multiple teams are involved.
- The Direct Payments team and finance teams are reviewing their communication frameworks to improve professionalism and clarity.
- Communication with neurodiverse residents has been discussed to ensure inclusivity and understanding.

Learning Case Study: Listening, Learning, Acting: A Family's Experience with Adult Services

Background

A statutory complaint was raised by a parent and carer regarding the adult social care services provided to their two sons. The complainant expressed concerns about communication failures, inappropriate consultation with their husband, disregard for their son's advanced decisions, insufficient support and funding, lack of respite provision, and delays in receiving responses and documentation. The complaint highlighted the complexity of coordinating care for two individuals with high needs within a family context, and the importance of clear communication, respect for legal documentation, and timely service delivery.

Investigation findings

The investigation confirmed that an incorrect email address had initially been used, but this was later corrected. Staff had attempted to liaise with the complainant's husband due to his legal status as next of kin and holder of a financial Lasting Power of Attorney (LPA), but ceased contact following his written request. Regarding the advanced decisions, the documents submitted were acknowledged but not accepted due to concerns about their validity and the lack of prior awareness by the local authority. The investigation also found that while support plans had not been finalised, three care options had been proposed to address the sons' needs, including respite care and assistive technology. Delays in assessments and documentation were acknowledged, and the complainant was encouraged to support the completion of these processes. Although respite had been discussed and offered, it had not yet been taken up. The council also acknowledged delays in responding to queries and apologised for the lack of timely communication.

Learning

The council recognised several areas for improvement as a result of this complaint. Staff have been reminded to promptly update contact details for individuals holding legal authority, such as LPAs. Teams have been advised to actively explore and document advanced decisions during assessments and reviews. Additionally, the importance of collaborative working across teams when supporting family members with interconnected needs has been reinforced. These actions aim to ensure a more holistic, respectful, and responsive approach to care planning and service delivery in future cases.

6. Statutory complaint numbers

6.1 This year Adult Social Care completed 32[1] complaints which is a 33% increase on last year. Alongside the 32 formal complaints, in liaison with Adult Social Care teams, the Complaints Team swiftly resolved 7 low level complaints that had the potential to become formal complaints without this intervention.

Chart 1: Completed complaints by year 2021/22 – 2024/25

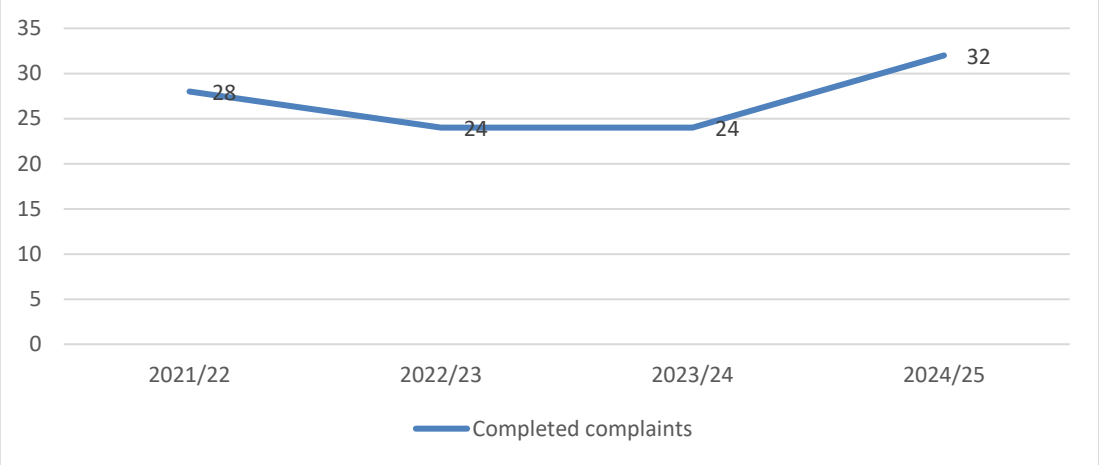


Table 1: Richmond Adult Social Care complaints by year.

2021/22 received	2021/22 completed	2022/23 received	2022/23 completed	2023/24 received	2023/24 completed	2024/25 received	2024/25 completed
32	28	22	24	23	24	32	32

6.2 Richmond is a small borough with a population of 195,200 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 service users. During 2024-25, 32 complaints were received and 32 closed which is a low number given that the department handled approximately 21,754 contacts (calls and emails) and provided long-term social care support to 2,022 people during the year. Also, whilst the Financial Assessments Team led on 1 complaint in 2024/25, they completed 1,590 financial assessments this year[2].

6.3 The Quality Assurance and Contract Management team dealt with 127 service concerns about adult social care external providers which is lower than the 168 service concerns last year. These were quickly resolved by contract officers, which is likely to have reduced the number of formal complaints.

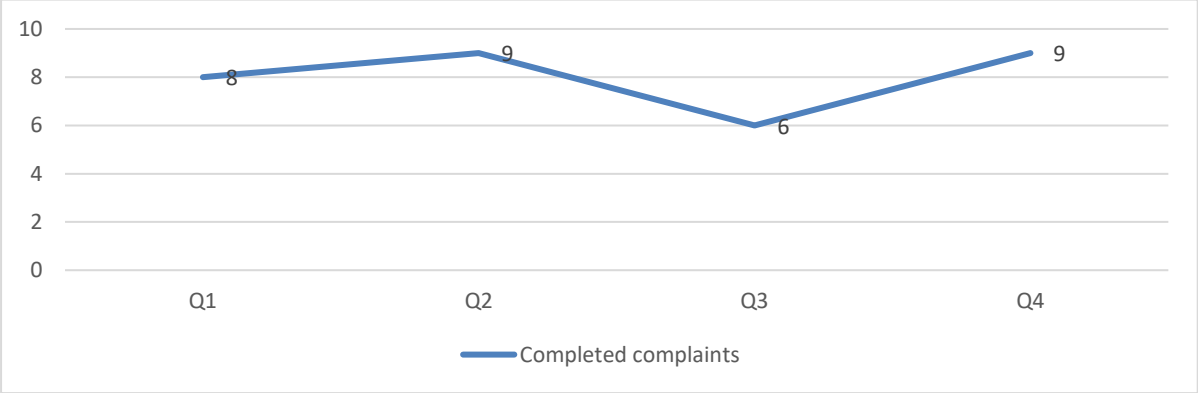
[1] Two of the complaints completed in the first quarter of this year were carried over from the previous year (2023-24). In total 40 new complaints were received during the year. Two of these will be carried over and completed in the first quarter of next year. The 32 new complaints received is a 39% increase with the number of complaints received last year (23).

[2] Last year the department handled 25,084 contacts, supported 2,043 people during the year and undertook 1,221 financial assessments.

6.4 Richmond Adult Social Care and Public Health Directorate responded to 117[3] 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.

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

Chart 2: Number of Adult Social Care Complaints received by quarterly period 2024/25



6.6 Adult Social Care encourages feedback and complaints. Richmond's smaller population likely leads to fewer complaints. The team addresses issues promptly, reducing formal complaints.

6.7 In addition to the 32 formal complaints, the Statutory Complaints Team addressed an additional 52 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 86 issues for Richmond Adult Social Care.

6.8 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 3** below to demonstrate the breadth of the work undertaken by the Complaints Team.

[3] The 117 Member Enquiries is 23% less than the 152 Member Enquiries in 2024-24

Table 2: Representations, issues or concerns handled by the Complaints Team in 2024-25

Type of case	Number
Formal statutory complaints.	32
Low level complaints sent to Adult teams for quick resolution.	7
Statutory complaint requests rejected (redirected) or no consent.	3
Non-statutory complaints/issues directed to other Council services or directorates.	19
Issues directed to external partners/agencies.	11
Data Protection/FOI requests/Right to Rectification, redirected to Information Governance Processes.	2
Safeguarding concerns directed to Adult Safeguarding procedures.	2
Insufficient information to progress.	1
Issues directed to the Council's legal/insurance services.	0
Complainants disengaged from the process	7
Restrictions under the Unreasonable Complainant Behaviour Policy	2
TOTAL	**86**

Learning Case Study: Addressing Miscommunication and Vulnerability in Social Care

Background:

A complaint was made raising concerns about the conduct of two social workers during a home visit. The complainant, who identifies as extremely vulnerable, expressed that the visit was unnecessary and could have been conducted over the phone. The individual also reported that the social workers did not wear personal protective equipment (PPE) despite a request, and alleged that they entered the home under false pretences by claiming to be from the Sensory Team when they were in fact from the First Response Social Work Team

Investigation Findings

The investigation involved a thorough review of case records and communications. It was found that the complainant had contacted both the Sensory Duty and Front Door Service to raise concerns and was advised to contact the complaints team. However, the option to assist in submitting the complaint was not offered, which was acknowledged as a service shortfall. There was no documented evidence that the complainant requested telephone only communication or objected to a home visit. In fact, records indicated agreement to the home visit. - PPE was not a requirement at the time of the visit and no record was found of a PPE request. However, the council acknowledged that had such a request been made, it would have been honoured. The complaint about deception regarding the workers' identity could not be substantiated due to lack of clarity about which social worker was involved.

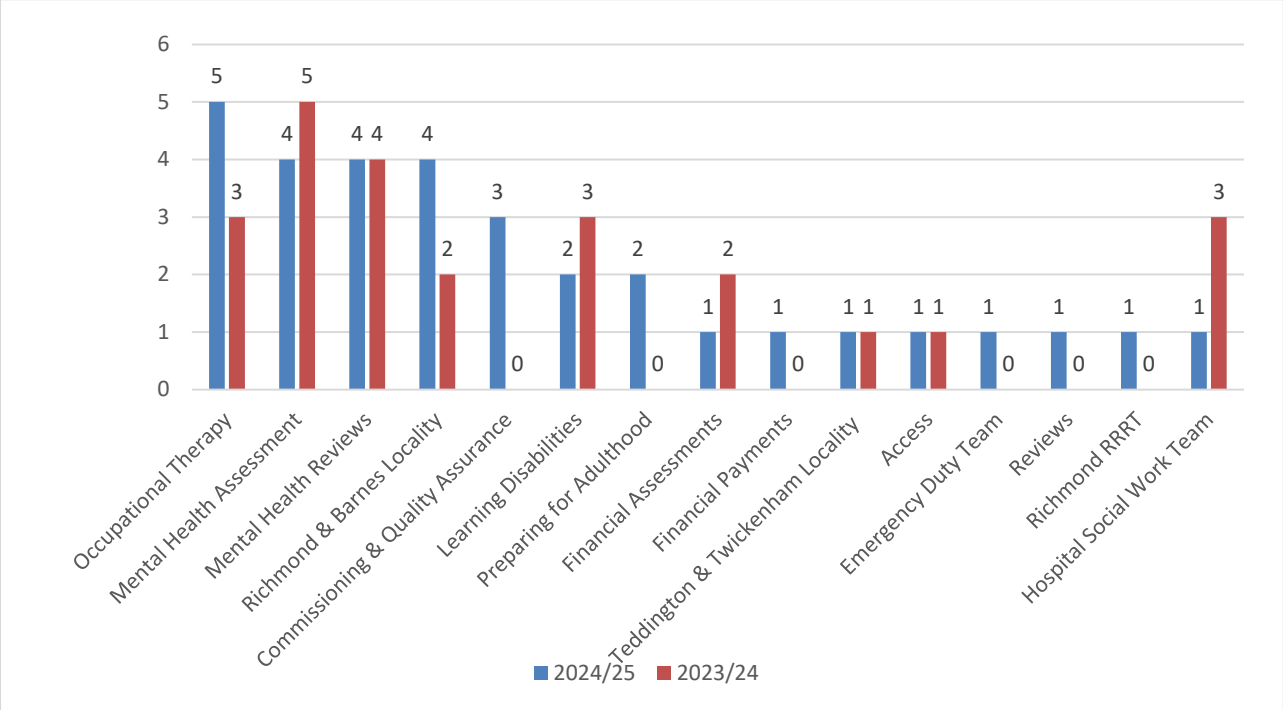
Learning and Service Improvements

The complaint highlighted areas for service improvement, particularly in communication and sensitivity to service user vulnerabilities. As a result:

- staff were reminded to offer both online and telephone options for submitting complaints and to assist service users in doing so when needed.
- When scheduling visits, staff will be required to check for any vulnerabilities or anxieties and record any reasonable requests, such as PPE use, to ensure a safer and more reassuring experience for service users.

7. Statutory complaints by team

Chart 3: Number of complaints by lead teams 1 April 2024/25 compared to 2023/24



- **Chart 3** presents the number of complaints received by teams throughout the year in comparison to the previous year. Formal complaints increased by 33% overall. More teams received complaints, but most only had a slight increase except for Mental Health Assessments, which handled one more complaint than last year.

Table 3: Number of Adult Social Care complaints by quarter 2024-25

Team	Q1	Q2	Q3	Q4	Total
Occupational Therapy	0	2	2	1	**5**
Mental Health Assessments	1	1	1	1	**4**
Mental Health Reviews,	1	2	0	1	**4**
Richmond & Barnes Locality	1	1	0	2	**4**
Commissioning & Quality Assurance	2	0	0	1	**3**
Learning Disabilities	1	1	0	0	**2**
Preparing for Adulthood	0	0	1	1	**2**
Financial Assessments	0	0	0	1	**1**

Team	Q1	Q2	Q3	Q4	Total
Financial Payments	1	0	0	0	**1**
Teddington & Twickenham Locality	0	0	1	0	**1**
Access Team	0	0	1	0	**1**
Emergency Duty Team	0	0	0	1	**1**
Reviews	0	1	0	0	**1**
Richmond RRRT	1	0	0	0	**1**
Hospital Social Work Team	0	1	0	0	**1**
	8	**9**	**6**	**9**	**32**

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 2023-24. Delays and lack of support remain top issues, similar to last year. Complaints about finance/charging have increased but are still low, with expected fluctuations in principal concerns each year.

Chart 4: Number of Complaints completed by principal issue 2024-25

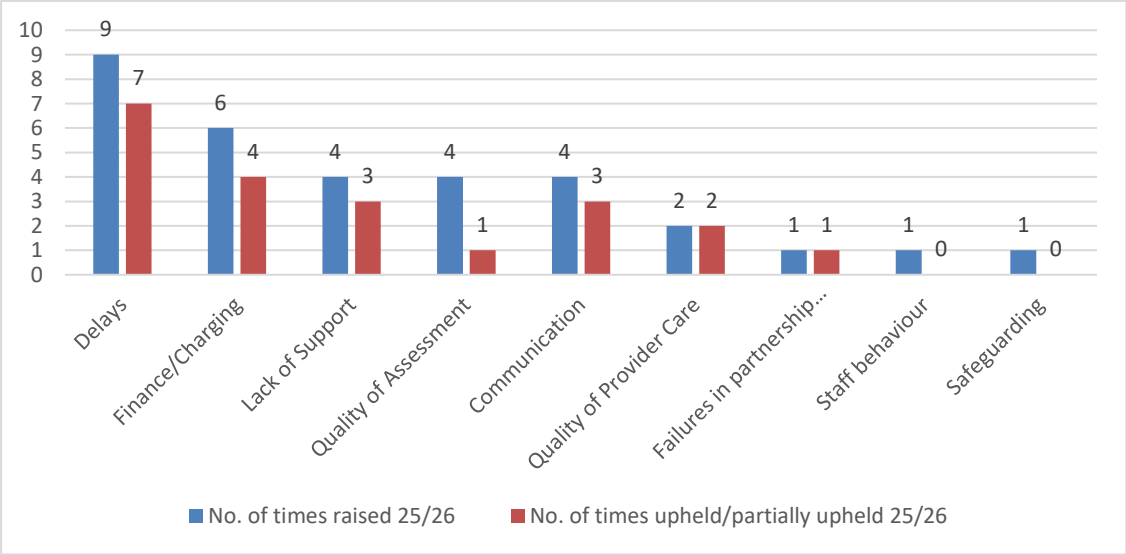
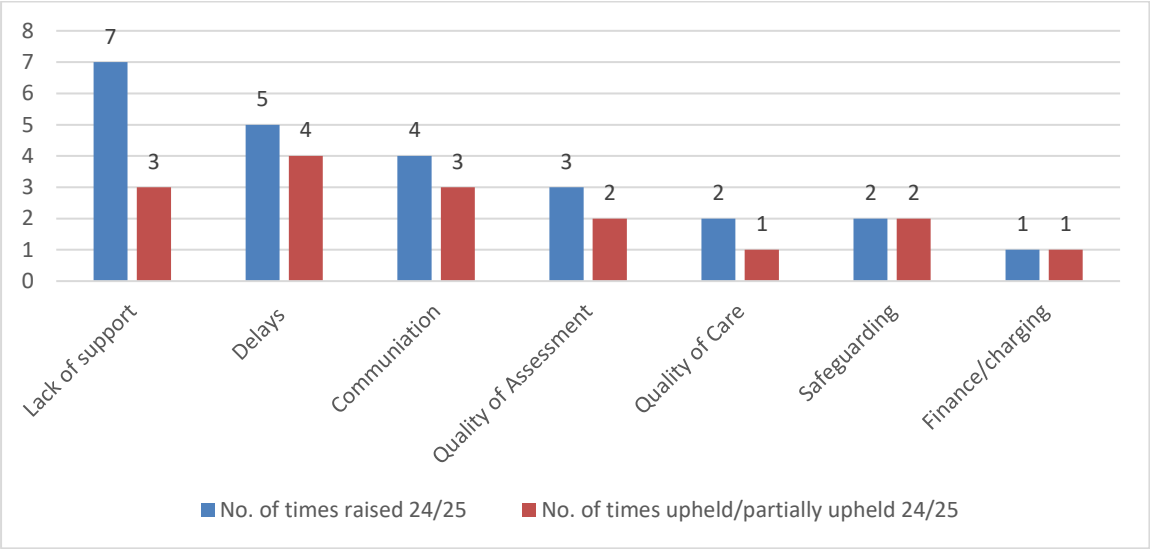


Chart 5: Number of Complaints completed by principal issue 2023-24



8.3 The most common complaint theme is **service delays**, covering equipment provision, assessments, and contact delays. As shown in **Chart 5**, most of these complaints were upheld or partially upheld. Despite the low overall numbers, it's expected that delays would be a frequent issue given the pressures in Adult Social Care.

8.4 Whilst there has been an increase in complaints about **finance/charging**, this issue was raised across a variety of teams. Issues ranged from complaints about care contributions, direct payment uplifts, incorrect charging and disputes about liability for placement costs.

8.5 Whilst many of the issues raised in complaints cross-over, a top-line summary of the 4 most raised principal issues is below:

Delays

- Delays in providing equipment.
- Delays in providing assessments /services following assessment
- Delays in financial processes
- Delays in communication

Finance/Charging

- Disputing financial contributions and care costs, including complaints of a lack of awareness of the need to contribute
- Incorrect charging or disputes about backdated charging
- Financial assessment queries
- Information provided by social care teams on benefits and financial contributions

Lack of Support

- Lack of awareness that social worker support would be removed
- Feelings that preferences for support have not been taken into account
- Perceptions of lack of support for areas outside the responsibility of adult social care
- Requested Reasonable Adjustments not being adhered to

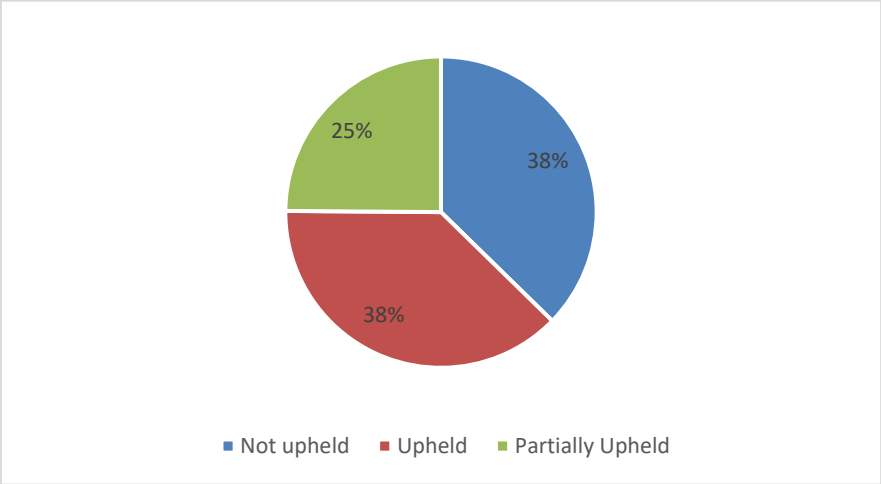
Quality of Assessment

- Unhappy with the amount of support hours provided.
- Disputing decisions within assessments
- Unhappy with the outcome of OT assessments
- Dispute about Disabled Facilities Grant needs

8.6 Other principal issues in complaints have not been analysed in detail due to the low numbers but for the top four issues above, it is important to remember that numbers are low and a certain number of complaints is to be expected.

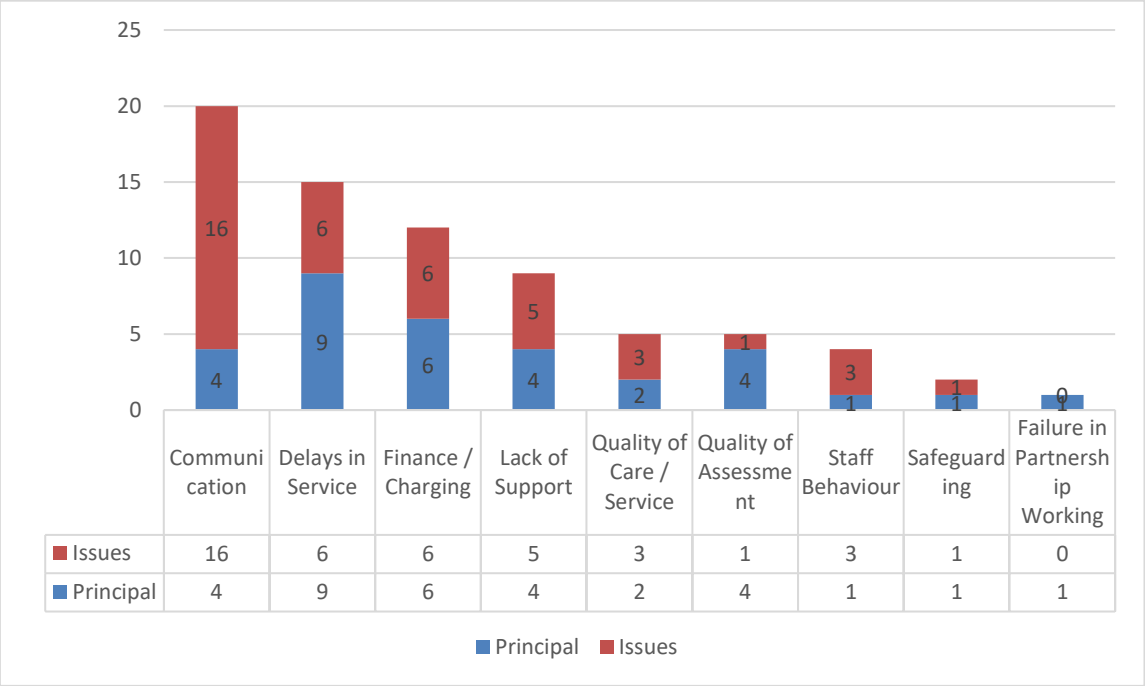
8.7 **Chart 6** below illustrates that most complaints were either upheld or not upheld (37.5% respectively). Where complaints are partially upheld, this means that some mistakes were made but not all the issues or complaints were substantiated.

Chart 6: Number of closed complaints by overall outcomes 2024/25



8.4 Whilst **Chart 4** has set out the principal issues for each stage 1 complaint, **Chart 7** below sets out each issue raised within the 32 stage 1 complaints. Across the 32 stage 1 complaints a total of 73 issues were raised, demonstrating the complexity of adult statutory complaints. This can present a challenge in determining the key motivation for making the complaint, as often issues like communication and delays are a thread through an entire complaint, yet the complainant's desired outcome is to have an assessment amended or a professional decision changed. For example, **Chart 7** demonstrates that whilst communication was raised 16 times, it was only a principal issue within 4 complaints.

Chart 7: Number of Adult Social Care Complaints received by issues 2024-25



Case Study: Improving Transparency and Family Involvement in Section 117 Aftercare Decisions

Background:
The complaint was raised regarding the Richmond Section 117 Panel. This is a multiagency social care and NHS panel that meet to agree after-care services for people that have been discharged from mental health wards. The complainant expressed concerns about the slow decision-making process of the Panel and perceived a lack of transparency and communication. The complainant highlighted the negative impact this process had on their family. They felt that the Panel's decision-making process was slow and negatively impacted their family. They also suggested that the Panel should involve the individual and their family more in the process and provide better information about what to expect. Additionally, the complainant suggested improvements to the Panel processes to ensure better involvement and information for the individual and their family.

Investigation findings:
The Richmond Section 117 Panel was established to support the principles of the statutory guidance on the Discharge from Mental Health Inpatient Settings. The Panel is composed of mental health and social care managers from various organisations and meets once a week to consider funding requests. The Panel's role is to ensure robust decisions around Section 117 aftercare are made jointly between Health & Social Care, make timely decisions based on assessed needs, identify the most suitable and cost-effective placement for the individual, and ensure that personalisation, service user choice, and control are maximized.

The investigation found that the Panel process was not responsible for the delays in discharge. The discharge planning started much earlier in the hospital stay, and the search for a suitable placement was ongoing. The Panel identified concerns about the suitability of the proposed placement and required further information before making a decision. The investigation also found that the social care Section 117 aftercare responsibility had transferred to another borough, which required further discussions and coordination.

Learning:
The complaint highlighted the need for better communication and transparency in the Panel's decision-making process. As a result, the Council has committed to improving the information provided to service users and their families about the Panel's role and the discharge planning process. A factsheet will be created to ensure that patients and their families are better informed. Additionally, the Council will ensure that service users and their families are involved in the ongoing discussions about placement options and that their views and wishes are taken into account.

9. External Care Provider complaints

9.1 The Quality Assurance and Contract Monitoring Team, that 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 Contracts Monitoring Team to inform the wider quality monitoring of services.

9.4 For this reporting year only 4 complaints were completed about care providers compared to 2 last year, and 5 the year before. Of the 4 complaints, 3 were investigated by the Quality Assurance and Contract Monitoring Team; 2 of these were about the equipment service and 1 was about a care provider. The remaining complaint was investigated by the Mental Health Reviews team as it raised several issues about social care support and an issue about the quality of a home care provider.

9.5 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, 127 service concerns were processed by the Quality Assurance and Contract Monitoring Team which is a reduction on the 168 service concerns last year.

9.6 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. Residents who draw on services 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.

Learning Case Study: Improving Community Equipment Delivery
Background

A complaint was submitted regarding the delayed delivery of essential community equipment by the Council's contracted Community Equipment Provider. The equipment was required urgently to support the hospital discharge of the complainant's husband. Despite the order being authorised on time, the equipment had not been delivered by the for several weeks. The complainant also reported being unable to reach the provider by phone or email and expressed concern about the excessively broad delivery window of 8 am to 8 pm.

Investigation findings

It was found that the provider did attempt to contact the person receiving a service but received no response. An urgent delivery was scheduled; however, the technician received no answer at the property and a subsequent delivery was not attempted due to staffing shortages, and the equipment was finally delivered several weeks later. This delay, particularly the missed delivery, led to the complaint being upheld. Additionally, the investigation confirmed that the complainant's difficulty in reaching the provider was due to high call and email volumes across the 21 London Boroughs served by the provider. This part of the complaint was also upheld. However, the concern about the long delivery window was not upheld, as the current contractual arrangement requires the provide to operate between 8 am and 8 pm to accommodate route planning and urgent needs.

Learning
The Council acknowledged the distress caused and committed to service improvements. Feedback on the failings was shared with the provider staff to prevent recurrence. Measures have been introduced to prioritise client communications, with professional enquiries being redirected to separate channels. The Council is also working closely with the provider to enhance resource management, prioritise urgent cases, and improve issue resolution through robust contract monitoring. Looking ahead, there are plans to offer narrower delivery windows to better accommodate clients' schedules and ensure timely delivery of urgent equipment on the first attempt.

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[4]. Also, where complaints have been extended past 25 days,

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

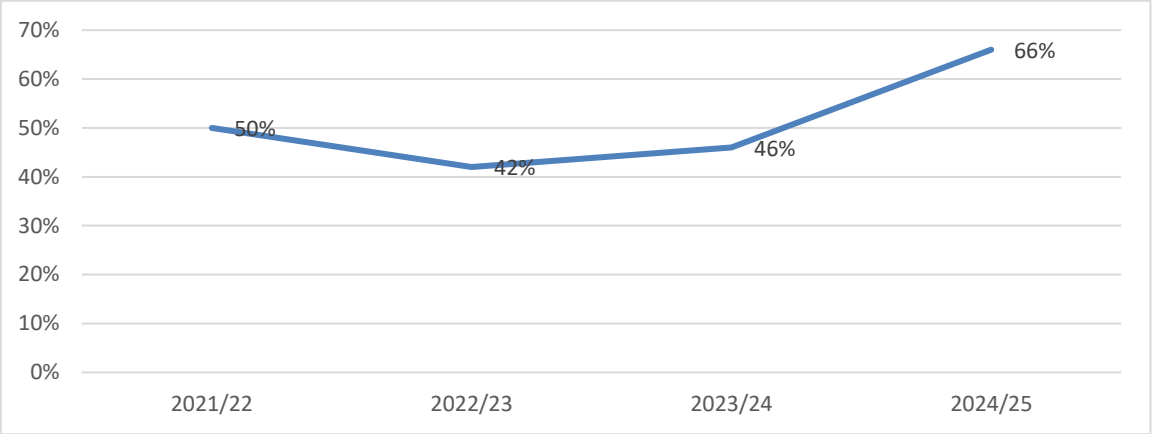
complainants have been consulted throughout and have not raised concerns about delays.

10.2 For this reporting period, Richmond received 32 new complaints but also completed 32 complaints. Timescales were measured for the 32 complaints closed during this year within the 25-day local target.

10.3 Of those, 21 (66%) were closed within 25 working days and 11 complaints (34%) exceeded this timeframe. **Chart 8** details response times for the last four years.

10.4 For the 34% complaints that exceed 25 days, the average resolution time was 35 days, and well within the statutory timeframe. Positively, no complaints exceeded the six-months statutory timeframe this year. 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



Learning Case Study: Improving Practice in Complex Care Coordination

Background

An adult social care complaint was submitted by a family carer who raised concerns about the handling of communication, staff contact, and safeguarding processes following the hospital discharge of their elderly mother. The complainant expressed that delays in responses, uncoordinated visits, and the nature of safeguarding interventions had a detrimental impact on both their and their mother's wellbeing.

Investigation Findings

The investigation acknowledged that there were delays in responding to the complainant's emails, with some responses exceeding three working days. While the volume of communication and staff caseloads were cited as contributing factors, the delay was partially upheld, and an apology was issued. It was also recognised that some correspondence could have been more sensitively worded.

Regarding staff contact, the complainant had requested that communication be conducted via email rather than telephone. Despite this, officers continued to use telephone contact, which caused distress. However, the investigation concluded that the telephone contact was necessary to progress the care assessment and funding application for the mother's long-term support. Therefore, this element of the complaint was not upheld.

In terms of safeguarding, two concerns had been raised by professionals regarding the complainant's insight into their mother's needs and the home environment. These concerns necessitated visits and direct communication. While the process was acknowledged to be intrusive and distressing, the investigation found that the local authority had a statutory duty to act in the mother's best interests. The safeguarding concerns were ultimately closed with no ongoing issues identified.

Learning from the Complaint

This case highlighted the importance of timely, sensitive, and person-centred communication, especially during periods of high stress for service users and their families. The investigation concluded that more effective communication and greater sensitivity could have mitigated the distress experienced. As a result, a case reflection session was scheduled for the involved staff to consider how their actions and processes are perceived by those receiving services. This reflective practice aims to improve future interactions and ensure that professional involvement is both necessary and proportionate, with a focus on minimising distress and maintaining trust. Actions were also taken to remind the social work team for the need for greater professional curiosity.

11. Equalities data and categories of support

11.1 This year 23 complaints were from, or on behalf of, residents of working age; between the ages of 18 and 64. A further 12 complaints concerned complaints made from, or on behalf of older adults (65 and over)[5].

11.2 17 complaints concerned females, and 15 complaints concerned males.

11.3 For the 23 complaints from, or on behalf of, residents of working age (18-64), where known:

- 35% were in receipt of support from mental health services.
- 22% were in receipt of physical support.
- 17% were in receipt of support from learning disability services.
- 13% were in receipt of personal care support.
- 4% were in receipt of sensory support.
- 4% were in receipt of support from learning disability services and SNAS Communication and Interaction.
- 4% were in receipt of physical support for mental health SNAS Communication and Interaction.

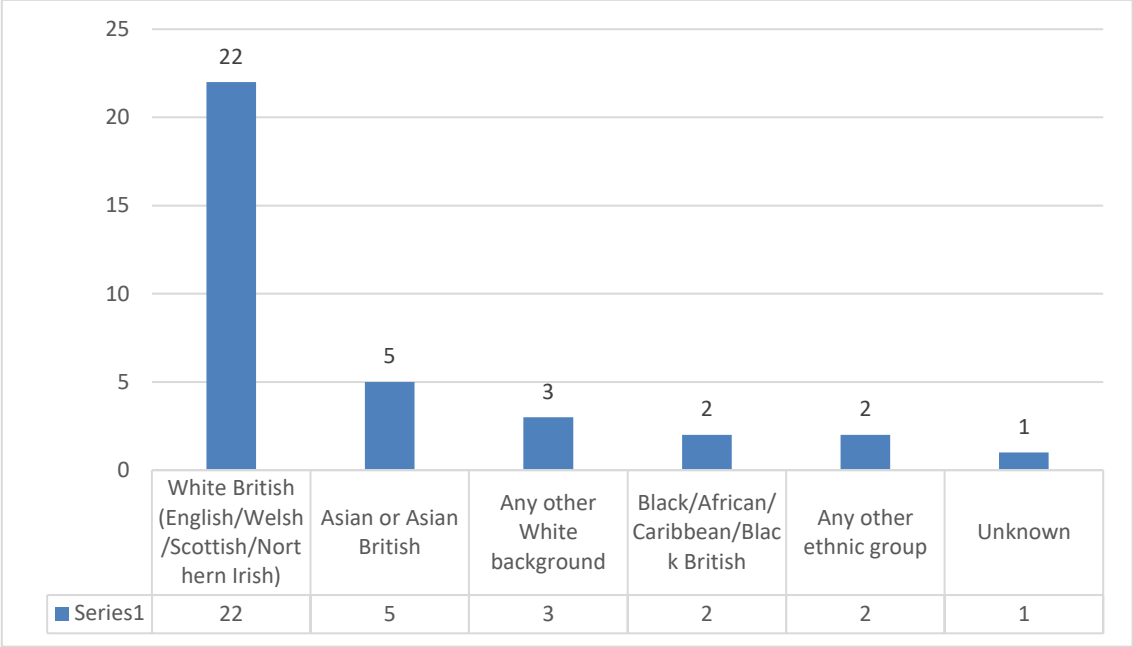
11.4 For the 12 complaints from, or on behalf of, residents in the older adult's category (65 plus):

- 50% were in receipt of personal care support.
- 17% were in receipt of support for access and mobility.
- 17% were in receipt of support for memory and cognition (primary) and personal care support.
- 8% were in receipt of services from learning disability services and social support.
- 8% were in receipt of physical support and sensory support.

11.5 **Chart 9** provides ethnicity data for residents drawing on services who made complaints (or had complaints made on their behalf). The majority were from a White background (71% or 25 people). In Richmond, 83% of Adult Social Care servicers users are from a White background. Black, Asian and Minority Ethnic Groups represent 17% of service users.

[5] 3 complaints include two people crossing both age categories

Chart 9: Richmond Adult Social Care Ethnicity Data 2024-25



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 2024-25.

12.2 Adult Social Care do 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 services.

12.3 This year Adult Social Care completed 6 stage one corporate complaints which is the same as last year. No complaints escalated to stage 2 compared to 3 last year.

12.4 Only 1 of the 6 stage 1 complaints was sent on time. Corporate Complaints have a shorter timescale than statutory complaints, but the complaints can be as complex as statutory complaints and require input from multiple teams. However, it is positive that all of these complaints were fully resolved for the person making the complaint at stage 1 and did not escalate.

12.5 Corporate complaints for Richmond Council are analysed in more detail within the Richmond Annual Corporate Complaints Report 2024-25.

13. Ombudsman Cases

13.1 This report provides a brief overview of Local Government and Social Care Ombudsman (LGSCO) closed by Adult Services. Detailed reporting on Corporate and Ombudsman Complaints is within Richmond Council's Corporate Complaints Report 2024-25.

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 2024/25 a total of 6 LGSCO enquiries and/or investigations were completed for Adult Social Care compared to 8 completed in 2023-24. It should be noted that 4 of the 6 complaints were made by one complainant. None of the 5 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 Of the 6 complaints for Adult Social Care the outcomes/status were as follows:

Table 4: Ombudsman cases by team and outcome

Quarter	Service Area	Subject	Outcome
1	Mental Health Assessments	Perceived lack of support under Section 117 Aftercare	Premature – diverted back to the complaints process
1	Quality Assurance	Standard of care in a care home	Not investigated as the care was arranged by the NHS rather than social care
2	Sensory Team	Unhappy with home visit when contact was requested over the phone	Premature – diverted back to the complaints process
4	Mental Health Assessments	Allegations that property was damaged when it was moved into storage by adult social care	Not investigated as courts are the best place to deal with compensation claims
4	Mental Health Assessments	Allegations that the Council did not offer support to move items out of storage to new accommodation and blocked attempts to complain about the matter	Not investigated as the complainant delayed bringing their complaint to the Ombudsman without good reason
4	Mental Health Assessments	About communication restrictions put in place due to alleged unreasonable behaviour	Not investigated as the Council regularly reviewed the communication restrictions and an Ombudsman investigation would not lead to a different outcome.

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:

- *" Thank you so much for all that you have done over the last few months to help us with [name's] rehabilitation and ongoing care. You have really been a joy to work with and your honest and caring attitude have made a difficult time so much more bearable. I All the very best to you, the Richmond Response Team are very lucky to have you". (RRRT)*

- "[*Name] called and wanted to pass on her sincere thanks for your visit. She said it was such a relief to have had your support and that you enabled them to have a relaxing fun afternoon. She said you have a lovely soothing voice and really reassured her and that you are wonderful!".* (Sensory Team)

- *"[Name} is an absolute rockstar. He communicates clearly and empathetically. He talks and writes like a real human and he even follows-up on his messages when he doesn't hear back. What a shining example for others to emulate". (*Sensory Team)

- "*I want to extend my deepest gratitude to [name] and [name] at Richmond Adult Social Services. Their support for [name] and me over the past year has truly been life-changing, and I am continually grateful for the professionalism, dedication and compassion they bring to their work. Their incredible work has had such a positive impact on [name] and me, and I'm delighted to know that their dedication is being recognized".* (Teddington and Twickenham Locality Team)

- *"[Name] was both kind, understanding and clear about her role as a social worker and fostered a positive, professional relationship with both myself and [name], understanding the challenges of my mother's multiple conditions and the impact they have on her ability to live independently and, indeed, to accurately describe her own challenges. [Name] was always empathetic and delicate while also remaining objective, and acted appropriately and effectively during both [name] CHC assessment and in the months that followed, leading toward the DoLs assessment she is currently in the process of progressing*". (Richmond and Barnes Locality Team)

- "*Thank you for your care towards [name]. You have been a god send in a time of great turbulence and plan. Thank you so very much for all the support and advice you have given us and for linking him with [name] who has been brilliant in terms of housing and*

care provision. Bless you and the team at Richmond, we are very grateful". (Mental Health)

- "[*Name] reported to be extremely grateful for the kindness and respect shown [name] throughout their conversation, and that he greatly appreciates the advice and information she provided at that time. He stated, "It felt like she has known me for years*". (First Contact)

- "*I just wanted to update you and express my gratitude. Your hard work has really improved things for the carers as well, making their tasks much easier now that the sink is unblocked and they can shower her without flooding the flat".* (Occupational Therapy".

15. Key achievements 2024/25

15.1 This year, the Complaints Team has demonstrated a strong commitment to ensuring the council remains fully compliant with the Complaints Handling Code jointly developed by the Local Government and Social Care Ombudsman (LGSCO) and the Housing Ombudsman Service (HOS). Through continuous review and refinement of internal processes, the team has worked diligently to embed the principles of fairness, transparency, and accountability into every stage of complaint handling. Regular training, a new Corporate Complaints Policy, adding complaint handling responsibilities to all new job descriptions, improving induction information on complaints practice, and collaborating with service areas have fostered a culture of learning and improvement. The Complaints Manager also held a session with the Think Bigger Network to look at complaints through the perspective of storytelling, to further embed a positive complaints culture that prioritises listening to our residents. As a result, the council is better equipped to respond to complaints effectively and in line with national standards, reinforcing public trust and driving service excellence.

15.2 This work led to the Complaints Team being honoured with the Team of the Year award at the December 2024 Staff Awards for exemplifying the organisational value of Leading By Example. This value recognises that leadership is not confined to roles or titles - it's about stepping up, taking responsibility, and setting a standard that others aspire to. Throughout the year, we consistently demonstrated dependability, professionalism, and a commitment to continuous improvement. We tackled complex and sensitive complaints with empathy and integrity, supported each other and staff through challenging cases, and proactively refined processes to improve outcomes for residents. Beyond our own performance, we played an important role in supporting services across the organisation to improve their own complaint handling. Through tailored guidance, collaborative briefings, and constructive feedback, we have helped further embed a culture of learning and accountability, enabling services to respond more effectively, robustly, more confidently and compassionately to residents' concerns.