Appendix 4 - A few examples of complaints that have lead to us putting things right and improving our services:-

- A family member raised a complaint after a service user passed away and a joint investigation was instigated by KMPT to look into the circumstances. The complaint investigation by the Approved Mental Health Professionals (AMHP) Service concluded that there had been a delay in a record being shared with the service user's GP following an assessment. As a result, a corrective action to ensure that the AMHP team send reports to GP within 72 hours of completion was implemented. It was also agreed that the content of these reports would be reviewed to ensure that the information shared with GPs is clear, concise and accurate.

- A complaint investigation acknowledged that there was a breakdown in communications between the Promoting and Supporting Independence Team and the service user, in part because they had experienced a change of allocated worker three times over a relatively short period. The team reviewed their procedures in consideration of the need for service users to have continuity during the assessment and placement process. As a result, the team instigated a 'buddy' system for their social workers to ensure consistency, so if a member of staff is unavailable the client is able to speak with another team member who is familiar with their case.

- A complaint raised delays in progressing care plans due to the absence of the allocated worker and this absence resulted in a breakdown of communication and a delay in care provision being arranged. This led to the Lifespan Pathways 26+ Management Team being reminded to review and reallocate outstanding work when a member of staff is absent for a length of time.

- The restrictions instigated by the government as a result of the Covid-19 pandemic triggered a great many changes in the way in which Adult Social Care worked, particularly during the height of the restrictions during the summer of 2020. Many people we support and their families were understanding of the need for the changes, this ranged from staff working from home resulting in most care needs assessments and reviews being conducted virtually via telephone or video call, to the temporary restrictions and sometimes closure of services across the county. There were, however, a number of complaints received which, again, related to the communications people received, or did not receive, about these changes, which ultimately meant that they were not provided with realistic expectations or the information they required to make informed choices.

- In a complaint, a service user raised that they were not aware that a telephone call from the social care team was being conducted as a formal review of his care needs in place of a face-to-face visit. Following this complaint, staff were reminded to ensure that service users were made aware that a formal review was taking place, even if it is happening by telephone rather than in person.

Appendix 4 - A few examples of complaints that have lead to us putting things right and improving our services:-

- Many complaints and enquiries were received from the parents and carers of people with learning disabilities who usually attend day care centres. Under varying government guidelines, day services were at times closed and at others restricted, in order to comply with the guidance around social care 'bubbles' and to reduce the risk of infection to service users. The lack of communication was the principal issue within these complaints as service users and their families generally felt they were not informed of what was happening with their services and why.

- Alongside communication issues, disputed charges are one of the other main themes of complaints that are received by Adult Social Care. Communication often plays a part in these complaints also, both between the Council and service users, and with our partners. Several complaints during 2020-21 related to incorrect fees being applied to someone's accounts due to miscommunications between service providers and the Council when services were not supplied according to the usual schedule. For example, a break was not recorded on the client record system for a someone who was admitted to hospital, which led to them being charged in error for services they did not receive.

- There were also some cases where there was confusion around the temporary funding provided by the government under Covid-19 measures for residential care. One person was not informed that the funding had ceased until receiving a letter stating the charges would be backdated for nearly a month. The backdated charges were waived as a result of the complaint, which highlighted the need to ensure that charging letters were sent out in a timely way to ensure transparency.

- Numerous cases raising concerns about the way in which KentCare Invoices are presented led to a review of these which is still underway. A Governance Group meets on a regular basis to discuss the progress of the current changes. These include adding a current cost of care to the invoice to make this more transparent and providing a front summary sheet in a larger font. The team are also looking to work closely with a range of citizens in receipt of care over the next few months to better understand and develop the KentCare Invoice content further.