# What complaints can teach us about better care and better commissioning

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Complaints usually begin because something has gone wrong. But they can also tell us where systems are repeatedly falling short, what could have prevented those failures and what providers, commissioners and government need to do differently.

Care England has been working with the Local Government and Social Care Ombudsman (LGSCO) to make its published decisions and wider learning more accessible and useful to care providers. Its 2025-26 Annual Review, published today, records 3,938 adult social care complaints, a 22% increase on the previous year. Of the complaints investigated, 77% were upheld, while organisations complied with 99.8% of the Ombudsman's recommendations.

As part of that work, we reviewed almost 450 published complaint decisions featured in the Ombudsman's adult social care bulletins between June and August 2026. The purpose was not to create a league table or to name and shame individual organisations. We wanted to understand what these cases, taken together, were telling us.

What we found matters to providers, but it also points to wider issues around assessment, commissioning, funding, communication and whether the system can turn assessed need into actual care.

## The provider picture: smaller, but important

Only a relatively small proportion of the decisions we reviewed directly concerned independent care providers. Where provider fault was found or acknowledged, however, a consistent set of themes emerged.

Poor communication was common. Families were not always told promptly when incidents happened or when a person's condition changed. Complaint responses sometimes failed to explain what had happened or what the organisation had done as a result.

Care planning and record keeping also repeatedly featured. In some cases care had not been delivered in accordance with the agreed plan. In others, incidents or decisions had not been recorded sufficiently well to demonstrate what happened. Medication administration and escalation of deteriorating health appeared in a smaller number of higher-risk cases.

Financial administration also featured, including charges for care that had been cancelled or not received and inadequate explanation when the cost or structure of a care package changed.

The themes from our review closely match the Ombudsman's annual findings, which highlight delay, poor communication and insufficient record keeping as recurring issues across adult social care.

There is also a positive lesson.

An upheld complaint does not necessarily mean an organisation got everything wrong. Some cases were upheld only in part. In others, providers had already recognised the fault, apologised, offered a remedy and changed their practice before the Ombudsman became involved.

The Ombudsman's own case studies make clear that organisations are not expected never to make a mistake. What matters is how they respond when something goes wrong: acknowledging the problem, explaining it honestly, apologising where appropriate, putting things right and taking proportionate steps to prevent it happening again.

For providers, much of the learning is practical and preventable: keep care plans current, make sure the care delivered reflects assessed needs, record incidents and decisions properly, communicate with families, have clear clinical escalation processes, explain changes in fees or care clearly, and make complaint routes and escalation arrangements easy to understand.

Good complaint handling is not an admission of organisational failure. Done well, it is evidence of a learning organisation.

## When the provider is not the source of the problem

Most of the intelligence we reviewed, however, concerned local government.

That gives care providers another role which can easily be overlooked.

Providers are often the people closest to the individual receiving care. They may therefore be the first organisation to see that an assessed package is no longer sufficient, that a council review has been delayed, that funding has not followed a change in need, that a family has received an unexpected bill, or that responsibility is being passed between different parts of the health and care system.

Providers cannot and should not become legal representatives for every person they support. They can, however, identify the warning signs.

A provider can document that someone's needs have changed, evidence that the current package is no longer meeting those needs, request a review, provide records to support a family challenging a decision and ensure that the person understands where an unresolved complaint can be taken.

This matters most when people and families are caught between organisations.

The Ombudsman has highlighted cases where people were incorrectly directed towards CQC when an unresolved individual complaint should have been signposted elsewhere. CQC has an essential regulatory role, but it does not resolve individual complaints in the same way as the Ombudsman. Getting that distinction right can prevent individuals and families reaching a dead end.

Providers can therefore play an important role not only in preventing their own complaints but in helping people secure the accountability and redress to which they are entitled elsewhere in the system.

## Assessed need must remain purchasable

One of the strongest recurring issues in the decisions we reviewed was a gap between what somebody had been assessed as needing and what the funding or commissioning arrangement could actually purchase.

The principle is straightforward.

A statutory assessment should not become an abstract description of need. Where a council has assessed that a person requires a particular level of care and support, the commissioning and funding arrangements must be capable of securing it.

One Ombudsman decision shows particularly clearly what can happen when that does not happen. Although the case concerned a community-based package rather than residential care, the principle applies much more widely.

The council had assessed that the person required 61 hours of support each week. The established provider subsequently increased its hourly rate. Both the family and provider repeatedly alerted the council to the resulting funding gap.

The assessed need did not change. The funding did.

Eventually, the available funding purchased only around 48 of the 61 hours which the council itself continued to assess as necessary. Debt accumulated and the individual was left at risk.

The Ombudsman concluded that once the council knew the existing rate could no longer secure the assessed support, it should have acted. It could either have identified a suitable alternative service able to meet the assessed need within the available funding or increased the rate so that the necessary care could continue. It did neither. The remedy included changes to the council's approach, including planned annual rate reviews and stronger escalation where cost changes threatened care delivery.

That is a much bigger issue than a disagreement between a provider and commissioner about price.

> ***What happens to the person when the care and support a council has assessed as necessary can no longer be purchased at the commissioning rate?***

The Ombudsman case demonstrates the possible consequences: reduced care, debt, loss of continuity and risk of harm.

## Residential top-ups illustrate the same principle

The same issue can arise in residential care.

A top-up is legitimate where a council can identify suitable accommodation that can meet the person's assessed needs within the available personal budget, but the individual or family chooses a more expensive option.

It is quite different where no suitable placement is actually available at the council's rate.

In one upheld case, a council had not demonstrated that there was a suitable alternative placement available within the person's personal budget but nevertheless treated the difference between its usual rate and the care home fee as a top-up.

The Ombudsman found fault. The Care Act framework requires the council to ensure that at least one suitable and available option can meet the person's assessed needs within the personal budget before a top-up is required simply because a more expensive placement has been chosen.

For providers and families, that creates an important question whenever a top-up is proposed:

> ***What suitable placement, capable of meeting the person's assessed needs, is actually available at the council-funded rate?***

If there is none, the issue may not simply be whether the family can afford the difference. It may be whether the personal budget itself is sufficient to purchase the assessed need.

## Funding needs to move when costs and needs move

Care England hears regularly from providers about commissioning rates and annual fee uplifts being agreed well after the costs to which they relate have already taken effect.

This is especially significant in a workforce-intensive sector.

The National Living Wage increased to £12.71 from 1 April 2026, a statutory 4.1% increase. Providers were required to pay that increase from 1 April; the obligation does not wait for local fee negotiations to conclude.

Care England's own work has repeatedly identified delayed fee uplifts, placements that no longer reflect the cost or complexity of care being provided and a wider mismatch between statutory cost increases and commissioning income. Previous sector survey evidence found that the majority of responding providers did not receive local-authority fee increases sufficient to cover the increase in the National Living Wage.

The Ombudsman decisions do not, by themselves, show how widespread delayed annual fee uplifts are nationally. What they do show is the potential consequence when funding does not keep pace with the cost of meeting an assessed need.

This is why commissioning rates cannot be treated solely as a commercial issue between councils and providers.

If an inadequate or delayed funding decision means the assessed package can no longer be delivered, it becomes an issue about the person receiving care.

## Commissioned care: understanding where responsibility sits

The Ombudsman decisions also show how commissioned care can blur where responsibility sits.

Sometimes the original failure occurred within a provider: care was not delivered as agreed, a family was not properly informed, medication processes failed or records were inadequate. Because the council had commissioned the service, however, the council remained accountable for ensuring the person's needs were met.

In other cases, provider failure was compounded by commissioner failure. A care problem might occur within a service, but the council then failed to follow through safeguarding concerns, monitor whether commissioned hours were actually being delivered, properly communicate the outcome to the family or identify recurring concerns through its contract-management arrangements.

There were also examples where provider care itself was not found to be at fault, but the council's subsequent complaint handling was.

Keeping those responsibilities clear matters.

We should not assume that every Ombudsman finding against a council means council staff caused the original care failure. Nor should commissioning care externally remove the council's responsibility to understand whether the service it has purchased is delivering the person's assessed outcomes.

The learning has to work in both directions. Providers need sound governance, accurate records and clear escalation. Commissioners need visibility, responsive contract management and systems that identify when the package they are purchasing is no longer working.

## Local failings can also reveal national pressures

Repeated Ombudsman findings about delayed assessments, reviews, safeguarding, funding decisions and commissioned care cannot always be explained simply by saying individual councils need to perform better.

In some cases, that will be part of the answer.

But the wider evidence also raises a harder question about whether similar failures across different councils reflect wider structural pressure.

ADASS reported in its 2026 Spring Survey that councils had overspent adult social care budgets by £715 million and that more than 400,000 people were waiting for an assessment, care and support, a direct payment or a review. More than half of directors reported only partial or no confidence in their ability to meet safeguarding duties.

The Local Government Association has separately estimated that councils face a £7 billion funding gap by 2028/29, with adult social care among the largest sources of additional cost pressure. Its modelling identifies almost £5.8 billion of additional adult social care cost pressure by 2028/29 compared with 2025/26.

These figures do not excuse maladministration and they do not prove that funding caused any individual Ombudsman finding.

They do, however, justify asking a wider question.

> ***If different councils are repeatedly experiencing similar problems around assessment, review, sufficient funding, safeguarding capacity and securing appropriate care, are***

> ***we seeing isolated administrative failures or the consequences of a system being asked to deliver statutory duties without sufficient capacity and funding?***

That question should concern central government as much as individual councils.

## Turning complaint intelligence into prevention

Ombudsman decisions are useful for more than identifying who was at fault.

Their wider value is in helping prevent the same problems from happening again.

For providers, there are some immediate checks:

- Is the current care plan still aligned with the person's needs, and can we demonstrate that the commissioned package is sufficient to deliver it?
- Are significant incidents, changes and decisions recorded and communicated properly?
- When needs increase, are we escalating this formally rather than quietly absorbing additional care?
- If funding no longer purchases the assessed level of support, have we documented the risk and asked the commissioner to review it?
- When a family is asked to pay a top-up, is there actually a suitable council-funded alternative available?
- Are complaints dealt with candidly, promptly and with clear evidence of what has changed?
- Where the problem lies elsewhere in the system, are we helping the person and family understand how to challenge the decision and where they can obtain independent redress?

For commissioners, complaint intelligence can identify where assessment, financial decision-making, safeguarding, commissioning oversight and complaint handling require improvement.

And for government, recurring patterns can reveal where the answer cannot simply be another request for councils and providers to improve their processes. If the available funding cannot purchase assessed need, or statutory costs take effect months before commissioning income catches up, the remedy may need to sit at national level.

## Continuing the conversation

Care England will continue working with the LGSCO to turn complaint intelligence into practical learning for providers and commissioners.

That includes making published decisions easier to understand, identifying recurring themes, helping providers get the basics right and making it clearer when an issue needs to be escalated beyond the provider.

It also means using that evidence constructively with government where local failures appear to point to wider structural pressures.

The aim is not to generate more complaints for the sake of it, or to shield organisations from legitimate challenge.

It is to make sure that when something goes wrong, people are heard, problems are resolved earlier, organisations learn from them and the same preventable failures are less likely to happen again.

**The LGSCO team will be at the Care Show on stand B17. Providers with questions about complaint handling, escalation, signposting, commissioned care or the Ombudsman's role are encouraged to go and speak to the team.**

> ***Complaints tell us where the system has failed one person. Used properly, the learning from them can help stop it failing the next.***