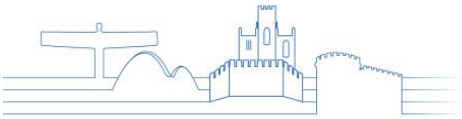
Northumberland
County Council

In partnership with



NHS
North East and
North Cumbria

Complaints Annual Report 2023-24: Adult Social Care and Continuing Health Care Services

- **Adult social care**
- **Continuing health care (CHC) services**

Contents

1.0 Introduction

1.1 **This 'Complaints Annual Report' report covers adult social care and the NHS responsibilities for continuing healthcare (CHC) and related services which the Council delivers under a partnership arrangement with North East and North Cumbria Integrated Care System.**

1.2 **The report describes what people have said about our adult social care services in Northumberland and what we have learned as a consequence during 2023/24. The report also describes what people have said about NHS continuing healthcare funded by North East and North Cumbria Integrated Care System and about supporting people in their own home or in a care home.**

1.3 **This report emphasises our approach to listening and respecting all feedback offered, valuing each individual's perspective on the care they receive, and resolving issues raised by people in Northumberland. It also explains in the appendices the custom and practice in complaint handling which have evolved to meet the requirements of the national regulations as well as providing some equalities information.**

1.4 **Complaints about adult social care and health care are handled under a single set of national regulations introduced in 2009. These regulations emphasise that complaints should be approached positively as opportunities for learning, as well as providing a means by which people can ask the organisation to address the specifics of poor services or bad decisions which affect them individually.**

2.0 Adult social care and CHC complaints – 2023/24

2.1 **The complaints service directly handled all the social care and continuing healthcare complaints made to Northumberland County Council. Please note that some complaints closed were carried over from 2022/23 and some complaints received in 2023/24 will carry over into 2024/25. The table below notes the numbers of complaints received in 2023/24 and the previous two years:**

Complaints received	2021/22	2022/23	2023/24	Trend
Adult social care	55	43	66	⇧
CHC	2	2	5	⇧
Total	57	45	71	⇧

2.2 **Over the past year we have seen an increase in the number of complaints being made. Analysis suggests that the increase in complaints is the result of more people wishing to complain in the first instance. However, please note the findings in section 2.5 below. To give an idea of scale, the number of complaints received should be set against a total number of service users and carers open to adult social care of around 7,000 and 2,000 respectively.**

2.3 **The table below notes the numbers of complaints responded to in 2023/24 and the previous two years:**

Complaints responded to	2021/22	2022/23	2023/24	Trend
Adult social care	55	28	75	⇧
CHC	1	2	6	⇧
Total	56	30	81	⇧

ADULT SOCIAL CARE COMPLAINTS

2.4 **The table below shows the outcomes from the responded to adult social care complaints, whether upheld, not upheld, or partly upheld. The CHC complaints data follows later from section 2.17.**

Complaint outcomes	2021/22	2022/23	2023/24	Trend
Upheld	14	7	19	⇧
Not upheld	19	10	33	⇧
Partly upheld	19	10	20	⇧
Other outcomes	3	1	3	⇧
Total	55	28	75	⇧
Upheld and partly upheld combined	33	17	52	⇧

2.5 **The table below shows the above information as a percentage. In general terms, we find that most complainants have a point, sometimes an important one. Partly upheld complaints will have at least one element that is upheld and other element(s) that are not upheld. Please note the decrease in partly upheld complaints and also upheld and partly upheld complaints combined. Analysis suggests this decrease is related to more people wishing to use to use the complaints process in the first instance, which is their right, rather than less formal routes. Over 2023/24, 'other outcomes' refers to two complaints that were withdrawn following rapid intervention by the relevant manager, and a complaint that was 'not determined' (the available evidence was limited and didn't allow a conclusion to be drawn).**

Complaint outcomes	2021/22	2022/23	2023/24	Trend
Upheld	25%	25%	25%	⇨
Not upheld	35%	36%	44%	⇧
Partly upheld	35%	36%	27%	⇩
Other outcomes	5%	3%	4%	⇧
Upheld and partly upheld combined	60%	61%	52%	⇩

2.6 The table below shows the complaints responded to by service area. Care management continues to receive the most complaints, which is to be expected in the context of the number of service user contacts for that service area, although the number of complaints remains low compared to the work done which suggests that staff get things right most of the time.

Service area complained about	2021/22	2022/23	2023/24	Trend
Adult social care teams	33	16	35	⇧
Community substance abuse	1	0	0	⇨
Complaints team	0	0	1	⇧
Finance team	2	0	9	⇧
Home improvement service	3	4	0	⇩
Home safe	1	2	11	⇧
Independent provider	10	3	10	⇧
In-house provider	0	0	0	⇨
Occupational therapy	1	2	3	⇧
Northumberland Communities Together	1	0	0	⇨
Onecall	0	1	0	⇩
Risk & Independence	0	0	1	⇧
Safeguarding adults' team	1	0	1	⇧
Self-directed support team	1	0	0	⇨
Senior management	0	0	1	⇧

Short term support service	**1**	**0**	**2**	⇧
Telecare	**0**	**0**	**1**	⇧
Total	**55**	**28**	**75**	⇧

2.7 **The complaints involving home safe service relate to hospital discharges. Some concerns have been raised around communication, notably around the reablement service, and the costs of residential care following discharge. However, it should be noted that 9 of the 11 complaints about home safe were not upheld, which reflects positively on the ongoing audit programme within this service.**

2.8 **The complaints involving independent providers were about the standard of service provision or quality of care. On more than one occasion the contracts & commissioning team carried out an unannounced visit to ensure actions had been implemented. Improvement plans were put in place and support provided by the local authority.**

2.9 **Most complaints relating to the finance team involved charging, for example, when a service user had died and the subsequent communication with the family. Please note, the finance team rely on the adult social care records being accurate and up to date, and if this is not the case, incorrect or insensitive communication can be sent out. For this issue to be resolved, analysis suggests that the interface between adult social care operational staff and the finance team is crucial, and a review has been requested to determine if any other improvements can be made. Of the 9 complaints around the finance team, 8 were partly upheld or upheld. Actions have been taken and individual staff members have been supported to improve practice. There is also evidence that the issues were discussed with the whole of the finance team, and checklists created.**

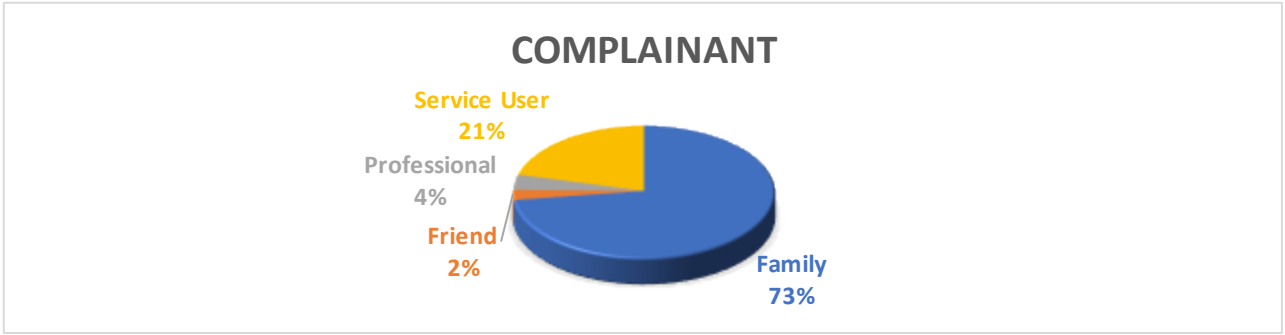
2.10 **The subject matter of the complaints responded to is shown in the following table:**

Subject matter	2021/22	2022/23	2023/24	Trend
Adaptations & equipment	**0**	**0**	**0**	⇨
Attitude or conduct of staff	**4**	**2**	**6**	⇧
Communication / information	**15**	**6**	**15**	⇧
Contact arrangements	**0**	**0**	**0**	⇨

Disagreement with assessments / reports	**1**	**0**	**3**	⇧
Disagreement with decisions	**7**	**3**	**8**	⇧
Failure to follow procedure	**2**	**1**	**8**	⇧
Failure to meet needs	**0**	**0**	**1**	⇧
Finance / funding	**6**	**1**	**8**	⇧
Services not in place	**0**	**1**	**3**	⇧
Speed or delays in service	**3**	**0**	**4**	⇧
Standard of service provision	**17**	**14**	**19**	⇧
Total	**55**	**28**	**75**	⇧

2.11 **Key areas relate to 'communication' and the 'standard of service provision'. Please note that concerns around charges are an underlying issue for many people; and in this context, complaints about service provision are not unexpected, especially when analysis suggests people have, quite rightly, high expectations of services, and are expected to contribute (more) towards the cost of their care.**

2.12 **Over 2023/24, complaints were raised either by the service user, family members, friends, or professionals as follows:**



2.13 **Of the complaints made by service users, 35% were around assessments and care planning, in contrast to family complaints where these related to 37%. The other categories of complaints raised by families which were relatively high, 22% in relation to quality or standard of service and 20% in relation to finance or funding.**

2.14 **The complaints raised by professionals were in relation to failure to follow procedures, attitude or conduct of staff, and the standard or quality of service provision.**

2.15 **In general, complaints involving adult social care community teams related to assessments and care planning at 38%. These involved disagreement with assessed needs, delays in assessing needs, service users' expectations being raised, and services not put in place before transferring roles. Some complaints were around poor communication, delays in sourcing care resulting in additional costs to the service user, and relevant paperwork not being completed**

2.16 **What these complaints tell us is addressed in the section on learning.**

CHC COMPLAINTS

2.17 **In respect of CHC complaints, these remain low because significantly fewer clients are CHC funded than social care funded. The table below shows the outcomes from the complaints responded to, whether upheld, not upheld, or partly upheld, over the past three years.**

Complaint outcomes	2021/22	2022/23	2023/24	Trend
Upheld	0	0	1	⇨
Not upheld	0	1	3	⇧
Partly upheld	0	1	2	⇧
Other outcomes	1	0	0	⇩
Total	1	2	6	⇧
Upheld and partly upheld combined	0	1	3	⇧

2.17 **What this data tells us is addressed in the section on learning.**

2.19 **The table below shows the CHC complaints responded to by service area.**

Service area complained about	2021/22	2022/23	2023/24	Trend
Adult social care teams	1	1	3	⇧
Home Improvement Service	0	0	2	⇧

Nurse assessment team	0	1	1	⇨
Total	1	2	6	⇧

2.20 The following table shows the subject matter complained about for CHC complaints as a number:

Subject matter	2021/22	2022/23	2023/24	Trend
Attitude or conduct of staff	0	1	0	⇩
Communication / information	0	0	1	⇧
Disagreement with assessments / reports	0	0	1	⇧
Disagreement with decisions	1	0	1	⇧
Failure to follow procedure	0	0	0	⇨
Failure to meet needs	0	0	1	⇧
Finance / funding	0	0	1	⇧
Services not in place	0	0	0	⇨
Speed or delays in service	0	0	0	⇨
Standard of service provision	0	1	1	⇨
Total	1	2	6	⇧

2.21 What complaints tell us is addressed in the section on learning.

3.0 Learning from the people who use our adult social care services

3.1 **Many of the issues have been reported over 2023/24 reflect the kind of situations which can occur from time to time in a large care organisation, but we take each one seriously, and take steps to address both the individual situation of the complainant and any wider issues about systems, training and guidance which are raised, as the table below describes in general terms.**

Key Themes	Responses to upheld complaint
Delays e.g. to arranging a service, appointment, or assessment	**Set up service, appointment or assessment at the earliest practicable time and apologise.** **Issue addressed through individual or team supervision as appropriate.**
Communication e.g. lack of response to phone calls	**Apology given.** **Ensure individual and team, as appropriate, comply with existing communication policy.** **Individual supervision and training as appropriate.**
Staff attitude e.g. failure to handle a difficult situation sensitively	**Apology given.** **Issue addressed through individual or team supervision and training as appropriate.**
Quality of service provision e.g. treatment which caused poor outcomes or homecare provision that was of poor quality	**Apology given.** **On-going monitoring and review of service quality.** **Service review through contract team and/or operational management.**
Questions about the information in reports or assessments	**Factual errors are amended, text clarified as appropriate, and explanations given about outcomes and conclusions.**
Processes – especially financial, legal, and poorly understood assessment processes	**Restitution/refund or waiving of charge if appropriate.** **Emphasis on explaining matters.** **Review any financial arrangements to make sure that they are correct.**

	Advice/signposting especially in respect of court matters and how adult social care work relates to this. **On-going monitoring of effectiveness of processes.**

3.2 Where complaints have been resolved relatively quickly and satisfactorily the common factor is the most appropriate manager making early contact with the complainant, often face to face, and taking prompt action to resolve matters. It is important to listen and to acknowledge people's experiences; and to apologise as appropriate.

3.3 Listening to the views and experiences of the people who use our services and of carers is extremely important, but what is more important is how we respond to this.

3.4 The following section provides a selection of 'thumbnail' portraits by subject matter in the key areas for complaints responded to over 2023/24; specifically, 'Communication/information', 'Disagreement with assessments/reports', 'Disagreement with decisions', 'Finance/funding', and 'Standard of service provision'. The 'thumbnails' illustrate the variety of complaints received and the actions taken to resolve complaints and improve services where they were upheld, or party upheld.

3.5 Communication/information:

a. Finance team
After the service user had passed away, a family member complained about the outstanding charges when they believed everything had been paid. On investigation, it was found that the family member had taken over responsibility for managing the service user's finances after their partner had died. It was also found that the service user's financial position had changed as a result. Unfortunately, the finance team hadn't written to the family member about this, nor had the team changed the amount that taken after a rise in charges. These omissions resulted in some outstanding charges, which were reduced on review to take into account only the increase in the service user's income over the period in question, and not the increase in charges. An apology was given for the team's mistakes, and assurances given that steps had already been taken to prevent recurrence.

b. Home safe
A family member complained to the NHS about the discharge arrangements for the service user. Some elements of the complaint were for the home safe service who found that the assessment and discharge processes that they were responsible for were correctly followed. However, an apology was given for any misunderstanding about home safe's role, and this was clarified as part of the response, a key point being that the service does not decide who is discharged, this function sits with the NHS.

3.6 Disagreement with assessments/reports

a. **Homesafe**
A family member complained that the service user hadn't been assessed as having nursing needs when the family had been asked to look for a nursing home. On investigation, it was found that the service user didn't have health needs above the level that a residential placement in a care home would be expected to meet, and this advice was given to the family. However, subsequently, there was a deterioration in the service user's health, and the ward staff informed the social worker that nursing care would now be required, and this information was then shared with the family.

b. **Risk & Independence**
A family member complained about the decision to remove the service user's 1:1 care after which they had fallen. On investigation, it was found that the social worker reviewed the records, spoke to the care home staff, and to the service user who did not want the 1:1 care, before concluding her assessment. However, the social worker did not consider or assess the service user's mental capacity when the records suggested reason to doubt this; nor did she speak to the family. An apology was given for the mistakes in this case, and the social worker was supported to improve their practice. Also issues around risk were discussed I the response letter, suggesting that even with 1:1 support, a fall may not have been preventable.

3.7 Disagreement with decisions:

a. **Care & support**
A deaf service user complained that a visit was arranged with a family member as British Sign Language interpreter when they preferred an independent interpreter. On investigation, it appears that the care manager didn't follow the guidelines although she did ask the service user if there was anyone who was able to support her with BSL. However, as the conversation developed, it appears that the care manager did not confirm whether they had a preferred interpreter and instead she concentrated on the plans to assess the service user's needs and used a family member to interpret. An apology was given, and the care manager was reminded about the importance of following process. A new assessment was offered and accepted but with an interpreter of the service user's choice.

b. **Mental health**
A service user complained that they had not been given an increase in hours as agreed in a review. On investigation, it was found that following reports that the service user was struggling with their mental health, that the team manager asked the duty team, in the absence of the allocated key worker, to arrange a home visit to review the situation. The investigation found that a member of the duty team had visited and suggested an increase in hours; then that team manager had reviewed the proposal and requested further information, including evidence of what other alternatives had been explored, and an analysis of risk. The outcome was that the service user did not need the degree of increase that the member of staff had originally suggested, and apology was given for raising the service user's expectations. The member of the duty team was also supported to reflect on their involvement in this case with a view to improving practice.

3.8 Finance/funding

a. Finance team
A family member complained that the recently deceased service user's 'final account' letter had been sent his wife, who had predeceased him. On investigation, it was found the service user's wife had been his financial agent (the person with whom the finance team corresponds) but on her death, the records had not been updated. An apology was given, and relevant staff reminded about the correct process for closing 'involvements'. The finance team also added in a second check before a 'final account' letter is issued.

b. Mental health
A family member complained that an invoice for the service user's one day/week of daycare was incorrect, with additional care added which he had not received. On investigation, it was found that the social worker was new in post and that he had tried to input the care package onto the system instead of delegating to the admin team, as would be expected. As a result, 5 units of day care were entered rather than 2 units. A full day at a day centre is 5 hours but 1 unit is a morning or an afternoon session at a day centre, so 2 units (1 day) should have been entered, not 5 units (2½ days). An apology was given, and the social worker reminded about the process he should follow. The system and invoice were corrected.

3.9 The standard of service provision

a. Care & support
A family member complained about the way a case had been handled, leaving the service with an inadequate care package leading a community-based nurse to arrange a readmission. On investigation, it was found that the care plan wasn't adequate from the outset, for example, it didn't address how the service would be able to take his medication or whether his preferred provider would be able to meet his needs. There was too much reliance on what the service said he was able to do, and the social worker didn't ask for consent to consult with the family. In addition, mental capacity wasn't formally considered, and the final assessment document didn't meet the expected standard. Apologies were given for the faults found and the member of staff was supported them to improve their practice.

b. Independent provider
A family complained about the standard of care provided by the care provider, in particular timings and that on one occasion that a male carer attended. On investigation, it was found that the calls were within the 30 mins window that had been explained to the service user. In respect of the male carer, due to staffing pressures one male carer was found to have attended on occasion supported by a female colleague, who had provided the service user with personal care while he waited elsewhere in the property. An apology was given, and assurances given that female carers would send whenever this was possible.

4.0 Adult social care and CHC complaints looked at by the Ombudsmen

4.1 It is the right of all complainants to ask the appropriate ombudsman to consider their complaint at any point if they remain dissatisfied. It is usual for the ombudsman to ask the complainant to exhaust local procedures before getting involved.

4.2 The Local Government and Social Care Ombudsman (LGSCO) considers complaints about adult social care. The Parliamentary and Health Service Ombudsman (PHSO) considers complaints about care funded by the Clinical Commissioning Group – Northumberland. Where a complaint relates to both adult social care and health, it is considered by the Joint Team.

4.3 Although every reasonable effort is made to resolve matters, we direct the complainant to the relevant ombudsman should they remain dissatisfied in every final complaint response letter.

4.4 The table below gives the numbers of investigation decisions received over the past three years.

Decisions	2021/22	2022/23	2023/24	Trend
LGSCO	9	9	9	⇨
PHSO	1	0	0	⇨
Joint Team	2	1	0	⇩
Total	12	10	9	⇩

4.5 The LGSCO's "Annual Review of Local Government Complaints" (July 2024) says, "In 2023–24, 14% of all the complaints we received [about local authorities in England] were about adult social care and we upheld 80% of the complaints we investigated. They show that discharging their statutory requirements and delivering services that people are entitled to is a significant challenge for local authorities across the country".

4.6 Over 2023/24 we received a slightly lower number of decisions about adult social care than the previous year. Additionally, only one of these decisions was upheld, and steps have been taken, to the LGSCO's satisfaction, to prevent recurrence. For comparison, over 2023/24 LGSCO upheld 69% of the complaints they investigated about Northumberland County Council services, including adult social care.

4.7 Analysis suggests that during the complaints resolution process we are able to recognise when we have got things wrong and to take appropriate remedial action. This is evidenced in some of LGSCO's decisions, for example, when

they conclude that they could not "add to" the existing findings and outcomes.

4.8 Please note, the LGSCO will highlight any faults even when our own investigation has already identified and remedied the issues raised. The LGSCO is the final stage in the complaints process and there is no appeal except through judicial review.

4.9 We always comply with the recommendations LGSCO has made, to put things right for the complainant and/or to improve our services, as appropriate.

4.10 Almost all the decisions LGSCO makes are available to read on their website:

https://www.lgo.org.uk/information-centre/councils-performance

4.11 The following pages summarise the outcomes from those Northumberland adult social care complaints considered by LGSCO in 2023/24.

Summary of complaint Adult services	Summary of ombudsman's final decision
22 009 553 **Ms X complained the Council moved her to a care home without her knowledge. She complained the Council did not give her information about finances and refused to provide her with an advocate when she requested one. Ms X also complained the Council disposed of her personal belongings and has not investigated her complaint. Ms X says this has affected her mental health.**	**Ms X and the Council have differing views on the items left in her house and information provided when she moved. Our investigations are evidence based and we are unable to accept one person's word against another. If there is a conflict of evidence, we make findings based on the balance of probabilities […]** **The Council has provided case notes as evidence of events in this case. The case notes detail multiple occasions when Ms X told the Council to end her tenancy and remove all remaining items in the property after it delivered the items she requested. The Council also provided signed documents to evidence Ms X agreed to end the tenancy and the Council would dispose of any remaining items.** **The Council also appropriately checked and decided Ms X had capacity to make decisions about her accommodation.** **The case notes detailed events around Ms X moving into the care home. There is no reference to Ms X being confused and it recorded she said she wanted to move to the care home. The evidence confirmed the Council provided Ms X with the information about paying for care and she was unhappy about this but still wanted to be in a care home. There is no evidence Ms X requested an advocate.**

	On the balance of probabilities, based on the evidence I have seen, I do not find fault in the Council's actions. **Not upheld: No Fault**
23 000 269 **Mr X complains about the Council's decision not to complete another care assessment despite asking for one. He says he needs support and help as he cannot do things himself and has memory problems.**	**We will not investigate this complaint about the Council's decision not to complete another care assessment. This is because there is insufficient evidence of fault to justify an investigation.** **Closed after initial enquiries - no further action**
22 006 026 **Mr X complained that the Council did not carry out a proper assessment of his need for care and support under the Care Act 2014 in 2022. In particular, he says he was not given sufficient opportunity to express his views and he only met the social worker once.** **Mr X also complained about the way officers communicated with him. He says they terminated his calls and did not call back when he left messages. He feels he has been ignored. He says he was also accused of harassing officers due to the frequency of his contact.** **Mr X says he needs practical and financial support to help him budget, manage his household bills and maintain his home. He says the Council has not provided an accessible service because officers in the Adult Social Care team are not available when he calls and do**	**There was no fault in the way the Council carried out an assessment of Mr X's needs under the Care Act 2014 in 2022 and decided he did not meet the eligibility criteria. Nor was there fault in the way officers communicated with Mr X and put special arrangements in place to manage his contact.** **Not upheld: No Fault**

not call back promptly when he leaves messages	
22 016 881 **Mr X complained on behalf of his wife, Mrs X, about the care provided to her at a residential care home and about the care charges the Council asked him to pay.**	**We found no fault regarding the care provided to Mrs X but found fault regarding the Council's care plans and regarding its response to our enquiries**. The Council has agreed to provide an apology and a financial remedy to address the injustice identified.** **Upheld: Fault and Injustice** ****During their enquiries the ombudsman asked for all the care home records, and in good faith the complaints team shared all the records they had. However, these were not complete, and when this mistake was noticed part way through the ombudsman's process, steps taken to provide all the records.**
23 008 088 **Ms X complains the Council failed to appropriately safeguard or provide the required care and support to her relative, Ms Y, prior to her death. She says failures in the adult social care assessment and safeguarding processes ultimately contributed to Ms Y's death. She wants the Council to accept its failings and improve its services.**	**We will not investigate Ms X's complaint about the care and support provided to her relative Ms Y, prior to her death. This is because the Council has already referred the case for a multi- agency safeguarding adult review and we could not achieve more than this.** **Closed after initial enquiries - no further action**
23 011 672 **Mr X complains about the Council's handling of his son's care and support, and of the Council opening**	**We will not investigate this complaint about the Council's handling of Mr X's son's care and support,**

safeguarding enquiries due to concerns about the consistency of his son's care and support.	**and of the Council making safeguarding enquiries for his son. This is because it is out of jurisdiction as the Council is not responsible for the matters complained about [because the client is CHC funded].** **Closed after initial enquiries - out of jurisdiction**
23 012 779 **Mrs B complained about the standard of care her late mother, Mrs C, received from her care provider on behalf of the Council prior to her death. Mrs B says she should have received hospital care sooner. Mrs B says Mrs C should have been entitled to Continuing Health Care (CHC) funding when she left hospital in 2022 but she was not invited to the meeting to discuss this. Ms B says she was ignored when she said she wanted a GP called specifically for her mother rather than rely on a nurse practitioner attending during a ward round. Mrs C was admitted to hospital following the nurse visit, but Ms B says she should have gone to hospital sooner.**	**We will not investigate this complaint about care provided to Mrs B's late mother, Mrs C, by her care provider on behalf of the Council. This is because further investigation could not add to the Care Provider's response or make a different finding of the kind Mrs B wants.** **Closed after initial enquiries - no further action**
23 013 660 **Mr X complained about the Council's failure to safeguard his parents, who are now deceased. Mr X says the matter has been ongoing since 2009 and he is preparing to begin court proceedings. Mr X says the matter has caused him significant distress. He wants the Council to pay significant compensation which he says it had promised previously. He seeks £500 per day since 2009.**	**We will not investigate this complaint about the Council's failure to safeguard Mr X's parents. The courts are best placed to consider claims for significant sums of compensation** **Closed after initial enquiries - out of jurisdiction** **[Mr X made a complaint related to his parents over 10 years ago and this was investigated and responded to**

	at the time.]
23 008 153 **Ms B says the Council arranged a residential rehabilitation placement. On her first night Ms B says she was assaulted, she suffered injuries and continuing associated medical problems. Ms B wants financial compensation.**	**We will not investigate Ms B's complaint because:** • **it is unlikely we will find evidence of fault;** • **it is unlikely we can add to the organisation's investigation; and** • **it is unlikely investigation would lead to a different outcome or achieve anything worthwhile.** **Closed after initial enquiries - no further action** **[This complaint was not published on the ombudsman's website to prevent identification of the complainant.]**

5.0 Adult social care enquires received in 2023/24

5.1 The Complaints Service also responds to a number of 'enquiries' from service users, carers, families, and members of the public and which relate to adult social care services.

5.2 Enquiries can escalate into complaints if they are not dealt with satisfactorily or in a timely manner. At first contact the Complaints Service provides or arranges answers or explanations to resolve the issues raised.

5.3 Typically, enquiries managed by the complaint service are contacts from members of the public, including the children, young people or adults who use our services, who may wish to complain but we can deal with their concerns immediately; or from people who have a specific question about our services; or from people who are not sure who to contact or who believe we are the responsible body.

5.4 In the course of 2023/24, 208 enquiries were recorded by the team that related to adult services. The table below shows the number of enquiries received over the past three years.

Enquiries received	2021/22	2022/23	2023/24	Trend
Adult social care	154	216	208	⇩

5.5 The majority of these enquiries related to our services and were dealt with directly by the team. These included instances where issues could be signposted elsewhere so that the person was put in touch with expert staff. Sometimes service users contacted us to make comments or suggestions which were passed on to relevant services or used to help improve services.

5.6 The table below notes the enquiries received by service area:

Enquiries by service area	2021/22	2022/23	2023/24	Trend
Adult social care teams	69	128	81	⇩
Complaints team	2	2	0	⇩
Continuing healthcare	11	8	9	⇧
Contracts & commissioning	0	0	1	⇧

Finance	**17**	**16**	**15**	
General	**2**	**0**	**0**	
Home improvement service	**3**	**1**	**4**	
Homesafe	**0**	**0**	**7**	
Independent social care providers	**11**	**15**	**14**	
In-house residential care	**0**	**0**	**0**	
Joint equipment and loan service	**0**	**1**	**11**	
Northumberland Communities Together	**0**	**1**	**0**	
Occupational therapy	**13**	**9**	**17**	
Onecall	**3**	**0**	**0**	
Other Council service areas	**3**	**13**	**16**	
Other NHS	**6**	**10**	**3**	
Safeguarding adults	**12**	**8**	**14**	
Self-directed support team	**2**	**0**	**7**	
Short term support service	**0**	**4**	**8**	
Telecare	**0**	**0**	**1**	
Total	**154**	**216**	**208**	

5.7 Each enquiry can take anything from a matter of minutes to several hours to complete. Many enquiries are dealt with over one to two working days.

5.8 Some enquiries contain information that was handled under the adult multiagency safeguarding procedures, especially information relating to independent providers. In these cases, we let the enquirer know that they should contact the complaints team after the safeguarding process is complete if they remain dissatisfied with the outcomes.

5.9 Analysis suggests the decrease in enquiries related to adult social care operational teams, has been offset by an increase in enquiries about other adult social care related services areas. Despite this change, most people are still making contact with the right organisation first time when they have a query or concern. This suggests that our complaints publicity is effective.

6.0 Adult social care compliments received in 2023/24

6.1 Adult social care receives considerably more compliments from people who use our services, their carers, and families than complaints. Compliments are a way of confirming that by and large we are doing a good job.

6.2 Collectively, the compliments we receive are mainly about how helpful, kind, and professional staff have been; or about the quality of the services we commission or provide. Staff are encouraged to acknowledge compliments especially when people have taken the time and trouble to write at what may have been very difficult periods of their lives, including end of life care.

6.3 In 2023/24 adult social care received 603 compliments from members of the public although we are very aware that staff receive kind words verbally from the people who use our services, their families, and carers on a daily basis.

6.4 As part of our on-going work in adult social care, to monitor how well our contracted providers are performing we ask them to report both complaints and compliments each quarter.

6.5 Overall, both adult social care compliments and continuing healthcare compliments have increased over the past year.

6.6 The table below shows the number of compliments received over the past three years:

Compliments received by	2021/22	2022/23	2023/24	Trend
Adult social care	399	536	603	⇧
CHC	188	138	195	⇧
Total	587	674	798	⇧

6.7 The two tables below show the compliments received by service area over the past three years:

Compliments by service area	2021/22	2022/23	2023/24	Trend
Adult social care teams	36	88	116	⇧
Brokerage	3	0	0	⇨
Complaints Service	1	1	1	⇨

Commissioning	**0**	**0**	**2**	
Enquiry referral coordinators	**1**	**4**	**24**	
Finance	**1**	**6**	**3**	
Home improvement service	**0**	**73**	**49**	
Home safe	**4**	**16**	**28**	
Horticultural unit	**0**	**3**	**2**	
Independent providers*	**286**	**232**	**295**	
Independent providers**	**4**	**12**	**2**	
In-house care home	**0**	**2**	**3**	
In-house day services	**8**	**14**	**5**	
Joint equipment and loan service	**0**	**20**	**9**	
Occupational therapy	**27**	**33**	**30**	
Onecall (single point of access)	**0**	**0**	**4**	
Risk & independence team	**0**	**7**	**13**	
Safeguarding adults' team	**1**	**0**	**2**	
Self-directed support team	**1**	**0**	**0**	
Short term support service	**25**	**24**	**8**	

Telecare	**0**	**0**	**4**	⇧
Wardens	**0**	**1**	**2**	⇧
Welfare rights	**1**	**0**	**1**	⇧
Total	**399**	**536**	**603**	⇧

***Reported by providers**
****Reported directly to the Council**

CHC compliments*	2021/22	2022/23	2023/24	Trend
100% NHS funded packages	**93**	**63**	**121**	⇧
Part NHS funded packages	**95**	**75**	**74**	⇩
Total	**188**	**138**	**195**	⇧

***Reported by providers**

7.0 Advocacy for adult social care and CHC complainants

7.1 **In respect of advocacy for people wishing to make an adult social care complaint, the Complaints Service is always mindful that on occasion the use of an advocate may be a constructive way to support the complainant to achieve a positive outcome from their complaint. Advocacy is not a right under the regulations for adult social care complaints.**

7.2 **The Complaints Service can access advocacy for adult social care complaints from local providers as necessary and with the agreement of the complainant. Decisions are made on a case-by-case basis. Please note that many complaints about adult social care come from a family member or family friend on behalf of the service user. In each case we ask for the service user's consent unless they lack the mental capacity to make a complaint in their own right; in these cases, we make a best interest decision.**

CHC complaints

7.3 **In respect of advocacy for people who wish to make a complaint about CHC funded care packages the complainant has a right to advocacy if they so choose and we signpost people to the relevant contracted provider.**

Other information

7.4 **Over 2023/24, the Complaints Service hasn't needed to use advocacy. In respect of the CHC complaints, the offer of advocacy wasn't pursued.**

7.5 **In general terms and irrespective the different advocacy arrangements in place the Complaints Service considers how to meet the varying needs of complainants on a case-by-case basis making reasonable adjustments as appropriate. This is particularly important in relation to complainants whose first language is not English and those with communication difficulties.**

8.0 Conclusions and future plans for adult social care complaints

8.1 **We continue to be guided by the aim of responding to complaints in an appropriate and proportionate manner, understanding the perspective of each family member or service user that makes a complaint, and where possible aiming to resolve things at an early opportunity.**

8.2 **Over 2023/24 a review of complaint categories was undertaken and new categories of complaints have been agreed from 2024/25:**

- **Assessments and Care Planning**
- **Attitude or conduct of staff**
- **Availability of service provision**
- **Communication and/or Information**
- **Failure to follow procedures.**
- **Finance/Funding**
- **Quality or Standard of Service**

8.3 **We also continue to learn lessons, to make changes to improve things for individuals and their families, and to draw on what we learn to improve our services more generally. For example, the 'lessons learned' and 'storyboard templates' have been updated and are now being used following complaints to evidence that learning is taking place. These should be shared at the relevant forums, for example, quality workshops, team meetings, and social worker and care manager forums. Please see the complaints analysis process chart in appendix 2.**

8.4 **Over 2023/24 a new quarterly meeting with relevant senior managers has been set up to review complaints, enquiries, and compliments. This meeting discusses the themes, issues, trends, outcomes, and actions taken. Further action to improve services may result from discussion in this forum.**

8.5 **Over 2023/24, we have introduced a bespoke case management system. An improved range of management reports is becoming available to ensure compliance with service levels whilst analysis reports will provide statistics and trend analysis to aid service improvement.**

8.6 **We will continue to focus on handling enquiries promptly to try to prevent unnecessary escalation and dissatisfaction.**

8.7 **We will also continue to support managers in resolving complaints at a local level and in a timely manner by help in individual cases and complaints training as appropriate.**

8.8 **Overall, we have had a positive year with many compliments received and enquiries dealt with at an early stage. We have successfully resolved most of the issues raised locally even when we have not been able to agree with the complainant's perspective. However, we always speak to people to hear their views and take their concerns very seriously. We are committed to improving**

our services and continue to receive support from staff and managers throughout the organisation in our day-to-day work.

8.9 For further information about this report or adult social care and CHC complaints, please email the Complaints Manager for Adult Social Care Complaints james.hillery@northumberland.gov.uk

9.0 Appendix 1: How we handle individual adult social care and CHC complaints

9.1 We work to the principle in that all feedback is welcomed, is taken seriously, complaints are investigated thoroughly, and a response provided in a timely manner. We aim to learn lessons from all feedback and utilise findings to influence and improve services going forward.

9.2 The adult social care the 2009 complaints regulations require us to send an acknowledgment to the complainant within 3 working days. The regulations also say we must "investigate the complaint in a manner appropriate to resolve it speedily and efficiently". The process should be person-centred with an emphasis on outcomes and learning.

9.3 To this end when we receive a complaint and in discussion with the complainant and the service, we develop a 'resolution plan' which may be refreshed as required.

9.4 The action we take to resolve a complaint should be appropriate and proportionate to the circumstances of the case, taking into account risk, seriousness, complexity, or sensitivity of events. The officers tackling the complaint should not feel limited about the actions they can take but they should avoid lengthening the process. For example, a well-meant apology or an opportunity to meet and discuss the issues may suffice. Alternatively, the complaint may warrant a 'formal' investigation. Whatever the case we should always speak to the complainant to understand their experience and to ask them what they would like us to do to put things right. We should also keep them informed of progress and of any findings throughout their complaint.

9.5 The process ends with a final written response from the appropriate manager in which the complainant is directed to the Local Government and Social Care Ombudsman should they remain dissatisfied with how we have handled their complaint or with our findings.

9.6 While there are no statutory timeframes, we aim to resolve complaints within 20 working days where practicable. Of the complaints responded to over 2019/20, 55% (35 of 63) were dealt with within 20 working days across adult social care and CHC complaints; and all were provided within the timeframe agreed with the complainant.

9.7 Our adult services process can be summarised as follows:

Complaint received

⇩

Take appropriate and proportionate action to resolve the issues

⇩

Send response letter confirming actions and outcomes

9.8 Apologising is usually appropriate even if only because the person feels they have had a bad experience or because they felt strongly enough about their

experience that they felt moved to make a complaint. The Scottish Public Services Ombudsman says, "A meaningful apology can help both sides calm their emotions and move on to put things right. It is often the first step to repairing a damaged relationship. It can help to restore dignity and trust. It says that both sides share values about appropriate behaviour towards each other and that the offending side has regrets when they do not behave in line with those values."

10.0 Appendix 2: Complaints analysis process