Northumberland County Council

In partnership with

Northumbria Healthcare NHS
NHS Foundation Trust

and

NHS
Northumberland
Clinical Commissioning Group

Complaints Annual Report 2019/2020

- **Adult social care and children's social care**
- **Continuing health care services**

Contents

Introduction

0.1 This 'Complaints Annual Report' report covers adult social care, children's social care and the NHS responsibilities for continuing health care and related services which the Council delivers under a partnership arrangement with Northumberland Clinical Commissioning Group.

0.2 The report is in two parts and describes what people have said about both our adult and children's social care services in Northumberland and what we have learned as a consequence during 2019/20. The report also describes what people have said about NHS continuing healthcare funded by Northumberland Clinical Commissioning Group and about supporting people in their own home or in a care home.

0.3 Part 1 of the report covers adult social care complaints and CHC care and related services complaints; part 2, children's social care.

0.4 This report emphasises the approach in both adults and children's social care services to listening and respecting all feedback offered, valuing each individual's perspective on care they receive, and resolving issues raised by people in Northumberland. It also explains in the appendix the differences in custom and practice in complaint handling which have evolved to meet the requirements of the relevant national regulations and guidance in both service areas.

0.5 Complaints about adult social care and health care are handled under national regulations introduced in 2009. As noted above, we handle complaints on behalf of Northumberland CCG about continuing healthcare funded care.

0.6 The arrangements for the statutory management of complaints from children and young people (and their representatives) are set out in the Children Act 1989 and Representations Procedure (England) Regulations 2006. This legislation requires that everyone who provides social services must have procedures in place to respond to complaints made about those services.

0.7 Despite significant differences in detail, both sets of regulations and guidance 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.

PART ONE
Adult social care complaints – 2019/20

1.1 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 2018/19 and some complaints will carry over into 2020/21. The table below notes the numbers of complaints received in 2019/20 and the previous two years:

Complaints received	2017/18	2018/19	2019/20	Trend
Adult social care	24	34	50	⇧
CHC	3	5	8	⇧
Total	27	39	58	⇧

1.2 Over the past three years we have experienced a fairly consistent raise in the number of complaints being made.

1.3 The table below shows adult social care complaints received by three county councils that have similarities with Northumberland, based on the available data:

Complaints received	2017/18	2018/19	2019/20	Trend
Cumbria	107	X	X	⇩
Durham	104	81	X	⇩
Lancashire	333	329	X	⇩

1.4 The table below shows the comparative number of adult social care complaints received per 1,000 service users based on the most recent figures available:

Area	Approximate number of adult social care service users	Complaints per 1,000
Cumbria	8,000	13.4
Durham	18,500	4.4
Lancashire	11,000	29.9
Northumberland	7,000	7.1

1.5 The table below notes the numbers of complaints received and responded to in 2019/20 and the previous two years:

Complaints responded to	2017/18	2018/19	2019/20	Trend
Adult social care	21	26	54	⇧
CHC	5	6	9	⇧
Total	26	32	63	⇧

1.6 In line with the increase of complaints received, we have seen an increase in the numbers responded to over 2019/20.

ADULT SOCIAL CARE COMPLAINTS (CHC complaints data follows later)

1.7 The table below shows the outcomes from the responded to adult social care complaints, whether upheld, not upheld, or partly upheld:

Complaints outcomes	2017/18	2018/19	2019/20	Trend
Upheld	5	3	13	⇧
Not upheld	6	13	25	⇧
Partly upheld	10	10	16	⇧
Total	21	26	54	⇧
Upheld and partly upheld combined	15	13	29	⇧

1.8 The table below shows the above information as a percentage and suggests that while the overall trend of upheld and partly upheld complaints outcomes is upward, overall proportionally fewer complaints are being fully or partly upheld this year and last than previously:

Complaints outcomes	2017/18	2018/19	2019/20	Trend
Upheld	24%	12%	24%	⇧
Not upheld	29%	50%	46%	⇧
Partly upheld	47%	38%	30%	⇩
Upheld and partly upheld combined	71%	50%	54%	⇧

1.9 The table below provides some comparative data for complaint outcomes with the other county councils identified above, using the most recent data:

Area	Upheld and partly upheld complaints
Cumbria	37%
Durham	57%
Lancashire	49%
Northumberland	54%

1.10 The table below shows the complaints responded to by service area. Care management continues to have 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. We have also seen an increase in the numbers of complaints related to independent providers who, like care management, have a higher number of service user contacts.

Service area complained about	2017/18	2018/19	2019/20	Trend
Care management	12	15	32	⇧
Finance team	6	4	4	⇨
Home improvement service	X	X	1	⇧
Independent provider	1	2	10	⇧
In-house provider	X	1	1	⇨
Occupational therapy	X	X	1	⇧
Onecall	X	1	1	⇨
Safeguarding adults team	2	2	X	⇩
Self-directed support team	X	X	1	⇧
Short term support service	X	1	3	⇧
Total	21	26	54	⇧

1.11 In respect of these increases, we are seeing more people willing to challenge professionals formally – in part this is at least in part due to higher expectations of services; and in part because service users are expected to contribute (more) towards the cost of their care. Charges are increasingly an underlying issue in many complaints. In this context, the key issues complained about, such as 'disagreements', 'funding/charges', and particularly 'standard of service provision' are to be expected.

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

Subject matter	2017/18	2018/19	2019/20	Trend
Adaptations & equipment	X	X	1	⇧
Attitude or conduct of staff	3	2	2	⇨
Breach of confidentiality	1	X	X	⇨
Communication / information	3	3	7	⇧
Contact arrangements	X	1	1	⇨
Disagreement with assessments / reports	X	X	4	⇧
Disagreement with decisions	1	7	3	⇩
Failure to follow procedure	1	4	3	⇩
Finance / funding	7	4	9	⇧
Health & safety	X	1	X	⇩
Speed or delays in service	1	X	2	⇧
Standard of service provision	4	4	22	⇧
Total	21	26	54	⇧

1.13 As noted above, key areas relate to 'disagreements', finance/funding' and the 'standard of service provision'.

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

CHC COMPLAINTS

1.15 In respect of CHC complaints, these remain low in comparison to adult social care complaints. The table below shows the outcomes from the complaints responded to, whether upheld, not upheld, or partly upheld, over the past three years.

Complaints outcomes	2017/18	2018/19	2019/20	Trend
Upheld	1	2	1	⇩
Not upheld	3	2	1	⇧
Partly upheld	1	2	7	⇧
Total	5	6	9	⇧
Upheld and partly upheld combined	2	4	8	⇧

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

1.17 The table below shows the complaints responded to by service area. Care management continues to have the most complaints, and as noted above, is to be expected in the context of the number of service user contacts for that service area compared to others. Similarly, the nurse assessment team which oversees the CHC eligibility process is understandably complained about as well.

Service area complained about	2017/18	2018/19	2019/20	Trend
Care management	4	4	5	⇧
Nurse assessment team	X	2	2	⇨
Occupational therapy	1	X	1	⇧
Support planners	X	X	1	⇧
Total	5	6	9	⇧

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

Subject matter	2017/18	2018/19	2019/20	Trend
Attitude or conduct of staff	1	X	1	⇧
Disagreement with assessments / reports	1	1	1	⇨
Disagreement with decisions	1	1	X	⇩
Failure to follow procedure	X	X	3	⇧
Finance / funding	X	2	1	⇩
Speed or delays in service	2	2	X	⇩
Standard of service provision	X	X	3	⇧
Total	5	6	9	⇧

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

2. Learning from the people who use our adult social care services

2.1 **Many of the issues have been reported over 2019/20 reflect the kind of situations which can occur from time to time in a large care organisations – 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.**

2.2 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.

2.3 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.

2.4 The following section provides a selection of 'thumbnail' portraits by subject matter in the key areas of communication/information, finance/funding and the standard of service provision to illustrate the actions taken to resolve complaints and improve services where they were upheld and party upheld.

2.5 Communication/information:

1. **A family member complained that the care manager didn't properly explain the purpose of a recent review meeting nor how the care plan would be changed. In addition the family member felt that their views had not been properly considered before decisions were made. During the investigation it became clear that the family member hadn't been properly informed although their views had been considered. The investigating officer met the family member and went through the relevant documentation explaining the review process and why certain decisions had been made, again with a further personal apology for their experiences. The family member was satisfied with this.**

2. **A service user's mother was concerned that she had had no update or documentation back from her son's social worker about her carer's assessment. She was also unhappy with the content of her son's care needs assessment and felt that it didn't match his needs and that there were inaccuracies and assumptions about how much care she and her husband could realistically offer. An apology was offered about the lack of communication and a satisfactory resolution negotiated about the support to be offered – a multi-disciplinary team meeting was arranged to allow all parties to discuss the situation and to agree the level of support to be provided by each.**

3. **A family member complained because she did not understand why her father now required two carers rather than one; and as a result his charges had doubled. She also complained that no one had told her about 'risk to staff' meetings that had been held. On investigation it was found that due to the service user's behaviour a new care plan had been put in place although it was acknowledged that the family member should have been more closely involved but weren't. An apology was given and the 'risk to staff' meetings explained. Assurances were also given that should there be any impact on the care plan then they would be kept informed as necessary.**

2.6 Finance/funding:

1. **A daughter complained that the finance team had continued to write to her mother for the settlement of the outstanding charges for her father's residential service before he died despite her requests otherwise. On investigation this was found to be correct and to be the result of an individual's omission (not updating the records). An apology was provided and the individual spoken to about their error. The final charges were also reduced to take into account the fact that the complainant's father had gone into hospital several days before he died and did not return to the care home, something the complainant also raised. The records showed that shortly after his admission that "it was highly unlikely that (the service user) will be leaving the hospital therefore his placement … can be ended".**

2. **A service user complained that his disability related expenditure assessment was flawed because it wrongly discounted some of his expenditure. On investigation it was found that the finance team had correctly checked with the allocated key worker and asked them for a view on the service user's DRE as he had set it out before coming to a decision. Unfortunately, the allocated key worker had incorrectly discounted come of his expenditure. In this context, a social worker was allocated to the case and asked to assess the service user's DRE in person. As a result, it was agreed that the service user's DRE was higher than thought and his charges reduced as a result.**

3. **A parent complained that his daughter's social worker was taking too long to arrange her move from residential care to a more independent setting. As a result, he said, she was being financially disadvantaged. On investigation it was found that the service user had recently lost her eligibility for CHC and as a consequence was being charged for her residential placement. However, due to the charges she was finding it difficult to save money to help her with the move and to continue with her current set of activities. It was agreed that there had been some delay and an apology given. In addition, some of the charges were waived to take the delay, which was not the service user's fault, into account. The family was satisfied with this outcome.**

2.7 The standard of service provision

1. **A service user complained about STSS – some miscommunication was found with visiting times and who should confirm visits (the service user's son or the service) and an apology was given for the overall standard of service as it did not meet the expectations of the service user. However, some specific learning was identified both for the service and the wider organisation:**

    - **Communication processes reviewed between services to support care provision e.g. making sure directions are known, especially if in a more rural setting.**
    - **Work undertaken with the hospital to address issues raised in the complaint around having to repeat patient details and story at each contact with acute and community services.**

- **Information and messages given at point of discharge about STSS care packages reviewed to reduce risk of mixed messages around capacity and STSS availability.**
- **Training needs of front line staff around young carer awareness reviewed with support from Northumberland carers.**
- **Making sure health care colleagues have an appropriate leaflet and details about how to refer for a carer's assessment.**

2. **A family member was unhappy that carers were not carrying out personal care tasks (bathing) for her husband in the way he preferred. The local team manager raised this with the provider and set up a monitoring regime to make sure the agreed changes were embedded. The complainant was satisfied with this outcome.**

3. **The family of a service user complained about the quality of care the service user received in a care home before he died – the family felt that his personal care had not been consistently provided. On investigation it was found that the care home records in this case were not good enough to show that care had been consistently provided and that no discussion about the service user's care plan or medical history had taken place with the family; nor had the family been asked provide information on what the service user liked and disliked or his day to day care needs. The care home provided a suitable apology and took steps to remedy the faults that had been found.**

4. **A daughter complained that she would not pay the charges for her mother's stay in an out of authority care home due to the poor quality of care which resulted in her developing several pressure sores. On investigation it was found that the quality of care had been considered by the local safeguarding team and neglect substantiated. The charges were written off and a suitable apology given.**

5. **A service user complained about the way in which her care transferred from STSS to a long term care provider; and also about how some STSS had carried out assessments. On investigation it was found that while the STSS care and the transfer had been well managed 'behind the scenes' the service user had not been informed either verbally or in writing by the sharing of the relevant documentation (the period in question was over Christmas/New Year). An apology was provided and steps taken to remind relevant staff about due process. In respect of the assessments, these were found to have been carried out appropriately although it was acknowledged that fuller communication may have helped at the time. The relevant staff were reminded about this.**

6. **A family member complained about the care manager's apparent failure to take timely action to support her mother to go home after a period of recovery in a care home following a fall. On investigation it was found that the care manager had not acted in a timely way and had also not followed process when arranging care resulting in delays. An apology was given and appropriate management action with the care manager to prevent recurrence.**

2.8 **In respect of learning from other adult social care complaints, for example, following a complaint about staff attitude, the process for dealing with calls to**

Onecall has been changed. Now all messages received by Onecall for the team managers are recorded on swift rather than only in an email; and following two complaints related to hospital discharges, the Homesafe teams have been reminded about the processes for the arranging of temporary and permanent care home placements.

2.9 In respect of independent providers, the complaints team works closely with the contracts and commissioning team and shares all complaints and outcomes with them – this information helps inform the regular monitoring and other work that that team undertakes with providers contracted to the Council.

CHC COMPLAINT EXAMPLES

2.10 The following section provides a selection of 'thumbnail' portraits from CHC complaints by subject matter in the key areas of procedure and the standard of service provision to illustrate the actions taken to resolve complaints and improve services where they were upheld and party upheld.

2.11 An apparent failure to follow procedure:

1. **A family complained at the way the CHC procedures had been conducted and believed that the CHC assessment had not been done within the guidelines laid down. On investigation, it was found that the assessment complied with the national framework although it was acknowledged that another care home representative should have replaced the senior carer when he left the meeting early (the nurse assessor spoke to this person the next day to collate their views for the assessment). In addition, an apology was given because when the family challenged the nurse assessor about this, she initially offered a further assessment without agreement from either the team or senior manager. To prevent recurrence, when the CHC team books in CHC assessments they now make clear to members of the MDT that they should stay for the duration of the meeting and if this is not possible that they arrange for a deputy to attend. The family were advised to appeal if they disagreed with the panel outcome.**

2. **A family member complained that the service user's care and support plan had been changed without agreement. On investigation it was found that a draft care plan, which showed the changes being proposed, all of which had been discussed with the service user and complainant, had been sent out to the existing provider. It was also found that the provider misunderstood that the care plan was still in draft and they assumed that another provider was now taking over some of the tasks as had been discussed. As a result, certain elements of the care plan were stopped causing some unnecessary upset to the client. Action was taken to reinstate the care plan and appropriate apologies given.**

2.12 The standard of service provision:

1. **A service user complained about the quality of the OT service. On investigation it was found that the OT acted appropriately in respect of their professional tasks although they should have been more proactive when the service user postponed visits by making contact rather than**

waiting. An apology was given and the member of staff reminded about best practice around communication.

2. **A family member complained about their experiences of the CHC process. It was found that a support planner referred on to a care manager to complete a checklist. Unfortunately, this was received as a request for advice and he was told to refer to the district nursing service to complete the forms. The district nursing service did this but there was some to-ing and fro-ing before the nurse assessment team was satisfied that the forms were correctly completed. Some miscommunication was also found in respect of the CHC process which adversely affected the complainant's experiences. An apology was given and some training/awareness raising arranged for the services involved.**

3. Adult social care complaints looked at by the Ombudsmen

3.1 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.

3.2 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.

3.3 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.

3.4 The table below gives the numbers of investigation decisions received over the past three years. Typically we have found that around 6 or 7 complainants ask the LSCGO to consider a complaint that adult social care has tried to resolve.

Decisions	2017/18	2018/19	2019/20	Trend
LGSCO	4	9	9	⇨
PHSO	0	0	0	⇨
Joint Team	1	1	0	⇩
Total	5	10	9	⇩

3.5 Over 2018/19 we received a higher than average numbers for adult social care based on on-going LGSCO involvement in a number of cases at the end of March 2018 (three). Although the 2019/20 numbers have decreased on last year, analysis suggests that the numbers of people who choose to ask LGSCO to consider their complaint may now be increasing from the historically typical 6 or 7 or less to 7 or 8 or more per year. As noted earlier in this report, in part this is likely due to high expectations of services; and in part because service users are expected to contribute (more) towards the cost of their care and this is an underlying issue in many complaints. In addition, it can also be an indication of the quality of the relationship that the complainant has with the Council.

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

https://www.lgo.org.uk/your-councils-performance

3.7 Analysis suggests that during the complaints resolution process we are able to recognise where we have got things wrong and to take appropriate remedial action. Please note that in recent years the LGSCO has changed

their focus and will highlight any faults in the original case handling over how effectively we investigated and remedied the issues raised. The LGSCO is the final stage in the complaints process and there is no appeal except through judicial review.

3.8 The table below provides some comparative data for LGSCO complaints outcomes with the other county councils identified above, using the 2020 data available on the LGSCO website:

Area	Upheld	Not upheld	Closed after initial enquiries	Total
Cumbria	5	2	2	9
Durham	9	5	3	17
Lancashire	12	9	12	33
Northumberland	1	2	6	9

3.9 The following pages summarise the outcomes of those Northumberland complaints considered by LGSCO in 2019/20.

Summary of complaint Adult services	Summary of ombudsman's final decision
18 019 496 **Mr U says that:** **• The decision regarding funding for his aunt, A, to remain in her placement was delayed, causing her upset and worry;** **• The Council handled the issue badly, adding to A's distress**	**The Ombudsman will not investigate this complaint about the delay in making a funding decision for a residential placement. This is because we cannot add anything to the investigation previously carried out by the Council, or achieve anything further for the complainant.**
17 012 868 **Mr X complained that:** **• The Council failed to communicate with him properly, and** **• failed to investigate safeguarding issues in relation to his brother, effectively.**	**Mr X complained that the Council failed to properly communicate with him and failed to investigate a safeguarding referral about his brother, Mr P. However, he has now decided to withdraw his complaint. The Council has taken action that he is content with and he feels his brother's interests are now being properly addressed.**
19 001 245 **Mr X complained the Council had ended his carer's support without considering the impact on his health and going against his Care Plan.**	**The Ombudsman should not investigate this complaint. This is because it is unlikely an investigation would find fault or add anything to the Council's own investigation.**
19 005 461	**This complaint outcome has not been published on the LGSCO website due to the nature of the subject matter. Adult social care became involved**

Mr C says that: **• His daughter, D's school erroneously accused her of threatening to carry out a high school shooting;** **• The School did not investigate the matter properly or safeguard D; and** **• The Council's investigation was flawed and did not safeguard D properly.**	**because the pupil in question was 18 years old. Adult social care staff made sure this person was safe and receiving the help they needed and as a result were drawn into the wider complaint.** **The Ombudsman cannot investigate this complaint about the response by the Council and one of its schools to allegations made about the complainant's daughter. This is because the Ombudsman cannot investigate complaints about the internal management of schools, or about the Council's actions in relation to something that concerns the management of a school.**
19 004 096 **1. Mrs G is complaining about the care and support provided to her and her husband, Mr G, by Northumberland Council (the Council) and Northumbria Healthcare NHS Foundation Trust (the Trust).** **2. Mrs G complains that the Council stopped her Direct Payments and refused to accept her applications for Disabled Facilities Grants (DFGs). Mrs G also complains that the Trust failed to provide Mr G with a mobility scooter.**	**The Ombudsmen will not investigate this complaint about the care and support provided to a couple with significant health needs by the Council and Trust. This is because an investigation by the Ombudsmen would be unlikely to identify fault by the organisations concerned.**
19 013 439 **Mr X complained the Council did not take any action when he raised**	**Mr X complained the Council did not take any action when he raised concerns about financial and emotional abuse of his mother by his brother. We should not investigate this late complaint. Mr X could have complained**

concerns about financial and emotional abuse of his mother by his brother. He has incurred significant court fees which he believes are a result of fault by the Council.	**sooner but in any event, it is unlikely we would find fault in the Council's actions or be able to achieve a meaningful outcome for Mr X.**
18 017 024 and 19 006 210 **Mr X says he was persuaded against his better judgement to move into his current flat which he says is not suitable for him. He says the Council's allocations policy disadvantages him.**	**The Council did not persuade Mr X to move into his current accommodation or fail to help him consider a further move.**
19 001 041 **Mrs A complains that her mother, Mrs B, was prescribed medication in 2016 without her family's knowledge, which affects her quality of life and subdues her. Mrs A says because she was prescribed this medication she does not meet the criteria for Continuing Health Care (CHC) funding and has been assessed as having enough capital to contribute towards her care.**	**The Ombudsman cannot investigate Mrs A's complaint about the actions taken regarding her mother, Mrs B. This is because the actions complained of were not taken by the Council so the Ombudsman cannot investigate them.**
18 018 034 **Mrs B complained about the way the Council dealt with adaptations at her Council property. Mrs B**	**The Ombudsman found that the Council's target for the works was unrealistic and further delays meant Mrs B and her family had to live in unsuitable circumstances and have one family member living elsewhere for longer than they should have. An apology and payment to Mrs B is**

complained the Council delayed completing the works and unreasonably refused to pay compensation to reflect damage to her flooring and the impact the extended building works had on her family.	**satisfactory remedy for the injustice caused.**

4. Adult social care enquires received in 2019/20

4.1 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.

4.2 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.

4.3 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.

4.4 In the course of 2018/19, 129 enquiries were recorded by the team that related to adult services; and 102 that related to children's services.

4.5 Of the total 231 enquiries received, the vast majority 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.

4.6 In respect of individual school matters please note that while the Council's authority is limited, in most cases we were able to offer suitable advice; or to put the person in touch with the relevant service within the Council for advice or on occasion practical help. For example, with concerns about bullying or where the child has been identified as having a special educational need or disability.

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

Enquiries received	2017/18	2018/19	2019/20	Trend
Adult social care	128	102	118	⇧

Enquiries by service area	2017/18	2018/19	2019/20	Trend
Care management	66	58	72	⇧
Complaints team	X	1	X	⇩
Continuing healthcare	7	6	1	⇩

Contracts & commissioning	X	X	1	⇧
Finance	12	8	9	⇧
General	X	X	1	⇧
Home improvement service	5	X	1	⇧
Independent social care providers	13	5	6	⇧
Joint equipment and loan service	3	6	5	⇩
Northumbria Healthcare	3	X	3	⇧
Occupational therapy	3	9	7	⇩
Onecall	3	1	2	⇧
Other organisations	1	2	2	⇨
Safeguarding adults	8	4	3	⇩
Self-directed support team	1	X	3	⇧
Short term support service	2	2	2	⇨
Welfare rights	1	X	X	⇨
Total	128	102	118	⇧

4.8 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.

4.9 Some enquiries contain information that was handled under either adults or children's 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.

4.10 Analysis suggests that the majority of people are making contact with the right organisation first time when they have a query or concern. This suggests that our publicity is effective.

5. Adult social care compliments received in 2019/20

5.1 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.

5.2 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.

5.3 In 2019/20 adult social care received 442 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.

5.4 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. Unfortunately, providers have been unable to share data from quarter 4 to date due to the pandemic but we hope to be able to receive by the end of September 2020.

5.5 In this context, adult social care compliments have decreased over the past year and continuing healthcare compliments similarly. Analysis suggests that we are continuing to provide opportunities for people to tell us what they think; and we will continue to make sure that feedback is registered appropriately.

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

Compliments received by	2017/18	2018/19	2019/20	Trend
Adult social care	532	485	442	⇩
CHC	206	159	117	⇩
Total	738	644	559	⇩

5.7 The table below shows adult social care compliments received by three county councils referred to above, based on the available data:

Complaints received	2017/18	2018/19	2019/20	Trend
Cumbria	108	X	X	⇩
Durham	297	125	X	⇩
Lancashire	615	692	X	⇧

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

Compliments by service area	2017/18	2018/19	2019/20	Trend
Care management	57	94	110	⇧
Complaints Service	2	2	3	⇧
Contracts & commissioning team	X	X	2	⇧
Finance	6	8	5	⇩
Home improvement service	10	1	2	⇧
Home safe	1	2	4	⇧
Independent providers*	289	194	145	⇩
In-house day services	68	61	59	⇩
Joint equipment and loan service	2	4	2	⇩
Occupational therapy	6	24	24	⇨
Onecall (single point of access)	2	5	6	⇧
Risk & independence team	X	X	1	⇧
Safeguarding adults team	X	4	4	⇨
Self-directed support team	10	7	4	⇩

Short term support service	77	78	70	⇩
Welfare rights	1	1	1	⇨
Total	532	485	442	⇩

*Reported by providers

CHC compliments*	2017/18	2018/19	2019/20	Trend
100% NHS funded packages	77	64	48	⇩
Part NHS funded packages	129	95	69	⇩
Total	206	159	117	⇩

*Reported by providers

6. Advocacy for adult social care and CHC complainants

6.1 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.

6.2 The Complaints Service is able to 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

6.3 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

6.4 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.

7. Conclusions and future plans for adult social care complaints

7.1 We continue to be guided by the aim of responding to complaints in an appropriate and proportionate manner, understanding the perspective of each child, young person or adult that makes a complaint and where possible aiming to resolve things at an early opportunity.

7.2 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.

7.3 Over the coming year, 2020/21 we will continue to improve accessibility to make compliments, complaints and comments and the ways in which we demonstrate learning from complaints. As part of our other development work we will continue to work alongside contracted adult social care providers to report on all their registered compliments and complaints regardless of funding arrangements.

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

7.5 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.

7.6 Overall, we have had a positive year with many compliments received and enquiries dealt with at an early stage. We have successfully resolved the majority of 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.

7.7 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@northumbria-healthcare.nhs.uk

8.0 How we handle individual adult social care and CHC complaints

8.1 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.

8.2 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.

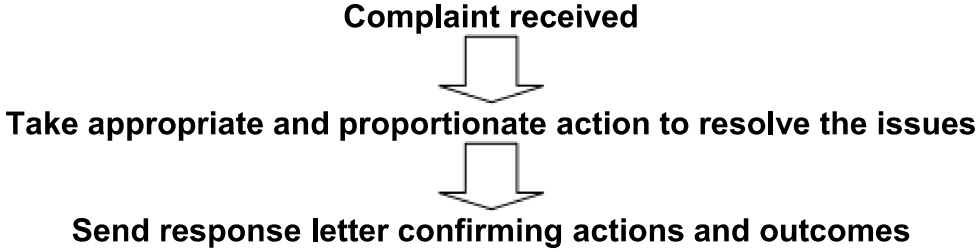
8.3 To this end when we receive a complaint and in discussion with the complainant and the service, we develop a 'resolution plan' which may be refreshed as required.

8.4 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 in order to put things right. We should also keep them informed of progress and of any findings throughout their complaint.

8.5 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.

8.6 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.

8.7 Our adult services process can be summarised as follows:



8.8 **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."**

PART TWO
Annual Complaint Report for Children's Social Care 2019/20

1.0 Introduction

Children's Social Care aim to provide high quality services and customer care at all times. However, it is appreciated that service users may, from time to time, be unhappy with the service they receive and wish to express their dissatisfaction with those services. Children's Social Care are happy to receive this feedback and investigate where something may have gone wrong and have to opportunity to put it right, so far as is possible. This process can provide vital points of learning for the Service and lead to necessary improvements.

The Service also welcomes comments, compliments, and suggestions to provide a broad and balanced feedback of service user experiences.

1.1 Requirement for an Annual Report

The Children Act 1989 Representations Procedure (England) Regulations 2006 require the submission of an Annual Report by every local authority which "provides a mechanism by which the local authority can be kept informed of the operation of its complaints procedure." This report has been prepared by the Complaints Manager in conjunction with Regulation requirements and provides data and analysis of information in relation to the complaints made to the Children's Social Care Client Relations Team and those referred to the Local Government and Social Care Ombudsman (LGSCO). This information is produced with the aim of providing intelligence to show where lessons can be learned and service improvements may be required.

The data used for this report is from received during the period 1 April 2019 to 31 March 2020.

1.2 Making a complaint

Children Social Care staff ensure that all children of an appropriate age, who are new to the care system are in receipt of a complaints leaflet. Information is also readily available to children and young people via the website and the Mind of My Own app.

In order to raise a concern or make a complaint, children, young people, their parents/carers/guardians/appropriate adult may:

- **talk to the relevant social care support staff to let them try and resolve the issue with them direct;**
- **Email or write to the clientrelations@northumberland.gov.uk team**
- **Telephone the Client Relations Team on 01670 628888**
- **Use the MOMO app.**

2.0 Numbers and Analysis

2.1 Complaints received

2.2 The table below shows how many complaints have been recorded for Children's Social Care broken down into individual financial years. The table shows that there has been an increase in complaints, however, this can be accounted for due to change within the Client Relations Team and the way in which complaints/feedback are now being recorded and managed.

2.3 In addition, corporate complaints in relation to Children's Social Care are now being received and managed by the Client Relations Team.

Year	Social Care	Corporate	Total
2017/18	27	Not recorded	27
2018/19	44	2	46
2019/20	46	4	50

2.4 Of the 50 complaints received, only 3 were from young people. 1 was from a current Looked After Child and 2 were former Looked After Children.

2.5 Whilst the majority of formal complaints are from adults either on behalf of or about a child or young person; the Council have found that children and young people tend to raise concerns through the many other routes available to them. This includes their allocated social worker, IRO, through care team meetings or advocates. From reviewing the data provided by the individual residential units, most of the issues raised are more related to day to day issues within the units rather than service processes or procedures, for example complaints have been recorded regarding the quality or repetitiveness of meal provision or how disagreements between residents have been dealt with. From recordings it is evidenced that the issues have been dealt with promptly and effectively.

2.6 Statistically, our Units have recorded the following for 2019/20.

Unit	Complaints
Barndale	0
Coanwood	0
Kyloe	24
Phoenix	2
Thorndale	4

2.7 **Although the figures look high for Kyloe House, it is considered that this is due to the fact it is a secure children's home and often deals with the most challenging of young people.**

2.8 Complaints resolved at Stage 1

2.9 **Of the 50 complaints received during 2019/20, 7 were not progressed. Reasons for not progressing a complaint in accordance with regulations include the complainant being involved in a concurrent investigation such as court proceedings (Regulation 8) or being outside the 12 month timescale for making a complaint (Regulation 9). A complaint can also be refused if there is a more appropriate, alternate process such as an appeal or Tribunal.**

2 complaints were withdrawn by the complainant;
17 partially upheld;
7 were fully upheld; and
16 of these complaints were not upheld.

2.10 **Only 3 complaints were progressed to Stage 2. One of those progressed remains on-going.**

2.11 **In comparison, 15 complaints were progressed to Stage 2 in 2018/19 due to complainants remaining dissatisfied with their initial response. Significant work has been undertaken during 2019/20 by the department to improve the quality of investigation and response provided at Stage 1 and it is hoped this figure demonstrates the positive result of that work.**

2.9 Complaints escalated to Stage 2

2.10 **3 complaints have been escalated to Stage 2 this year. 1 of these complaints was corporate and therefore follow the corporate process which involves a senior manager undertaking a review of the investigation at outcomes at Stage 1. The remaining 2 were dealt with under the statutory children's regulations via independent investigation. One of these complaints remains on-going as it has been escalated to Stage 3 Review Panel.**

2.11 **One complaint saw the council making the unprecedented decision of stopping the complaint at Stage 2 due to the complainant's unacceptable behaviour towards Council officers. This decision was made in accordance with Annex 5 of the Getting the Best from Complaints guidance and was only made following multi-agency working and legal advice.**

2.12 Complaints escalated to Stage 3 - Review Panels

2.13 **Of the complaints recorded during 2019/20 only one has been escalated to Stage 3 Review Panel.**

2.14 **The purpose of the Review Panel is to consider the standard and quality of investigation undertaken at Stage 2, highlight any problems in that investigation and to provide the complainant with an opportunity for further reconsideration of their complaint points. The Review Panel can offer further suggestion on remedy for the Council to consider.**

2.15 Due to Covid-19 restrictions, there has been some delay in progressing the Stage 3 Review Panel, however, arrangements for a virtual panel hearing are underway.

2.16 Complaint response timescales

2.17 At Stage 1 complaints should be responded to within 10 working days, with an extension to 20 working days in certain circumstances. For the 2019/20 year response figures are as below:

15 complaints were responded to within 10 working days;
18 complaints were responded to within 20 working days; and
11 complaints took over 20 working days to respond to.

2.18 This demonstrates that 77% of all complaints were responded to within statutory timescales. This is an improvement from 2018/19 where response rates within timescale was 59% (18% increase).

2.19 It should be noted that focus is very much on resolution of complaint issues and that although 11 of the complaints were over the 20 working days timescale for formal response, most of those complaints involved delays due to officers meeting with complainants to attempt resolution before a final written response was provided. Complainants are kept informed of any delay, the reason for it and when they can expect a further update.

2.20 Complaint handling will be analysed to ensure lessons can be learned to further improve response timescales wherever possible.

2.21 Complaint response at Stage 2

2.22 At Stage 2, statutory legislation states that complaints should be responded to within 25 working days or 65 working days depending on complexity, etc. The majority of complaints at stage 2 within Northumberland have been extended to the 65 working day timeframe due to various issues including complexity of the complaint, the number and availability of staff to be interviewed, contact having to be made with former employees, availability of complainants and IO/IP.

2.23 Three complaints recorded in 2019/20 have been escalated to Stage 2. One was a corporate complaint and therefore not within the statutory process. This complaint was responded to within the 20 working day timeframe for the corporate process.

2.24 As previously mentioned, one of the Stage 2 children's social care complaints was stopped by the Council. The remaining Stage 2 investigation took 112 days to complete. This was in part due to the introduction of Covid-19 restrictions during the investigation period of the complaint. This has been accounted for by the IO within his report. Whilst not within statutory timescales, the complainant was kept informed of progress by the IO, the reasons for delays and was given the option to progress to the LGSCO at any time.

3.0 External review

3.1 Local Government and Social Care Ombudsman

3.2 The Local Government and Social Care Ombudsman (LGSCO) look at complaints about Local Authorities once a complaint has completed all stages of the Local Authority complaint process. If a complaint has not been considered by a Local Authority, the LGSCO will usually refer it back to the Authority to look into and class this as a "premature" complaint. They are independent of all Government departments and have the same powers as the High Court to obtain information and documents. If they find the Authority has done something wrong they will make recommendations to put things right.

3.3 The LGSCO produce an Annual Letter in relation to every Local Authority to indicate how many complaints have been received during the year, with the outcome of each complaint and an indication of how each Local Authority has performed. All information can be found via

https://www.lgo.org.uk/your-councils-performance

3.4 The 2019/20 Annual Letter indicates that NCC have received 6 decision notices; 2 were closed after initial enquiries due to 1 being outside their jurisdiction for investigation and 1 where the complainant was asking for an outcome outside of their remit.

3.5 Of the remaining 4 complaints 3 were upheld and 1 not upheld.

3.6 When comparing the statistics on the LGSCO website to other similar authorities (as determined by LGSCO), NCC indicate similar levels of complaint referrals to the LGSCO and comparative findings.

Council	Closed after initial enquiry	Upheld	Not Upheld	Total
Northumberland	2	3	1	6
Durham	12	3	2	17
Middlesbrough	7	0	1	8
Nottinghamshire	4	4	2	10

4.0 Categorisation of Complaints

4.1 When complaints are recorded, the Client Relations Team assess and determine the nature of the complaint and what the content relates to. At the present time the complaints can only be allocated one category, however, a number of the complaints involve more categories and it is hoped that future system changes will support improved intelligence gathering.

4.2 The following table indicates how the complaints were categorised according to the content and nature of the complaint being made.

Category	Number
Communications/Information	8
Delay in Service	1
Failure to follow policy/procedure	2
Standard of service	20
Staff manner/attitude	0
Breach of confidentiality	6
policy	0
Issue with social worker	6
Disagree with officer decision	7

4.3 Standard of service has been the biggest categorisation of complaints, however, this includes complaints where there are maybe several issues being considered and they cannot all be categorised individually. Of the 20 complaints categorised as standard of service, only 2 were upheld in full with a further 4 being partially upheld.

5.0 Lessons learned

5.1 During 2019/20 the focus has been very much around using the learning from complaints and other feedback to identify where service improvements may be required. This could take the form of individual staff or team training/supervision or departmental process change.

5.2 Senior management have commenced a project to ensure all learning is taken forward to make sure it is embedded into practice. A project manager for quality assurance has been appointed and will be working closely with the Complaints Manager for Children's Services to clarify how this can be achieved.

5.3 In the interim, information regarding complaints is now a standard item on team meeting agendas to make sure there is discussion and learning taken from not only the outcomes of complaints but the complaint management, handling and investigation also.

5.4 Information is also presented quarterly to the Children's social care leadership team in relation to the learning from complaints.

5.5 Examples of the lessons learned can be seen below:

Complaint	Outcome/lesson learned
Young person removed from the home due to allegations made by a younger sibling. Parent made complaint that no financial support was offered to young person whilst out of the family home.	Complaint partially upheld as financial support was offered but was not subsequently paid. Case recordings were unclear. Young person was reimbursed for the relevant time period, apology given and individual and team training was undertaken.
Resident made a safeguarding referral against a neighbour asking for complete confidentiality. Social worker inadvertently shared the identity of the complainant to the family. This resulted in harassment from the family and police involvement.	The complaint as fully upheld and financial remedy offered to the complainant. Individual staff training was undertaken in relation to Data Protection and safeguarding.
Parent complained that gifts provided for children in foster care were not passed on by social worker in a timely manner leading to distress for both children and parents.	Complaint upheld – social worker stated they had been too busy. This was addressed by individual supervision with the particular member of staff and time management training. There was also feedback across the department via management about the impact on the children and reminders about timeliness of actions.
Complaint regarding delays in adoption process and experience of potential	Complaint was partially upheld. Complainant is providing the Council

adopter. Adopter felt they had "jumped through hoops" to comply with all requirements of council to ensure the adoption could go through. Towards the end of the process, due to a problem with the delay in the process, they were told they had "breached" the requirements by booking a holiday before the process was complete during what they described as an upsetting contact. Adopter felt this was inappropriate at a stressful time and caused considerable distress.	**with an impact statement that can be used for staff training event to raise awareness of how language can create negativity.**

5.6 Summary

5.7 Improvements to complaint handling, and response times particularly, are noted within this report. Work on further improvements will continue to try and ensure the Council are as compliant with regulatory requirements as possible.

5.8 Lessons learned will remain the focus of this department to make sure service provision is continually reviewed and improved moving forward. This supports the ethos and focus of both OFSTED and the LGSCO. In addition to complaint and enquiry information, the department will be looking at compliments received in order to capture where there are examples of good practice and promote these within the department.

5.9 A programme of training will be identified using complaints and other customer feedback to support this.

5.10 Training will also be provided to Elected Members regarding children's social care complaints and legislation. This will include elements of how they can assist their constituents with accessing the complaints process and feed into service improvements.

6.0 Further information regarding complaints

6.1 **Should further information be required in relation to any aspect of this report or the handling of children's social care complaints, please do not hesitate to contact the Complaints Manager for Children's Services on 01670 628888 or via email clientrelations@northumberland.gov.uk**

6.2 **Information can also be found on the Council website www.northumberland.gov.uk**