Northumberland County Council

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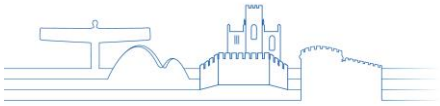


NHS North East and North Cumbria

Complaints Annual Report 2021-22: Adult Social Care and Continuing Health Care Services

- **Adult social care**
- **Continuing health care services**

Contents

0. Introduction

0.1 **This 'Complaints Annual Report' report covers adult 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 describes what people have said about our adult social care services in Northumberland and what we have learned as a consequence during 2021/22. 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 **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.**

0.4 **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.**

1. Adult social care complaints – 2021/22

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 2020/21 and some complaints received in 2021/22 will carry over into 2022/23. The table below notes the numbers of complaints received in 2021/22 and the previous two years:**

Complaints received	2019/20	2020/21	2021/22	Trend
Adult social care	50	44	55	⇧
CHC	8	3	2	⇩
Total	58	47	57	⇧

1.2 **Over the past year we have seen an overall increase in the number of complaints being made, although slightly lower than two years ago.**

1.3 **The table below notes the numbers of complaints responded to in 2021/22 and the previous two years:**

Complaints responded to	2019/20	2020/21	2021/22	Trend
Adult social care	54	41	55	⇧
CHC	9	3	1	⇩
Total	63	44	56	⇧

1.4 **In line with the increase of complaints received, we have seen a corresponding increase in the numbers responded to over 2021/22.**

ADULT SOCIAL CARE COMPLAINTS

1.5 **The table below shows the outcomes from the responded to adult social care complaints, whether upheld, not upheld, or partly upheld. Please note this table and the following ones in this section relate to the 55 responded to adult social care complaints. The CHC complaints data (one complaint responded to in 2021/22) follows later from section 1.12.**

Complaint outcomes	2019/20	2020/21	2021/22	Trend
Upheld	13	8	14	⇧

Not upheld	25	14	19	⇧
Partly upheld	16	19	19	⇨
Other outcomes	0	0	3	⇧
Total	54	41	55	⇧
Upheld and partly upheld combined	29	27	33	⇧

1.6 **The table below shows the above information as a percentage and confirms the upward trend of upheld complaints. 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 whereas other elements are not upheld. Over 2021/22, 'other outcomes' include one complaint that could not be determined and three complaints that were withdrawn.**

Complaint outcomes	2019/20	2020/21	2021/22	Trend
Upheld	24%	20%	25%	⇧
Not upheld	46%	34%	35%	⇧
Partly upheld	30%	46%	35%	⇩
Other outcomes	0%	0%	5%	⇧
Upheld and partly upheld combined	54%	66%	60%	⇩

1.7 **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. We have also seen an increase in the numbers of complaints related to independent providers. Again, the numbers remain low in the context of the work done. Overall, analysis suggests that many service users, carers, and families hold positive views about independent providers in Northumberland.**

Service area complained about	2019/20	2020/21	2021/22	Trend
Care management	32	29	33	⇧
Community substance abuse	0	0	1	⇧
Finance team	4	5	2	⇩

Home improvement service	**1**	**3**	**3**	⇨
Home safe	**0**	**0**	**1**	⇧
Independent provider	**10**	**3**	**10**	⇧
In-house provider	**1**	**0**	**0**	⇨
Occupational therapy	**1**	**0**	**1**	⇧
Northumberland Communities Together	**0**	**0**	**1**	⇧
Onecall	**1**	**0**	**0**	⇨
Safeguarding adults' team	**0**	**0**	**1**	⇧
Self-directed support team	**1**	**1**	**1**	⇨
Short term support service	**3**	**0**	**1**	⇧
Total	**54**	**41**	**55**	⇧

1.8 Please note that charges continue to be an underlying issue in many complaints, around 1 in 5. In this context, the key issues complained about, such as 'disagreements', 'communication' and the 'standard of service provision' are to be expected. Analysis suggests that this is at least in part due to people having, quite rightly, high expectations of services; and in part because service users are expected to contribute (more) towards the cost of their care.

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

Subject matter	2018/19	2019/20	2020/21	Trend
Adaptations & equipment	**1**	**0**	**0**	⇨
Attitude or conduct of staff	**2**	**2**	**4**	⇧
Communication / information	**7**	**7**	**15**	⇧

Contact arrangements	**1**	**0**	**0**	⇨
Disagreement with assessments / reports	**4**	**3**	**1**	⇩
Disagreement with decisions	**3**	**7**	**7**	⇨
Failure to follow procedure	**3**	**4**	**2**	⇩
Finance / funding	**9**	**4**	**6**	⇧
Health & safety	**0**	**0**	**0**	⇨
Speed or delays in service	**2**	**0**	**3**	⇧
Standard of service provision	**22**	**14**	**17**	⇧
Total	**54**	**41**	**55**	⇧

1.10 As noted above, key areas relate to 'disagreements', 'communication' and the 'standard of service provision'.

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

CHC COMPLAINTS

1.12 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.

Complaint outcomes	2019/20	2020/21	2021/22	Trend
Upheld	**1**	**1**	**0**	⇩
Not upheld	**1**	**0**	**0**	⇨
Partly upheld	**7**	**2**	**0**	⇩
Other outcomes	**0**	**0**	**1**	⇧
Total	**9**	**3**	**1**	⇩
Upheld and partly upheld combined	**8**	**3**	**0**	⇩

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

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

Service area complained about	2019/20	2020/21	2021/22	Trend
Care management	5	2	1	⇩
Independent provider	0	1	0	⇩
Nurse assessment team	2	0	0	⇩
Occupational therapy	1	0	0	⇨
Support planners	1	0	0	⇨
Total	9	3	1	⇩

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

Subject matter	2018/19	2019/20	2020/21	Trend
Attitude or conduct of staff	1	0	0	⇨
Disagreement with assessments / reports	1	1	0	⇩
Disagreement with decisions	0	0	1	⇧
Failure to follow procedure	3	1	0	⇩
Finance / funding	1	0	0	⇨
Speed or delays in service	0	0	0	⇨
Standard of service provision	3	1	0	⇩
Total	9	3	1	⇩

1.16 What 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 2021/22 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.

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 to 'disagreements', 'communication' and the 'standard of service provision' to illustrate the actions taken to resolve complaints and improve services where they were upheld and party upheld.

Key complaint categories for complaints responded to over 2021/22 are 'Standard of service provision', 'Communication/information', and 'disagreements'. Taken together these complaints suggest, irrespective of outcomes (people make complaints because they are unhappy about staff or services), that services are not always meeting the expectations of service users, their families, and carers; and that this is, in part, due to perceived issues around quality and, in part, due to service users and their families and carers not knowing what to expect.

As a result of this analysis and other sources of information, work is currently underway with all service areas to make sure that all relevant staff are clear about their role and the expected standards; and that appropriate information is being communicated to service users, their families, and carers at the right time, especially about charging and the recording of such (11 of 56 complaints responded to over 2021/22 related in some way to charging (10) or interim health funding (1); and of these, 9 related to the care management function and 2 to the finance team).

2.5 Communication/information:

1. **A family complained about the lack of communication and information around a change in site being managed by a day care provider. On investigation it was found that while initial information was shared in a timely way, communication with care management had been lacking and the changes were introduced very suddenly leading to anxiety and upset for the service user and their family. An apology was made. To prevent recurrence, the commissioning team reviewed the contract and decided to include a more detailed process in the contract for this provider.**

2. **A service user complained that his adult social care & support plan had been placed into his homecare file at his home, and that this could be read by any of his carers. It contained personal information. On investigation, it was found that the care & support plan should not have been placed in the homecare file, that homecare staff had not followed procedure. An apology was given, and remedial action taken to prevent recurrence. In addition, all of the homecare provider's case managers and senior case managers were reminded about the correct procedure – all staff must follow the checklist which outlines clearly which documents are to go into both the office file and the customer's file at home; and that senior case managers should sign off all files before they are taken to the customer's home.**

3. **A father complained because monies had been taken despite his son not restarting day care until a later time than the finance team believed. On investigation, it was found that the system hadn't been updated in a timely manner by the care manager to reflect the necessary changes, which in turn had a knock-on effect for the finance team and charges. An apology was given, the system updated, and the relevant member of staff reminded about the expectation to update the system in a timely manner.**

4. **The wife of the service user was unhappy about an apparent lack of calls back and because she had not had a carer's assessment despite her request. On investigation, it was found that her messages had been responded to each time and while her husband had been assessed, she had not been offered or received a carer's assessment. This happened because the referral information only mentioned the husband's care and support assessment. However, the complainant should still have been offered a carer's assessment as matter of routine. An apology was given, and the relevant member of staff reminded about the expectations around carer's assessments.**

5. **A family member complained about the lack of communication from the service user's social worker about future accommodation. The social worker had also called and inadvertently upset the service user's mother despite an existing communication plan to call the family member. On investigation, it was found that the social worker had not handled matters in the way they should have done, and they were supported to learn from this episode and to improve their practice. An apology was given, and a plan put in place to address the family's concerns about future accommodation. The family member appeared satisfied with this outcome.**

6. **A family member complained about the charges his mother was being asked to pay for a respite stay when he'd been previously been told that there would be nothing to pay; and that the care manager appeared to be avoiding his calls and emails seeking clarity about the situation. On investigation it was found that the care manager had given inaccurate information about charges and had seemingly avoided**

raising this situation with her manager after the complainant had raised his queries. An apology was given, and the member of staff spoken to about how she had responded and supported to improve her practice.

2.6 Disagreements:

1. **A family member complained that her deceased parents (and now their respective estates) were out of pocket after paying rent on their tenancy throughout their time in a care home; and that they should have been made permanent residents. On investigation, it was found that both parents had come into care for respite that was later amended to temporary stays and that this had remained the case until both died within a short time of each other several months later. As a result of these findings, the complaint was upheld, and the estates reimbursed with an appropriate sum to reflect the monies they paid in rent. Steps were also taken to review other temporary stays to make sure this status was still appropriate.**

2. **A family member complained that she was having to manage her husband's care package using her own resources to supplement the direct payment because his level of need hadn't been fully recognised and she had been left to get on with things. On investigation, this was found to be largely correct, and it was acknowledged that without her initiative and management her husband wouldn't have been able to live independently at home. Steps were taken to make sure the care & support assessment accurately reflected the service user's level of need, that the direct payment was able to cover all the necessary costs, and that his care package was meeting his assessed needs. An apology was given, and an appropriate financial remedy provided. To prevent recurrence, follow up work was undertaken with the relevant service areas.**

3. **A son complained about the care and treatment his father (since deceased) had received whilst a temporary resident at a care home in addition to complaints about the involvement of adult social care. This was a long and complex investigation, and the findings were shared with the relevant senior managers for information and action as appropriate. In short, some good practice was noted, however, fault was identified in the way a Mental Capacity Act assessment was carried out in this case. In addition, the social worker's communication was found to be insensitive and unprofessional in some emails, getting names wrong on occasion. It was also found that the care home didn't provide appropriate care to the client for a number of reasons explained in detail in the findings. Several apologies were given.**

2.7 The standard of service provision:

1. **A service user complained after agreeing that staff could help her by tidying and by removing certain items from her property before her hospital discharge. On her return home she said that she found some items left outside and ruined, some of which she had wanted to keep; some other items inside had been broken or lost; that there wasn't a**

clear pathway through the house to allow her to use her walking frame; and that she couldn't get to her clothes or access the heating system. On investigation, it was found that the list that the staff had worked to didn't clearly set out what was to be done and that the work hadn't been completed. The investigating manger discussed matters with the support planners and agreed how they would approach this kind of work in the future to avoid a recurrence of what happened in this case. In addition, an apology and a suitable financial remedy were given.

2. **A daughter complained that her father had been 'kept' in a care home for much longer than was necessary before he was 'allowed' to go home. Consequently, he had a larger charge to pay for his stay than expected. She also raised several other matters related to the team and how the case had been handled and how staff had responded to her over time. On investigation, it was found that the service user was unable to make his own health and wellbeing decisions and that the daughter and other family members had a legal power to make these decisions. However, the process staff had followed to support the family to decide whether he should remain in care or go home was unnecessarily protracted. Evidence was not found to support many of the other issues raised but an apology was given for the time taken to resolve matters and the Council paid the care home fees in recognition of this. The daughter was also given assurances that several improvements had been made around Mental Capacity Act processes and procedures since the events that affected her father and the family.**

3. **A family member complained about several issues related to his father's care in a care home over the weekend of Storm Arwen, that he was hungry and hadn't had a bath on his return home. On investigation it was found that the staff had done as much as they reasonably could in the circumstances and overall had managed the situation well. The records showed that the service user had eaten properly but had refused all help with personal care. However, an apology was given because the family had some difficulty gaining access to the care home when they visited because the front door was not staffed as it usually would have been.**

4. **A family member complained about the response from adult social care when she asked for help caring for her husband after his health deteriorated. She felt that she had been left to get on with things by herself. On investigation, it was found that some immediate assistance was provided but that there was not a prompt enough follow-up to reassess the situation. An apology was given for this and assurances that the member of staff was being supported to improve their practice (as events transpired, the service user's condition improved).**

5. **A daughter complained that the homecare provider staff hadn't worn appropriate PPE when they visited her father; nor had they investigated properly when she raised this with them, responding back to her by text message. On investigation, it was found that staff had followed the provider's PPE procedures. In respect of the text message, it was**

accepted that this wasn't an appropriate way of responding but in mitigation, the relevant member of staff had tried to call first without success. An apology was given.

2.8 In respect of carers, during 2021/22 the complaints team updated internal processes to make sure the senior manager who leads on carers issues is kept informed about relevant complaints from the outset.

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.

2.10 In respect of learning from complaints decided by the Local Government and Social Care Ombudsman, one decision led to the introduction of a more formal framework for considering appeals against decisions on disability-related expenditure, to ensure that they are made in a manner consistent with the LGSCO's advice about what is legally required.

3. Adult social care and CHC 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. Historically, we have found that around 6 to 8 complainants ask the LSCGO to consider a complaint that adult social care has tried to resolve, although more recent analysis has suggested this average is likely to increase.

Decisions	2019/20	2020/21	2021/22	Trend
LGSCO	9	6	9	
PHSO	0	0	1	
Joint Team	0	0	2	
Total	9	6	12	

3.5 Over 2021/22 we received a higher than average numbers for adult social care. A rise in complaints to LGSCO is in part likely due to higher 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 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.

3.7 **We always comply with the recommendations the Ombudsman has made, to put things right for the complainant and/or to improve our services, as appropriate. The Ombudsman "has also identified that actions taken suggest a positive culture within NCC about the benefits of responding to and learning from complaints" and suggested that "NCC increasingly recognises the importance of being open and accountable" (from the Annual Ombudsman Complaint Report 2021/22 issued in July 2022).**

3.8 **Almost all the decisions LGSCO make are available to read on their website:**

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

3.9 **The following pages summarise the substantive outcomes of those Northumberland adult social care complaints considered by LGSCO in 2020/21. Please note that LGSCO made more decisions than the ones noted below, the ones not reported on are those where the LGSCO considered the complaint 'premature', where there was insufficient information for LGSCO to progress the complaint, or where the person requested their complaint not to proceed, for example. These decisions are not routinely shared with the Council.**

Summary of complaint Adult services	Summary of ombudsman's final decision
19016735 Joint Working Team **Mr B complains about his father's care and treatment by the Trust and the Council.**	**Mr B complains the Trust refused to detain his father, Mr C, in hospital. The Trust properly considered whether to detain Mr C. Mr B also complains the Council did not offer Mr C a placement in a care home. Mr C did not want to go into a care home but preferred to be at home with his wife. There is no fault.**
20000293 **Ms X complains about the way the Council has dealt with Ms Y's direct payment account and its decision to decline arranging a further independent audit of her account.**	**The Council is not at fault for declining to offer a further independent audit to Ms Y. The Council is at fault as its communication with Ms Y lacked clarity which caused upset to her. The Council has apologised to Ms X and Ms Y for the confusion and upset caused which is an appropriate remedy. I have therefore completed my investigation.**
21003949 **Mr X complains that works to his bathroom carried out under a Disabled Facilities Grant were of poor quality and led to problems in his home. Mr X would like the Council to redo the bathroom.**	**We have found no evidence of fault in the way the Council facilitated the works at Mr X's property or in the way it responded to Mr X's reports of defects and offered to carry out remedial works. So, we have completed our investigation.**
20001819 **Mr X complained that the Council failed to consider holiday travel**	**There was fault by the Council which caused injustice to Mr X.**

and accommodation costs for a carer as a disability-related expense. He says this caused him an injustice because he was concerned he may not be able to go on holiday. **Mr X said that he had already arranged a holiday before the Council changed its approach to charging and this has impacted him financially.**	**The Council has taken the recommended action to remedy that injustice:** • **apologise to Mr X for the fault identified;** • **pay a modest sum to acknowledge the time and trouble caused by the need to pursue the matter with the Council; and** • **review Mr X's request for holiday costs for his carer to be considered a DRE.**
20010361 **Mrs X complains the Care Provider commissioned by the Council breached social distancing and other COVID-19 precautions, acted insensitively after her relative Mrs Y's death, did not provide documents the family sought, and did not deal properly with the complaint about those matters. Mrs X says this distressed the family.**	**We shall not investigate this complaint. We would not be able to reach a clear enough view about whether any fault by the Council caused Mrs Y's death. Some points are more properly for the courts or the Information Commissioner. Other points are not in themselves significant enough to warrant investigation.**
20012826 Joint Working Team **Mrs B is complaining about the care and treatment provided to her husband, Mr B, between February and May 2020 by the Trust), the Council, and the care home.**	**We found fault by the care provider as it failed to maintain accurate and complete nutritional records for Mr B, an elderly man at risk of malnutrition. We also found fault by the Trust as staff failed to inform Mr B's family that his dentures were broken. The provider and the Trust will apologise for this fault. We found no fault by the Council in terms of the care it provided to Mr B.**

21001784 **Mr X complains the Council:** **a) Cancelled his care package in November 2020 and did not properly consider his needs when doing so.** **b) Did not put in place a care package after reinstating his care in March 2021.** **c) Cancelled his care package in October 2021.** **2. Mr X says he has not received the care he needs, and his parents had to come and live with him to provide care and support.**	**The Council was not at fault for failing to provide care to Mr X nor for its decision to cancel his care package.**
21016768 **Miss X complains the Council failed to involve her family when it made decisions about her late father's care. Miss X says the Council has breached the family's human rights and they have been threatened with court proceedings due to unpaid care charges.** **Miss X says the whole incident has caused her and her family significant mental anguish and the Council has caused them unnecessary time and trouble.**	**We will not investigate this complaint about the Council's actions regarding Miss X's late father when he was in care. This is because the Council has already provided a remedy for the injustice caused to the family which goes beyond what we would usually recommend. Therefore, there is nothing further we can achieve from an investigation of this complaint.**

21005828 Joint Working Team **A Care Home Association complained about the way the Council and the CCG dealt with its complaint made on behalf of its members.**	**We did not find fault in the way the Council and the CCG considered the complaint from the Association.**
21011466 **Ms X complains the Council has failed to provide information to the public about a care service she operates in its area. Ms X says the Council has a statutory duty to make this information available.**	**We will not investigate this complaint about information the Council provides to the public about care services in its area. This is because there is no evidence of fault as the Council's actions are in line with legislation and statutory guidance.**
21008788 **On Ms X's behalf, her representative complains about the way the Council dealt with data protection issues involving Ms X's personal information.**	**We will not investigate this complaint about the Council's handling of Ms X's personal information. This is because the Information Commissioner's Office is the body best placed to deal with data protection issues.**
C-2028442 PHSO **This complaint related to an OT's judgment about the potential adaptability of a property to meet the needs of a disabled adult.**	**We have declined this complaint as it is "Out of Time" to our service.**

4. Adult social care enquires received in 2021/22

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 2021/22, 154 enquiries were recorded by the team that related to adult services.

4.5 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.

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

Enquiries received	2019/20	2020/21	2021/22	Trend
Adult social care	118	96	154	⇧

Enquiries by service area	2019/20	2020/21	2021/22	Trend
Care management	72	52	69	⇧
Complaints team	0	0	2	⇧
Continuing healthcare	1	7	11	⇧
Contracts & commissioning	1	6	0	⇩
Finance	9	14	17	⇧
General	1	0	2	⇧

Home improvement service	**1**	**3**	**3**	⇩
Independent social care providers	**6**	**2**	**11**	⇧
In-house residential care	**0**	**1**	**0**	⇩
Joint equipment and loan service	**5**	**0**	**0**	⇨
Northumbria Healthcare	**3**	**1**	**1**	⇨
Occupational therapy	**7**	**4**	**13**	⇧
Onecall	**2**	**0**	**3**	⇧
Other NCC	**0**	**0**	**3**	⇧
Other organisations	**2**	**4**	**5**	⇧
Safeguarding adults	**3**	**1**	**12**	⇧
Self-directed support team	**3**	**1**	**2**	⇧
Short term support service	**2**	**0**	**0**	⇨
Total	**118**	**96**	**154**	⇧

4.7 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.

4.8 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.

4.9 Analysis suggests that the increase of enquiries is related to most people making contact with the right organisation first time when they have a query

or concern. This suggests that our complaints publicity is effective. However, the increased contacts related to occupational therapy and to safeguarding suggests some people may not be sure about what to expect from these services and this issue is being picked up in the work noted in section 2.4 above.

4.10 Analysis also suggests that the increasing contacts relating to CHC and to finance reflects the importance of charges to families and to service users and an increased awareness of costs.

5. Adult social care compliments received in 2021/22

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 2020/21 adult social care received 587 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.

5.5 Overall, adult social care compliments have decreased over the past year although continuing healthcare compliments have increased. Analysis suggests that the overall decrease is the result of competing work priorities rather than a change in quality of services, with the staff TUPE in October 2021 and the subsequent organisational changes planned for over the latter half of the year resulting in less compliments being shared with the complaints team. Compliments reported by independent providers have, as would therefore be expected, remained more or less unaffected.

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

Compliments received by	2019/20	2020/21	2021/22	Trend
Adult social care	442	536	399	⇩
CHC	117	157	188	⇧
Total	559	693	587	⇩

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

Compliments by service area	2019/20	2020/21	2021/22	Trend
Brokerage	0	0	3	⇧
Care management	110	74	36	⇩

Complaints Service	**3**	**2**	**1**	
Enquiry referral coordinators	**0**	**0**	**1**	
Contracts & commissioning team	**2**	**0**	**0**	
Finance	**5**	**2**	**1**	
Home improvement service	**2**	**0**	**0**	
Home safe	**4**	**8**	**4**	
Independent providers*	**145**	**334**	**286**	
Independent providers**	**0**	**0**	**4**	
In-house day services	**59**	**1**	**8**	
Joint equipment and loan service	**2**	**3**	**0**	
Occupational therapy	**24**	**31**	**27**	
Onecall (single point of access)	**6**	**22**	**0**	
Risk & independence team	**1**	**1**	**0**	
Safeguarding adults' team	**4**	**1**	**1**	
Self-directed support team	**4**	**1**	**1**	
Short term support service	**70**	**56**	**25**	

Welfare rights	**1**	**0**	**1**	⇩
Total	**442**	**536**	**399**	⇧

***Reported by providers**
****Reported directly to NCC**

CHC compliments*	2019/20	2020/21	2021/22	Trend
100% NHS funded packages	**48**	**68**	**93**	⇧
Part NHS funded packages	**69**	**89**	**95**	⇧
Total	**117**	**157**	**188**	⇧

***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 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

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 **Over 2021/22, the Complaints Service hasn't needed to use advocacy. In respect of the CHC complaint, the offer of advocacy wasn't pursued.**

6.5 **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.**

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 family member or service user 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, 2022/23, we will continue to deliver a framework developed to improve complaint handling. This includes considering a range of different ways to use complaints as a positive learning tool and procuring a bespoke case management system which we hope to have in place by the start of 2023. An improved range of management reports will then be available to ensure compliance with service levels whilst analysis reports will provide statistics and trend analysis to aid service improvement.**

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, and despite the challenges of lockdown and increased home working, 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.**

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@northumberland.gov.uk**

Appendix 1: 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 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:

Complaint received

Take appropriate and proportionate action to resolve the issues

Send response letter confirming actions and outcomes

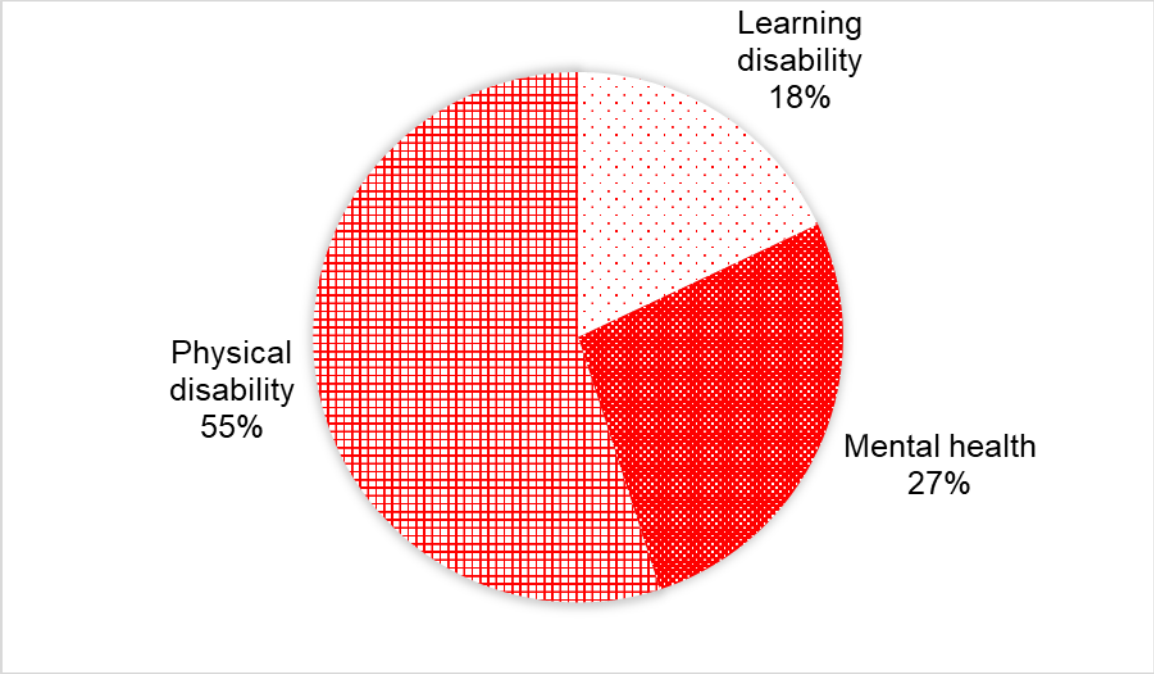
8.8 Apologising is usually appropriate even if only because the person feels they have had a bad experience or because they felt strongly enough about their

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."

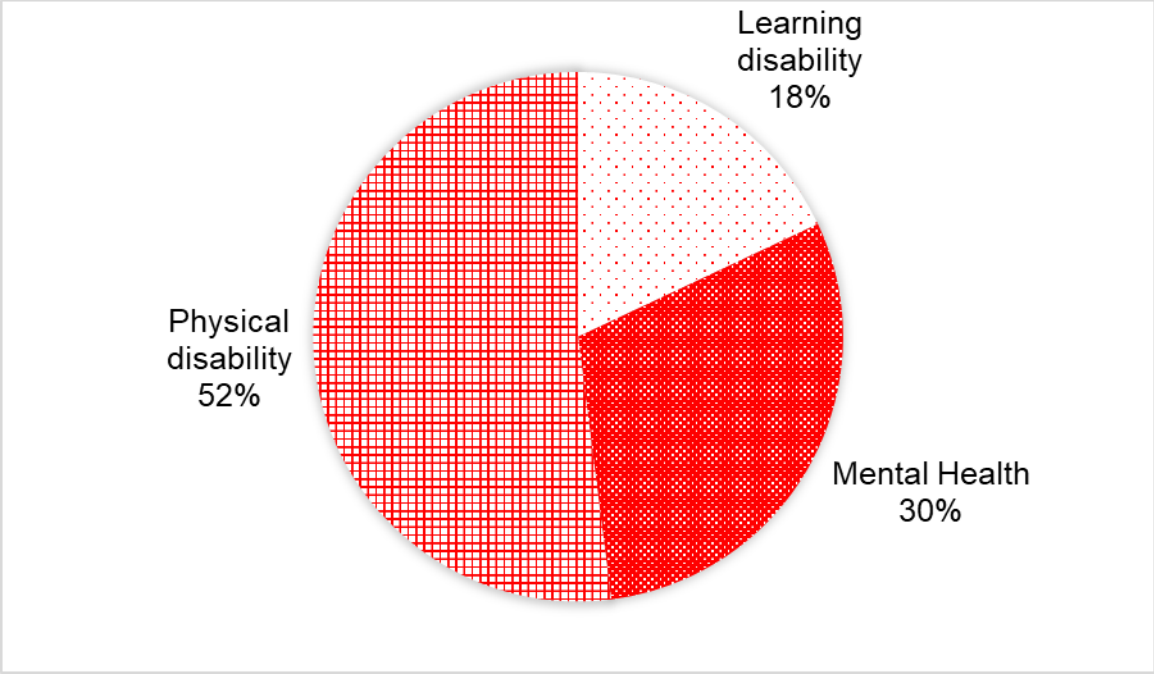
Appendix 2: Equalities Information

9.1 The following equality data is based on 55 complaints responded to over 2021/22. Please note that although 56 complaints were responded to over 2021/22, one complaint, made by a provider, did not relate to any individual service user and has been excluded. The pie charts show proportions, first by complaints, then by adult social care overall, for 'category' then 'gender'. The numbers of complaints responded to are comparatively very small and no conclusions can be drawn although we continue to monitor the situation.

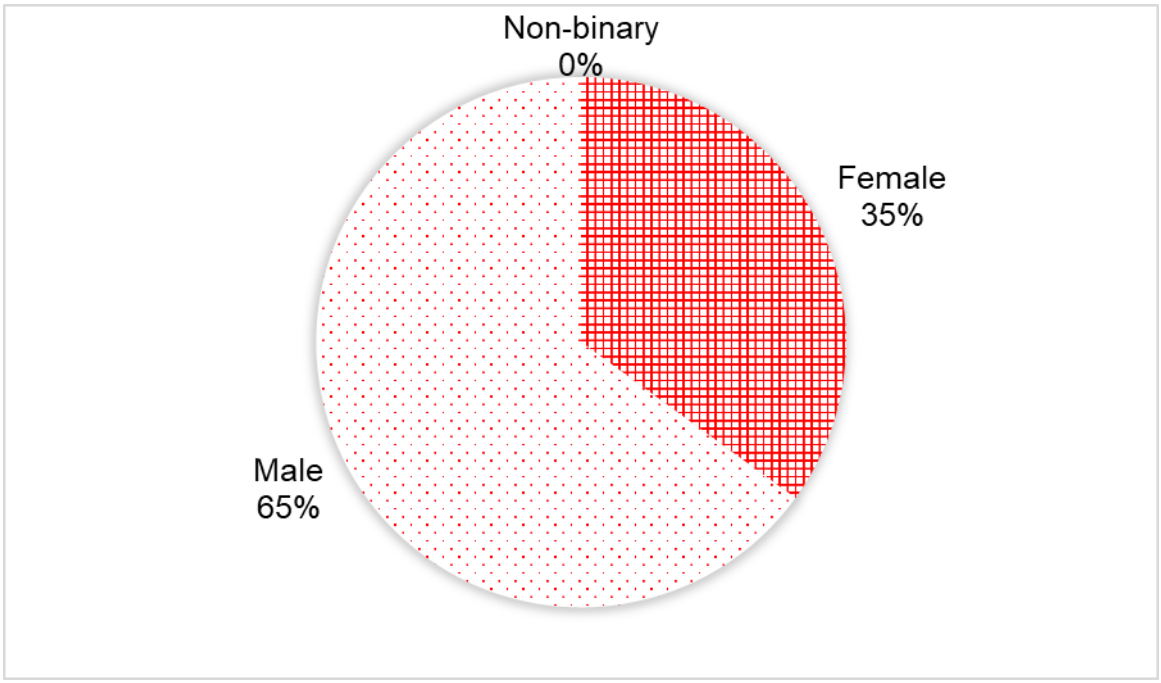
- **Responded to complaints by client category**



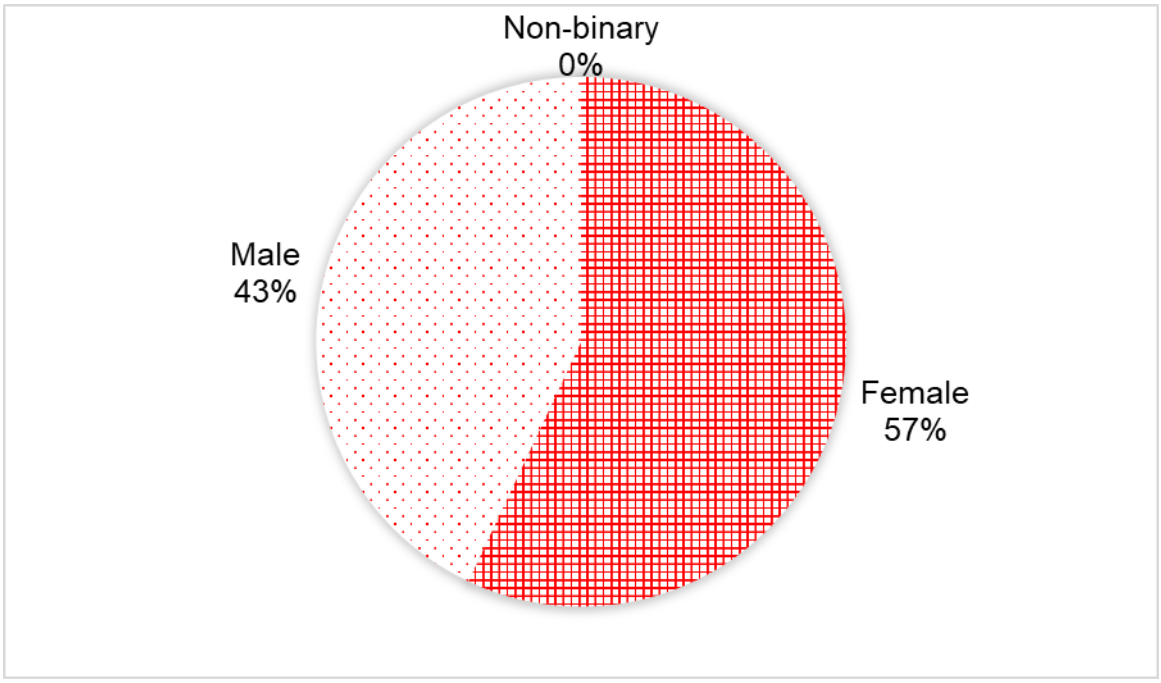
- **Adult social care by client category**



- **Responded to complaints by gender**



- **Adult social care by gender**



9.2 The tables below provide equalities data by ethnic group then by age, with the overall adult social care data alongside the complaints data for responded to complaints. As noted above, the numbers of complaints responded to are comparatively very small and no conclusions can be drawn although we continue to monitor the situation.

- **Responded to complaints by client ethnic group**

Ethnic Group (Headline categories taken from the 2011 Census)	No. of Clients (March 2021)	% of total	% in N'land Population (Census 2011)	Complaints
White	6,877	99.1%	98.4%	100%
Asian / Asian British	26	0.4%	0.8%	0%
Black / African / Caribbean / Black British	4	0.1%	0.1%	0%
Mixed / multiple ethnic groups	15	0.2%	0.5%	0%
Any other Ethnic Group	12	0.2%	0.1%	0%

- **Responded to complaints by age**

Age Range	No. of Clients	% of total	No. of complaints	% of total
Under 18	29	0.4%	0	0%
18-24 years	394	5.6%	3	5.5%
25-44 years	932	13.2%	11	20.0%
45-54 years	586	8.3%	5	9.1%
55-64 years	742	10.5%	6	10.9%
65-74 years	950	13.4%	7	12.7%
75-84 years	1610	22.8%	10	18.2%
85+ years	1824	25.8%	13	23.6%