Northumberland
County Council

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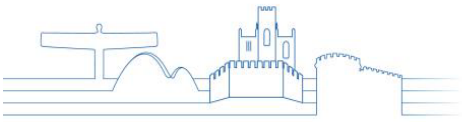


NHS
North East and
North Cumbria

Complaints Annual Report 2022-23: Adult Social Care and Continuing Health Care Services

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

Contents

1.0 Introduction

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

1.2 **The report describes what people have said about our adult social care services in Northumberland and what we have learned as a consequence during 2022/23. The report also describes what people have said about NHS continuing healthcare funded by North East and North Cumbria Integrated Care System and about supporting people in their own home or in a care home.**

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

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

2.0 Adult social care complaints – 2022/23

2.1 The complaints service directly handled all the social care and continuing healthcare complaints made to Northumberland County Council. Please note that some complaints closed were carried over from 2021/22 and some complaints received in 2022/23 will carry over into 2023/24. The table below notes the numbers of complaints received in 2022/23 and the previous two years:

Complaints received	2020/21	2021/22	2022/23	Trend
Adult social care	44	55	43	⇩
CHC	3	2	2	⇩
Total	47	57	45	⇩

2.2 Over the past year we have seen an overall decrease in the number of complaints being made, and slightly lower than two years ago.

2.3 The table below notes the numbers of complaints responded to in 2022/23 and the previous two years:

Complaints responded to	2020/21	2021/22	2022/23	Trend
Adult social care	41	55	28	⇩
CHC	3	1	2	⇧
Total	44	56	30	⇩

2.4 Unfortunately, over 2022/23 there were some unexpected and longer-term absences within the complaints service, and a higher than anticipated number of complaints received in quarter 4 (January to March 2023). Despite best efforts, this resulted in the decrease in numbers of complaints responded to. Please note that the work done to resolve matters and to put things right as necessary, was carried out promptly and communication with the complainants maintained. Please see section 9.7 that shows the one-stage adult social care complaints process and that infers the critical importance of making sure the formal response meets the expected standard.

ADULT SOCIAL CARE COMPLAINTS

2.5 The table below shows the outcomes from the responded to adult social care complaints, whether upheld, not upheld, or partly upheld. The CHC complaints data follows later from section 1.12.

Complaint outcomes	2020/21	2021/22	2022/23	Trend
Upheld	8	14	7	⇩
Not upheld	14	19	10	⇩
Partly upheld	19	19	10	⇩
Other outcomes	0	3	1	⇩
Total	41	55	28	⇩
Upheld and partly upheld combined	27	33	17	⇩

2.6 The table below shows the above information as a percentage. In general terms, we find that most complainants have a point, sometimes an important one. Partly upheld complaints will have at least one element that is upheld and other element(s) that are not upheld. Over 2022/23, the 'other outcomes' refers to a complaint that was withdrawn.

Complaint outcomes	2020/21	2021/22	2022/23	Trend
Upheld	20%	25%	25%	⇨
Not upheld	34%	35%	36%	⇧
Partly upheld	46%	35%	36%	⇧
Other outcomes	0%	5%	3%	⇩
Upheld and partly upheld combined	66%	60%	61%	⇧

2.7 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. Overall, analysis suggests that many service users, carers, and families hold positive views about independent providers in Northumberland.

Service area complained about	2020/21	2021/22	2022/23	Trend
Adult social care teams	29	33	16	⇩
Community substance abuse	0	1	0	⇩
Finance team	5	2	0	⇩
Home improvement service	3	3	4	⇧
Home safe	0	1	2	⇧
Independent provider	3	10	3	⇩
In-house provider	0	0	0	⇨
Occupational therapy	0	1	2	⇧
Northumberland Communities Together	0	1	0	⇩
Onecall	0	0	1	⇧
Safeguarding adults' team	0	1	0	⇩
Self-directed support team	1	1	0	⇩
Short term support service	0	1	0	⇩
Total	41	55	28	⇩

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

Subject matter	2019/20	2020/21	2021/22	Trend
Adaptations & equipment	0	0	0	⇨
Attitude or conduct of staff	2	4	2	⇩

Communication / information	**7**	**15**	**6**	⇩
Contact arrangements	**0**	**0**	**0**	⇨
Disagreement with assessments / reports	**3**	**1**	**0**	⇩
Disagreement with decisions	**7**	**7**	**3**	⇩
Failure to follow procedure	**4**	**2**	**1**	⇩
Finance / funding	**4**	**6**	**1**	⇩
Services not in place	**0**	**0**	**1**	⇧
Speed or delays in service	**0**	**3**	**0**	⇩
Standard of service provision	**14**	**17**	**14**	⇩
Total	**41**	**55**	**28**	⇩

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

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

CHC COMPLAINTS

2.11 **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	2020/21	2021/22	2022/23	Trend
Upheld	1	0	0	⇨
Not upheld	0	0	1	⇧
Partly upheld	2	0	1	⇧
Other outcomes	0	1	0	⇩
Total	3	1	2	⇧
Upheld and partly upheld combined	3	0	1	⇧

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

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

Service area complained about	2020/21	2021/22	2022/23	Trend
Adult social care teams	2	1	1	⇨
Independent provider	1	0	0	⇨
Nurse assessment team	0	0	1	⇧
Total	3	1	2	⇧

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

Subject matter	2020/21	2021/22	2022/23	Trend
Attitude or conduct of staff	0	0	1	⇧
Disagreement	1	0	0	⇨

with assessments / reports				
Disagreement with decisions	**0**	**1**	**0**	⇩
Failure to follow procedure	**1**	**0**	**0**	⇨
Finance / funding	**0**	**0**	**0**	⇨
Services not in place	**0**	**0**	**0**	⇨
Speed or delays in service	**0**	**0**	**0**	⇨
Standard of service provision	**1**	**0**	**1**	⇧
Total	**3**	**1**	**2**	⇧

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

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

3.1 **Many of the issues have been reported over 2022/23 reflect the kind of situations which can occur from time to time in a large care organisation, but we take each one seriously, and take steps to address both the individual situation of the complainant and any wider issues about systems, training and guidance which are raised, as the table below describes in general terms.**

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

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

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

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

3.4 The following section provides a selection of 'thumbnail' portraits by subject matter in the key areas 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, or party upheld.

Key complaint categories for complaints responded to over 2022/23 are 'Standard of service provision', 'Communication/information', and 'Disagreement with decisions'. Taken together these complaints suggest, irrespective of outcomes, that services are not always meeting the expectations of some 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.

Over 2022/23 work has been carried out 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. We will monitor our complaints over 2023/24 to determine the degree to which this work has affected the key categories.

3.5 Communication/information:

1. **A family member complained about the service user's homecare provider, that carers were not staying for the full time or completing the tasks required. They were also unhappy about a seemingly rude email received from a member of office-based staff. On investigation, it was found that carers were completing the tasks that the service user allowed them and that there were occasions when the service user asked the carer to leave before the end of their allotted time. In respect of how this affected charges, it was found that the service user's maximum charge was low and well under the amount of care that was being provided. In respect of the email, the member of staff had apparently meant to send it to the care manager and an apology was given for this mistake. The care provider manager arranged for herself and another senior member of staff to be this family member's point of contact.**

2. **A family member complained about his mother's discharge arrangements to a care home, in particular, that an information pack had not been shared. He was concerned about his mother's contribution towards her services and about 'top-ups'. On investigation no evidence was seen to show that an information pack had been provided. An apology was given. In addition, it was also found that the care home in question hadn't signed up to the Council's 'Short Term Discharge Placement' (STDP) agreement which meant that they could legitimately charge a 'top-up' after the temporary NHS funding (interim health funding) ended, something both the family and care manager were unaware. To prevent recurrence, the vacancy list that is shared between the commissioning and adult social care teams was clarified to show whether a care home was charging 'top-ups' for STDPs or not. The family's member's concern that his mother had been incorrectly charged was not upheld.**

3. **A family member complained about her experiences of communication with her mother's care manager, in respect of charges and general communication. On investigation it was found that the service user moved from a NHS funded, block-booked bed in a care home to an adult social care funded care residential bed in another care home. Unfortunately, it appears the allocated worker referred to the bed being 'funded' which caused some upset when the invoice was sent. In respect of communication more generally, it was found that the allocated worker had changed three times over a comparatively short period of time (with good reason), and that the resulting communication with the service user and their family hadn't been as good as the service would have wanted. An apology was given for the faults found.**

3.6 Disagreement with decisions:

1. **A service user complained about the decision to refuse her a ramp to her home. On investigation, it was found that the individual member of staff who handled the original request had misunderstood the assessment guidance that the request should have still been put through for assessment. The relevant senior occupational therapy manager liaised with the relevant service who took steps to prevent recurrence, and an occupational therapist was allocated and asked to see the service user as a priority. An apology was also given.**

2. **A family member complained about the decision to offer homecare, not residential care, as had been hoped. On investigation, it was found that there was sufficient doubt about the client's mental health to look again at the client's eligibility for services and to make a new decision. An apology was offered.**

3.7 The standard of service provision:

1. **A family member raised some concerns about the adult social care team's involvement in their mother's discharge. On investigation, it**

was found that staff had followed due process throughout although an apology was given for the way two members of staff came across to family during a meeting when they were describing the outcome from earlier discussions with the service user. The issue at hand was seemingly minor but it was important to the family. Both members of staff reflected on their communication and used this experience to inform their future practice.

2. **A family member complained that the care and support package hadn't kept up with his wife's changing needs and private care had been bought to address this. On investigation it was found that reviews had been carried out appropriately and the service user's direct payment adjusted to take into account any increases in care required. However, it didn't appear that the couple had fully understood how charges applied in this case and this was explained in some detail with an apology given.**

3. **A family member complained about the quality of input being provided to the service user and whether they were able to live at home safely. On investigation, it was found that a number of concerns met the safeguarding adults standard, and the investigating manager shared the sense of concern about the service user's ability to manage safely. An apology was offered, and the service user was referred on to a social worker for a full assessment.**

4. **A family member complained about a lack of input when the allocated member of staff went off poorly. On investigation, it was found that the case was reallocated to duty, but this was not explained, and that there was then a delay allocating the case to another member of the team. An apology was given and the reasons for delay explained and addressed.**

5. **A family member complained about the service user's homecare provider, that carers were not staying for the full time or completing the tasks required. They were also unhappy about a seemingly rude email received from a member of office-based staff. On investigation, it was found that carers were completing the tasks that the service user allowed them and that there were occasions when the service user asked the carer to leave before the end of their allotted time. In respect of how this affected charges, it was found that the service user's maximum charge was low and well under the amount of care that was being provided. In respect of the email, the member of staff had apparently meant to send it to the social worker and an apology was given for this mistake and for its contents. The care provider manager arranged for herself and another senior member of staff to be this family member's point of contact.**

3.8 In respect of carers, we make sure the senior manager who leads on carers issues is kept informed about relevant complaints from the outset.

3.9 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.

3.10 In respect of learning from complaints decided by the Local Government and Social Care Ombudsman, one decision led to a revision to the 'risk to staff' process.

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

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

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

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

4.4 The table below gives the numbers of investigation decisions received over the past three years. 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 recently this average has increased.

Decisions	2020/21	2021/22	2022/23	Trend
LGSCO	6	9	9	⇨
PHSO	0	1	0	⇩
Joint Team	0	2	1	⇩
Total	6	12	10	⇩

4.5 Over 2022/23 we received lower numbers for adult social care than the previous year, although higher than the historical average. 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.

4.6 Please note, of decisions made over 2022/23, LGSCO made two, not shared directly with the Council, to give advice (only); and a third decision when LGSCO decided that they were not the appropriate body to deal with the issues. Despite these decisions, we continue to monitor the apparent increase in the numbers of people approaching LGSCO to determine whether any changes to complaints handling or to service delivery are needed.

4.7 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. This is evidenced by a number of LGSCO's decisions. For example, in the first complaint in the table on the following page, in their final decision report LGSCO said, "I am satisfied with the action taken by the Council already to improve its practice […] For this reason, I do not make any further service improvement recommendations".

4.8 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.

4.9 We always comply with the recommendations LGSCO has made, to put things right for the complainant and/or to improve our services, as appropriate. LGSCO has said "[the Council] continues to perform well compared to similar organisations" (from the Annual Ombudsman Complaint Report 2022/23 issued in July 2023).

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

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

4.11 The following pages summarise the outcomes from those Northumberland adult social care complaints considered by LGSCO in 2022/23. Please note those decisions where the LGSCO considered the complaint 'premature' or that they are the appropriate body to deal with the issues, are not routinely shared with the Council but are noted on the table below.

Summary of complaint Adult services	Summary of ombudsman's final decision
20014396 **Mr X and his parents, Mr and Mrs Y complained about the Council's failure to ensure adaptations to their property, funded by a Disabled Facilities Grant, were carried out to an acceptable standard and related matters.**	**The Ombudsman found the Council to be at fault because it did not properly record variations to the Schedule of Works. The Council agreed to apologise for the frustration caused to the complainants. They did not identify any other areas of fault. The Ombudsman is unable to interfere with the Council's professional assessment that the overall standard of the adaptation was acceptable.** **All actions satisfactorily completed.**
21011766 **Mr X complained that the Council stopped providing him with support in February 2021 despite his ongoing need for help to manage his home and finances.**	**The Council was at fault for ending its support of Mr X without warning and without considering referring him to an advocate. The Council has agreed to apologise to Mr X, pay him [a sum of money] and take action to improve its service.** **All actions were satisfactorily completed. The action to improve the Council's services included a revision to the 'risk to staff' process; and all senior and team managers were reminded about the process.**
21018793 **Mrs X complained the Council failed to advise her that respite care for her husband's residential care was chargeable.**	**After consideration of the information provided by the Ombudsman, the Council offered to waive the respite care charges. The Ombudsman discontinued their investigation because the Council's offer resolved the outstanding issue.**

22002090 **A Joint Team investigation – only the elements relevant to the Council are recorded here.** **Ms A complains about the care and treatment of her late brother. That the Council failed to provide appropriate support for Mr B and failed to properly manage safeguarding processes about Mr B.**	**There would have been limits to what each of the services involved in Mr B's life could have done to improve his situation. He lived independently and, seemingly, had the mental capacity to make his own choices about who he associated with and how he lived his life. However, when viewed together, the combined impact of the failings in Mr B's care throughout this time it notable. Collectively, had services responded more appropriately to Mr B's situation, in a more timely manner, he may have responded more positively. This in turn could have led to more regular engagement, better relationships and this could have led to changes which would have reduced the stress, frustration and upset Mr B often experienced. However, there are too many variables and unknowns to be able to do anything more than speculate about this.** **The combined faults of the Council [and the other NHS bodies] have left Ms A with considerable, understandable, uncertainty and distress about lost opportunities. This is an injustice to her. In each of the organisations' responses to the complaint they have acknowledged this uncertainty, and the possibility that Mr B may have lost out on support which would have been helpful. Viewed alongside the services' openness about their individual failings, and the steps they have taken to prevent recurrences, these acknowledgements are a proportionate response to the injustice. As such, the Ombudsman did not recommend any further action.**
22004685 **No information available.**	**Referred back for local resolution (Premature Decision - advice given)**
22005097 **No information available.**	**Advice given. The body complained about is not in the Ombudsman's jurisdiction.**

22005146 **Mrs X complained on behalf of her late father-in-law, Mr Y, about the care he received in a care home. She said he suffered from dehydration and malnutrition whilst in its care; and the care home did not recognise he had pneumonia or call a GP when he was unwell.**	**The Ombudsman did not investigate this complaint about a care home. The Ombudsman is satisfied the Care Provider has properly considered Mr Y's care records and investigated the complaint. The Ombudsman can't say Mr Y suffered malnutrition, as his weight remained in a health BMI range. The Care Provider said that Mr Y's wife had alerted staff to him being unwell one weekend. It said the nursing staff completed observations and contacted the out-of-hours GP service for advice. The on-call GP decided a visit was not necessary. The Care Provider has made service improvements around communication with family and case recording as necessary. The Ombudsman could not add anything further to its investigation and further investigation would not lead to a different outcome.**
22007702	**Referred back for local resolution (Premature Decision - advice given).**
22007769 **Mrs B says the Council has failed to pay for residential placements it contracts with them to provide care to residents on its behalf. Mrs B says the Council says it will look into the matter but then fails to follow it up. Mrs B says they have to chase the Council for money it should pay routinely and its failure to do so places residents at risk of eviction.**	**The Ombudsman would not normally investigate matters about contractual matters but in cases where the Council's failure to pay for placements it contracts with a Care Provider places a resident in jeopardy and puts them at risk of eviction, they may consider it further. However, in this case the Council has confirmed there are no outstanding payments owed and agreed to clarify this with the Care Provider. The Council's actions have not caused residents in the homes a significant enough injustice to warrant an Ombudsman investigation.**

22002250 **Mrs D complains about a contract for home improvements in 2014.**	**The Ombudsman logged this complaint under the category of 'Housing' although the responsible service, from the Council's perspective sits within 'Adults, Ageing and Wellbeing'.** **Mrs D signed a contract for home improvements with a contractor in 2014. She wrote to the Council in 2020 complaining about the contract and that works had not been done correctly. The Council explained it could not investigate her complaint because it was made too late. It did, however, offer to assist her outside of the complaints process. It acted as a go-between with the contractor. Subsequently the contractor offered a remedy to Mrs D which she refused.** **Mrs D complains about events that took place in 2014. The Ombudsman saw no basis to warrant investigation of those matters. The Ombudsman expects a complaint to be made within 12 months. The Council has also applied its 12-month rule to the complaint.** **In addition, the main source of the complaint is not the Council because it has no contractual role. Mrs D has the option to purse the dispute with the actual contractor through the courts. The Ombudsman would expect her to use that route.**

5.0 Adult social care enquires received in 2022/23

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

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

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

5.4 In the course of 2022/23, 216 enquiries were recorded by the team that related to adult services. This continues the noticeable increase over the past two years. Please note the numbers of enquiries during 2020/21 was lower than expected by around a fifth based on the previous three years, likely due to the pandemic.

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

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

Enquiries received	2020/21	2021/22	2022/23	Trend
Adult social care	96	154	216	⇧

Enquiries by service area	2020/21	2021/22	2022/23	Trend
Adult social care teams	52	69	128	⇧
Complaints team	0	2	2	⇨
Continuing healthcare	7	11	8	⇩
Contracts & commissioning	6	0	0	⇨

Finance	**14**	**17**	**16**	⇩
General	**0**	**2**	**0**	⇩
Home improvement service	**3**	**3**	**1**	⇩
Independent social care providers	**2**	**11**	**15**	⇧
In-house residential care	**1**	**0**	**0**	⇨
Joint equipment and loan service	**0**	**0**	**1**	⇧
Northumberland Communities Together	**0**	**0**	**1**	⇧
Occupational therapy	**4**	**13**	**9**	⇩
Onecall	**0**	**3**	**0**	⇩
Other Council service areas	**0**	**3**	**13**	⇧
Other NHS	**5**	**6**	**10**	⇧
Safeguarding adults	**1**	**12**	**8**	⇩
Self-directed support team	**1**	**2**	**0**	⇩
Short term support service	**0**	**0**	**4**	⇧
Total	**96**	**154**	**216**	⇧

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

5.8 Some enquiries contain information that was handled under the adult multiagency safeguarding procedures, especially information relating to

independent providers. In these cases, we let the enquirer know that they should contact the complaints team after the safeguarding process is complete if they remain dissatisfied with the outcomes.

5.9 Analysis suggests 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 noticeable increase in contacts may also be the result of organisational changes within adult social care during 2022/23 and we anticipate that these should reduce over time.

6.0 Adult social care compliments received in 2022/23

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

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

6.3 In 2022/23 adult social care received 536 compliments from members of the public although we are very aware that staff receive kind words verbally from the people who use our services, their families, and carers on a daily basis.

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

6.5 Overall, adult social care compliments have increased over the past year and continuing healthcare compliments have decreased. Analysis suggests that the decrease in continuing healthcare compliments is likely the result of work pressures for independent providers and their focus on core business post pandemic, rather than a reduction in quality, and this is borne out by the reduction in complaints reported by independent providers.

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

Compliments received by	2020/21	2021/22	2022/23	Trend
Adult social care	536	399	536	⇧
CHC	157	188	138	⇩
Total	693	587	674	⇩

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

Compliments by service area	2020/21	2021/22	2022/23	Trend
Adult social care teams	74	36	88	⇧
Brokerage	0	3	0	⇩

Complaints Service	**2**	**1**	**1**	
Enquiry referral coordinators	**0**	**1**	**4**	
Finance	**2**	**1**	**6**	
Home improvement service	**0**	**0**	**73**	
Home safe	**8**	**4**	**16**	
Horticultural unit	**0**	**0**	**3**	
Independent providers*	**334**	**286**	**232**	
Independent providers**	**0**	**4**	**12**	
In-house care home	**0**	**0**	**2**	
In-house day services	**1**	**8**	**14**	
Joint equipment and loan service	**3**	**0**	**20**	
Occupational therapy	**31**	**27**	**33**	
Onecall (single point of access)	**22**	**0**	**0**	
Risk & independence team	**1**	**0**	**7**	
Safeguarding adults' team	**1**	**1**	**0**	
Self-directed support team	**1**	**1**	**0**	
Short term	**56**	**25**	**24**	

support service				
Wardens	**0**	**0**	**1**	⇧
Welfare rights	**0**	**1**	**0**	⇩
Total	**536**	**399**	**536**	⇧

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

CHC compliments*	2020/21	2021/22	2022/23	Trend
100% NHS funded packages	**68**	**93**	**63**	⇩
Part NHS funded packages	**89**	**95**	**75**	⇩
Total	**157**	**188**	**138**	⇩

***Reported by providers**

7.0 Advocacy for adult social care and CHC complainants

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

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

CHC complaints

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

Other information

7.4 **Over 2022/23, the Complaints Service hasn't needed to use advocacy. In respect of the CHC complaints, the offer of advocacy wasn't pursued.**

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

8.0 Conclusions and future plans for adult social care complaints

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

8.2 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.

8.3 Over the coming year, 2023/24, 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 the introduction of a bespoke case management system which we hope to have in place during 2023/24. 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.

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

8.5 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.

8.6 Overall, we have had a positive year with many compliments received and enquiries dealt with at an early stage. We have successfully resolved most of the issues raised locally even when we have not been able to agree with the complainant's perspective. However, we always speak to people to hear their views and take their concerns very seriously. We are committed to improving our services and continue to receive support from staff and managers throughout the organisation in our day-to-day work.

8.7 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

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

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

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

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

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

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

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

9.7 Our adult services process can be summarised as follows:

Complaint received

⇩

Take appropriate and proportionate action to resolve the issues

⇩

Send response letter confirming actions and outcomes

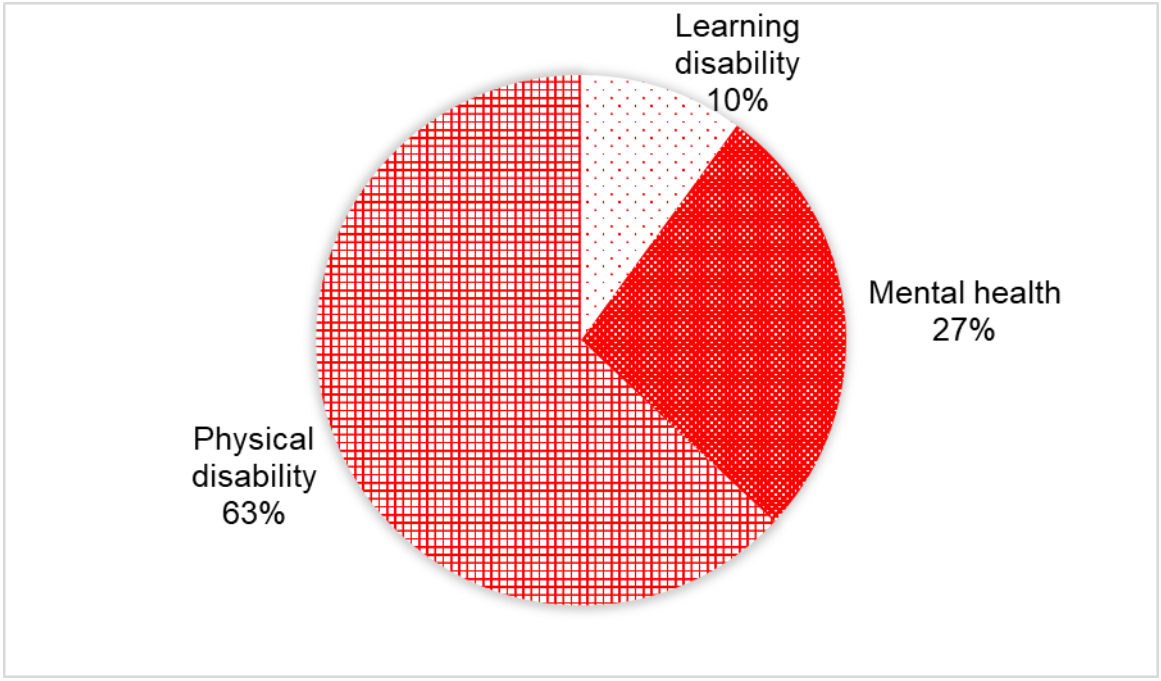
9.8 Apologising is usually appropriate even if only because the person feels they have had a bad experience or because they felt strongly enough about their

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

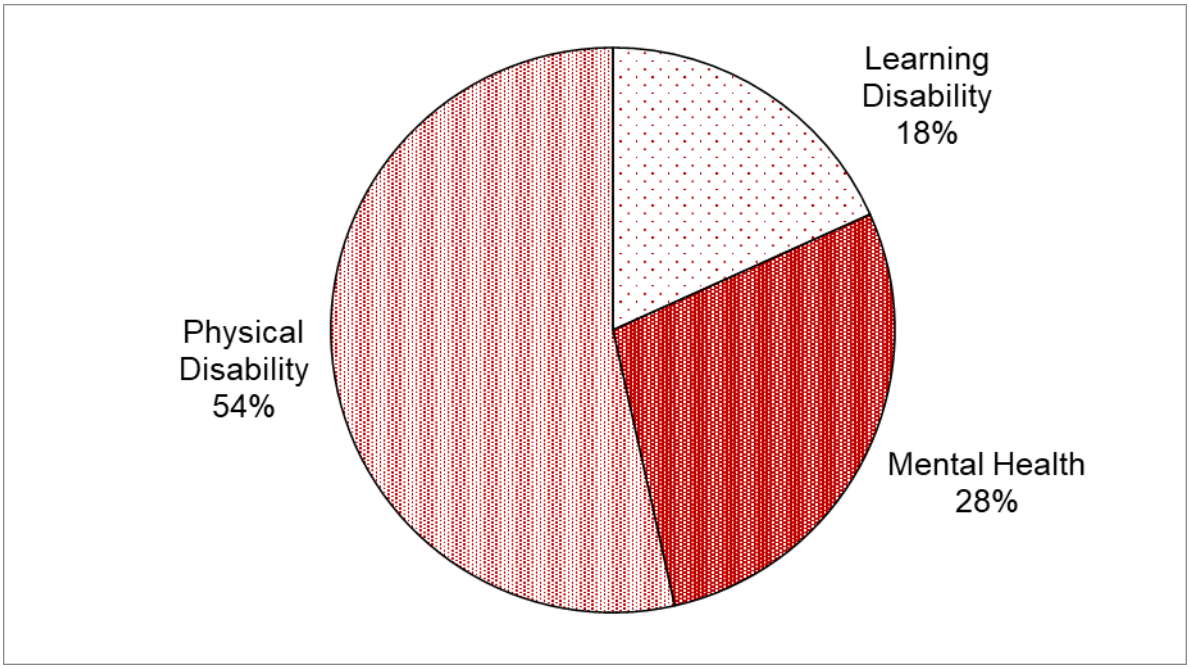
10.0 Appendix 2: Equalities Information

10.1 The following equality data is based on 30 complaints responded to over 2022/23. 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.

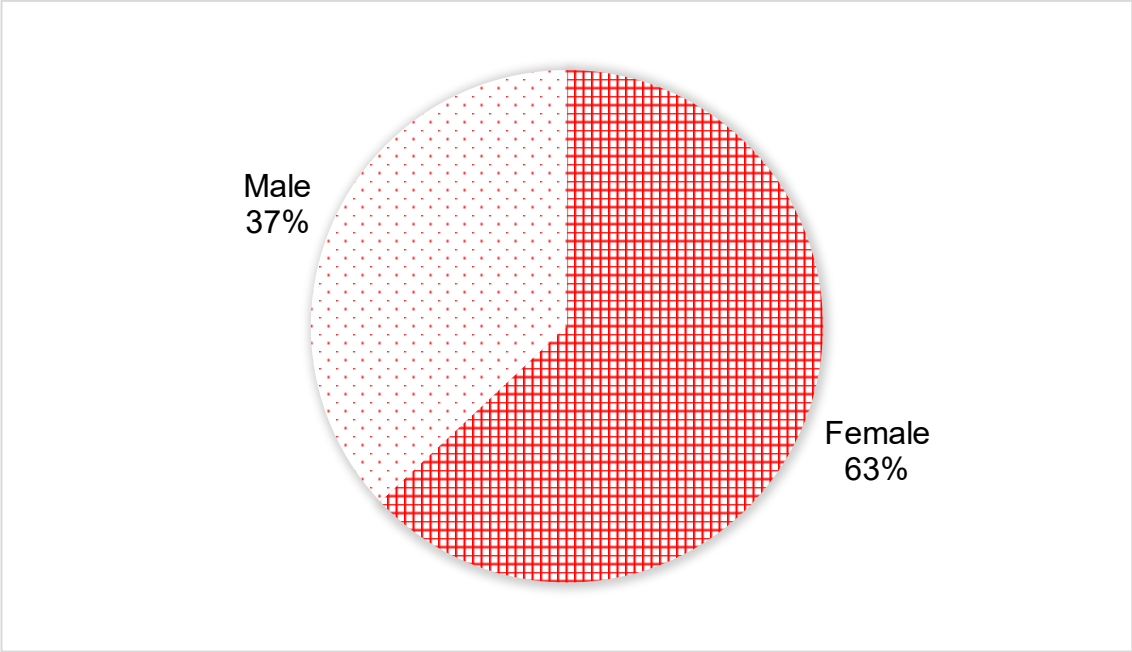
- **Responded to complaints by client category**



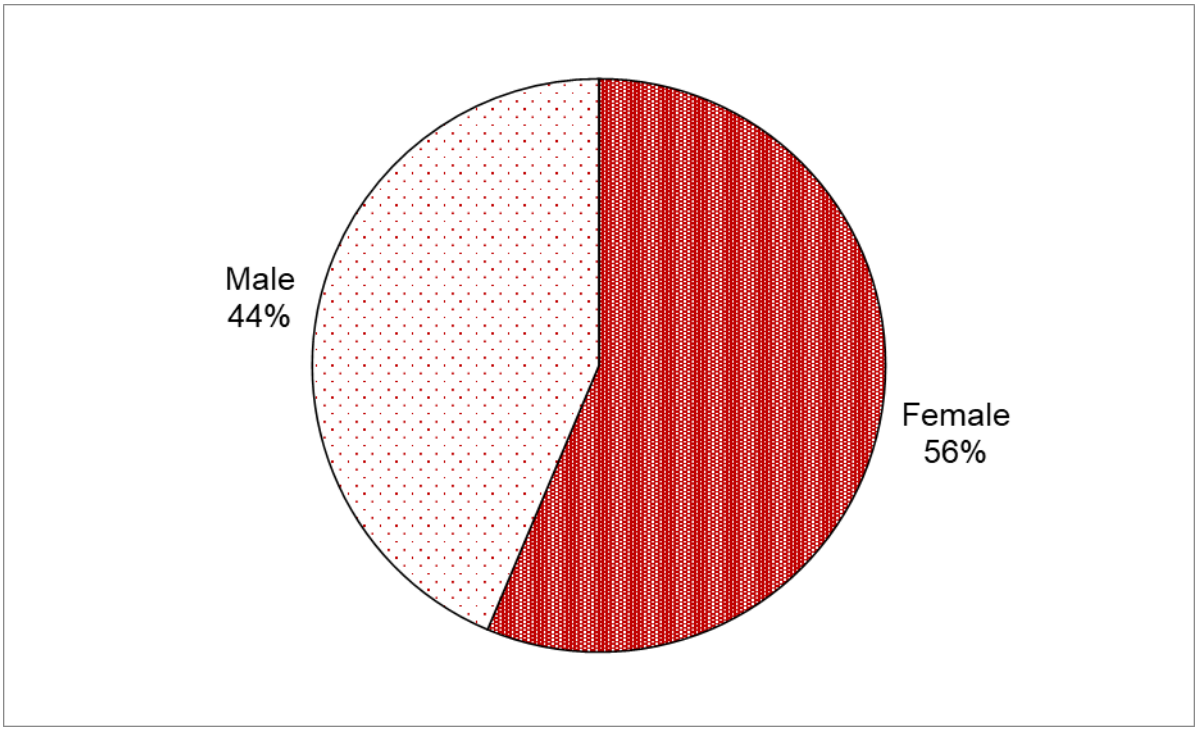
- **Adult social care by client category**



- **Responded to complaints by gender**



- **Adult social care by gender**



10.2 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 (December 2022)	% of total	% in N'land Population (Census 2011)	Complaints
White	7,181	96.7%	98.4%	100%
Asian / Asian British	38	0.5%	0.8%	0%
Black / African / Caribbean / Black British	6	0.1%	0.1%	0%
Mixed / multiple ethnic groups	22	0.3%	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	39	0.5%	0	0%
18-24 years	407	5.5%	0	0%
25-44 years	1097	14.8%	5	16.7%
45-54 years	614	8.3%	2	6.7%
55-64 years	795	10.7%	7	23.3%
65-74 years	980	13.2%	2	6.7%
75-84 years	1657	22.3%	5	16.7%
85+ years	1839	24.8%	9	30.0%