Northumberland County Council

In partnership with

Northumbria Healthcare NHS
NHS Foundation Trust

and

NHS
Northumberland
Clinical Commissioning Group

Complaints Annual Report 2020/2021

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

Contents

Introduction

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

0.2 **The report is in two parts and describes what people have said about both our adult and children's social care services in Northumberland and what we have learned as a consequence during 2020/21. The report also describes what people have said about NHS continuing healthcare funded by Northumberland Clinical Commissioning Group and about supporting people in their own home or in a care home.**

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

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

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

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

0.7 **Despite significant differences in detail, both sets of regulations and guidance emphasise that complaints should be approached positively as opportunities for learning, as well as providing a means by which people can ask the organisation to address the specifics of poor services or bad decisions which affect them individually.**

PART ONE
Adult social care complaints – 2020/21

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 2019/20 and some complaints will carry over into 2021/22. The table below notes the numbers of complaints received in 2020/21 and the previous two years:

Complaints received	2018/19	2019/20	2020/21	Trend
Adult social care	34	50	44	⇩
CHC	5	8	3	⇩
Total	39	58	47	⇩

1.2 Over the past year we have seen a drop in the number of complaints being made, although higher than two years ago.

1.3 The table below shows adult social care complaints received by Durham County Council which has similarities with Northumberland.

Complaints received	2018/19	2019/20	2020/21	Trend
Durham	81	81	75	⇩

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

Area	Approximate number of adult social care service users	Complaints per 1,000
Durham	18,500	4.4
Northumberland	7,000	6.7

1.5 The table below notes the numbers of complaints received and responded to in 2020/21 and the previous two years:

Complaints responded to	2018/19	2019/20	2020/21	Trend
Adult social care	26	54	41	⇩

CHC	6	9	3	⇩
Total	32	63	44	⇩

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

ADULT SOCIAL CARE COMPLAINTS (CHC complaints data follows later)

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

Complaints outcomes	2018/19	2019/20	2020/21	Trend
Upheld	3	13	8	⇩
Not upheld	13	25	14	⇩
Partly upheld	10	16	19	⇧
Total	26	54	41	⇩
Upheld and partly upheld combined	13	29	27	⇩

1.8 The table below shows the above information as a percentage and suggests that while the trend of upheld complaints is downwards, over 2020/21 we have found that most complainants have a point, albeit a comparatively minor one in many cases:

Complaints outcomes	2018/19	2019/20	2020/21	Trend
Upheld	12%	24%	20%	⇩
Not upheld	50%	46%	34%	⇩
Partly upheld	38%	30%	46%	⇧
Upheld and partly upheld combined	50%	54%	66%	⇧

1.9 The table below provides some comparative data for complaint outcomes with Durham County Council, using the most recent data:

Area	Upheld and partly upheld complaints
Durham	43%
Northumberland	66%

1.10 **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 a decrease in the numbers of complaints related to independent providers which is matched by an increase in compliments noted later in this report. Analysis suggests that this trend reflects the positive views held by many service users, carers, and families about independent providers in Northumberland and how they have coped during the pandemic.**

Service area complained about	2018/19	2019/20	2020/21	Trend
Care management	15	32	29	⇩
Finance team	4	4	5	⇧
Home improvement service	X	1	3	⇧
Independent provider	2	10	3	⇩
In-house provider	1	1	X	⇩
Occupational therapy	X	1	X	⇩
Onecall	1	1	X	⇩
Safeguarding adults team	2	X	X	⇨
Self-directed support team	X	1	1	⇨
Short term support service	1	3	X	⇩
Total	26	54	41	⇩

1.11 **Despite the overall decrease in complaints, charges continue to be an underlying issue in many complaints. 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.**

1.12 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	X	1	X	⇩
Attitude or conduct of staff	2	2	2	⇨
Communication / information	3	7	7	⇨
Contact arrangements	1	1	X	⇩
Disagreement with assessments / reports	X	4	3	⇩
Disagreement with decisions	7	3	7	⇧
Failure to follow procedure	4	3	4	⇧
Finance / funding	4	9	4	⇩
Health & safety	1	X	X	⇨
Speed or delays in service	X	2	X	⇩
Standard of service provision	4	22	14	⇩
Total	26	54	41	⇩

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

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

CHC COMPLAINTS

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

Complaints outcomes	2018/19	2019/20	2020/21	Trend

Upheld	**2**	**1**	**1**	⇩
Not upheld	**2**	**1**	**0**	⇩
Partly upheld	**2**	**7**	**2**	⇩
Total	**6**	**9**	**3**	⇩
Upheld and partly upheld combined	**4**	**8**	**3**	⇩

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

1.17 The table below shows the complaints responded to by service area. Care management continues to have the most complaints, and as noted above, is to be expected in the context of the number of service user contacts for that service area compared to others. The nurse assessment team is responsible for overseeing the process that determines eligibility for CHC funding and has received no complaints – in part this can be explained by the pause to carrying out assessments during the pandemic.

Service area complained about	2018/19	2019/20	2020/21	Trend
Care management	**4**	**5**	**2**	⇩
Independent provider	**X**	**X**	**1**	⇧
Nurse assessment team	**2**	**2**	**X**	⇩
Occupational therapy	**X**	**1**	**X**	⇩
Support planners	**X**	**1**	**X**	⇩
Total	**6**	**9**	**3**	⇩

1.18 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	**X**	**1**	**X**	⇩
Disagreement with assessments / reports	**1**	**1**	**1**	⇨
Disagreement	**1**	**X**	**X**	⇨

with decisions				
Failure to follow procedure	**X**	**3**	**1**	⇩
Finance / funding	**2**	**1**	**X**	⇩
Speed or delays in service	**2**	**X**	**X**	⇨
Standard of service provision	**X**	**3**	**1**	⇩
Total	**6**	**9**	**3**	⇩

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

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

2.1 **Many of the issues have been reported over 2020/21 reflect the kind of situations which can occur from time to time in a large care organisations but we take each one seriously, and take steps to address both the individual situation of the complainant and any wider issues about systems, training and guidance which are raised, as the table below describes in general terms.**

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

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

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

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

2.4 The following section provides a selection of 'thumbnail' portraits by subject matter in the key areas of 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. Please note that work is on-going to better understand the issue of charging and complaints to determine what changes, if any, may be needed to systems, processes, and/or training programmes. However, it should be noted that service users whose care is fully funded by the Council i.e. who do not have to contribute towards the cost of their care, may be more likely to express dissatisfaction with their service (from an analysis of the most recent adult social care survey).

2.5 Communication/information:

1. **A family member complained that her mother hadn't been offered a care package on the Council's contract and as a result she had been paying more for her care privately. On investigation it was found that the allocated worker hadn't clearly explained to the client her options or provided the relevant information in writing, and as a result it seemed more likely than not that the client would have chosen to have her care arranged by adult social care had she received and understood all the information presented. The difference in cost was offered as an *ex gracia* payment and an apology made. The member of staff concerned was reminded about the importance of making sure clients understand all their options and are given the relevant information sheets.**

2. **A son complained that he had received a finance letter indicating that the sender had spoken to his father and would review his case in a year's time even though his father had died several weeks earlier. On investigation it was found that this standard, un-amended letter was accompanied by a cover letter for the executor's records. The IO acknowledged that the finance letter should not have been sent and a full apology was given. The member of staff concerned was reminded about their responsibilities and the effect their lapse of judgement had had.**

3. **A family member complained that they'd had no response to any of their emails sent to the team manager, all related to a specific service user. On investigation, it was found that the team manager was on a planned extended leave from work and that they had put on their 'out of office', properly directing people to manager covering for them. IT was also asked to look into this matter because the complainant said that they'd not received any 'out of office' replies and had checked their 'junk' folder – IT confirmed that the 'out of office' had been put on before the complainant's first email was sent and IT concluded that the complainant's email provider's security filters had likely stopped the 'out of office' notifications. An apology was given to the complainant for their experiences and the issues they had raised in their emails to the team manager were addressed promptly.**

2.6.1 Disagreements:

1. **A family member complained that his mother was being given more care than she needed and as result was having to pay more. On investigation it was found that the care package involved carers checking on the service user's welfare and administering her medication. She had dementia and was unable to manage her medication safely without help. She received daily calls and additional time was set aside for the carer to collect her medication from the pharmacist once a week and to book it in. The son believed that this additional time could be incorporated into one of the existing visits. On investigation this was not found to be the case – advice to social workers is clear about the minimum amount of time a visit should last when medication is logged in and/or dispensed. The son was offered alternatives, such as arranging his mother's care privately, should he and his mother remain dissatisfied with the social worker's assessment.**

2. **A service user complained about why it had been decided that she now had to ask her social worker for money when she had previously been able to ask the finance team (the Council is her court appointed deputy for finance). On investigation, it was found that it is the social worker who should be the decision maker about budgets and payments and in this case, it appears that the service user had been bypassing this arrangement. An apology was made and an explanation given about what had gone wrong. The members of staff involved were remined about their respective roles. A new budget was also set up with the service user with which she was happy.**

3. **A family member complained about why a social worker had placed her husband into a particular care home following treatment in hospital. On investigation it was found that the service user had been ready for discharge and that the MDT had decided, with involvement from the family member, that a care home placement was needed (the client had dementia and some challenging behaviours). It was also found that the son, who held a legal power to make decisions on behalf of his father, had agreed to the placement, the only suitable one that was available at the time despite a search by the social worker.**

4. **A family member complained about the decision to charge her father for his care based on half the money in a joint account, most of which the complainant said was hers. On investigation it was found that the family member, who held a legal power to manage the service user's financial affairs, had not disclosed any meaningful detail about the account. Without this information it was (correctly, according to the guidance) assumed that half of the money belonged to the service user and in this context, the service user had been assessed correctly and charged accordingly.**

2.7 The standard of service provision:

1. **A family member complained about the standard of care her mother received from a care provider. On investigation, it was found that the family member had raised her concerns promptly with the provider but no response had been given. Similarly, the provider was unable to provide assurances that the carer had followed the care plan. Apologies were given, the charges waived, and the contracts and commissioning team involved so that they could use these findings in their inspection programme.**

2. **A family member complained about the care her mother had received in a care home. On investigation it was found that mistakes had been made but each had been appropriately reported and addressed with no harm to the service user. The investigating officer considered that communication was an underlying issue and steps were taken to try to improve the relationship between family and the staff at the care home.**

3. **A service user complained that no one was taking responsibility for the remedial work that was needed to his bathroom following work done by the Council to deal with a significant water leak under his property. On investigation it was found that this case had drifted. Joint action was quickly agreed by the relevant services (Home Improvement Service and the housing repairs department) and the necessary 'putting right' was carried out promptly.**

4. **A person complained about the difficulties they had experienced trying to get a care & support assessment. On investigation it was found that the relevant staff service had acted appropriately but it was noted that there may have been some confusion on the caller's part because no assessment referral from her GP had been received as she believed. However, an apology was made for their experience.**

5. **A family member complained about the apparent lack of response from adult social care when she reached out for help for her mother in a crisis and that subsequently little was done to support her mother who has mental health and alcohol related problems. On investigation, evidence of good practice within the records was found, however, there were gaps in recording, communication should have been better at times, and there was also a misunderstanding about what constitutes a safeguarding concern, and whilst it should not be expected for family to understand this, professionals should be able to explain this to family members and thereby not create misconceptions. There was also a breakdown in communication with the complainant as it appears she had not been fully**

informed of her mother's reluctance to accept support (she was able to make this decision for herself). Steps were taken with the member of staff to improve practice around record keeping and with the wider teams around communication with families.

2.8 In respect of learning from other adult social care complaints, for example, following a complaint about staff attitude, the process for dealing with calls to Onecall has been changed. Now all messages received by Onecall for the team managers are recorded on swift rather than only in an email; and following two complaints related to hospital discharges, the Homesafe teams have been reminded about the processes for the arranging of temporary and permanent care home placements.

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

CHC COMPLAINT EXAMPLE

2.10 The following section provides an example 'thumbnail' portrait from the responded to CHC complaints.

2.11 An apparent failure to follow procedure:

1. **A family member complained that their relative had not been provided with a personal health budget sufficient to meet all her needs and as a consequence she had had to use her own money to make sure her needs were met. On investigation, it was found more likely than not that the service user had required a larger package of care than had been funded. In addition, it appears that staff suggested that there was an upper limit to the CHC funding that the service user was able to receive. This was wrong and apologies given for this and the other faults identified in the investigation. The monies the service user had paid out privately were reimbursed and a number of learning opportunities identified for both the staff involved in this case and the wider social work/care management teams.**

1.

3. Adult social care complaints looked at by the Ombudsmen

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

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

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

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

Decisions	2018/19	2019/20	2020/21	Trend
LGSCO	9	9	6	⇩
PHSO	0	0	0	⇨
Joint Team	1	0	0	⇨
Total	10	9	6	⇩

3.5 Over 2018/19 and 2019/20 we received a higher than average numbers for adult social care. Although the 2020/21 numbers have decreased, analysis suggests that the numbers of people who choose to ask LGSCO to consider their complaint may now be increasing from the historically typical 6 or 7 or less to 7 or 8 or more per year. Please note that during lockdown LGSCO suspended taking new complaints and contacting councils, however, this was caught up from the summer of 2020 onwards. As noted earlier in this report, a rise in complaints to LGSCO is in part likely due to high expectations of services; and in part because service users are expected to contribute (more) towards the cost of their care and this is an underlying issue in many complaints. In addition, it can also be an indication of the quality of the relationship that the complainant has with the Council.

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

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

3.7 Analysis suggests that during the complaints resolution process we are able to recognise where we have got things wrong and to take appropriate

remedial action. Please note that in recent years the LGSCO has changed their focus and will highlight any faults in the original case handling over how effectively we investigated and remedied the issues raised. The LGSCO is the final stage in the complaints process and there is no appeal except through judicial review.

3.8 The table below provides some comparative data for LGSCO complaints outcomes with Durham County Council, using the 2021 data available on the LGSCO website:

Area	Upheld	Not upheld	Closed after initial enquiries	Total
Durham	10	0	5	15
Northumberland	3	1	2	6

3.9 The following pages summarise the substantive outcomes of those Northumberland 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
19 020 559 **Ms X complains about the conduct of a person she believed to be a council officer.**	**The Ombudsman cannot investigate Ms X's complaint. This is because the Council is not responsible for the matter complained about.** **(Please note that while this complaint was aimed at adult social care, LGSCO have logged it under 'corporate and other services'.)**
19 017 603 **Mrs X complained the Council failed to provide full information about her financial assessment and the costs of her care before she started receiving care from a new care provider.**	**The Ombudsman found there was fault causing injustice when the Council failed to provide enough information about charging. The Council agreed to a suitable remedy.** **(In our original complaint response, we acknowledged that we hadn't provided the information sheet that would have told Mrs X that she would be a full charge payer because she owned a second home – this fact only became apparent to Mrs X when she was financially assessed which was after her service began. As part of our follow up, we took steps to remind relevant staff about providing full information on charging, the process, and keeping a suitable record.)**
20 000 824 **Ms Q, says that the manager of a care home refused to allow her to see her sister who was dying of cancer.**	**The Ombudsman will not investigate this complaint about the refusal of a care home to allow the complainant to visit her sister. This is because there is no worthwhile outcome that he could achieve through additional investigation.**
20 001 884 **Mr C, complained on behalf of his son, that the Council has failed to increase his son's Personal**	**The Ombudsman found the Council identified the correct steps to resolve the issue, which was a reassessment of Mr X's needs. As such, we discontinued our investigation because nothing further could be achieved**

Budget along with inflation over the last few years, as a result of which he does not receive enough money anymore to meet his needs.	**for Mr X.**
20 004 092 **Ms A complains in her own right and on behalf of her father, Mr D, that the Council failed to:** **a) make a refund of council tax properly;** **b) assess charges for care properly;** **c) consider the "ownership" of a joint bank account;** **d) deal with complaints properly and in a timely manner.**	**The Council has recognised and apologised for faults in a delayed council tax refund, and some aspects of its financial assessments for community support and residential care. The Ombudsman considers the actions taken and the apologies provided are sufficient to remedy the errors made. The Ombudsman does not find fault in the Council's approach to assessing Mr D's finances for charges related to his long-term residential care. It has made legitimate enquiries about withdrawals from a bank account.**
20 007 684 **Mr X complained for his mother Mrs Y that the Council:** **a) did not complete an assessment of Mrs Y's mental capacity to make a decision about going into a care home, which was not in line with its responsibilities under the Mental Capacity Act;** **b) did not tell Mrs Y a cheaper room may have been available** **c) did not give her full, transparent information about the different fees for different room types so she was not properly informed when making the decision**	**The Ombudsman found:** **a) There was no fault in not completing a mental capacity assessment;** **b) It is common practice for care providers to have different rates for private paying individuals and councils. Councils are often contracting at a reduced rate compared with private individuals because they are commissioning multiple beds. This is market forces and not fault;** **c) We would expect the Council to provide a leaflet or signpost a self-funder to independent financial advice and there is no record of any signposting Mrs Y to independent financial advice in this case;** **d) There was nothing to be added to the Council's complaint response by setting out the full detail of a call between a social worker and Mr X … I note the Council's reason for giving full details of a phone call between Mr X and an officer. I do not share the Council's view that transparency or an inability to deliver Mr X's desired outcome required it to give a word for word account; and**

d) tarnished his character and motives by using information selectively in its complaint response and failed to address the substantive issues **e) Failed to challenge the care provider's lack of openness about fees.**	**e) The Council had no involvement in fees and it is not at fault.**

4. Adult social care enquires received in 2020/21

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 2020/21, 96 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	2018/19	2019/20	2020/21	Trend
Adult social care	102	118	96	⇩

Enquiries by service area	2018/19	2019/20	2020/21	Trend
Care management	58	72	52	⇩
Complaints team	1	X	X	⇨
Continuing healthcare	6	1	7	⇧
Contracts & commissioning	X	1	6	⇧
Finance	8	9	14	⇧
General	X	1	X	⇩

Home improvement service	**X**	**1**	**3**	⇧
Independent social care providers	**5**	**6**	**2**	⇩
In-house residential care	**X**	**X**	**1**	⇧
Joint equipment and loan service	**6**	**5**	**X**	⇩
Northumbria Healthcare	**X**	**3**	**1**	⇩
Occupational therapy	**9**	**7**	**4**	⇩
Onecall	**1**	**2**	**X**	⇩
Other organisations	**2**	**2**	**4**	⇧
Safeguarding adults	**4**	**3**	**1**	⇩
Self-directed support team	**X**	**3**	**1**	⇩
Short term support service	**2**	**2**	**X**	⇩
Total	**102**	**118**	**96**	⇩

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

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

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

5. Adult social care compliments received in 2020/21

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 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.

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 increased over the past year and continuing healthcare compliments similarly. Analysis suggest that this increase has been achieved by our independent providers whose efforts during the pandemic have been greatly appreciated. In-house day services by contrast have seen a reduction in compliments due to being suspended for much of the same period.

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

Compliments received by	2018/19	2019/20	2020/21	Trend
Adult social care	485	442	536	⇧
CHC	159	117	157	⇧
Total	664	559	693	⇧

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

Complaints received	2018/19	2019/20	2020/21	Trend
Durham	125	81	66	⇩

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

Compliments by service area	2018/19	2019/20	2020/21	Trend
Care management	94	110	74	⇩
Complaints Service	2	3	2	⇩
Contracts & commissioning team	X	2	X	⇩
Finance	8	5	2	⇩
Home improvement service	1	2	X	⇩
Home safe	2	4	8	⇧
Independent providers*	194	145	334	⇧
In-house day services	61	59	1	⇩
Joint equipment and loan service	4	2	3	⇧
Occupational therapy	24	24	31	⇧
Onecall (single point of access)	5	6	22	⇧
Risk & independence team	X	1	1	⇨
Safeguarding adults team	4	4	1	⇩
Self-directed support team	7	4	1	⇩
Short term support service	78	70	56	⇩

Welfare rights	**1**	**1**	**X**	⇩
Total	**485**	**442**	**536**	⇧

***Reported by providers**

CHC compliments*	2018/19	2019/20	2020/21	Trend
100% NHS funded packages	**64**	**48**	**68**	⇧
Part NHS funded packages	**95**	**69**	**89**	⇧
Total	**159**	**117**	**157**	⇧

***Reported by providers**

6. Advocacy for adult social care and CHC complainants

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

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

CHC complaints

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

Other information

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

7. Conclusions and future plans for adult social care complaints

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

7.2 We also continue to learn lessons, to make changes to improve things for individuals and their families, and to draw on what we learn to improve our services more generally.

7.3 Over the coming year, 2021/22 we will continue to improve accessibility to make compliments, complaints and comments and the ways in which we demonstrate learning from complaints. As part of our other development work we will continue to work alongside contracted adult social care providers to report on all their registered compliments and complaints regardless of funding arrangements. As noted above, we are also working to better understand the issue of charging and complaints to determine what changes, if any, may be needed to systems, processes, and/or training programmes.

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 the majority of issues raised locally even when we have not been able to agree with the complainant's perspective. However, we always speak to people to hear their views and take their concerns very seriously. We are committed to improving our services and continue to receive support from staff and managers throughout the organisation in our day to day work.

7.7 For further information about this report or adult social care and CHC complaints, please email the Complaints Manager for Adult Social Care Complaints james.hillery@northumbria-healthcare.nhs.uk and from 01 October 2021 james.hillery@northumberland.gov.uk

8.0 How we handle individual adult social care and CHC complaints

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

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

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

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

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

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

8.7 Our adult services process can be summarised as follows:

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."**

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

1.0 Introduction

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

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

1.1 Covid Response

Children's Services rose to an unprecedented challenge in March 2020 due to the Covid pandemic and completely re-evaluated their way of working. The work of the Client Relations Team, who deal with complaints and customer feedback in relation to Children's Services was also impacted with all team members working from home and adjusting to provision of service via the virtual world.

The Adoption and Children (Coronavirus) (Amendment) Regulations 2020 made some temporary change to the complaint regulations but only in relation to Stage 3 Review Panel hearings in that the timeframes for requesting and holding the Review Panels, usually within 30 working days, was changed to "as soon as is reasonably practicable". It also changed the requirements relating to the completion of the panel notes and undertaking of panel recommendations to "as soon as reasonably practicable."

The Local Government and Social Care Ombudsman (LGSCO) suspended all casework activity on new or existing complaints from 26/3/2020 to 29/06/2020 to try and assist local authorities adjust to the new working arrangements.

Some complaints were impacted due to the closure of the archive facilities as this impacted access to written archived records.

1.2 Requirement for an Annual Report

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

The data used for this report is from received during the period 1 April 2020 to 31 March 2021.

1.3 Making a complaint

Full information on how to make a complaint or provide feedback is available on the Council website.

https://www.northumberland.gov.uk/Children/Family/Compliments.aspx

Children's Services staff ensure that all children of an appropriate age, who are in receipt of services as a Looked After Child, are provided with a copy of a complaints leaflet. Information is also readily available to children and young people via the Council website and the Mind of My Own app.

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

- talk to the relevant support staff to let them try and resolve the issue with them direct;
- Email the clientrelations@northumberland.gov.uk team
- Write to the Complaints Manager for Children's Services at County Hall, Morpeth, Northumberland, NE61 2EF
- Telephone the Client Relations Team on 01670 628888
- Use the Mind of My Own app.

2.0 Numbers and Analysis

2.1 Complaints received

2.2 The table below shows how many complaints have been recorded for Children's Services (both social care and education) and under which process, broken down into individual financial years. The figures demonstrate a decrease in those recorded under the social care process and an increase in those recorded under the corporate process. This is due to reconsideration by this Council of the way in which complaints are considered from the outset.

Year	Social Care	Corporate	Total
2018/19	**44**	**2**	**46**
2019/20	**46**	**4**	**50**
2020/21	**33**	**14**	**47**

2.3 A greater number of complaints are now being received from adults in relation to their involvement with children's social care where their dissatisfaction relates solely to the impact on themselves and not the child. Where it is clear the adult complaining is not doing so on behalf of or in relation to a child but still require a response, then they are considered under the corporate process. [Getting the Best from Complaints statutory guidance; Sections 2.7 and 2.8] .

2.4 Of the 47 complaints received, only 1 was from a young Looked After person.

2.5 It is generally understood that children and young people tend to raise concerns through the many other routes available to them. This includes their allocated social worker, IRO, through care team meetings or advocates. From reviewing the data provided by the individual residential units, most of the issues raised are more related to day to day issues within the units rather than service processes or procedures, for example complaints have been recorded regarding how staff have dealt with a disagreement between residents. It is evidenced that the issues have all been dealt with promptly and effectively.

2.6 Statistically, our Units have recorded the following for 2020/21.

Unit	Complaints 2019/20	2020/21
Barndale	**0**	**0**
Coanwood	**0**	**5**
Kyloe	**24**	**44**
Phoenix	**2**	**1**
Thorndale	**4**	**4**

2.7 Although the figures look high for Kyloe House and there has been a significant increase in the last year; it is considered that this is due firstly to this being a secure children's home who are dealing with the most challenging of young people unhappy with their situation. Complaints have included, for example, issues about food standards and staff touching washing.

2.8 Secondly, it is considered that the increase in complaints this year is due to the Covid restrictions which have presented an additional and significant challenge for the young people. They have been unable to have family visits or go out on activities and a great many of our young people have understandably struggled with this.

2.9 All complaints regarding internal issues have been recorded and investigated and of the 44 complaints received, all matters were resolved satisfactorily without the need for further escalation to the formal complaints procedure.

2.10 A total of 10 complaints were received for the other residential units. All were dealt with promptly, fully investigated and resolved to the satisfaction of the young people involved without need for further escalation.

2.11 Formal Complaints resolved at Stage 1

2.12 Of the 47 complaints received during 2020/21 (33 social care and 14 corporate); 4 were not progressed (3 social care and 1 corporate). Reasons for not progressing a complaint include the complainant being involved in a concurrent investigation such as court proceedings (Regulation 8) or being outside the 12 month timescale for making a complaint (Regulation 9). A complaint can also be refused if there is a more appropriate, alternate process such as an appeal or Tribunal.

Of the 43 complaints that were accepted and then progressed;

1 complaint was subsequently withdrawn by the complainant;
1 complaint has been placed on hold at the complainant's request;

12 were partially upheld;
11 were fully upheld; and
18 of these complaints were not upheld.

2.13 Significant work is now being undertaken by the department to improve the quality of investigation and response provided at Stage 1 to increase customer satisfaction, embrace a learning culture from customer feedback and to reduce overall costs that independent investigations inevitably incur.

2.14 Complaints escalated to Stage 2

2.15 Of the 43 complaints taken forward during 2020/21, only 3 complaints have been escalated to Stage 2. One of these complaints was corporate and therefore followed the corporate process which involved a senior manager undertaking a review of the investigation and outcomes at Stage 1. The remaining 2 have been dealt with under the statutory children's regulations via independent investigation.

2.11 Complaints escalated to Stage 3 - Review Panels

2.12 Of the complaints recorded during 2020/21 only one was escalated to Stage 3 Review Panel.

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

2.14 Due to Covid-19 restrictions and in accordance with The Adoption and Children (Coronavirus) (Amendment) Regulations 2020, there was some delay in progressing the Stage 3 Review Panels, however, arrangements for these meetings to be held virtually have been progressed.

2.16 Complaint response timescales

2.17 At Stage 1 children's social care complaints should be responded to within 10 working days, with an extension to 20 working days in certain circumstances. For the 2020/21 year where 29 social care complaints were accepted and taken forward, the response figures are as below:

9 were responded to within 10 working days;
11 were responded to within 20 working days; and
9 took over 20 working days to respond to.

2.18 This demonstrates that 69% of social care complaints were responded to within statutory timescales. Of the remaining 9 that went over timescales, further extensions were agreed with the complainant and were done to continue attempts to agree a suitable way forward in terms of remedy.

2.19 At Stage 1 of the corporate complaint process, complaints should be responded to within 15 working days.

2.20 For the 2020/21 year where 13 corporate complaints were accepted and progressed, the response figures are as below:

5 were responded to within the 15 working days;
8 took over 15 working days to respond to.

2.21 Again where delay was a factor, communications with the complainant were clear regarding why and when response could be expected.

2.19 It should be noted that focus within any complaint process remains very much on resolution. Whilst timescales are extremely important and should be adhered to, particularly within the statutory complaint processes, every effort is made to attempt satisfactory resolution and delays are often experienced due to the availability of either officers or the complainant to meet direct to discuss or due to extended deliberations on resolution. Complainants are kept informed of any delay, the reason for it and when they can expect a further update.

2.20 Complaint response at Stage 2

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

2.23 Three complaints recorded in 2020/21 have been escalated to Stage 2. One was a corporate complaint relating to an admissions complaint and therefore not within the statutory process. This corporate complaint was responded to within the 20 working day timeframe agreed for the corporate process. The complaint was not escalated further.

2.24 The two complaints escalated for independent investigation within the children's process are ongoing, with one nearing adjudication stage.

2.25 Complaint response at Stage 3

2.26 Only statutory social care children's complaints can be escalated to Stage 3. This involves 3 independent panellists sitting on a Review Panel to consider the investigations and findings at Stage 2 to ensure the process has been followed correctly, the investigation has been robust and the findings logical and fair.

2.27 Although no complaints taken during 2020/21 have escalated to Stage 3, a total of 3 complaints from the previous year 2019/20 were considered during this financial year. The Review Panels were put on hold at the beginning of 2020/21 due to Covid preventing face to face meetings and the facility for full virtual meetings to be held not being fully confirmed.

2.28 All 3 Review Panels were completed during 2020/21. The Review Panels are the last opportunity for the Council to rectify any issues identified and despite

negotiations for suitable remedy all 3 complainants escalated their concerns to the LGSCO.

3.0 External review

3.1 Local Government and Social Care Ombudsman

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

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

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

3.4 The 2020/21 Annual Letter indicates that the LGSCO received 11 complaints in relation to NCC Education and Children Services during 2020/21 and have also issued 11 decision notices; 2 complaints were Upheld; 4 were closed after initial enquiries; 4 were referred back to NCC for consideration (known as premature referral to the LGSCO) and 1 was deemed invalid/incomplete.

3.5 Of the 2 complaints that were Upheld; the LGSCO were satisfied that NCC had already appropriately remedied 1 of the complaints.

3.6 The LGSCO website only publishes the decision notices where an assessment has been undertaken by them, therefore only 6 of the complaints received in relation to Northumberland County Council were assessed and decisions published.

3.7 A comparison has been undertaken on the statistics available on the LGSCO website to other similar authorities (as determined by LGSCO). The comparison to the available comparators is below:

Council	Closed after initial enquiry	Upheld	Not Upheld	Total
Northumberland	**4**	**2**	**0**	**6**
Durham	**10**	**4**	**1**	**15**
Middlesbrough	**6**	**1**	**4**	**7**
Nottinghamshire	**12**	**6**	**2**	**20**

3.8 The LGSCO are encouraging local authorities not to become too fixated on the numbers of complaints received and instead focus on outcomes and remedies as they believe that is a true marker of complaint performance.

3.9 Top level information provided on LGSCO's website shows the Council's performance in its entirety across all departments and not specifically in relation to

children's services. However, the figure shown indicates that **45%** of complaints they received and investigated in relation to Northumberland County Council were upheld. Their information advised that this compared to an average of **63%** in similar authorities.

3.10 The LGSCO also acknowledged that they were satisfied Northumberland County Council had successfully implemented their recommendations in all cases considered (**100%**). They confirmed this compared to an average of **99%** in similar authorities.

3.10 In the final top level comparator identified by the LGSCO, it confirmed that Northumberland County Council had provided satisfactory remedy before the case reached the Ombudsman in **20%** of complaints received. This compared to an average of **10%** in similar authorities.

3.11 This would indicate that NCC are performing well in terms of complaint handling and consideration.

4.0 Categorisation of Complaints

4.1 When complaints are recorded, the Client Relations Team assess and determine the nature of the complaint and what the content relates to. Complaints often involve multiple areas or categories of complaint and therefore the numbers are higher than the number of complaints actually received. For example, one complaint could be about a delay in service but also include an element regard a potential data protection breach. This is now being recorded.

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

Category	2019/20	2020/21
Communications/Information	**8**	**22**
Delay in Service	**1**	**4**
Failure to follow policy/procedure	**2**	**5**
Standard of service	**20**	**17**
Staff manner/attitude	**0**	**3**
Breach of confidentiality	**6**	**2**
policy	**0**	**1**
Issue with social worker	**6**	**4**
Disagree with officer decision	**7**	**1**

4.3 Communication is now the subject of the largest number of complaints, however, this can be somewhat accounted for by the big change over the last year in the use of electronic communications (text message/teams meetings/instant messenger/What's App, etc). There is somewhat of an unrealistic expectation from a lot of service users that the allocated social worker should respond in the same instant fashion when they message through these platforms. This is not always possible and it is about managing customer expectations from the outset. This is being tackled in lessons learned.

5.0 Lessons learned

5.1 During the past 2 years the Council focus has been very much around using the learning from complaints and other feedback to identify where service improvements may be required. This could take the form of individual staff or team training/supervision or departmental process change.

5.2 During 2020/21 a Working Group was created to:

- identify patterns and trends from complaints
- identify learning from complaints and how this will be disseminated.
- ensure actions identified within the outcomes of complaints are followed up and it is recorded when actions are completed.

5.3 Information is gathered by the Complaints Working Group on a monthly basis and reported to Children's Services Senior Leadership Team (CSCLT). The information and themes for learning are also reported on a quarterly basis to the Quality and Performance Audit Group (QPAG).

5.5 Findings within complaint investigations have been used to create a plan for service improvements for the forthcoming year including steps to improve the following:

- Managing communications with parents/service users more effectively in light of the increased use of instant messaging during the pandemic.
- Working with non-resident parents to ensure they are kept up to date with progress in their child's case.
- Improved recording to evidence decision making in cases.
- Improved recording to evidence discussions and follow up to queries by parents/ carers.
- Improved information regarding framework being operated within and how this is communicated with parents to ensure they understand this e.g if a parent signs section 20 what this means.
- Recognising and involving necessary outside support agencies, such as domestic abuse workers in parenting assessments.
- Provide feedback from meetings and distribution of minutes.

5.6 A programme of training to address all findings and improve service practice has been created.

6.0 Compliments

6.1 Examples of good practice can also be obtained from positive feedback received. All compliments received into the department are recorded and fed back to management. This year 59 compliments have been recorded taken from feedback provided by service users, parents/representatives and other professionals.

6.2 Whilst many related to support provided in general and the positive outcomes from the involvement of Children's Services; others related to the quality of specific pieces of work and how this quality was quantified. Any good examples are taken forward to use within training materials.

6.3 Anonymised examples from the compliment received are provided below.

- [Social worker] has really gone out of her way to ensure that everything has been done well for the young person meaning the young person has been able to go and live with family. This has been a complex case and the court process has not been easy. [Social worker] has confronted every problem head on and dealt with it. [Social worker] has gone over and above which should be recognised.

- [Parent] remains positive about future supports from Children's Services and [social worker] has helped change their view of Children's Social Care.

- The quality of [foster carer's] care and dedication to meeting [young person] needs has been outstanding..Throughout the care proceedings and while awaiting their move [foster carer] has never failed to advocate for them, build life story work where there has been little material from the birth family and celebrate their short life. [Foster carer] always produced excellent detailed written reports for Looked After Review meetings and gave a real sense of fully understanding the young persons needs. [Foster carer] also tried to build a positive relationship with the birth parents and has given a clear and independent view of what was in [young person's] best interests particularly when the panel date to decide [young person's] future was delayed. This was done very professionally and in my view [foster carer] was right. [Foster carer] is a carer we should all celebrate; a huge asset to Northumberland Children's Services and to the children placed in her care.

- The Judge repeatedly expressed thanks to [social worker] for the work done. [Social worker] pitched and facilitated the introductions between [young person] and [parent] really well; which enabled them both to establish and build on their relationship and has ultimately resulted in the best possible outcome for [young person]. [Social worker] is to be commended for their hard work.

- Excellent quality of [social worker] report and presentation to this morning's ICPC. [Social worker] summarised their concerns and their involvement including the history of past harm. This was a challenging case that required considerable preparation and tenacity to engage the family. [Social worker] engaged the family well; getting them to attend the meeting where they were able to participate. The ICPC was conducted using Signs of Safety material and analysis but due to work by [social worker] the meeting was flexible and smart enough to do this in a way the parents understood. [Social worker] and a good plan which should really help you achieve some positive outcomes for the child.

- Massive thank you to [family first officer] for your involvement. Without you and your work I wouldn't be where I am now. You've taught me so much, this whole thing has given me so much growth & taught me lessons that will last me a life time I am so proud of myself for how far I've come. The kids have been removed from child protection. From the bottom of my heart I thank you so much you truly are amazing at what you do.

- I would first of all like to thank [Early Help worker] from the bottom of my heart for all support with my family over the last 6 months , this [early help worker] is an absolute asset to your team it's rare to meet someone so committed to their job

and it certainly shows how dedicated they are to helping people. I can't ever thank the worker enough so again from the bottom of my heart I wanna thank the early help team for all your input and support ..... I couldn't of got through all of this without you, you've been a god send to my family.

- Anti social behaviour in the Ashington area has been in decline and this is believed to be due to the work of the detached youth project in that area. Well done from Northumbria Police.

7.0 Summary

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

7.2 Training will also continue to be provided across the department regarding both complaint processes to improve complaint knowledge and handling in general. The Complaints Manager is engaging with new managers to the department and also attending individual team meetings to promote positive complaint interaction and investigations.

8.0 Further information regarding complaints

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

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