Annual Complaints Report
Adult Social Care, Richmond
2020-21

Table of Contents

1. Introduction

1.1 The production of a complaints report is a statutory requirement for Adult Social Care to provide an overview of the complaints received and handled through the Local Authority's statutory complaints procedure. This report is designed to meet this requirement of Adult social care and is a public document.

1.2 The Local Authority has a duty to ensure that any individual (or appropriate person acting on their behalf) who wishes to make a complaint about the actions, decisions or apparent failings of a local authority's social care provision have access to the Adults statutory complaints procedure.

1.3 Richmond Council's Adult Social Care complaints are managed within the remit of the Resident Engagement Service. The Statutory Complaints Team currently comprises a Complaints Manager, which is a statutory requirement, supported by two complaints officers. The Statutory Complaints Team sit within the same management structure as the Corporate Complaints and Ombudsman Team.

2. Legislation

2.1 There is a legal requirement for the Local Authority to have in place a complaints procedure, in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 for the management of social care complaints.

2.2 The Regulations cover Adults Social Care and Health services and/or any of its commissioned services and/or independent services.

3. Overview of the Statutory Adults Complaints Procedure

3.1 The complaints procedure is a single stage process for both Health and Social Care services. The Local Authority has a total of six months (or 65 working days) to resolve a complaint from start to finish. Within this single stage, a complainant may receive a further investigation if not satisfied with the initial response or be offered the opportunity to meet to discuss their complaint.

3.2 Internal performance indicators aim to provide the complainant with a first response within 25 working days. Any further response must be completed by the six-month statutory timescale. The complaint can be progressed to the Local Government and Social Care Ombudsman (LGSO) following the final response from the Local Authority or at any time.

3.3 Complaints should be recorded and monitored by the complaints team. All complainants should be offered the opportunity to discuss their complaint with a complaints officer and assessed for risk by the complaints team in liaison with the

relevant social care team. Complaints that are deemed very high risk will be referred to the appropriate investigation route such as invoking safeguarding procedures.

3.4 A complaint is defined as "an expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a local authority's adult social services provision that requires a response".

3.5 Complaints can be made by the service user receiving a direct service from Adult Social Care or by a person on their behalf such as an advocate or family member where the service user has provided their written consent and they are deemed to be acting in the person's best interests.

3.6 Where a service is provided by a contractor on behalf of the Council, a complaint can either be made directly to the provider service or to the complaints team at Wandsworth Council. Whilst the complaints team will encourage a provider to firstly attempt resolution through its own procedures, if this is not possible, the Quality Assurance and Standards team will investigate.

3.7 Service users who fund their own care for services that are regulated by the Care Quality Commission do not fall under this procedure.

3.8 Complaints will be considered if they are made within 12 months of the incident although the Council can apply their discretion to waive this time limit in some instances.

4. Adult social care complaints received

4.1 The services received 35[1] new complaints (which includes two provider related complaints). This is a 53% decrease on the 74 complaints processed last year.

4.2 **Table 1** details the complaints received over the last 5-year period. There has been a gradual decrease in the number of complaints. There are factors that could have affected the decrease in the number of complaints. Service users facing additional challenges due to the Covid-19 Pandemic may not have prioritised making a complaint. Additionally, better complaints handling at the point of contact within services may have reduced the number of formal complaints. A key objective for the forthcoming year is to strengthen the presence of the complaints team within the adult's directorate which will further enhance insight into complaint trends.

4.3 **Chart 1** details the complaints received for each quarterly period. The majority of complaints were received in Quarter 1 and Quarter 3.

[1] In addition to the 35 complaints received, eight complaints received in the previous year were closed in the first quarter of this year. Three complaints received this year will be closed in the first quarter of next year. This means that 40 complaints were closed in this reporting year. This is a 46% decrease on the 74 complaints processed last year.

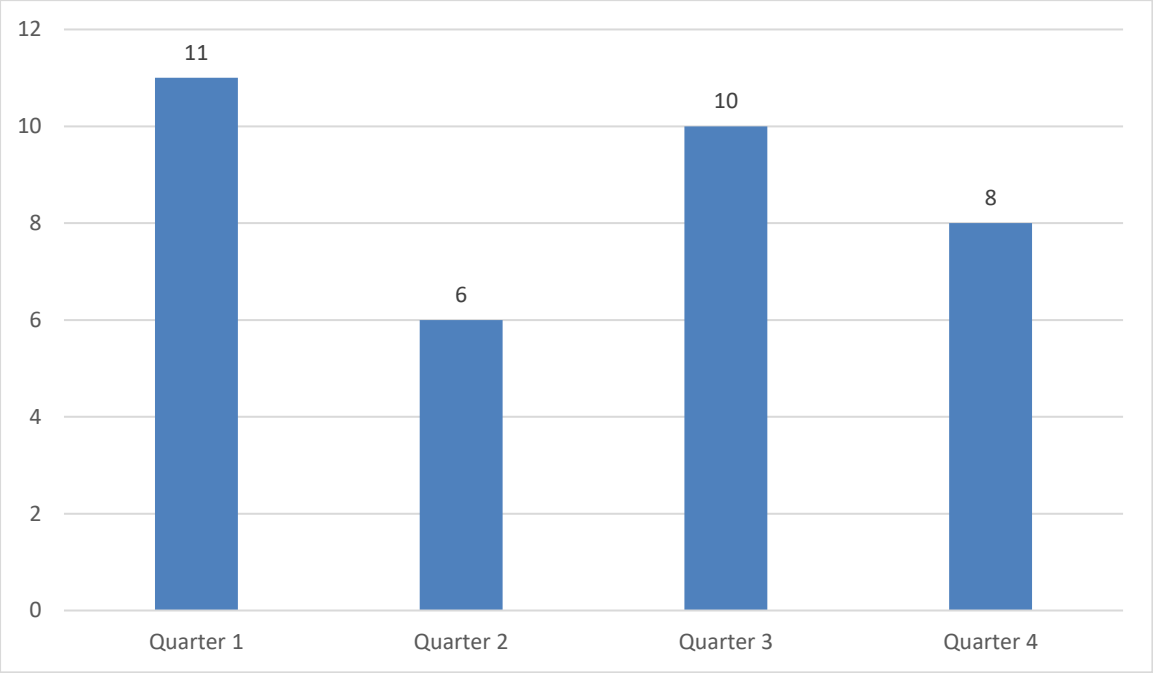
4.4 The volume of complaints should be set in context by looking at the overall level of contact and interaction Adult Social Care has with its residents and service users. During 2020/21 35 complaints were received and 40 closed but that is a low proportion given that the department handled approximately 7,900 contacts and supported 2,030 people during the year. Also, while the Financial Assessments Team recorded two formal complaints in 2020/21 it was responsible for processing in excess of 1,295 financial assessments this year.

4.5 Complaints should also be viewed positively as a high number of complaints can be a sign of and transparent organisation which welcomes feedback to enable complaints to provide valuable insight into service performance. Teams work hard to provide quality social care and good outcomes, but mistakes happen. A good complaints process promotes learning and honesty so than when mistakes happen, they are put right to prevent the same mistakes from reoccurring.

Table 1: Richmond Adult Social Care complaints by year.

Richmond adult social care	2016/17	2017/18	2018/19	2019/20	2020/21 received	2020/21 closed comparator
	109	66	56	74	35	40

Chart 1: Number of Adult Social Care Complaints received by quarterly period 2020/21



5. Complaints received by service area and team

5.1 **Table 2** details the current structure of teams with service areas for Adult Social Care. **Chart 2** details the number of complaints received by the teams with these service areas during the reporting year.

5.2 The Richmond and Barnes Locality received the highest number of complaints, although due to the reduction in complaints this year, the numbers across teams are not particularly significant. Also, as locality teams support by far the highest volume of residents across all services, who are also service users receiving long-term care, it is expected that they would receive a higher number of complaints. Richmond and Barnes received 50% less complaints than last year (14 compared to seven this year). However, this figure is consistent with the overall number of complaints which have reduced by 53%. Furthermore, Mental Health Assessments received six complaints, followed by Teddington and Twickenham locality which received five.

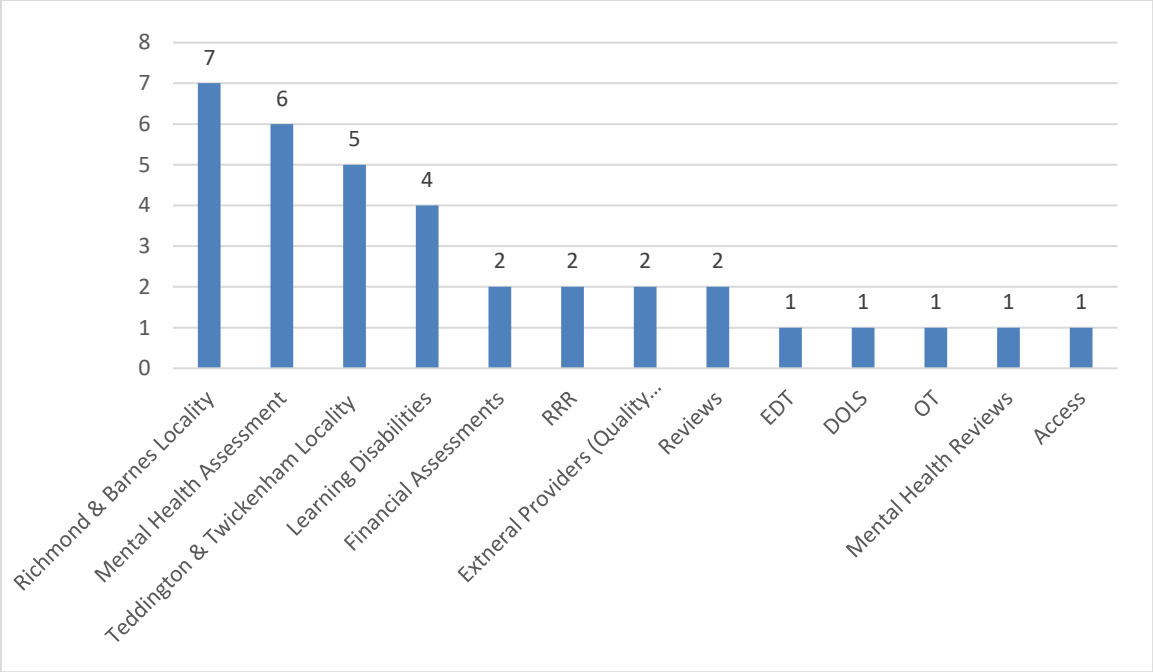
5.3 More notable is the reduction in complaints about external care providers investigated by the Quality Assurance and Contract Monitoring team which reduced by 86% from 14 received last year, to two received this year. Aside from the Covid-19 Pandemic's potential impact on complaint numbers, this could also be attributed to an improvement in the way care providers are managing complaints at point of receipt through their own complaints processes, and good partnership working with the Quality Assurance team.

Table 2: current structure of Adult Social Care service areas and teams

Service Area	**Teams**
Early Help and Enablement	Hospital social work teams Richmond Response and Rehab (RRR) Occupational Therapy
Community Services	Richmond and Barnes Locality Teddington and Twickenham Locality
Mental Health & Learning Disabilities	Mental Health Assessment, Casework and Substance Misuse Mental Health AMHP, Reviews, Accommodation and Projects Learning Disabilities Emergency Duty Team
Finance	Financial Assessments Payments
Promoting Independence	Access Reviews Brokerage

Service Area	Teams
In House provider services	Café Sunshine[2] Day Centres and Transport
Commissioning – Adult Social Care and external provider management	Quality Assurance and Contracts Management
Professional Standards and Safeguarding	Safeguarding DOLS

Chart 2: Number of Adult Social Care Complaints received by teams 1 April 2020-21[3]



[2] Café Sunshine is a non-profit café in Dimond Jubilee Gardens managed by people with learning disabilities

[3] If teams are measured against the 40 complaints closed this year, the numbers would be adjusted slightly for the following teams; Richmond & Barnes (8), Mental Health Assessment (5), Teddington & Twickenham (6), RRRT (3) and external Providers (5). Numbers for other teams would remain the same.

Table 3: Number of Adult Social Care complaints received by teams and quarter 2020-21

Team	Q1	Q2	Q3	Q4	Total
Richmond & Barnes Locality	**3**	**2**	**2**	**0**	**7**
Mental Health Assessment	**0**	**1**	**2**	**3**	**6**
Teddington & Twickenham Locality	**3**	**0**	**1**	**1**	**5**
Learning Disabilities	**1**	**2**	**1**	**0**	**4**
Financial Assessments	**1**	**0**	**1**	**0**	**2**
Richmond Response and Rehab	**1**	**0**	**0**	**1**	**2**
External Care Providers (Quality Assurance & Contract Monitoring)	**0**	**0**	**1**	**1**	**2**
Reviews (Social Care)	**0**	**1**	**1**	**0**	**2**
Emergency Duty Team	**1**	**0**	**0**	**0**	**1**
DOLS	**1**	**0**	**0**	**0**	**1**
Occupational Therapy	**0**	**0**	**1**	**0**	**1**
Mental Health Reviews	**0**	**0**	**1**	**0**	**1**
Access	**0**	**0**	**0**	**0**	**1**
					35

5.4 Service areas are committed to working in partnership to resolve multi-faceted complaints that involve two or more teams, as one combined complaint response makes the process of complaining easier for the service user. When a complaint has issues that require a response from multiple teams, a lead team is appointed, based on where most of the issues fall. For recording purposes complaints have been recorded against the lead team. However, two of the complaints this year were joint investigations. One was led by Richmond and Barnes Locality with input from the Finance team, the other was led by the Reviews team with input from the Teddington and Twickenham locality team.

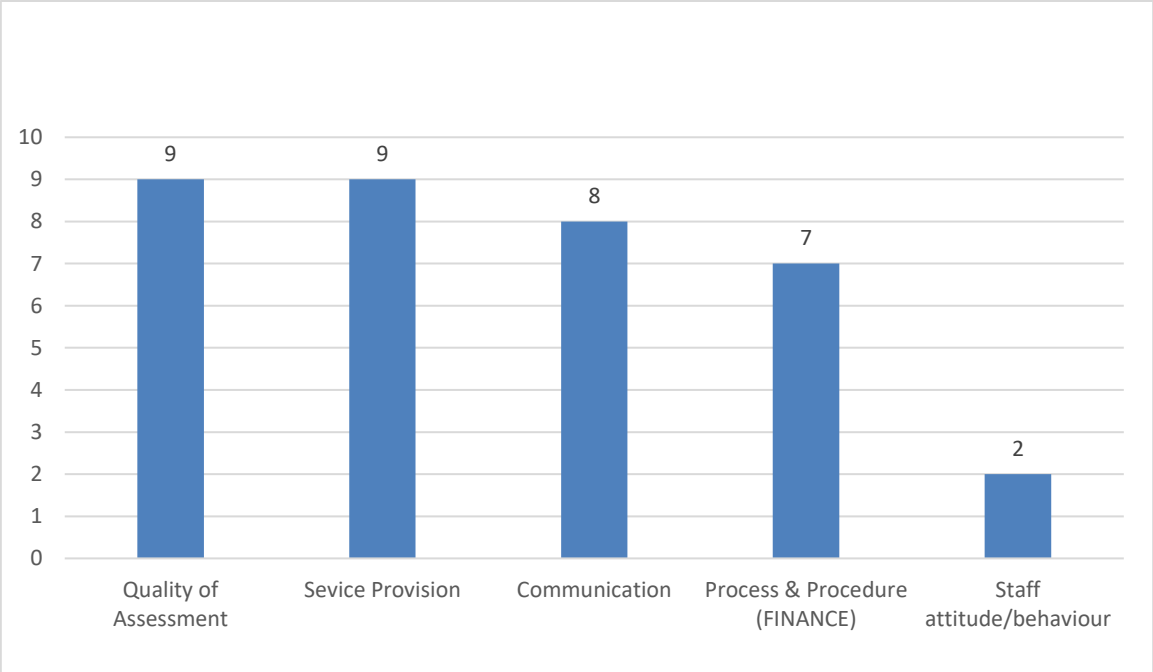
5.5 Teams across Adult Social Care regularly receive comments and feedback from service users and/or carers and generally these issues tend to be resolved directly by the staff. This year six of the formal complaints received were withdrawn and most of them resolved outside of the process at the request of the complainant because the relevant service area was able to resolve the issues without the need for a formal written response. One complaint was re-directed through safeguarding procedures. These complaints are still recorded so that the issues raised can be included in the analysis of issues and contribute to learning, given that they were initially raised formally and, other than providing a written response, work was put into resolving the complaint.

6. Complaints received by Issue

6.1 Complaints analysis is regularly reviewed at senior management level and there is an ongoing focus and commitment on service improvement.

6.2 Quality of Assessment and Service Provision (nine complaints each or 26%) was the main primary issues raised by complainants during 2020-21. This was followed by Communication (eight complaints or 23%), Process and Procedure (seven or 20%), Staff attitude (two or 6%). These are detailed in **Chart 3** below.

Chart 3: Number of Adult Social Care Complaints received[4] by Primary issue 2020-21



6.3 As these themes are quite broad, complaints also contain secondary issues to inform a deeper analysis of what we are being told by complainants. Further breakdown of secondary issues raised in the top three primary issues are detailed in **Charts 3, 4 and 5.**

6.4 Complaints about the quality of assessments were mainly about the outcome; two complaints were specifically about outcomes of Deprivation of Liberty Safeguarding (DoLS) assessments and the remaining were about the outcomes of social care assessments of need. Two complaints were about the length of time to carry out assessments. Overall, the number of complaints are low in comparison to the number of assessments carried out each year. Three out of these nine complaints were upheld.

[4] If complaint issues were measured against the 40 closed complaints this year, the numbers would be adjusted slightly for the following issues: Service Provision (14), Process and Procedure (6), and Confidentiality would be added (1). Other issues remain unchanged.

6.5 Issues about service provision is a broad theme and concerns raised were about perceptions of the quality of care, the amount of support received or how the department met its duty of care once a person has been assessed and receiving social care support. Four out of the nine complaints raising this issue were upheld. These related to aspects of the quality of care by people received through their ongoing social care support.

6.6 Complaints mainly concerning communication raised issues about the quality, accuracy and timeliness of information, but also about how lack of information creates perceptions of people feeling uninvolved in issues affecting them.

6.7 The top three primary issues, Quality of Assessment, Service Provision and Communication, are broken down in **Charts 4, 5 and 6**

Chart 4: Quality of Assessment secondary issues

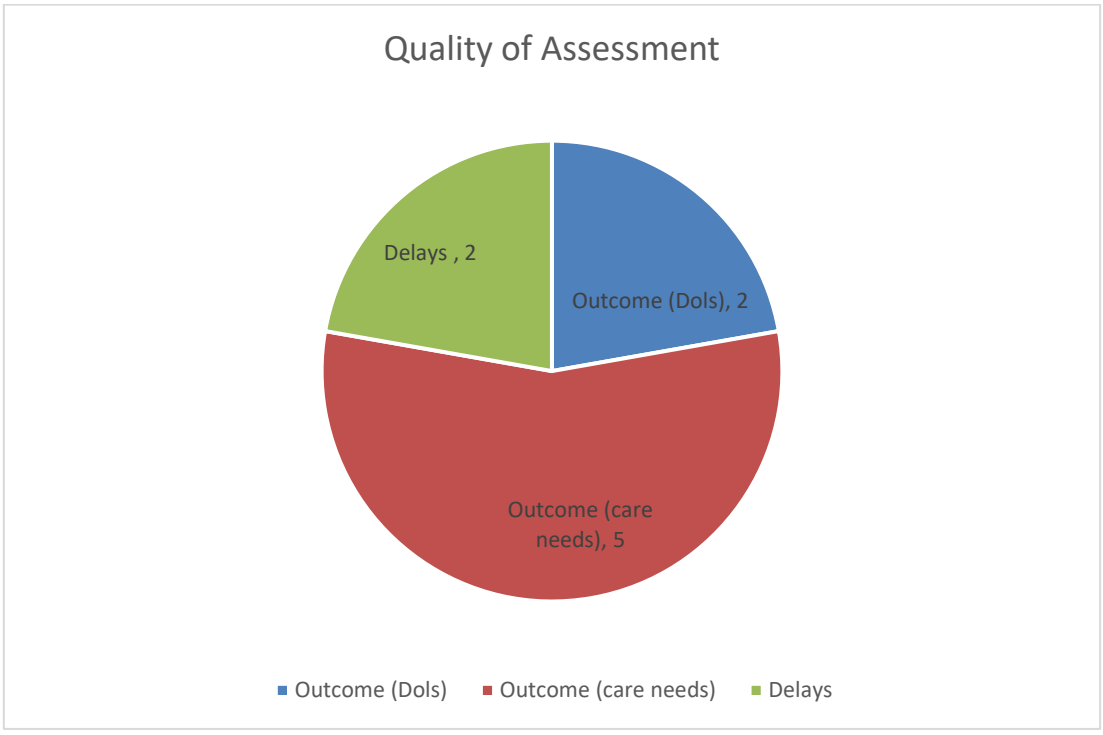


Chart 5: Service Provision secondary issues

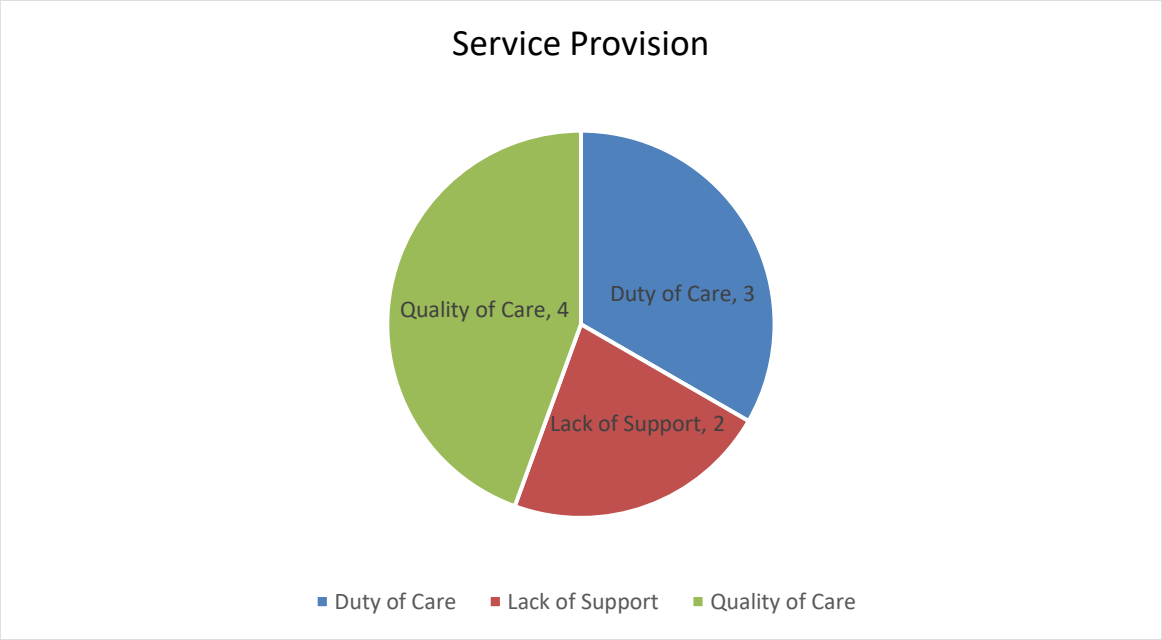
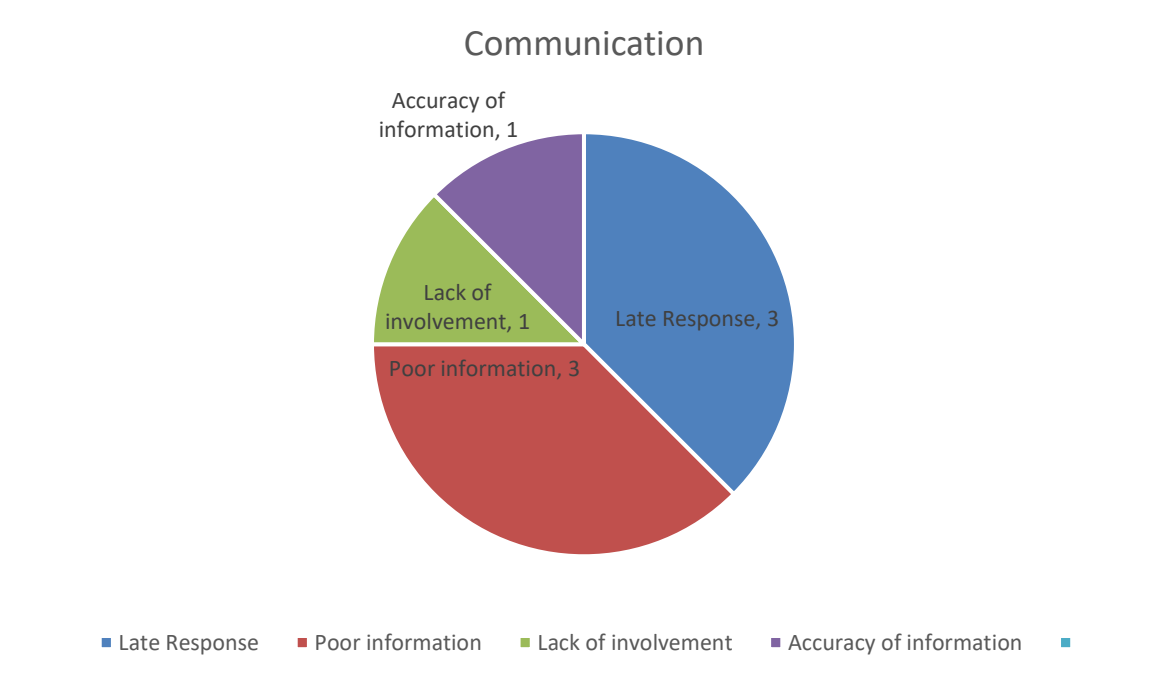


Chart 6: Communication secondary issues



6.8 All seven complaints about process and procedure raised issues about financial errors due to perceived non-adherence to process of procedures. Three complaints were about the cost of services and four were about incorrect charging. Only two of these seven complaints were upheld. One of these was about ensuring suspension of care is added to the hospital admissions screening tool, to avoid people being charged for care when admitted to hospital.

6.9 The two complaints about Staff Attitude/Behaviour raised issues with regards to perceived rudeness and prejudice and neither were upheld.

6.10 A more detailed breakdown on complaint outcomes is detailed in **Section 8**. Learning from these complaints is detailed in **Section 12**.

7. Response Times

7.1 Complaints should be investigated and completed within a statutory timescale of six months. Within this six-months, the Statutory Regulations allow Council's to respond to complaints flexibly, so that investigations can be tailored to best meet the needs and desired outcome of the person making a complaint.

7.2 Complainants are kept fully informed and often agree with investigating managers to allow more time for their investigation, over and above the initial 25 working days. The average length of time to respond across all complaints received this year was 33 days.

7.3 The Council has a best practice KPI of 25 working days to respond to adult social care complaint in writing. If the complainant is not happy with the first response, there is an opportunity to escalate. This could involve another written response, possibly at a more senior level, or a meeting if this is felt to be the most effective way of resolving the complaint.

7.4 If the Council cannot resolve the complaint in its entirety within six months, it should consider signposting to the Local Government and Social Care Ombudsman (LGSO). This is to ensure that complaints escalated to the LGSCO are in time[5]. Throughout the complaint being investigated, the complainant is be kept informed of the progress and any cause for delay.

7.5 For this reporting period, Richmond received 35 complaints but completed 40 complaints; eight from last year were closed this year and three from this year will be closed next year. Timescales were measured for the 40 complaints closed during the year which included withdrawn complaints which were completed within 25 days.

7.6 Of those, 18 complaints (45%) were closed within 25 working days and 22 (55%) exceeded this timeframe. **Chart 7** details response times for the last three years.

7.7 The timeliness of responding to complaints within 25 days has remained the same as last year which again, could be attributed to the Covid-19 Pandemic; it should also be noted that this year, no complaints breached the statutory six-month timescale[6] for fully resolving the complaint. Additionally, during the height of the Covid-10 Pandemic it was agreed and fully communicated to complainants that complaint investigations would take longer as the emergency response had to be prioritised.

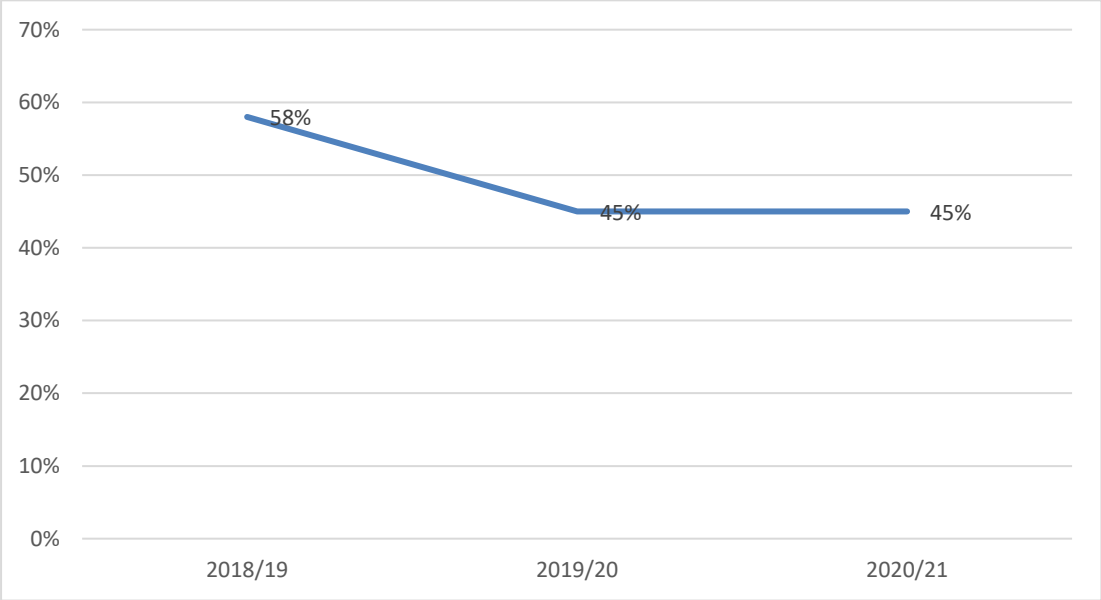
[5] Requests for independent reviews by the LGSO should be made within 12 months of the incident happening

[6] Six months is calculated as 182.5 days although this includes non-working days.

7.8 For the 55% of complaints that exceed 25 days, the average response time was 35 days, which is still well within the statutory timeframe.

7.9 Where complaints take longer than 25 days, extensions are agreed with the consent of the complainant and complainants are kept informed at all stages.

Chart 7: Percentage of complaints responded to in writing within 25 working days



8. Complaint Outcomes

8.1 Looking at the 40 complaints that were closed during the year; Whilst slightly more complaints (38% or 15 complaints) were not upheld, 20% (or eight complaints) were upheld and 20% (or eight complaints) partially upheld. These are shown in **Chart 8**.

8.2 Last year 30% of complaints were not upheld and 37% were partially upheld.

8.3 This year's data could also be looked at another way. Combined, 40% (or 16) complaints contained issues that were upheld. Adult social care complaints are multi-faceted and sometimes span multiple teams so it is expected that some complaints will have a mix of upheld and not upheld issues. This should be viewed positively as it demonstrates an organisation that is transparent and receptive to learning from complaints.

8.4 Often complaints that were partially upheld, did not uphold the substantive issues such as decisions and actions, but recognised that communication and interactions with people receiving services, could have been better. Again, this is positive, as it demonstrates that professionals recognise the importance of reflection on all aspects

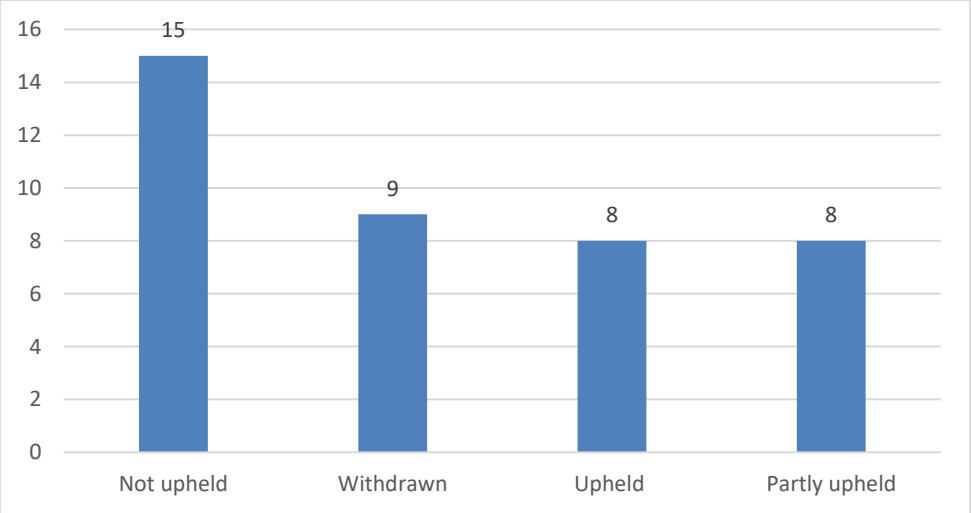
of their practice and value the perceptions of the people they support. Learning from these complaints is discussed in **Section 13** of this report.

8.5 For this year, the upheld findings were mainly in respect of accurate recording and the quality of information or communication. For example, quality or lack of information resulted in incorrect charging or a misunderstanding about the costs of care, and delays and unclear communication caused additional frustration to people using services. Staffing and work pressures in some teams were at times, a contributory factor, especially as this year council officers were faced with other priorities with regards to responding to the Covid-19 Pandemic.

8.6 Outcomes were measured against 29 closed complaints which received a formal response and excluded the nine complaints withdrawn. Withdrawn complaints were either resolved verbally to the complainant's satisfaction or diverted to other processes such as safeguarding. Withdrawn and no consent complaints are still included in the figures so that the themes and issues raised are incorporated into our overall analysis and feed into learning. Also, these complaints require professional time to record and resolve.

8.7 Service managers use complaint outcomes to improve practice on an individual level with staff and it is also disseminated at team and operational meetings. As the complaints team increase its presence in directorates over the next year, we will support practice development through strengthened quarterly reporting and briefings for operational staff on good complaints handling.

Chart 8: Number of closed complaints by outcomes 2020/21



9. Provider Complaints

9.1 The Quality Assurance and Contract Monitoring Team, that sit within the Commissioning Service, investigate provider complaints for Adult Social Care. This includes residential and domiciliary care services. Complaints regarding a commissioned provider services that are received directly by the Complaints Team, will be logged and processed in accordance with the Statutory Complaints Procedure

and referred to the Quality Assurance and Contract Monitoring Team to investigate and monitor as required.

9.2 If the care provider service has not had the opportunity to investigate the complaint through its own process, the complaints team may ask the complainant if they agree to firstly attempt local resolution with the care provider. If the complainant does not feel local resolution is possible, or they have attempted to resolve their complaint with the provider, the Council will investigate.

9.3 This does not include complaints by 'self-funders' who are able to complain directly to the care provider and/or the Local Government and Social Care Ombudsman (LGSO). Whilst complaints received by self-funders will be signposted to the relevant provider and/or LGSO, information received by self-funders about the quality of provider services will be passed to the Quality Assurance and Contracts Monitoring Team to inform the wider quality monitoring of services.

9.4 For this reporting year, only two new external provider complaints (compared to 14 last year) were received and recorded by the Complaints Team and both related to domiciliary care. The decrease this year could be attributed to better handling of complaints at point of contract by providers as well as the Covid-19 Pandemic. However, it should also be noted that some provider services such as Day Centres were closed during the Pandemic and this may have also affected numbers.

9.5 The issues in one complaint identified that the provider should better monitor their electronic records, improve the quality of record keeping by carers and remind carers of care standards and good communication. The second complaint was about carers using PPE correctly.

9.6 In addition to the two new complaints, four provider complaints were closed from last year. They were about carers missing visits, neglect within a care home, and incorrect charging by a home care agency

10. Equalities data and categories of support

10.1 Where age is known, this year 13[7] complaints received concerned complaints made from, or on behalf of, service users of working age; between the ages of 18 and 64. A further 19 complaints concerned complaints made from, or on behalf of, service users in the older adult's category (or over 65).

10.2 Where gender is known, 19 complaints concerned females and 13 complaints concerned males.

[7] The equalities numbers are different to the total number of complaints and may affect percentages because some people raised more than one complaint in the year. Where this has happened, their equalities data has only been counted once.

10.3 For the 13 complaints from, or on behalf of, service user of working age (18-64), where known:

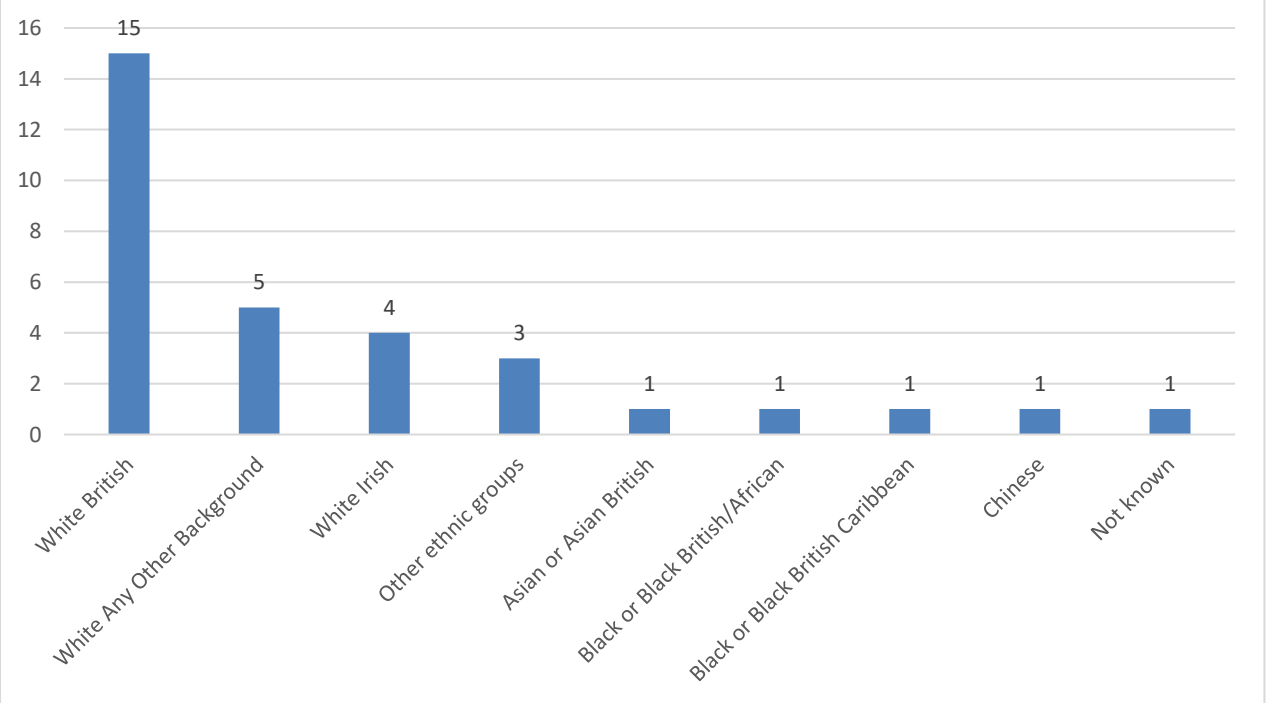
- 50% were in receipt of support from mental health services
- 25% were in receipt of support from learning disability services
- 15% were in receipt of support for physical support for access and mobility
- 8% or one person was in receipt of physical support for personal care

10.4 For the 19 complaints from, or on behalf of, service users in the older adult's category (65 plus):

- 68% were in receipt of physical support for personal care only
- 11% (or two people) were in receipt of physical support for access/mobility only
- 5% (or one person) was in receipt of physical support for personal care and mental health
- 5% (or one person) was in receipt of physical support for personal care and sensory impairment
- 5% (or one person) was in receipt of physical support for personal care and memory/cognition
- 5% (or one person) was in receipt of physical support for personal care and access/mobility.

10.5 Where known, **Chart 9** provides ethnicity data for the service users who made complaints, or had complaints made on their behalf.

Chart 9: Ethnicity Data 2020-21



11. Corporate Complaints

11.1 The complaints team only received 1 Corporate complaint at Stage 1 for Adult Social Care which was processed in accordance with the Council's Corporate complaints procedure. Detailed reporting on Corporate Complaints is within Richmond Council's Corporate Complaints Report 2020-21.

11.2 Adult Social Care do not receive many corporate complaints. Sometimes complaints are put through this process if a complaint is received from people not in receipt of a statutory service, who may care for a service user but be unhappy about how the actions of social care have affected them personally.

12. Ombudsman Cases

12.1 A complainant has the right to refer their complaint to the Local Government and Social Care Ombudsman at any time. Generally, the Ombudsman will seek to ensure that the Local Authority has been provided with the opportunity to first respond to the complaint in accordance with the Council's own statutory complaints process.

12.2 During 2020/21 a total of six new Ombudsman complaints were received for Adult Social Care[8]. This is consistent with last year, when five complaints were received for Adult Social Care.

12.3 Whilst six new complaints were received and closed, in total four complaints were closed, one of which was brought forward from last year and received a final decision this year[9].

12.4 Of the six new complaints for Adult Social Care the outcomes/status were as follows:

Complaint details	**LGSO decision**
Complaint about the quality of care provided to mother by an external provider and outstanding financial contributions towards the care.	The Ombudsman found that whilst the provider was at fault for late care visits, the complainant received more than the amount they were charged so there was no basis to refund charges. No fault was found against the Council.
Social worker's decision as to father's discharge and not conducting a Mental Capacity Assessment.	An apology was provided and a remedy of £500.00

[8] The Annual Corporate Complaints Report for Richmond 2020-21 provides details of all Ombudsman complaints received across all Richmond Council services.

[9] Of those two cases received last year and closed this year, one was about an external social care provider and the Ombudsman did not find sufficient evidence to investigate. The other was about a financial assessment which was premature and diverted back through the Statutory Complaints process.

Failure to communicate the outcome of an assessment within a reasonable timescale.	No fault was found.
Complaint about a request for a safeguarding assessment/serious care review	Still open a final decision will be made next year.
A decision by adult social care to override Lasting Power of Attorney following the death of an elderly service user.	No fault was found.
A failure to assess and meet a service user's needs.	The ombudsman found there was a delay in providing emergency support and the council agreed to pay £200 to remedy the injustice.

13. Learning from complaints

13.1 Learning from the experience of people using services can identify where services, policies and procedures can be improved, keep senior management informed of issues that are important to people, improve communication and strengthen relationships. Some of the learning identified is detailed below.

13.2 Some complaints focused on the quality of assessments. In response to these:

- A commitment was made to provide more oversight from supervisors to ensure that Social Workers are sending out copies of all completed assessments and support plans to service users in a timely manner, and that this is documented.

- From one complaint about the outcome of a social care needs assessment, an apology was given and an increase to current package of care.

13.3 Complaints about how well people have been communicated with often also include substantive issues about decisions and the level of care and support provided.

13.4 Even where substantive issues were not upheld, often investigating managers recognised that communication could have been better and offered apologies and a commitment that staff would reflect on their interactions.

- One complaint addressed the importance of contacting people in a timely manner, with a promise to discuss the issues with the wider team to improve response times and interactions.

- Another complaint committed to ensuring that staff use correct templates and send out letters in their own names so that service users and know who to contact.

13.5 Where complaints raised issues about service provision:

- It was recognised how important it is for hospital teams to consider an advocacy referral for a person who is moving and lacks capacity, especially where there is no allocated advocate.

- The importance of strong inter-partnership working was acknowledged, and this resulted with a commitment for closer working between social workers and Brokerage to ensure suitable placements are identified and accessed in a timely way. The investigating manager said that they are continuously looking for ways to develop and improve systems within adult social care.

13.6 Process and procedure were mainly complaints to do with charging and the cost of care. Many of these also overlapped with issues of communication:

- One case accepted that errors in writing to the wrong family member resulted in incorrect invoicing and steps were put in place to prevent this from happening again.

- Processes were put in place to ensure that suspension of care is put onto screening templates used by health and social care staff so that people are not incorrect charged during periods of hospital admission.

13.7 Whilst the number of complaints directly about external care providers were low, there was learning from complaints both with regards to social care practice around sourcing and putting in place care and learning directly for care providers. With regards to the Local Authority:

- The Quality Assurance Service Concern and Local Authorities complaints leaflets will be included in folders for service users, so they know how to raise concerns.

- When transferring care from an existing provider, the local authority will always confirm the level of support so that a review of care needs can be carried out if appropriate.

- It was agreed to improve the clarity of information about people's needs within support plans to enable care providers to deliver the right services.

With regards to care providers:

- A care agency was reminded to ensure their office monitors and audits their electronic records so that they can properly address issues with care

workers. In addition, the Council's quality assurance officers would randomly request 'planned v actual' reports to carry out and independent audit of care visits.

- Care workers were reminded of care standards when completing communication care records and these records will be routinely audited by the care providers.

14. Compliments

14.1 Positive feedback regarding staff or service delivery is another way in which the department can learn how well things are going. Staff are reminded to report compliments they receive and recognise the value of sharing this feedback. Some examples are outlined below:

"Over the several years first comforting action happened this morning when the postman arrived. I received my Carer Card. Attached letter indicates that my assessment was done by you. You made me happy. You gave me comfort and support. You made me feel that I am not alone in case something happens to my wife or to my son. I have a telephone number and behind that number, will be a helping voice".

"I really want to say, how helpful it was to work together with [name]. It was a pleasure to work along in the patient's best interest and taking a complex family along too. We wish we have many more colleagues with such professionalism, kindness and diligence. Thank you".

"Thanks for all your help over the last couple of days. Your compassion and professionalism has been a real comfort".

"I'd like to thank you today for your prompt response to a difficult clinical situation and arranging an urgent MHA assessment there within 2 hours! Also, for your professionalism when dealing with the client and her partner and liaising with the ambulance and police services. I was very glad we managed to have her safely transported to hospital. I and my team very much appreciate it, thank you".

"I would like to say a big thank you to [name] and her team for all the support and advice they have given my Mum and Dad. They also arranged for some extra financial help so that my Dad could buy a new laptop. He was lost without it as he relies on it for a number of things. They are a fabulous team and I don't know what we would do without them".

"I just hopped of the phone with [name]. He was really happy with the chat that he had with you. Spoke very highly of you and though you were fantastic. Thank you for reaching out to him!".

"We would like to take this opportunity to express our thanks for all the time you have given over to [name's] case and to wish you all the very best".

"I wanted to bring to your attention how helpful [name] has been in dealing with me regarding my 93 year old mum and social care for her. It's been quite a long winded process applying for financial assistance for her over the last few months (following her decline after a fall two years ago) and now hopefully she is all set up to allow her to stay in her own home for the time being. I felt that [name] was extremely patient, easy to talk to and she really listened to all the issues I had with my mum. She has been very efficient in getting the ball rolling and keeping contact with us. I'm most impressed".

15. Going forward:

15.1 The key priorities for 2021/22 are as follows:

- Last year saw challenges with regards to staffing capacity and turnover which affected performance around complaint processes and practice. A change programme was put in place and whilst some of these priorities were delayed, in February 2022 a permanent Statutory and Corporate Complaints Manager was appointed and at the end of the financial year. Additionally, a permanent Statutory Complaints Officer was appointed and will be taking up post in June 2021.

- The Statutory and Corporate Complaints Manager will oversee the following priorities:
    - **Further stabilising staffing in Complaints.**

    - Implementation the **new case management system** (CMS) across all complaint types which will improve workflow, processes and reporting including insight into and learning from complaints. Whilst this was due to go live in 1 January, the implementation has been delayed. The new go-live for Adult Statutory Complaints in June 2021, followed by Children's Statutory complaints, before being rolled-out to Corporate Complaints and FOI.

    - Provide an **enhanced advisory and quality assurance role** to operational teams including training to teams on good complaints handling. This will also involve strengthened management of complaints at the start of the process, with a focus on early resolution and identifying creative ways to resolve complaints. The complaints team will work collaboratively with the Quality Assurance and Contract Monitoring Team within Adult Social Care to identify and take forward learning from complaints.

    - Strengthening the team's **presence and interaction with Directorates** strategically and operationally with **enhanced quarterly reporting** to identify complaint numbers, trends, themes and learning.

    - **Working in partnership with the Information Governance Team** to triage complaints that raise Data Protection issues such as the Right to

Rectification and data breaches, to ensure that, where appropriate, they are addressed through Information Governance processes.