Sefton Council

Adult Social Care Complaints

1 April 2016 – 31 March 2017

June 2017

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Executive summary

This year, the Customer Response Team received the following contacts:

Type of Contact	Number of contacts received 2015/16	Number of contacts received 2016/17
ASC Complaint	211	136
Contact	66	82
MP/Councillor Correspondence	69	64
Corporate Complaint	13	21
Compliment	89	104
Public Health	7	9
TOTAL	**455**	**415**

Adult Social Care Complaints

	2011-2012	2012-2013	2013-2014	2014-2015	2015-16	2016-17
Total	**45**	**62**	**109**	**121**	**211**	**136**

Last year we received **211** complaints with **28%** being upheld either in full or in part. This year there was a decrease of **36%** in the number of ASC complaints received. We upheld **35%** of these complaints.

Key areas of complaint this year were as follows:

- Attitude of staff
- Casework decisions
- Delay in allocation
- Finance Funding
- Quality of service

We received **16** contacts from the Local Government Ombudsman concerning ASC Complaints and, to date, **6** of these identified faults with the Council which had caused injustice to the complainant, service user or both.

Learning from Complaints

There have been several areas of learning and areas for improvement which have been identified through the complaints received and these can be summarised as follows:

- The importance of accurate recording keeping and documentation
- Explaining clearly why casework decisions have been made
- Reviewing the process of allocating social workers to cases
- The importance of good, clear communication with service users and their families

Current Legislation and Overview of Adult Social Care Complaints Procedure

Complaints are handled according to The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and accompanying guidance (Listening, Responding, Improving). This legislation operates across Health and Adult Social Care and places significant emphasis on a personalised approach to complaints and 'learning from complaints'.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 can be viewed at
http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

The Listening, Responding, Improving guidance is available at
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_095408

ASC Complaints Procedure

The Adult Social Care Procedure has two stages:

1. Local Resolution
2. Local Government Ombudsman

The current legislation regarding adult social care complaints places a duty on a local authority to deal with any complaints relating to the services it provides in addition to any services that it commissions. The legislation provides local authorities with flexibility in terms of timescale for a response to the complaint (this is to be negotiated with the complainant) and this also allows the local authority scope to consider the best way to manage and respond to each individual complaint. If a resolution cannot be achieved at local level, the complainant has the right to request an independent review of the complaint by the Local Government Ombudsman.

The ASC Complaints Procedure is available for any individual who is accessing, or has accessed, adult social care services. An individual who has been affected by an action, omission or decision made by the local authority may also have the right to complain. A complaint may also be made by a suitable representative.

The complaints team is responsible for managing the complaints process and will consider a number of factors at the time of the initial contact

- Does the individual have the right to complain?
- Does the nature of the complaint falls within the scope of the current legislation?
- Is the complaint's procedure the most appropriate way to progress the matter (ongoing safeguarding / legal enquiries need to be considered and may take precedence).
- Is the complaint within timescale?

If the complaints team is satisfied with all the above, a timescale will be agreed with the complainant for a response and the matter will be progressed as per the current legislation.

Adult Social Care Complaints

The current legislation regarding adult social care complaints places a duty on a local authority to deal with any complaints relating to the services it provides in addition to any services that it commissions. There have been a number of LGO publications which emphasise that the local authority retains responsibility even if a complaint focuses on a commissioned service.

ASC Services

Category of Complaint	Number of Complaints received	Number of Complaints Upheld (in full or part)
Adaptations	1	0
Attitude / behaviour of staff	13	4
Availability of Service	6	2
Casework decisions	15	2
Delay in allocation	12	6
Finance / Funding	18	6
Hospital Discharge arrangements	2	1
Independent Living Fund	1	0
Quality / Reliability of service	39	15 (1 o/s at time of report)
Respite	5	3
Transport	4	0
TOTAL	**116**	**39**

Attitude / behaviour of Staff

It is often difficult to make a definitive finding about a staff member's attitude or behaviour unless there is a witness to the alleged conversation / visit during which the complainant was unhappy with this. However, on the balance of probability, we upheld four complaints in this category.

One of these complaints was upheld due to a staff member making a comment which was perceived as derogatory towards the families of service users. We believe that the staff member should have handled the matter in a much more sensitive manner and he should have listened to the relative and tried to be more proactive in assisting with the query. We offered sincere apologies to the complainant and confirmed that this would be dealt with via formal supervision sessions with the staff member.

One complaint was upheld due to a staff member not following up on actions agreed with a service user's relative. We agreed to deal with this via formal supervision sessions between the staff member and the line manager.

One complaint was upheld as a social worker attended an appointment with incorrect information about the service user which was unhelpful. Sincere apologies were offered to the family. We were unable to make a definitive finding with regard to the staff member's attitude in this case.

Delay in allocation

15% of the complaints we upheld concerned a delay in allocating cases to social workers. We do not have specific guidance or targets stipulating the timeframe for allocating a social worker to a case following receipt of a referral. However, we upheld these complaints if we believed that an unreasonable length of time had passed or if we had confirmed that a worker would be allocated within a timeframe and this had not happened.

We acknowledge that there is a high demand for adult social care assessments and we must prioritise referrals according to the perceived level of risk to the service users. This is a professional judgement.

We subsequently agreed to review the allocation process and a reduction in the number of complaints in this area suggested that this has been working effectively.

Finance / Funding

One complaint was raised due to incorrect advice being offered to a family concerning the funding for a placement. After investigating the complaint, we believed that the financial implications of the placement had not been adequately explained to the family.

The complaint above demonstrated the importance of accurate recording, especially in relation to the financial arrangements for a placement, and this was raised with all adult social care staff and discussed during the Standards Training.

One complaint was upheld as the service user had received numerous invoices for the same period showing different amounts outstanding. We acknowledged that this was confusing and explained why this had happened and clarified the amount outstanding on the account.

A complaint investigation highlighted that there had been a breakdown in communication between teams and subsequent human error which resulted in a provider not being paid the fees due. We understood that this was an individual error rather than being indicative of a systemic problem.

Another complaint was upheld due to a direct payment being suspended without explanation. This was due to human error and sincere apologies were offered to the complainant.

Finally a complaint in this category highlighted that we did not act upon receipt of a letter as we would expect and accepted that this caused a delay in addressing the service user's concerns about the length of the care calls. In view of this identified fault, we apologised to the complainant and amended the outstanding invoices accordingly.

Quality of Service

34% of the total number of complaints related directly to the services provided by adult social care. These complaints included issues such as:

- Not informed of the outcome of the assessment
- Communication – no returned calls / lack of response
  Poor communication between organisations following a hospital discharge leading to confusion over the care package
  Correspondence not responded to
- Difficulty to get a social worker allocated

- Delay in social care assessment progressing
- Support plans not shared with service user / carer as appropriate
- Quality / robustness of a safeguarding enquiry
- Service provision different from discussions held during professionals meeting.

Of these complaints, we upheld **38%**, either in full or in part.

Respite

We have received three LGO decisions, following investigations into complaints about the reduction in respite care, which found fault with the Council due to:

- A lack of consideration given to the sustainability of the placement when considering an appropriate level of respite
- Failing to properly assess the provision to meet the unchanged needs of a disabled man;
- Failing to explain how the new provision meets those needs;
- Failing to properly assess the family's needs for respite.

Financial remedies were agreed in all three cases. The LGO commented that the issues uncovered in these particular cases could potentially impact on other service users and their family members who had not complained. Therefore the LGO recommended that Sefton Council should arrange for its social care staff to have suitable training to explain to a service user and family if there is a proposed reduction in care and the rationale for this decision. The Recording Skills Training has subsequently been offered to all Adult Social Care staff.

Benchmarking

We contacted comparable local authorities to determine how the number of complaints we received and upheld compared. The results were as follows:

Local Authority	**Number of Complaints received**	**Number of Complaints Upheld (in full or part)**
Sefton Council	136	47
Local Authority 1	135	59
Local Authority 2	86	29

ASC Commissioned Services

Complaints about our commissioned services accounted for **15%** of the total number of complaints received.

Category of Complaint	Number of Complaints received	Number of Complaints Upheld (in full or part)
Casework Decision	1	o/s
Finance / Funding	3	0
Quality / Reliability of Service	16	8
TOTAL	**20**	**8 (1 o/s at time of report)**

We received one complaint about a decision for a care home to serve notice to a service user. The family complained that there was no warning that this action was to be taken and no clear reason was provided as to how this decision was made. This complaint was outstanding at the time of reporting.

The three complaints concerning finance / funding related to direct payment accounts. Issues in the complaints included the Council trying to recover surplus funds from the account and the Council challenging unauthorised expenditure. Two of these complaints were referred to the LGO and both investigations concluded that there was no fault on the part of the Council.

80% of the complaints about our commissioned services related to the quality of the service provided. As the table above demonstrates, half of these complaints were upheld. Issues raised in these complaints included:

- Poor communication
- Information not shared with family
- Daily log book not completed appropriately
- Standard of care / tasks not completed appropriately
- Missed calls
- Carers not staying for allocated time
- Continuity of care
- The administration of carers vouchers
- Day centre did not inform next of kin when a service user did not arrive at day centre – transport did not turn up and as a result the service user had no food, drinks or medication throughout the day.

If the LGO determines that a provider is at fault, she views the provider's actions as an extension of those of the Council and as such the Council will be accountable for any failings, including any remedies. With regard to our commissioned services, we have identified the following actions to support providers when managing complaints as follows:

1. Issue pro-formas to providers when we request they complete a complaint investigation (this will include a request for confirmation of documents reviewed)
2. Signpost providers to http://www.lgo.org.uk/adult-social-care/resources-for-care-providers to assist them with managing complaints
3. Review our contract to clarify actions the Council will take should fault with the provider be identified by the LGO and an associated payment recommended.

Local Government Ombudsman

All complainants are advised of their right to approach the Local Government Ombudsman (LGO) for an independent review of their complaint. The Local Government Act 1974 (Parts III and IIIA) empowers the LGO to investigate any allegation of maladministration against a local authority in connection to exercising its administrative functions or failure to provide a service. The LGO is not empowered by 1974 Act to award compensation. However, she has guidance on remedies if she identifies a fault which has resulted in an injustice to an individual. This year we had a significant increase in referrals to the LGO and had **16** contacts from the LGO as follows:

- **3** of these did not progress to an investigation.
- **6** cases identified fault causing injustice
- **1** case identified fault causing no injustice
- **2** cases did not have any fault found
- **4** awaiting Draft Decision

The 6 cases which identified fault with the Council's actions have been summarised as follows:

Complaint Summary	LGO's Findings	Remedy
Mrs X complains the Council cut the amount of care for her son although his needs have not changed including a reduction in respite from four to two weeks. She also complains the Council delayed in completing her carer's assessment.	The Council reduced the amount of respite without providing evidence of the change in need. The reassessment was not based on current needs as it happened nine months before the reduction took place. It also delayed in completing a carer's assessment without any explanation for the delay.	To complete the carer's assessment for Mrs X including the amount of respite that is required based on Mr Z's current circumstances. If minded to reduce the amount of respite, it should provide a proper explanation of the changes in circumstances that warrant a reduction. Apologise to Mrs X for the fault and pay her £250 to recognise her distress.
Mr X complains the Council: • reduced the number of days at the day care centre for his son, Mr A, from five days to four; • did not reduce the contribution Mr A paid for this care; and • did not provide them with information about activities Mr A could access on the day he was not at the day care centre.	There was fault when the Council reduced Mr A's care package and his parents' respite provision without explaining the reasons why it did this. The Council should carry out a reassessment of Mr A and his parents, make a financial payment and review the training it provides to its assessors. There was no fault when the	To ensure Mr A and his parents receive an annual review of their joint care plan. The Council should carry out a joint reassessment of Mr A and his parents' joint care plan. If the Council decides to reduce the support it provides from that provided up to March 2016, it should give a clear explanation of how any reduced support will still meet their eligible needs; The Council should provide Mr and Mrs X with information about free activities Mr A can access on the day he does not go to the day care centre; and pay Mr and Mrs X £200 for the distress and anxiety caused by the Council's

• reduced the number of respite days he and his wife received from 28 days to 14.	Council did not reduce Mr A's financial contribution to his care.	faults. The LGO stated that this is the third complaint where the Ombudsman has found fault in how the Council has explained its decisions to reduce support to service users and their Carers. The Council should ensure all its assessors are trained to provide clear explanations for reductions in care and to show how the reduced support will meet eligible needs. Evidence of this training should be provided to the Ombudsman within three months of the final decision.
Mr A complains about a delay in completing a carer's assessment. He also complains he was promised £300 but only received £180. As a result of the delay, he lost out on a carer's respite payment for 25 hours (for the year 2015/6). He also did not receive a care/support plan.	The Council delayed in assessing Mr A's needs as a carer, completing a support plan and approving a personal budget. It also failed to send him a support plan. This caused avoidable distress. To put matters right, it should apologise, make a payment and send people their support plans in future. It should also review 11 other cases to see if those people are similarly affected.	The Council should apologise to Mr A for the faults identified. The Council should ensure all carers receive copies of their support plans. The Council should pay Mr A £250 to reflect his avoidable distress. The Council should review another 11 cases identified in the course of the LGO investigation to see whether there have been any similar failings and if so, takes action to remedy any injustice. The Council should report back to the Ombudsman within three months of the final decision on Mr A's complaint with a summary of its findings on the 11 cases and any actions taken.
Mrs X complains on behalf of her son, Mr Y, that the Council delayed providing Mr Y with a suitable alternative placement when his care home closed.	The Council delayed providing a suitable alternative placement for Mr Y when his care home closed.	The Council agreed to pay £250 to Mr Y to acknowledge the disruption and any anxiety caused to him by the Council's delay; and £600 to Mr and Mrs X to acknowledge the worry and carer strain caused to them by the Council's delay.
The complainants, whom I shall call Mr and Mrs X, complain about the Council's decision to charge their disabled adult son (Mr Y) for transport to and from a day centre.	There was no fault in the Council's decision to charge Mr Y for transport to a day centre. The Council was at fault when it failed to charge Mr Y for eleven months of transport but this did not cause any injustice.	No remedy required.
Mrs H complains about the care provided to her mother, Mrs D, by a GP surgery and St Nicholas Care Home between	The Ombudsmen found a GP surgery provided appropriate care and pain management to an elderly patient at a	Within two months of the date of the Ombudsmen's final decision, the Council and the Home should: apologise to Mrs H for the distress caused by the faults identified with the Home's pain

January and February 2015. The particular complaints concerning the care provider were that staff at the Home did not act on Mrs D's weight loss or pain; the Home failed to recognised Mrs D was gravely ill on 24 February; there was a lack of communication and collaboration between the Surgery and the Home.	nursing home. However, there were failings with the nursing home's pain management and weight monitoring. The Home has taken appropriate action to improve these areas. The working relationship between the GP surgery and the nursing home was satisfactory. The Ombudsmen recommended the Council and the Home apologise for the distress caused by the failings identified.	management and record keeping.

Key Summary

£1550 paid to complainants and service users in recognition of the impact on them as a result of the Council's faults (anxiety, distress and carer strain).

Last year, 75% of the ASC complaints referred to the LGO identified fault with the local authority. We have seen a significant increase in the number of referrals to the LGO (50%) with 38% of complaints being upheld.

Learning from LGO complaints

- Carer's Centre to ensure that support plans are sent to all carers following assessment.
- Improved joint working between Commissioning Support Team and Adult Social Care Team to ensure that cases are managed well if a supported tenancy / alternative accommodation needs to be identified.
- Training for staff completing social care assessments to ensure that clear explanations are provided for any changes to the model of care.
- In two of these cases, we could have managed the expectations of the families better and from an earlier stage which could have improved the families' experiences of our services. This has been highlighted with adult social care staff to demonstrate the impact and the importance of managing expectations effectively.
- The importance of accurate recording and documentation was highlighted and we have developed a "Recording Skills" training package for adult social care staff. We have also highlighted this during team meetings as appropriate.

Compliments

Celebrating the positive work completed by staff is becoming increasingly important to raise awareness among staff of how their work and approach impacts on families and service users. Many of these compliments referenced improvement in the service user's quality of life and the subsequent relief that family members had now that a particular issue had been resolved. We have worked with our Communications Team to promote this positive feedback and have posters displayed in the social work team offices.

We received 104 compliments this year, compared to 89 last year, with families and service users expressing their gratitude to staff involved with their cases. The table below shows the teams which received this feedback:

> The attention, care and dignity you showed us was second to none. The attention you gave us was lovely and the patience you showed us was outstanding, under the circumstances you made us relax.

> I found it very helpful and I talked at length on a few occasions and he could not have been more attentive and helpful. He listened to all my concerns and how I felt and what I thought I needed to improve my quality of life and did everything and more to help.

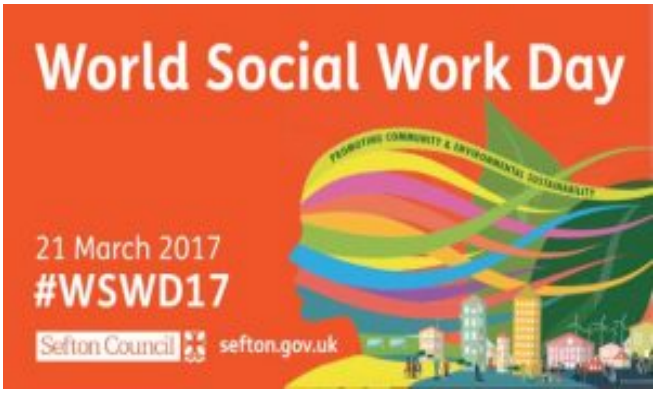
> Thank you again for finding a nice place for my relative. You once again did a great job under tremendous pressure. We are all very happy with the placement.

> Thank you to the department and particularly to our social worker for the excellent support over an extremely difficult time. Our relative's sudden life change was met by the social worker with understanding, positivity and diligence. We as a family were fortunate to have him in our corner at an extremely difficult time.

Team	**Number of Compliments**
Community Equipment Stores	7
Community Mental Health Team (North)	3
Community Mental Health Team (South)	1
Customer Access Team	1
DoLS	8
Lobby	18 (1 joint compliment with OT team)
North Hub	9
OT and Sensory	35 (1 joint compliment with Lobby)
Reviewing and Assessment Team	2
South Hub	17
Supported Living Team	3
Welfare Rights Team	1
TOTAL	**104**

> On behalf of my family we are so grateful to the social work team and the professional way they dealt with the closure of our relative's nursing home. The team was professional, very helpful, caring and considerate. They dealt with all aspects of the move calmly and efficiently even though it must have been a stressful time for them as well. My relative has suffered no adverse effects from the move and it is all down to your excellent team who took care of everything. No one will ever criticize adult care again in our presence!!

The positive work undertaken by adult social care staff was celebrated on World Social Work day (21 March 2017) and this internationally recognised event provided an occasion to celebrate and to publicise the work of our organisation and the activities of our social work staff. This year, our theme was "Promoting Community and Environmental Sustainability." Each social care team was encouraged to mark this event and many teams had team lunches.



Just a note to say thank you for the warmth and friendliness shown to my relative on your recent visit. Your calls to me were also much appreciated.

Thank you for your assistance – I really appreciated the information provided.

We are so grateful to you for battling on in our relative's best interest. Please convey the heartfelt thanks of all the family to your team, who gave us so much support throughout the negotiations. I felt that each one was a part of our extended family.

The staff member was very nice and helpful when completing an assessment

Thanks again for all your help. Our experience of the support from Sefton Social Services has been excellent through what has been a rather emotionally difficult time

Thank you to the drivers who delivered equipment to my relative's home - staff were very polite, helpful and understanding.

Thank you team, I couldn't have done it without you

Learning from Complaints

Complaints provide a valuable indication of areas where services may need to be reviewed or improved. Whilst some complaints can be resolved via an individual remedy, some identify actions that can be taken in a wider context to improve our services. Quarterly Reports are presented to the Adult Social Care Leadership Team to identify any trends and consider how learning points can be used to inform service planning.

Key issues identified via Complaints received 2016-2017:

- We need to be mindful of how we are perceived, especially when having difficult or challenging conversations.
- We need to ensure that we clearly evidence, record and explain our casework decisions.
- Financial implications of care provision should be adequately explained and documented
- Quality of our assessments, support plans, documentation and case notes could be improved.
- Communication could be improved.
- Quality of our commissioned services could be improved
- Timescales for responding to complaints is still an issue
- We need to improve how learning from complaints is shared across the adult social care teams

What actions has Sefton Council taken to address the above?

Standards Training was developed for ASC staff to achieve consistency around the quality of adult social care assessments, support plans and budgetary authorisations. The impact of good recording and documentation on complaints was discussed as part of these training sessions to increase staff awareness

Complaints Training was delivered to managers and senior social care staff and the learning objectives for the sessions were:

- To understand the complaints procedure
- To understand responsibilities around complaint handling / investigations
- To consider how we use learning from complaints to improve services

This training was well received and also provided a good opportunity for complaints staff and social care staff to reflect on how the organisation promotes a positive culture for complaints and how we can improve the way in which we learn from our complaints.

"Recording Skills" training session has been developed and is to be delivered to ASC staff.

We have reviewed the way in which we allocate cases to social workers to prevent unnecessary delays.

Senior managers have issued guidance to social care staff about respite provision

We have improved information for commissioned services to clarify their responsibilities around complaints handling to support them. We also hope that this will mitigate against financial penalties for the Local authority.

The importance of accurate recording has been highlighted with particular teams during team meetings to reinforce the significance of this and the impact of the Council not having accurate and contemporaneous documentation.

How can we evidence learning from complaints?

Overall the number of complaints received this year has decreased by a significant percentage which suggests that staff have resolved issues as they arose and to the individual's satisfaction without the individual making a complaint. This suggests that staff are demonstrating commitment to resolving issues promptly and efficiently to prevent matters escalating.

Last year, 8 complainants referred their complaints to the LGO with 6 of these (75%) identifying fault. This year, twice as many complaints were referred to the LGO and to date 44% did not progress to an investigation or did not identify any fault with the Council. In two of these cases, the LGO determined that the information provided to the complainant by the Council was sufficient and robust.

We have not received any complaints about respite since Quarter 2 which demonstrates that the way in which we communicate and evidence our decisions about this service provision has improved.

A provider developed a procedure to be followed should a service user not attend the day centre when expected. This followed a complaint made by a relative as the service user had not attended the day centre (not through choice) and had been left without food, drink and medication all day. The relative was concerned that there was no communication in place between the day centre and family. Had this been in place, the family could have been alerted earlier. Since the provider introduced the new procedure, we have not received any similar complaints.

We received a complaint concerning the Carers' Centre and this complaint was referred to the LGO. One of the identified actions was that we ensured that all carers, following a carer's needs assessment, received a copy of the support plan. This action was completed and we have not received any similar complaints.

We review of how requests for assessments are progressed to prevent unnecessary delays. We have since noted a reduction in the number of complaints received relating to this.

Conclusions and Recommendations

Complaints concerning Adult Social Care provide us with vital information to enable us to reflect on the effectiveness of the services we provide and commission. A poorly handled complaint is a missed opportunity to improve the services we provide, to identify any systemic problems and to reinforce the confidence and trust of the complainant and general public in the Local Authority.

To ensure that we create a positive culture around complaints, we need to continue with the programme of proactive engagement between social care staff and the complaints team. Complaints staff will meet with individual teams on a regular basis to highlight feedback received and reflect on learning from the complaints.

The quarterly complaints report for ASC will continue to be produced and shared with service managers to identify key themes and areas for improvement. This will allow the opportunity for staff to reflect on trends identified and to agree action plans as appropriate.

A recommendation from last year's ASC Complaints report was that the Health and Social Care Complaints Officer would attend the Quality Improvement Forum and Business Planning Meetings to ensure continued engagement and awareness of the Complaints Procedure with Adult Social Care Staff. This has taken place and feedback from complaints was used in part to inform the Standards Training which was developed for ASC staff to achieve consistency around the quality of adult social care assessments, support plans and budgetary authorisations.

Furthermore, the Health and Social Care Complaints Officer will support the Case Review Forum which will review and challenge complex Adult Social Care cases from across the service. The intention is that the Forum will:

- Support ongoing Quality Improvement across Adult Social Care
- Facilitate improved consistency in decision making within Adult Social Care
- Learn from past experience and specific cases examined
- Highlight areas of good practice

We agreed that specific complaints training would be provided to Adult Social Care staff, particularly those staff members involved in the investigation of complaints. This has been completed and we will facilitate refresher courses as required. The quality of the local authority responses is an area for continuous improvement which will benefit both complainants and the local authority.

Embedding learning from complaints into our practice is essential to improve our standards and demonstrate our commitment to listening to and acting upon feedback we receive. We need to improve how we capture this learning to ensure that it is analysed and acted upon. This can then be monitored to check the effectiveness of our process.

We will continue to focus on learning from complaints and compliments and for an action plan to be agreed by service managers in view of areas of concern highlighted. We will continue to monitor and reflect on complaints and feedback we receive to determine the impact of the identified actions below.

Recommendations:

1. To ensure that we create a positive culture around complaints, we need to continue engagement between social care staff and the complaints team. Complaints staff will meet with individual teams on a regular basis to highlight feedback received and reflect on learning from the complaints.

2. To produce a version of this report for Adult Social Care teams to highlight key messages and actions.

3. To complete a self-assessment of the Complaints process to ensure that it is person centred and accessible to all who may need to access this.

4. We discussed our response timescale and the low percentage of these which are responded to within the initial timeframe. We agreed to continue to aim to respond to complaints within **25 working days** (legislation does not stipulate a specific timescale) and will aim for **70%** of complaints for the year 2017/18 to be responded to within this timeframe.

5. The quality of the local authority responses is an area for continuous improvement which will benefit both complainants and the local authority. Complaints Training has been provided for adult social care staff as detailed above. Refresher sessions will be facilitated as required.

6. Embedding learning from complaints into our practice is essential to improve our standards and demonstrate our commitment to listening to and acting upon feedback we receive. We need to improve how we capture this learning to ensure that it is analysed and acted upon. This can then be monitored to check the effectiveness of our process. Each complaint investigation undertaken will have to include comments from the investigator about the learning that can be taken from that particular complaint.

7. To share case study challenges for teams to engage / reflect on complaints which identify how a situation could have been managed differently with a better outcome.