Lancashire County Council

Statutory

Adult Social Care Complaints and Customer Feedback Annual Report

For the period 1 April 2025 to 31 March 2026

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1 Executive Summary

Complaints and feedback provide valuable insight into the experience of people using Adult Social Care services and continue to drive service improvement.

During 2025/26, 701 complaints were closed, reflecting increased demand and rising expectations. While the overall proportion of people who complain remains low, the upward trend highlights ongoing system and workforce pressures. Most complaints continue to be resolved locally, demonstrating a strong focus on early resolution and accountability at service level.

The most common issues raised relate to communication, professional practice and timeliness. These concerns underline the importance of clear information, consistent standards and responsive services, particularly at key transition points such as assessment and hospital discharge.

Joint complaints with NHS partners continue to reflect the complexity of multi-agency working, with ongoing challenges in communication, coordination and clarity of responsibility.

Adult Social Care has used learning from complaints to strengthen practice, improve communication and enhance oversight. However, performance has been impacted during the year by pressures on capacity and the implementation of a new complaints system, affecting timeliness and reporting. Feedback from complaints investigations identified that pressures on capacity were consistently cited by almost all social workers and team managers as a significant contributory factor in delays.

Overall, complaints and feedback highlight both strong practice and areas requiring continued focus, with a clear commitment to improvement and better outcomes for people using services.

Key headlines 2025/26

- Only 1% of active cases[1] result in a complaint being made.
- Complaints increased to 701 (+17%)
- Communication remains the most common issue
- Majority of complaints resolved locally
- System and workforce pressures are impacting timeliness

[1] An active case includes any person or carer engaged in or affected by any Adult Social Care service, assessment, review, safeguarding activity, care intervention or statutory process during the year that could result in a complaint.

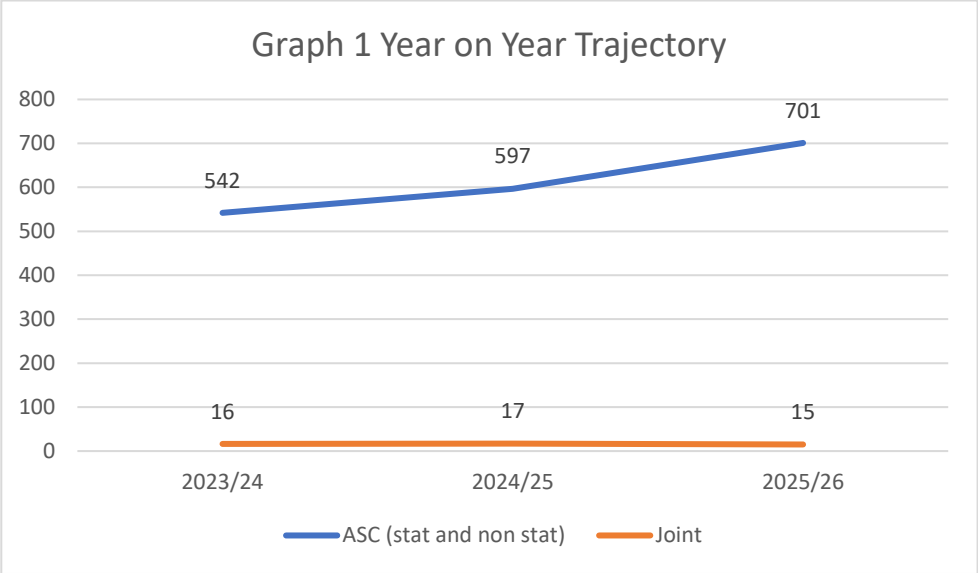
Total complaints received by the Local Government and Social Care Ombudsman increased from 44 in 2024/25 to 69 in 2025/26. The most common subject was charging with 23 complaints (one third). However, cases upheld for maladministration have reduced by 58%, from 12 in 2024/25 to 5 in 2025/26. This significant reduction is due to the introduction of a more proactive approach to offering financial remedies for upheld and late complaints in final letters, before complainants approach the Ombudsman.

2 Background

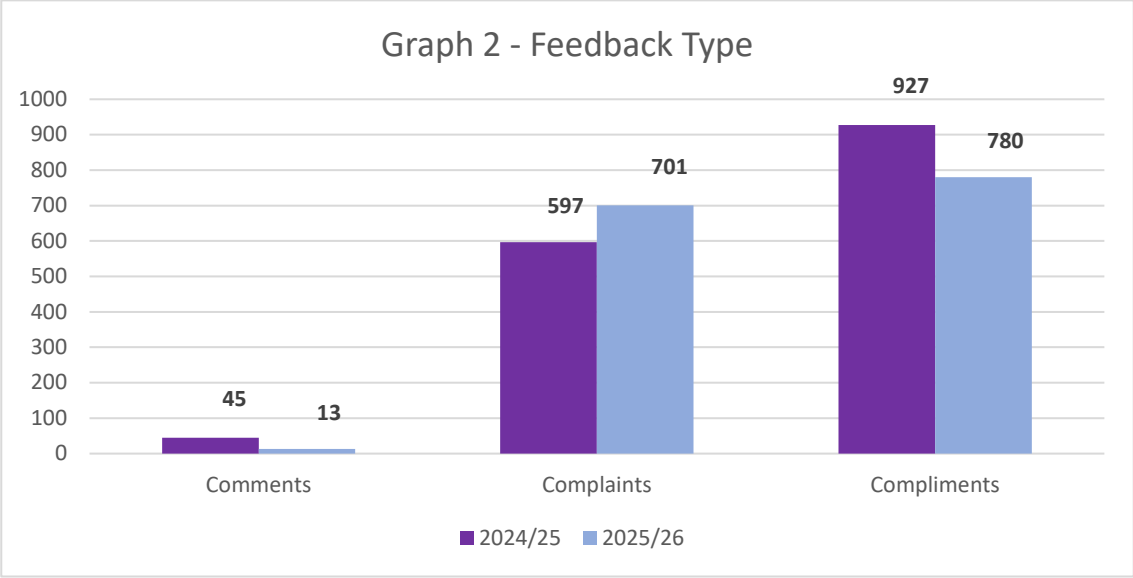
The Adult Social Care complaints procedure operates in line with the Local Authority Social Services and National Health Service Complaints Regulations (2009), ensuring that complaints are managed consistently, fairly and transparently.

This report summarises complaints, compliments and other feedback received between 1 April 2025 and 31 March 2026. It provides an overview of key trends, themes and learning, and demonstrates how feedback has been used to inform service improvement.

Graph 1 below shows that a total of 701 complaints were closed during the reporting period, with the trajectory increasing over time, whilst joint complaints with the NHS remain steady.



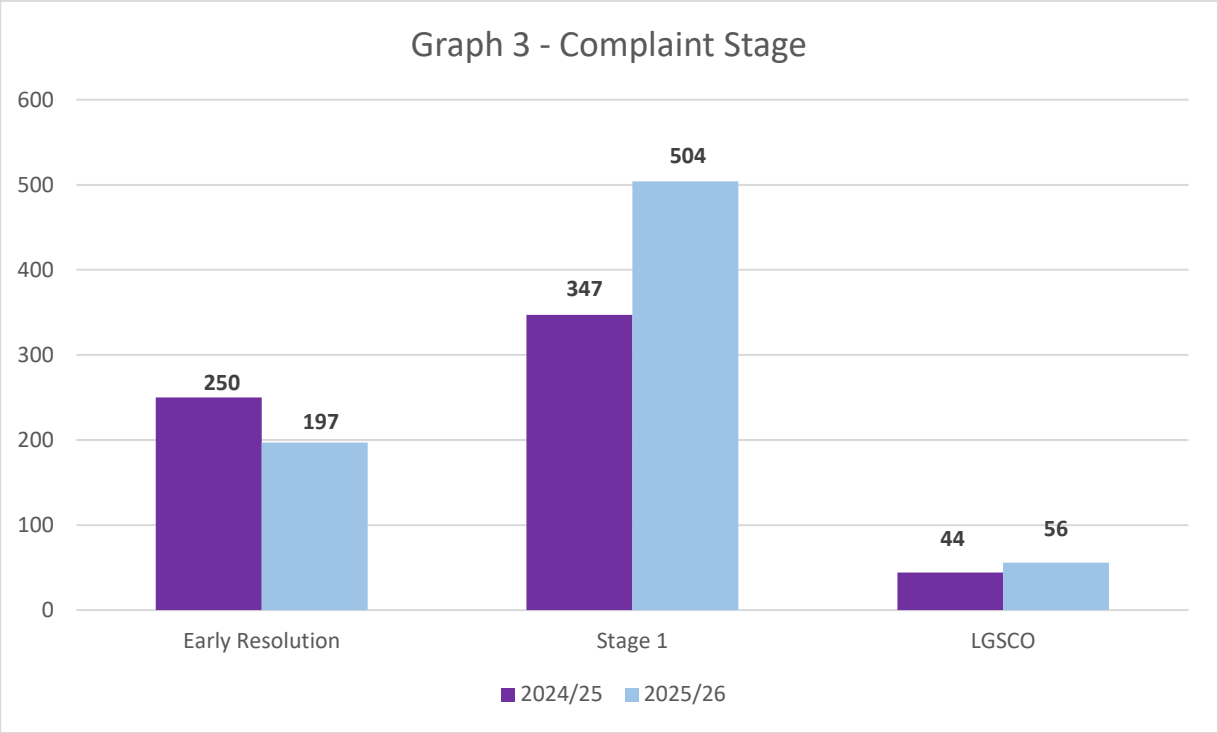
Graph 2 shows breakdown by feedback type. While complaints have increased compared to the previous year, compliments continue to exceed complaints overall, providing a balanced view of customer experience.



3. Breakdown of complaints by stage

The breakdown of Adult Social Care complaints is shown in Graph 3. A significant proportion of complaints are resolved at the earliest opportunity (28%), demonstrating a continued focus on resolving issues quickly and close to the point of service delivery. Where complaints progress, they are investigated and resolved locally through the council's single-stage complaints process.

A further 56 (8%) were resolved by a Local Government and Social Care Ombudsman (LGSCO) investigation. The LGSCO figures in graph 3 show total numbers of complaints decided in year.

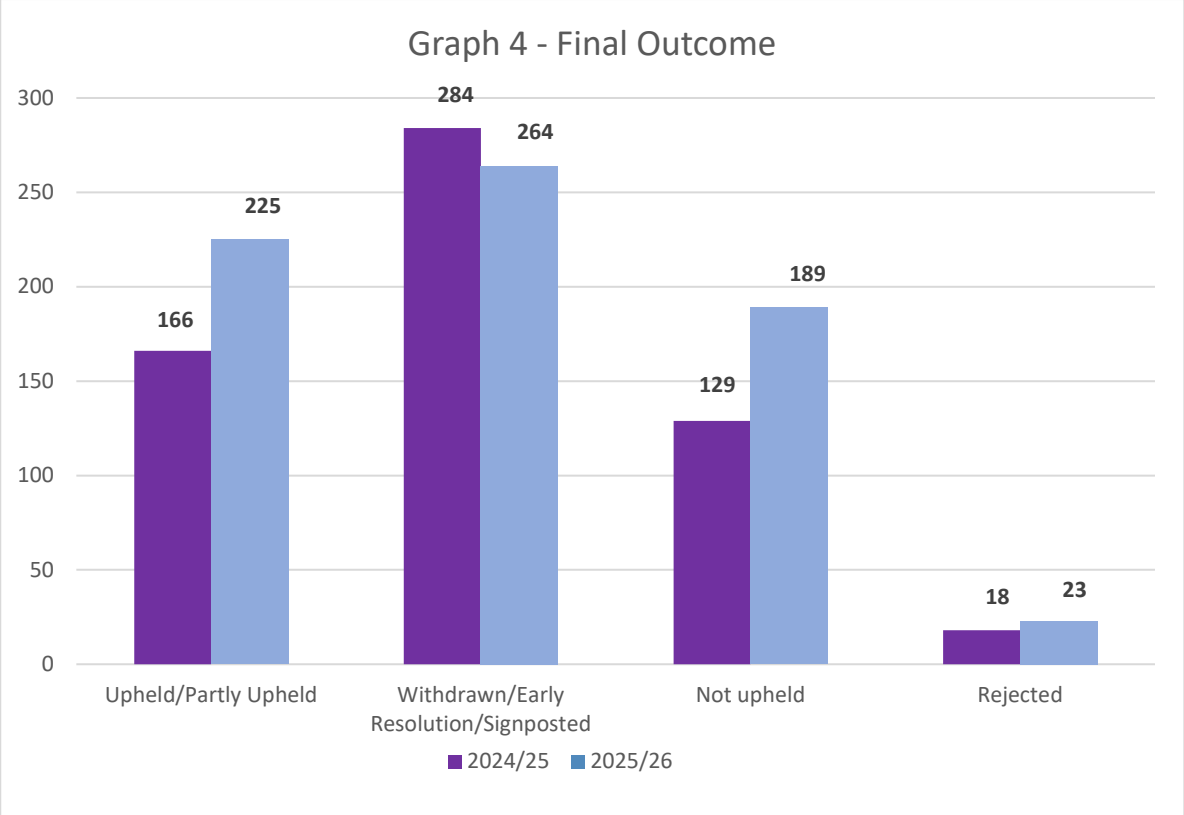


3.1 Breakdown of complaints by outcome

The outcomes of the 701 complaints closed during 2025/26 present a balanced picture of service performance. Just over half of complaints were withdrawn, resolved early or signposted, showing that many concerns are addressed quickly without the need for a full investigation.

A total of 32% (225) of complaints were upheld or partly upheld, highlighting that a significant proportion identify areas where the service did not meet expected standards.

Overall, these outcomes show that while many issues are resolved quickly, complaints continue to provide valuable insight into where improvements are needed, particularly in communication, professional practice and timeliness.



Due to the implementation of a new complaints management system in November 2025, full year data on financial remedies is not yet available.

Partial data from December 2025 to January 2026 shows that £11,265.82 was written off or waived in local complaint remedies, alongside £2,800 in time and trouble payments.

Work is ongoing to improve reporting, with complete data expected in future reporting periods.

3.2 Timescales

During 2025/26, 47 complaints (6.7%) exceeded the statutory timescale of six months, compared to 39 complaints (6.5%) in 2024/25. While this represents a small proportion of complaints, it means that 47 individuals experienced delays in receiving a response. Although the proportion of complaints breaching timescales has remained broadly similar, the increase in the number of delayed responses reflects continued service pressures.

A contributing factor during the year was the implementation of a new complaints handling system, which created challenges in tracking and progressing complaint responses. As an interim measure, alternative tracking arrangements in the form of Excel spreadsheets have been introduced to strengthen oversight and ensure complaints continue to be actively monitored.

Senior managers are strengthening oversight and prioritisation to ensure complaints are progressed and resolved in line with local timescales set out in policy and procedure. This is supported by ongoing management oversight and reinforced expectations for timely responses across the workforce.

3.3 What do people complain about?

For 2025/26, the most frequent subject of complaint was support planning (261), accounting for around a third of all complaints. The second largest category related to the social care assessment process, with 241 complaints (approximately 34%). The third largest category was financial, with 90 complaints (around 13%).

Analysis of complaints received during 2025/26 shows that the most common themes were:

- **Communication - quality, clarity and information sharing**
  This remains the most frequently cited issue across complaints. Concerns related to the clarity, consistency and timeliness of information provided to people and their families, particularly during periods of change, assessment or transition between services.
- **Professional practice - assessment, care planning and compliance**
  Complaints in this area highlighted concerns about aspects of professional practice, including the quality and timeliness of assessments, care planning and adherence to agreed processes and statutory duties. While many complaints were not upheld, these issues underline the importance of consistent and robust practice standards.
- **Timeliness - delays and responsiveness**
  Delays in progressing assessments, allocating workers or responding to enquiries were a recurring theme. These concerns often reflected wider service pressures and system challenges and contributed to dissatisfaction even where outcomes were appropriate.

Compared to 2024/25, complaints in 2025/26 show a shift away from financial assessment and care quality concerns, with greater emphasis on professional practice and timeliness, while communication remains the most common theme.

Learning from complaints continues to inform service improvement activity, with a particular focus on strengthening communication, reinforcing professional practice standards and improving timeliness and responsiveness across Adult Social Care.

Five examples of case studies are outlined in Appendix 1.

3.4 Internal learning processes

Adult Social Care continues to recognise the importance of learning from complaints to improve practice and outcomes for the people we support. Team managers attend complaints training to strengthen their ability to respond to customer concerns effectively and to ensure feedback is treated with appropriate importance. The Complaints Team continues to work closely with social care managers in the handling and review of individual complaints.

Up to November 2025, a monthly Adult Social Care complaints subgroup and Shared Learning Panel were in place to review upheld complaints, identify recurring themes and translate learning into service improvement and training activity.

Following the implementation of a new complaints handling system in November 2025, temporary limitations in reporting and data extraction have impacted the Shared Learning Panel. The introduction of the new system has also resulted in increased manual work for the Complaints Team, impacting capacity to maintain previous learning arrangements during this period.

Restoring effective shared learning arrangements is a priority. Work is ongoing to improve reporting functionality within the new system and once this is resolved, the Shared Learning Panel will be re-established to ensure learning from complaints is systematically captured, shared and embedded across Adult Social Care, supported by the Principal Social Worker and the Quality Assurance and Practice Improvement Team.

3.5 Summary of lessons learnt, and improvements made

Appendix 2(a) outlines the thematic learning identified from upheld complaints during 2025/2026 and the actions taken in response.

The following key lessons have been identified:

• Communication remains critical to people's experience and must be clear, timely, consistent and accessible to individual needs

• High quality, person-centred assessment and care planning are essential to ensure that support reflects the complexity of people's circumstances

• Timeliness of assessments, discharge planning and transitions is vital to avoid delays and gaps in support

• Clear communication of financial processes and implications is necessary to support informed decision-making

• Effective coordination across teams and services is required to ensure continuity of care

• Accurate and timely case recording underpins effective decision-making and service delivery

• Workforce capability, including training, supervision and oversight, is key to delivering consistent and high-quality practice

To address these issues and reduce the likelihood of recurrence, the following actions have been taken:

a. Strengthening Communication

Staff have been reminded of the importance of clear, timely and accurate communication, with particular emphasis on keeping individuals and families informed throughout complex processes such as discharge and placement planning. Expectations around

responding to enquiries promptly have been reinforced and communication standards are monitored through supervision and case oversight.

b. Improving Assessment and Care Planning

Managers have reinforced the importance of holistic, person-centred and Care Act compliant assessments. Additional training and support have been provided to improve assessment quality, and processes are being reviewed to support timely allocation and progression of work.

c. Enhancing Transition and Discharge Processes

Actions have been taken to improve the timeliness and coordination of transition assessments and hospital discharge planning. Oversight arrangements have been strengthened to ensure continuity of support and clearer communication with families.

d. Clarifying Financial Processes

Staff have been reminded to communicate financial implications at the earliest opportunity. Improvements have been made to ensure assessments are completed and recorded in a timely way, reducing delays in financial assessments and supporting more transparent discussions with families.

e. Strengthening Recording and Case Management

The importance of timely and accurate case recording has been reinforced. Managers are monitoring standards through supervision and audit activity to ensure that key actions are documented promptly and consistently.

f. Developing Workforce Capability

Targeted learning and development has been implemented, including training, supervision and opportunities for support from senior practitioners. Staff are encouraged to seek guidance and escalate complex cases at an early stage.

While formal oversight through the Shared Learning Panel has been impacted since November 2025 due to challenges with the reliability of reporting data from the current system, learning from complaints continues to be identified through investigations, management oversight and thematic review. Work is ongoing to strengthen reporting arrangements and ensure consistent sharing of learning across the service.

This structured approach supports continuous improvement and ensures that learning from complaints leads to clear changes in practice and service delivery, improving outcomes and experiences for people using Adult Social Care services.

3.6 Joint Complaints

A Joint Complaints Protocol continues to be in place with NHS partners. Joint complaint investigations remain complex, often involving multiple services within the council alongside Hospital Trusts and Integrated Care Boards (ICBs), with the complaints team

coordinating responses across organisations.

There were 15 closed joint complaints during 2025/26, which is broadly comparable to the previous year (17). Of these, 9 were not upheld and 6 were partially upheld. No complaints were fully upheld.

These complaints typically take longer to resolve as they involve multiple organisations and require coordinated multi-agency investigations. The main themes identified this year were Continuing Healthcare, discharge planning, communication with families and financial matters, particularly where individuals are self-funding or there is shared responsibility with health partners.

Learning from joint complaints has highlighted the importance of clear communication and managing expectations, particularly around roles and responsibilities between Adult Social Care and the NHS. Delays in case allocation, discharge arrangements, and multi-agency coordination were also identified, alongside the need to ensure sensitive information is handled appropriately and that individuals and their families feel supported throughout their contact with services.

Learning and service improvements from joint complaints are detailed in Appendix 2(b). In response, we will undertake thematic reviews focusing on Continuing Healthcare, discharge planning and finance, and continue to work collaboratively with NHS partners to improve joint processes. We will also review information provided to the public during discharge planning and service transitions to improve understanding and reduce complaints in these areas.

4. Compliments

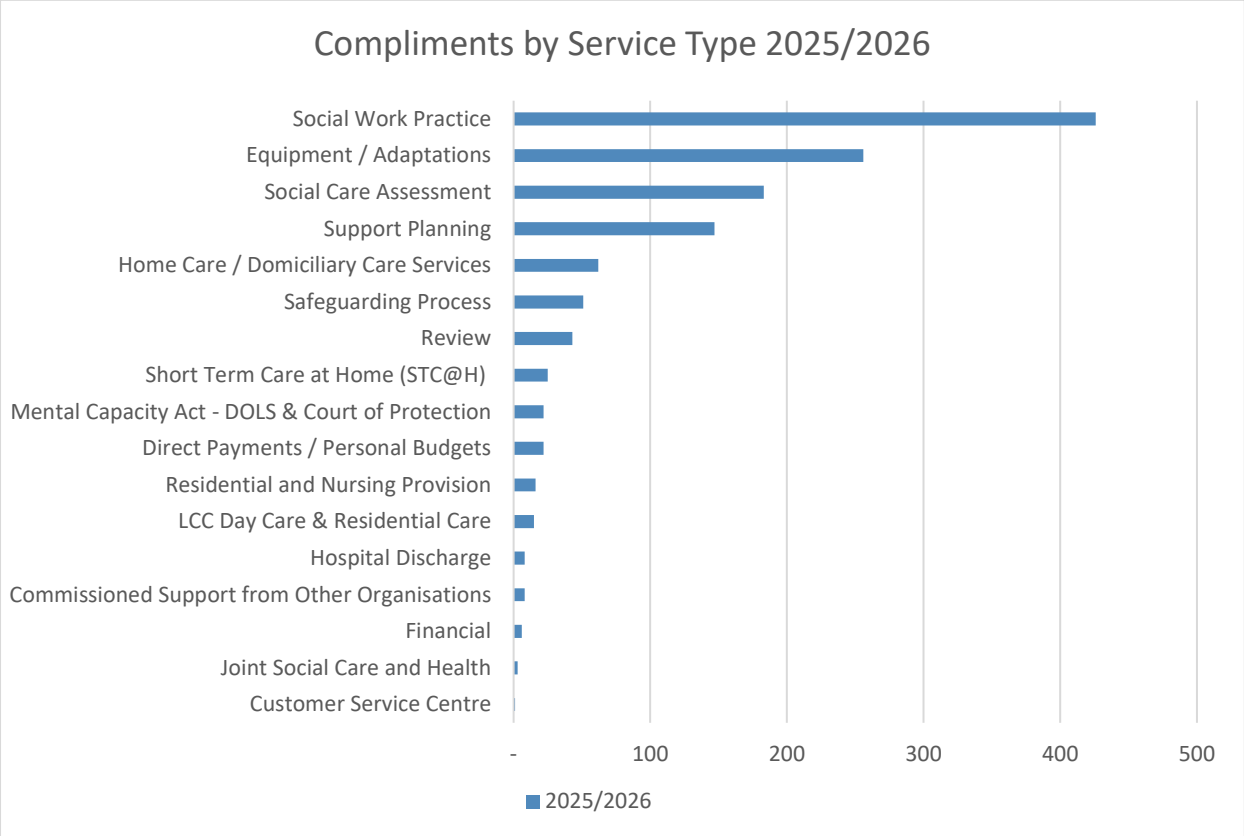
Compliments are primarily captured through *Your Views Count* feedback, from people who use our services, as well as from carers and professionals.

The total number of compliments decreased from 927 in 2024/25 to 780 in 2025/26. Of these, 503 were received through *Your Views Count*, with a further 277 submitted through other routes such as emails, cards and letters from people who use services, their families and council managers.

Compliments received through alternative routes cannot currently be categorised consistently, which limits the depth of analysis. The current recording system has presented challenges in supporting consistent use by staff and managers, and further development is underway to improve usability and reporting. This is likely to have contributed to the lower number of compliments recorded during the year.

A breakdown of the 780 compliments received is shown in graph 5.

Graph 5: Compliments by Service Type



The highest number of compliments related to Equipment and Adaptations, Assessment, Support Planning and Social Work Practice, reflecting the areas where people most directly experience the impact of support.

4.1 Themes

The most frequent reasons for compliments in 2025/26 related to Social Work Practice and Equipment and Adaptations, together accounting for 53% of all compliments.

The key themes were:

- Timely and effective assessment, support planning and provision of equipment that improves independence and quality of life
- Staff professionalism, knowledge and communication skills, which build trust and confidence during complex or sensitive situations
- Strong coordination and reliability, with staff keeping people informed and working effectively with families and partner services
- Staff going above and beyond expectations to provide reassurance, advocacy and practical support
- The personal qualities of staff, particularly their kindness, empathy, patience and person-centred approach

4.2 System Improvements and Future Developments

Compliments are usually reported monthly through the Shared Learning Panel, with word clouds used to highlight key themes and share learning across the service.

However, since November 2025, challenges with the reliability of reporting data following system implementation have affected the ability to consistently review and present compliment data. Work is ongoing to improve system reliability and to re-establish robust reporting arrangements.

4.3 Word Cloud

Examples of compliments are included in Appendix 3. The word cloud on the following page reflects the compliments referenced within this report.

Compliments received during 2025/26 continue to highlight the importance of skilled, compassionate and reliable practice. Across all service areas, people consistently value timely support, professional expertise and the kindness and dedication shown by staff, particularly where this supports independence and improves quality of life. These insights continue to inform service learning and development, supporting ongoing improvements to practice and the experience of people using Adult Social Care services.

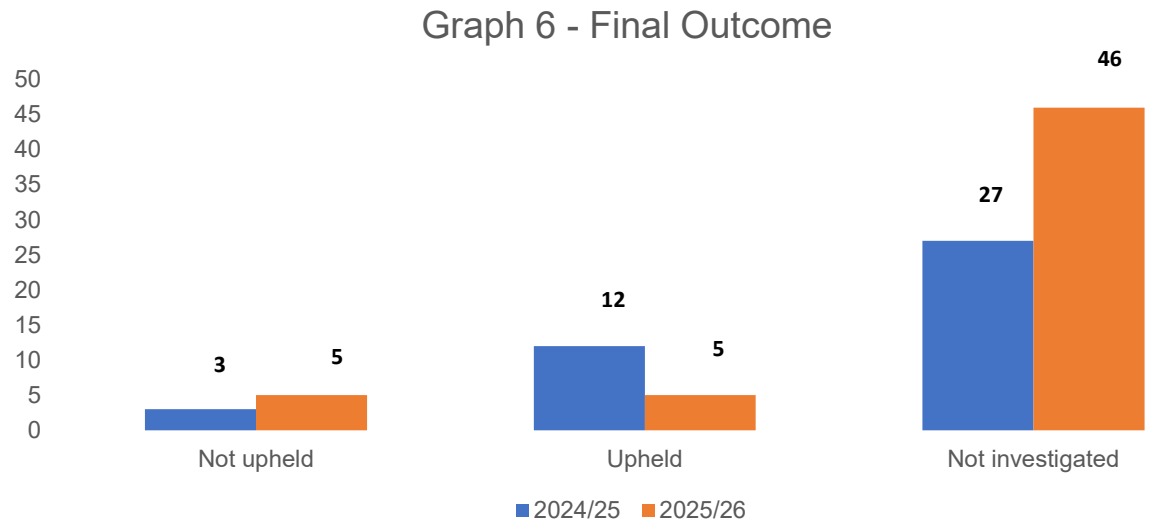

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meaningful
reduced
standards
straightforward
trouble
understand
non-judgmental
structured
successful
tailored
understood
individual
proactive
information
informative
interaction
outstanding
incredible
timely
reassuring
teamwork
seamless
grateful
listened
empathetic
independence
excellent
secure
extremely
handled
empowered
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considerate
coordinated
confusion
confidence
professional
encouraged
experience
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superb
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communication
patient
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happy
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equality
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attitude
efficient
team
focused
results
guidance
included
delighted
positive
worker
friendly
responsive
updates
simple
nothing
supported
thankful
collaborative
organised
collaboration
prompt
knowledgeable
smooth
stable
maintained
involved
explanations
compassionate
experienced
wellbeing
understanding
intervention
satisfied
responsible
respected
relatives
recommended
transparent
regained
personalised
trusted
thoughtful
turnaround

5. Ombudsman Complaints

The Local Government and Social Care Ombudsman provides the final stage for complaints about local authorities and some other organisations providing local public services. Their service is provided free of charge. Complainants approach the Ombudsman when all other options for pursuing their complaint are closed by the council, after it is considered that a proportionate response has already been provided. The Ombudsman will only consider complaints that have already been through the council's complaints procedures, although sometimes an early referral will be made to the Ombudsman when complainants continue to be dissatisfied and the council considers that it has not done anything wrong, or it has done all it can to resolve the matter.

In 2025/26, the Ombudsman received a total of 69 separate enquiries in relation to ASC complaints (in 2024/25 it was 44) of which 56 were decided.

Graph 6 below shows of the 56 Ombudsman ASC final decisions decided in 2024/25, 9% were not upheld, 82% were not investigated and 9% were upheld. There has been a significant decrease in the numbers of upheld Ombudsman complaints, evidencing that the council is proactive in learning from upheld complaints and providing remedies.



The upheld final decisions resulted in a total of £3,150 being paid out by the council as a direct result of Ombudsman remedies. As a result of the learning from the upheld complaints, a care home was reminded of the importance of signing new residents up to their GP as soon as possible and staff were reminded to provide the Council's financial information and to record having discussed the financial implications of care. There were not any ASC public reports in 2025/26.

Appendix 1: Case studies

The following case studies provide examples of complaints received during 2025/2026, demonstrating the learning and improvements identified as a result. They include complaints that have been concluded during the year, alongside an example of an ongoing complaint where learning has already been identified.

Case Study A: Communication and Reasonable Adjustments for Autism (Ongoing Complaint)

This complaint was raised by an autistic adult who reported ongoing difficulties communicating with the Council over a number of years, including a lack of consistent reasonable adjustments and unclear routes for engagement.

The complaint highlights concern about being passed between services, a lack of clear ownership of issues, delays in responses and communication styles not being understood. It also raises wider issues regarding unmet need for autistic adults who do not meet Care Act thresholds but still require support.

The complaint remains ongoing at the time of reporting. However, the issues raised reflect important themes regarding communication, accessibility and the Council's approach to self-advocacy.

Learning Identified to Date

- The importance of recognising and adapting to different communication needs, including for autistic individuals
- The need for consistent application of reasonable adjustments
- Ensuring clear ownership and points of contact when individuals raise concerns
- Supporting and valuing self-advocacy in interactions with services

This case highlights the importance of accessible communication, consistent application of reasonable adjustments and ensuring that individuals can engage effectively with the Council.

Case Study B: Transition Planning and Service Coordination

This complaint related to transition planning for three young people with Education, Health and Care Plans, including concerns about therapy provision, delays in assessments and gaps in social care support.

An independent investigation found that Speech and Language Therapy had been appropriately delegated and was not withdrawn. However, delays in completing transition assessments were upheld, with service capacity identified as a contributing factor. An element relating to inconsistent social care support during transition was partly upheld.

Outcome and Learning

- An apology was issued to the family
- Actions identified to improve timeliness of transition assessments
- Strengthened oversight to ensure consistent communication and support during transition

This case highlights the importance of timely assessments, effective coordination and maintaining consistent engagement with families during transition to adult services.

Case Study C: Financial Information and Delays in Assessment

This complaint related to concerns about a lack of clear information regarding the financial implications of non-residential care services, as well as delays in financial assessment and cessation of care provision.

The investigation found that while a Discharge to Assess package was appropriately implemented, there was insufficient evidence that financial implications were clearly communicated. Delays in completing and recording the Care Act Assessment also led to a delay in the financial assessment, and concerns raised by the family were not acted upon promptly. These elements of the complaint were upheld.

Outcome and Learning

- An apology was provided to the family
- Care charges totalling £3,493.42 were waived as a local remedy
- Improved practice around early communication of financial implications
- Reinforced expectations for timely case recording and responsive action

This case highlights the importance of clear financial communication, timely assessments and responding promptly to concerns raised by families.

Case Study D: Assessment and Discharge Planning

This complaint related to concerns about the assessment and discharge planning for an individual following a short-term care home placement, including whether their needs and family circumstances had been fully considered.

The investigation found that while discussions had taken place regarding care options, the assessment did not fully reflect the complexity of the individual's needs or the family's ability to provide support. A subsequent social work assessment identified that nursing care provision was required. This element of the complaint was upheld.

Outcome and Learning

- An apology was provided to the family
- A financial remedy of £200 was offered in recognition of delays in the complaint response
- Targeted learning and development implemented for the practitioner, including further training and supervision
- Reinforced use of holistic, Care Act compliant assessments and earlier escalation to social work involvement where required

This case highlights the importance of thorough, person-centred assessments and ensuring that discharge planning fully reflects both individual needs and family circumstances.

Case Study E: Hospital Discharge, Placement Delays and Communication

This complaint related to delays and communication difficulties during hospital discharge and aftercare planning, including challenges in identifying a suitable care home placement and a lack of clear and timely updates to the family.

The investigation found that while appropriate assessments were undertaken and placement searches commenced promptly, delays occurred due to limited provider availability and additional information requests required through the Complex Case Care Forum (CCF). However, communication with the family was not sufficient, with periods of unanswered contact, unclear updates and inaccurate information regarding placement availability. These elements of the complaint were upheld.

Outcome and Learning

- An apology was issued for delays, poor communication and inaccurate information
- Learning identified to improve communication with families throughout discharge planning, including clearer explanations of delays and decision-making processes
- Reinforced expectations for timely responses and regular updates
- Improved coordination and information sharing between teams to avoid misunderstandings and delays

This case highlights the importance of clear, consistent communication and proactive engagement with families during complex discharge planning and placement processes.

Appendix 2(a). Listening and Improving Themes

In response to listening and learning from complaints in 2025/2026, improvements have been made in the following thematic areas:

1. Communication

You said:

- Communication with families was not always timely or consistent
- Updates about care, placement decisions and delays were unclear or inaccurate
- Families felt they had to chase for responses
- Explanations of processes, including decision-making forums, were not always provided

We did:

- Staff have been reminded of the importance of providing clear, accurate and timely updates
- Managers have reinforced expectations around responding promptly to calls, emails and enquiries
- Improved guidance has been issued to ensure families are kept informed throughout complex processes such as discharge and placement planning
- Communication standards are being monitored more closely through supervision and case oversight

2. Assessment and Care Planning

You said:

- Assessments did not always reflect the full complexity of needs
- Discharge planning decisions did not always take account of family circumstances
- Transitions and assessments were delayed

We did:

- Managers have reinforced the importance of holistic, person-centred and Care Act compliant assessments
- Staff are receiving additional support and training to improve assessment quality
- Earlier escalation to social work involvement is encouraged where complexity is identified
- Allocation and workflow processes are being reviewed to improve timeliness

3. Transition Planning

You said:

- Transition assessments were delayed
- Communication and coordination during transition to adult services were inconsistent
- Support during transition periods was not always continuous

We did:

- Work is underway to improve the timeliness of transition assessments
- Oversight of transition cases has been strengthened to ensure continuity of support
- Managers are reviewing how work is allocated to reduce delays and improve coordination
- Staff have been reminded of the importance of maintaining regular contact with families

4. Financial Processes

You said:

- Financial implications of care were not clearly explained
- Delays in financial assessments caused confusion and distress
- Concerns raised by families were not always acted upon promptly

We did:

- Staff have been reminded to clearly communicate financial implications at the earliest opportunity
- Managers have reinforced the need for timely completion and recording of assessments to avoid delays
- Processes have been strengthened to ensure concerns raised by families are responded to promptly
- Learning has been shared across teams to improve consistency in financial discussions

5. Hospital Discharge and Placement Processes

You said:

- Delays occurred in identifying suitable care placements
- Processes such as panel or forum decision-making were not clearly explained
- Communication during discharge planning was not sufficient

We did:

- Improved guidance has been provided to staff on explaining discharge and placement processes to families
- Expectations around proactive communication during discharge planning have been reinforced
- Better coordination between teams has been promoted to reduce delays and avoid duplication
- Learning has been shared to ensure families understand the reasons for delays and decisions

6. Recording and Case Management

You said:

- Case notes and assessments were not always recorded in a timely way
- Delays in recording contributed to wider delays in processes such as financial assessments

We did:

- Staff have been reminded of the importance of timely and accurate case recording
- Managers are reinforcing expectations through supervision and audit activity
- Improved oversight is in place to ensure key actions are recorded without delay
- Recording standards are being monitored to support consistency and accountability

7. Workforce Development and Support

You said:

- Some decisions would benefit from greater experience or oversight
- Additional training and support for staff was needed

We did:

- Targeted learning and development plans have been implemented for staff
- Opportunities for shadowing and support from senior practitioners have been introduced
- Training, including Care Act compliant assessment training, is being reinforced
- Managers are promoting earlier escalation and use of supervision for complex cases

Summary

Learning from complaints in 2025/2026 has reinforced the importance of clear communication, timely and high-quality assessment and consistent coordination across services. Actions taken focus on strengthening practice standards, improving responsiveness and ensuring that people and their families are fully informed and supported throughout their care journey.

Appendix 2(b) Learning from Joint Complaints with the NHS

1. Communication and Information Sharing

A number of complaints highlighted ongoing challenges in communication, particularly in relation to Continuing Healthcare (CHC), discharge planning and explaining roles and responsibilities.

To address this:

- Staff should clearly explain the roles of Adult Social Care, Hospital Trusts and Integrated Care Boards, particularly where individuals are self-funding
- Communication with families should be consistent, timely and clearly recorded, including attempts to make contact
- Information about funding processes, CHC and care options should be shared in a way that is easy to understand
- Greater emphasis should be placed on ensuring people and their families feel supported and informed throughout their care journey

2. Professional Practice and Communication

Some complaints identified issues with how information was communicated and how individuals and families experienced interactions with staff.

- Staff should ensure sensitive discussions, particularly about finances, are held in appropriate private settings
- Professional communication should remain clear, respectful and supportive at all times, particularly during periods of stress or uncertainty
- Staff should take time to ensure individuals feel heard and involved in decision-making, even where outcomes differ from expectations
- Reinforcement of good practice in explaining complex legal processes, such as the Mental Capacity Act and CHC, has been identified

3. Process and System Improvements

Delays and coordination challenges across organisations were a recurring theme, particularly in discharge planning and case allocation.

- Continued focus on improving timeliness of social worker allocation and ongoing case management
- Strengthening multi-agency coordination, particularly in discharge planning and CHC processes
- Early escalation of delays, especially where partner agencies are involved, to reduce impact on individuals
- Improved clarity in recording people's wishes, including preferred place of care and end of life preferences, to inform planning

4. Multi-Agency Working and Governance

Joint working with NHS partners remains a key area for improvement, particularly where responsibilities overlap.

- Reinforce shared understanding of roles and responsibilities across organisations to reduce confusion and duplication
- Continue to use established protocols, such as the Non-Involvement Protocol, to ensure continuity where attendance is not possible
- Improve consistency of information sharing between agencies to support coordinated decision-making
- Strengthen recording practices to ensure accurate, clear and accessible records across systems

Appendix 3: Compliment examples

Assessment and Review

“There aren’t enough words to describe how grateful I am for your support, advice, assertiveness and humour. I couldn’t have got through this without you. You’ve given me hope that I’m going to be able to move forward in life and that it’s actually achievable. It feels like a new beginning.

You have helped, guided and supported me to see that I can do it. There needs to be a million more people like yourself in this world. You make such a difference in people’s lives and make them feel like life is worth living again. Thank you for being you.”

Social Work Practice

“We just wanted to sincerely thank you for everything you did. The way you listened so carefully to my dad’s wishes and made sure they were respected meant a great deal to us. You were calm, compassionate and incredibly understanding throughout. Your reassurance brought real comfort and it was so lovely to see my dad smile. We are truly grateful for your kindness and support.”

Safeguarding and Complex Case Work

“I would like to commend A on her responsiveness, communication, passion and care. She worked in a timely manner to achieve the aims and has been very supportive and patient during these challenging times.

Her communication skills are excellent and she explained everything clearly so I had a good understanding of developments. I had faith in her and trusted that she would achieve the best possible outcome. She went above and beyond on this complex case and is an asset to your service.”

Holistic Support / Multi-Team Approach

“I want to say a big thank you to all involved in my care, from my social worker to financial assessment services and everyone supporting me.

The understanding, care and support I’ve received - I will be forever grateful. After years of struggling, this has validated my needs and boosted my confidence and self-worth. It’s easy to complain, but I want you to know you are making a real difference in people’s lives. The kindness shown has meant everything to me.”

Reablement and Enablement

“They were brilliant. R was patient, very kind and understanding. L looked forward to her visits and is now able to cook basic dishes, which he loves doing.”

Hospital Discharge / End of Life Care

“I’m writing to express my sincere appreciation for the kindness and compassion shown to my late uncle and our family at end of life and afterwards.

S went above and beyond offering to sit with him in hospital to give me a break, supporting with funeral arrangements and even attending the service.

These acts of kindness helped make a very difficult time more bearable. I will always remember the support she gave us.”

Additional Feedback from Compliment Forms

Feedback received via formal compliment forms highlighted that individuals felt:

- They were treated with respect
- Their views were listened to and taken into account
- Information was provided at the right time and in a suitable format
- They were satisfied with the outcomes of their assessments and support

These compliments reflect the professionalism, compassion and person-centred approach demonstrated by staff across Adult Social Care throughout 2025/2026.