**Appendix 4**

**Lessons Learnt From Complaints**

Sandwell Council recognises the importance of learning from complaints as a key element of service improvement. Complaints provide an opportunity to identify weaknesses in our processes and service delivery, and CFT are committed to using this feedback constructively.

In line with the Complaint Handling Codes issued by both the HO and the LGSCO, we take a systematic approach to reviewing complaint outcomes. This includes identifying learning points, implementing corrective actions, and monitoring progress to ensure improvements are sustained. We ensure that any lessons learned from complaints are shared across the relevant teams and services, contributing to a culture of accountability, continuous improvement, and better outcomes for residents.

Set out below are some examples of lessons learned from different directorates of the council over the reporting period**:**

**Childrens & Education**

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| **Case 1** |
| **You said:** An Education, Health and Care Plan (EHCP0) request was made in March 2024, and while a draft plan was eventually issued on 18 November 2024, the overall process had already faced delays. The lack of further progress after the draft was issued left you extremely frustrated.You expressed serious concerns about the poor communication from the EHCP team and how the delays were affecting your child. You contacted senior staff, including the Director to raise awareness about how families and vulnerable children in Sandwell were being let down.You later escalated the complaint to the Local Government and Social Care Ombudsman, explaining that the delays, lack of clear information, and poor communication had left you feeling let down and unsupported. |
| **We did:** Due to the seriousness of the concerns, we escalated the matter to management. A meeting was organised, bringing together all EHCP staff who had been involved in the case from the beginning.We reviewed the situation in detail and identified where communication had broken down and where opportunities to support your family more effectively had been missed. We also clarified a misunderstanding around which professional advice could be included in the EHCP.The EHCP Manager provided you with a written apology, accepted responsibility, and explained the steps we were taking. We acted quickly to move the EHCP to finalisation. Everyone involved recognised the injustice faced by your child and committed to learning from what went wrong. |
| **Case 2** |
| **You said:** You raised a complaint on behalf of your grandchild, expressing concern that they were not in school. At first, it wasn’t clear what outcome you were hoping for, but it was clear that you were feeling frustrated and disappointed with the lack of support from various services.When we spoke directly, you shared how difficult the experience had been and how unsupported you felt. You wanted someone to listen and take your concerns seriously. |
| **We did:**We began by checking with the school to confirm whether your grandchild was attending and to identify any safeguarding concerns.After speaking with you, we gained a clearer understanding of your concerns and acknowledged how difficult the situation had been for you and your family. While we realised that most of your concerns fell outside the EHCP team's responsibilities, we made sure to point you in the direction of services that could help.We followed up with a compassionate written response, which summarised our conversation, clarified our role, and gave clear guidance on next steps and where to go for further support. |

[**Bereavement**](https://www.sandwell.gov.uk/burials)**-** [**Coroners**](https://www.sandwell.gov.uk/blackcountrycoroner)**-** [**Register Office**](https://www.sandwell.gov.uk/registeroffice)

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| **Case 1** |
| **You said:** You raised a complaint after becoming locked inside Fallings Heath Cemetery. You had entered after closing hours when the gates were still open but returned to find them locked and were unable to exit. You attempted to call the numbers listed on the information board inside the cemetery but were unable to reach anyone for help. |
| **We did:** We recognised the confusion and distress this situation caused and upheld your complaint in part. A review of the signage at the cemetery was carried out to ensure that it is clear, accurate, and easy to understand. We removed any incorrect contact numbers and made the Highways emergency number more prominent on the board. A clear message has also been added to explain that the gates are locked outside of opening hours. To improve consistency, the rear gate will now be closed daily in line with the cemetery’s operating hours. We are also reviewing how this process is managed to avoid similar incidents in the future. |
| **Case 2** |
| **You said:** You raised concerns after a patient fell during a transfer from a funeral director’s trolley to the digital autopsy scanner. This incident caused understandable upset and concern. |
| **We did:** Following investigation, we found that the fault lay with the funeral director in attendance. As a result, the procedures for safe handling and transfer have been reviewed and strengthened. New trolleys will be purchased where necessary to ensure equipment is fit for purpose. It is now mandatory for two funeral directors to be present during any transfer, and both must be on-site before any movement of the body to the scanner takes place. Additionally, the Radiologist at the Digital Autopsy Scanning Facility will now take the lead and instruct the funeral directors, ensuring no transfer occurs until all staff are present and ready. This will help prevent similar incidents and improve safety during the process. |
| **Case 3** |
| **You said:** We received feedback from families and funeral directors that the statutory declaration documents were confusing. These forms are used when the original grave owner is no longer available, but the wording caused uncertainty about who could legally access or make decisions about the grave. |
| **We did:** Our Bereavement Services team reviewed our processes and benchmarked them against other local burial authorities. We carefully revised the language in our forms to make it clearer and more straightforward. The updated documentation now explains that, where the original grave owner is deceased and there is no will or automatic right of burial being exercised, the applicant completing the form may be registered as the successor in title and receive the exclusive rights of burial. This new approach provides greater clarity and consistency for families, reducing confusion and helping to support future grave ownership decisions during what is often a difficult time. |

**Adults-Safeguarding**

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| **You said:** Client made a complaint expressing that he wasn’t being properly supported and that the VARM (Vulnerable Adult Risk Management) process was not working for him. He felt excluded from important decisions about his life and care. |
| **We did:** In response to his concerns, we took immediate steps to strengthen the VARM process around him. A new chair was appointed to lead the meetings, and a strong, supportive team was built to ensure he felt heard and included. The client began attending his VARM meetings regularly, giving him the chance to share his story, build relationships with professionals, and take an active role in planning his support. This approach reinforced the importance of involving individuals in decisions that affect them. It also strengthened safeguarding and allowed for better long-term planning tailored to his needs. To highlight this learning and share good practice, we created an anonymised animation based on his journey. This has become a valuable tool for staff training and service improvement. |

**Property, Strategic Assets & Land**

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| **You said:** A customer raised concerns that notices and plans related to council land disposals, especially open space, were not easily accessible on the council’s website. A local councillor also submitted an enquiry on the same issue. |
| **We did:** In response, we created a new dedicated webpage where all future notices and plans relating to the loss of open space are now published and available to download. This not only improves transparency for the public but also brings efficiency. For example, the company OpenSearch regularly requests PDFs of these plans — we can now direct them to the website, saving time and resources. |

**Museums and Libraries**

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| **You said:** In 2023–24, customers expressed dissatisfaction after a charge was introduced for reserving library books. Complaints were received, and reservation numbers dropped by 54%. |
| **We did:** As a result of the feedback and the clear impact on library use, the charge was removed in 2024–25. Following this change, book reservations increased by 80% compared to when the fee was in place. This demonstrated the importance of keeping library services accessible and affordable for all. |

**Urban Design & Building Services**

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| **You said:** Through feedback and consultation, customers asked for an easier and more efficient way to report Repairs and Maintenance issues for non-housing council buildings |
| **We did:** A new online portal was launched, allowing customers to log repair jobs 24/7. The portal also provides real-time updates, giving users better visibility and control. This improvement not only enhances the customer experience but also helps the council save resources by streamlining the reporting and tracking process. |

**Housing**

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| **Case 1** |
| **You said:** Customers raised concerns about inconsistency and a lack of transparency in how compensation was considered and awarded across housing complaints. |
| **We did:** A Compensation Policy was developed and published on the council website: Complaints & Compensation Policy. This has helped create a unified approach across housing services and ensures customers clearly understand when compensation may be offered as a form of redress. |
| **Case 2** |
| **You said:** There was a need for clearer, more consistent handling of complaints across housing services to improve customer experience and reduce errors. |
| **We did:** New complaints handling guidance was created and shared across all relevant teams. Training sessions and workshops are ongoing to support teams in embedding best practice. This promotes a unified service and helps reduce the risk of financial penalties from the Housing Ombudsman for poor complaint handling. |
| **Case 3** |
| **You said**: Residents reported issues with temporary heating provision, including a lack of records and uncertainty over whether the heating supplied was adequate. |
| **We did:** A clear process has been introduced for recording the delivery and collection of temporary heaters. This includes using sign-out sheets, taking photographic evidence, and making detailed notes. Residents are now asked if the heating provided is sufficient, and further support is offered where needed, ensuring better service and accountability. |
| **Case 4** |
| **You said:** Concerns were raised about inadequate record-keeping following Quality Assurance visits, leading to difficulties in responding effectively to complaints. |
| **We did:** A new form was developed to record visit outcomes and add them to case notes. This is now used by QAs and may be extended to other staff who assist with complaints. This change supports more accurate records, improves accountability, and helps deliver better outcomes for residents |
| **Case 5** |
| **You said:** Complaints were received regarding unclear property boundaries and tenant responsibilities, often causing confusion and disputes. |
| **We did:** Boundary issues are now addressed earlier by incorporating them into the Early Intervention Project. Clear information about boundaries and responsibilities is now provided to tenants at the start of their tenancy, helping to prevent future issues. |
| **Case 6** |
| **You said:** A series of complaints from residents at a block of flats revealed wider, unresolved issues within the building (Elmcroft) |
| **We did:** A working group was established to coordinate a full response to residents’ concerns. This demonstrated collaborative working between services and improved communication with residents. The group continues to drive improvements, with one team maintaining oversight for consistent progress. |

**Customer Feeback**

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| **Case 1** |
| **You said:** Customers told us they were frustrated with the lack of clear, accessible information about how to make a complaint, how the process works, and where to find our Customer Feedback Policy.  |
| **We did:** We recognised that customers needed easier and more direct access to this information. We now include a link to the Customer Feedback Guide in all correspondence sent by our team. This ensures customers can quickly and easily access information about complaints, compliments, the Ombudsman process, and how to raise their concerns. |
| **Case 2** |
| **You said:** In the Local Government and Social Care Ombudsman Annual Review Letter to the council it highlighted poor performance in responding to Ombudsman complaints and not fully adhering to their recommendations. This raised concerns about how seriously the council was taking complaint handling and accountability. |
| **We did:** The Chief Executive responded to the Ombudsman’s findings, committing to improvements in our complaint handling performance. The CFT arranged three training sessions delivered directly by the Local Government Ombudsman which was attended by 50 key officers from across the council who are involved in investigating and responding to complaints. The training was well-received, with excellent feedback from those who attended. As a result, we’ve already seen a marked improvement in how we handle and respond to Ombudsman cases and complaint demonstrating our commitment to learning and service improvement |