Board of Directors – Public

SUMMARY REPORT	Meeting Date:	27 July 2022
	Agenda Item:	16

Report Title:	**Annual Complaints Report 2021/22**	
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Accountable Director:	Beverley Murphy, Executive Director of Nursing, Professions and Operations	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	13 July 2022
Key points/ recommendations from those meetings	N/A	

Summary of key points in report
The Quality Assurance Committee welcomed the report and noted the significant improvement in the back log of complaints that had now received a response. The committee also noted the need to improve the quality of responses to complainants and to ensure that learning is extracted, leads to meaningful change in practice and is recognised across all service. This is the focus of improvement for 2022/23.
Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**		**Assurance**	✓	**Information**	✓

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*		*No*	***X***
CQC Getting Back to Good – Continuing to improve	*Yes*	✓	*No*	
Transformation – Changing things that will make a difference	*Yes*		*No*	***X***
Partnerships – working together to make a bigger impact	*Yes*		*No*	***X***
Is this report relevant to compliance with any key standards ?	**State specific standard**			

Care Quality Commission Fundamental Standards	*Yes*	✓	*No*		Regulation 16: Receiving and acting on complaints - Complaints must be appropriately investigated and appropriate action taken in response
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?				***X***	

Have these areas been considered ? YES/~~NO~~					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	✓	*No*	***X***	Learning from complaints is pivotal to improving service user experience.
Financial (revenue &capital)	*Yes*	***X***	*No*	✓	No financial impact noted, unless contractual penalties are incurred.
Organisational Development /Workforce	*Yes*	✓	*No*	***X***	This has been considered and we have developed a complaints training programme to be delivered in 2022/2023.
Equality, Diversity & Inclusion	*Yes*	***X***	*No*	✓	PFD could affect anyone. No known implications.
Legal	*Yes*	✓	*No*	***X***	Regulation and contractual breaches may result from poor complaint handling procedures.

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Annual Complaints Report 2021/2022

Contents

1. Introduction

Complaints processes within the NHS are governed by statute as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and through the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 – Receiving and Acting on Complaints.

To meet these regulations, SHSC must have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using services, people acting on their behalf or other stakeholders. These regulations make sure that people can make a complaint about their care and treatment and ensures that all complaints are investigated thoroughly and any necessary action taken where failures have been identified.

In 2021, the Parliamentary and Health Service Ombudsman began piloting revised NHS Complaint Standards, which set out how organisations providing NHS services should approach complaint handling. These standards come into effect during 2022 and apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.

Within SHSC, complaints are handled in line with the approved Complaints Policy, which aims to ensure that service users, their representatives and carers/relatives who are dissatisfied with the care or services provided by SHSC are able to raise their concerns and have them thoroughly and effectively investigated. The policy also sets out the timeframes for responding to complaints, individual roles in the process, the reporting structure for complaints information and resolution of complaints, that satisfies the complainant and is fair to staff. Local resolution aims to be open, fair, flexible, responsive and conciliatory.

It is important that complainants have an explicit means to challenge the outcome of their complaint, and all complainants are informed of their right to seek the intervention of the Parliamentary and Health Service Ombudsman, or Local Government Ombudsman, as appropriate. A system that deals positively with complaints and other feedback received is invaluable. It is recognised that such information is invaluable as a means of identifying problems, as well as areas of good practice and, as such, can be used as a lever for improving services.

Complaint Definitions

Concerns
Concerns are issues which are raised directly with the ward, team or service and are generally resolved within 48 hours.

Informal Complaints
Our preference is to resolve concerns at the earliest opportunity to minimise the level of dissatisfaction and distress experienced by the service user, their carers and/or their families, which can benefit everyone involved. Where appropriate, we ask the service to respond directly to the complainant to provide a satisfactory verbal outcome within 10 working days. This is considered an informal complaint. Where this is not possible, or the complainant remains dissatisfied with the response, this becomes a formal complaint and will be investigated in line with below.

Formal Complaints
We aim to acknowledge formal complaints within one working day and investigate and respond to all complaints within either 30 or 40 working days, dependent on complexity of the complaint.

Looking Back Overview

Throughout this report we compare and contrast to the previous year's performance, as well as through providing benchmarking information wherever possible. Within the Annual Complaints and Feedback Report 2020/2021 which was presented to the Quality Assurance Committee in July 2021, four key themes arising from complaints received were highlighted. These were:

- Communications (31%)
- access to treatment and/or drugs (13%)
- clinical treatment (12%)
- admissions and discharges. (12%)

56% of all complaints received within the year related to these four broad areas.

2. Our Improvement Journey

Internal Audit Opinion

360 Assurance undertook a consultancy review of the complaints handling in December 2019 following a review by the then managers of the service due to concerns raised by the CCG that SHSC was not meeting its target of 85% of complaints responded to within 25 days. There was a backlog of “fast track” complaints, which were not fast tracked and a lack of consistent approach. SHSC introduced patient safety investigators to address the investigation backlog and consistency issues alongside developing a standard template with which to respond.

Key areas for improvement were highlighted including:

- Utilising Ulysses for complaints management oversight,
- Assessing the effectiveness of the fastrack system,
- Reviewing the utilisation of a 25-day response period,
- Developing a methodology to embed learning from complaints.
- Update the complaints policy with the proposed changes following audit activity.

Care Quality Commission

Regulation 16 states that “the regulatory intention is to make sure that people can make a complaint about their care and treatment. To meet this regulation, providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, people acting on their behalf or other stakeholders. All complaints must be investigated thoroughly and any necessary action taken where failures have been identified.”

January 2020 Position

The Trust received a regulatory action as follows:

• *The trust must ensure that all complaints are monitored and responded to in a timely manner and in line with their own policy. (Regulation 16)*

In response SHSC developed the following actions to address this requirement.

TW11 - The Trust must ensure that all complaints are monitored and responded to in a timely manner in line with their own policy.	
Reorder capacity in Complaints Team to ensure response rate of 85% within 25 working days.	TW1101
Recruitment of Band 7 Complaints Manager.	TW1102
Implement new systems and processed based on 'Lean' workshops with relevant stakeholders.	TW1103

Revise Complaints Management Policy.	TW1104
Focussed review of the effectiveness of the Fast-track complaints process.	TW1105

This work was undertaken by the previous Director of Corporate Governance and actions were due to be addressed by September 2020 under Year one of the SHSC Back to Good Programme. Monitoring of the actions were reported through to Quality Assurance committee through the Back to Good Year One programme.

May 2021 Position

The CQC made the following observations following visits to the services and corporate team in their core service and well led inspection:

*"*The service treated concerns and complaints seriously and investigated them. However, it was not clear how they learned lessons from the results and shared these with the whole team and wider service. The trust told us that between 1 May 2020 and 1 May 2021 they had received 84 complaints, 20 of these were informal (fast-track) complaints, and 64 were formal complaints. The trust had improved their response time to complaints and the oldest open complaint was dated March 2021. In February 2021, the trust reported an 85% complaints response rate against an 80% target.

However, some patients, relatives and carers did not know how to complain or raise concerns. The trust did not have a complaints policy visible on their website for access by service users and carers. Stakeholders told us that the trust had recently changed the complaints process by phasing out the use of fast-track forms for informal complaints, however they felt that this was not communicated well.

The trust did not always use complaints for learning and consider investigations when complaints indicated an incident of harm to patient had occurred. This meant that opportunities for investigation and learning had been missed. The number of complaints and themes from complaints were not highlighted in the trust's performance report which reduced the oversight the board had of complaints and the risks these indicated in services.

A detailed service user experience report was presented on a quarterly basis to quality committee which included complaints and compliments numbers, response times and themes from complaints. Complaints were not discussed in the quarterly learning lessons report produced by the trust.

We reviewed six complaints which had been made to the trust since 1 May 2020. The themes from these complaints related mainly to concerns about communication and about care and treatment decisions. Responses to complaints were inconsistent in both their timeliness and completion of complaint action plans. The trust had difficulty in allocating staff to complete investigations into complaints in a timely manner."

As a result of this inspection activity SHSC received a regulatory action as follows:

- The trust must ensure that complaints are responded to in a timely manner via a process accessible to patients and staff and that they are used for processes of feedback and learning. (Regulation 16)

SHSC developed a year two Back to Good Action plan to address the requirement.

A4 - The trust must ensure that complaints are responded to in a timely manner via a process accessible to patients and staff and that they are used for processes of feedback and learning.	
Complete a pilot transition of Complaints service to Quality Directorate to improve liaison with related services, following move of line management from 13 September 2021.	A4.1
Undertake reviewing of staffing needs within Complaints Service to ensure appropriate resource allocation.	A4.2
Review of complaints monitoring and reporting and revisions made to ensure effective weekly reporting to clinical triumvirates and a good learning feedback loop.	A4.3
Training to be undertaken, as informed by Operations, to ensure those investigating complaints are properly equipped to do so.	A4.4

The actions were due to be delivered by September 2021 and this included the transition of the complaints function to the Quality Directorate on 30 September 2021.

Whilst the function moved over to the Directorate this was followed by a period of sickness and subsequent resignation of the Complaints Manager. There was also a recruitment period for a complaints officer. On review of the complaints workload, it became apparent that there was a significant backlog with complaints unanswered, unallocated or held in corporate quality assurance processes.

The procurement of training was not completed in line with the original timescale from Corporate Affairs and was rolled over into 2022.

Despite this, during inspection to the acute wards in December 2021 the following observations were made by CQC at practice level.

December 2021: Listening to and learning from concerns and complaints

*"*The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. Patients, relatives and carers knew how to complain or raise concerns. In the last 12 months there had been 20 complaints made across the service. Of these, three were subsequently withdrawn, four were fully or partially upheld and five were not upheld or were closed, with the remainder still ongoing. In the same time period the service received 30 compliments.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes and shared feedback from complaints with staff. Complaints were discussed and reviewed by managers at governance meetings and at weekly all staff business meetings. Staff protected patients who raised concerns or complaints from discrimination and harassment. We did not see that the service used compliments to learn, celebrate success and improve the quality of care."

Local Improvement Plan

As the function for managing complaints handed over to the Quality Directorate and the concerns about backlog, capacity and quality were identified; a rapid improvement plan was agreed to address the immediate concerns and ensure that timelines were set for the delivery of an improved complaints function.

The following plan was agreed:

	Objective	**Due Date**
1	Review the Complaints Management Processes to ensure they meet/oversee the new key performance indicators.	Completed Dec 2021
2	All new complaints to come through the safety huddle (anonymised) to identify any key safeguarding or quality issues for immediate action. **Action superseded.** New complaints' summary going to Director of Quality.	Oct 2021
3	Ensure all elements of complaints procedures are logged on Ulysses Risk Management System to enable easier oversight, performance management and reporting. This includes formal and informal complaints.	Dec 2021 Completed
4	Report complaints progress via tracker into weekly Serious Incident Panel meeting	Oct 2021 Completed
5	Revise Complaints Policy aligned to updated NHS complaints standards ensuring responsibilities clearly defined and flow-charts simple and understandable.	Revised date: Feb 2022
6	Key performance indicators to be presented monthly via Clinical Quality and Safety Group and incorporated into quarterly Patient Experience Report to the Quality Assurance Committee.	Oct 2021 Completed
7	Produce easy read versions of complaints and action log responses to support individuals and families to have accessible reports, where required.	Jan 2022
8	Complaint action plans to be monitored within clinical/corporate directorates and overview of performance to be incorporated within monthly Integrated Performance and Quality Reports (IPQRs).	Jan 2022
9	Recruitment to substantive Band 5 Complaints Officer	Sept 2021
10	Recruitment to replacement for Band 7 Complaints Manager	Jan 2022 Completed
11	Employ Family Liaison Officer to support family contact and access to information in the event of a serious incident/ complaint where the lead investigator requires support to work with a family.	Sept 2021 Completed
12	Heads of Nursing (HoN) to ensure each clinical triumvirate has a process in place to support: • Identification of investigator(s) within 3 working days of notification by Complaints Team	Nov 2021 Completed

	• Senior staff identification and attendance at Trust approved training • Attendance by HoN/Clinical Director (CD) at SI/Complaints Panel on a weekly basis • Development of action plans within 5 working days of receipt of a completed complaint following panel meetings • Monitoring of complaint action plans until closure.	
13	Ensure Complaints Policy and Processes are accessible to all, including members of the public.	Revised date: Feb 2022
14	Procure and deliver complaint investigation training in conjunction	Revised date: Mar 2022
15	Review processes for receipt and logging of compliments to ensure accurate recording.	Feb 2022

Where are we now? Improvement actions and plans

- Fast track system was abolished, however, occasionally forms do appear in service lines.
- The policy has been updated on two further occasions since the initial 360 Assurance audit opinion and further work is required. The policy is available on the website.
- Information is available in services and on the internet on how to complain.
- Complaints are now managed through Ulysses as the customer care centre.
- Oversight of the complaints timeliness is monitored through investigation panel.
- Heads of Nursing have clear responsibilities in relation to ensuring assignment of investigators and reviewing complaints as they come into the directorates.
- Key Performance Indicators are reported through Investigation Panel.
- Staff have received training to support easy read accessible responses.
- Learning is not routinely or robustly extracted from complaints, complaints are responded to but action planning to prevent recurrence on a wider service or SHSC level is not undertaken.
- Complaint timescales are set at 20 days for routine responses, however there is capacity to agree individual timescales which should be encouraged.
- Delays still occur in allocating investigators.
- The team consists of 1 x complaints manager and 1 x complaints officer, the PALS function has not been restored due to financial efficiencies.
- Investigations are undertaken by the clinical team in recognition of the need for learning to take place close to the clinical service. Some capacity is available via patient safety investigators or more senior staff for complex complaints as required.
- The backlog that was handed over in December 2021 (which went back to January 2021) has now been cleared.
- Complaints training is in development with the Patients Association.

In summary we have improved recruitment, processes and timeliness but quality and learning remain issues to be addressed in 2022/23.

3. Data, Key Themes and Analysis

The data contained in this report has been obtained from Ulysses, SHSC's risk management system. It can be seen in the information highlighted below that changes in the way data is captured and reported may produce inaccurate comparisons with previous years, as we transitioned to more robust data capture.

For the year 2021-2022, SHSC received a total of 149 complaints, which equates to an average of approximately three per week. This represents a significant increase in the number of complaints received during 2020/2021 (55) which averaged approximately one complaint per week.

The increase in the number of complaints received is likely to be due to a number of reasons.

- During 2021/2022, there were several changes of staff within the Complaints Team. This may have led to changes or inconsistencies in the identification and recording of formal complaints. For example, more complaints may have been considered as formal complaints during 2021/2022, in comparison to 2020/2021.

- It may also be due to clearer signposting and information that has been developed over time, to help service users and their families/carers/advocates to make a complaint.

- Fastracks were previously used within SHSC as another way service users could raise concerns/complaints. The removal of these may also have led to an increase in the number of formal complaints being recorded.

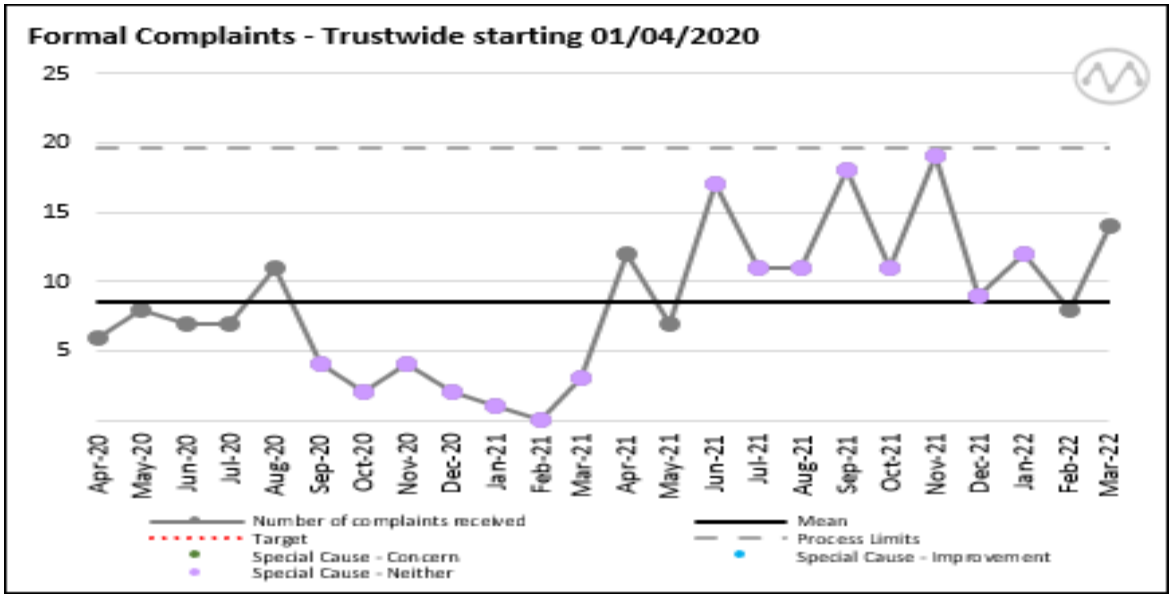
- NHS Trusts were advised that complaints processes could be paused as a way of enabling the NHS nationally to manage the Covid-19 global pandemic. Although SHSC made the decision not to pause complaints during this time, there were fewer complaints received during 2020/2021, which may have been as a result of Covid-19 and service user focus being affected.

Informal Complaints

During 2021/2022, the number of informal complaints has decreased from 103 in 2020/21 to 86 in 2021/22. That may account for some of the increases in formal complaints – as we are classifying differently. This figure does not include any concerns raised at service level that were immediately resolved.

Formal Complaints

The chart overleaf provides a breakdown of the formal complaints which were received from 1 April 2020 to March 2022.



The table below provides a comparison of the complaint classification reported in last year's annual report. There were no complaints registered under the appointments, prescribing and waiting times categories in 2020/2021. This has not remained a trend in 2021/2022 and the number of complaints received under these categories have been reintroduced in 2021/2022.

Access to treatment and drugs is the most common category of the complaints received during the last year and the top five subjects are the same, with access to treatment or drugs, patient care, values and behaviours, clinical treatment and communications again featuring.

Complaint Categories	**2020/21**	**2021/22**
Access to Treatment or Drugs	12	37 ⬆
Admissions and Discharges	8	7
Appointments	-	5 ⬆
Clinical Treatment	7	14 ⬆
Communications	18	10
Patient Care	5	30 ⬆
Prescribing	-	6 ⬆
Privacy & Dignity (PDW)	1	4 ⬆
Values And Behaviours	4	19 ⬆
Waiting Times	-	5 ⬆

Analysis of Top 3 Complaints

Access to Treatment and Drugs

The most significant change is the increase in access to treatment or drugs complaints received, which given the known waiting lists in specific services is not unexpected. 12 complaints were received in 2020/2021. In 2021/2022, there were 37 complaints received where access to services and service provision is recorded as a subject of the complaint and in 92% (n=34) of cases, these were the primary subjects of the complaint. The complaints related to a wide range of departments and specialties and there is no obvious trend in terms of numbers received or the departments involved.

A recommendation from this annual report is for services with significant waiting lists to ensure they have robust information on waiting lists available to service users referred into the service and for SHSC to consider information on the public website to ensure information is available. We should also consider how we respond to these complaints given this is a known service delivery issue and little may be gained from formal complaints.

Patient Care

In 2020/2021 SHSC received 5 complaints in comparison to 30 complaints in 2021/2022. Of these complaints, 77% (n=23) related to care needs not adequately and inappropriately met, 10% (n=3) related to care pathway issues, 3% (n=1) related to inappropriate care setting, 3% (n=1) related to risk assessments, 3% (n=1) related to multiple ward moves and 3% (n=1) related to slips and trips (unwitnessed). The highest number of complaints under this category were received for the Mental Health Recovery Team South at 27% (n=8), followed by Maple Ward 13% (n=4), Liaison Therapy 10% (n=3), followed by a proportionate number of complaints received across departments.

A broad theme from the complaints about care needs not being adequately met links to the transformation work underway within the recovery teams and the impact of this work could be monitored for impact via complaints as one performance indicator. In addition work to reduce the time spent waiting for admission to a bed or the use of out of area beds could also have a transformative impact on patient experience.

Values and Behaviours

In 2021/2022, SHSC received 19 complaints relating to values and behaviours, which is almost five times the number of complaints received in 2020/2021 when 4 complaints were received. Of these complaints, 25% related to breach of confidentiality, 15% to attitude of medical staff, 10% for nursing staff, 15% for attitude of other staff, 5% for administration and clerical staff,10% for failure to act in a profession, 10% for safeguarding, 5% for rudeness, and 5% for dissatisfaction with support from services. There is no obvious trend in terms of the departments involved.

SHSC is focussing on the Trust values and supporting staff with leadership behaviours as well as embedding coproduction. The value of understanding the experience of people who use services, their families, carers and significant others will support staff to consider the impact of their behaviours as well as support service users to gain insight into SHSC activities.

Complaints Outcome and Performance

In line with the Parliamentary and Health Service Ombudsman's (PHSO) definitions, a fully upheld complaint is one where the Trust is found to have made an error or provided a poor service that has had a negative impact on an individual; a partially upheld complaint is one where some failings have been identified but not in regard to all of the concerns raised.

The table overleaf provides details on the outcomes of the complaints received during 2021/2022.

Of the 149 complaints received, we have closed 126 complaints.

Closed	6
Closed - Not Upheld	50
Closed - Partially Upheld	43
Closed - Resolved at Service Level	2
Closed - Upheld	25
Outstanding	17
Withdrawn	2
(blank)	4
	149

The categorisation on the outcome of the complaint could be seen as subjective. Of the 149 complaints received in 2021/2022 and of the 126 complaints which have been closed, 50% were not upheld, 34% were partially upheld and 20% were upheld.

In 2021-2022 six complaints were escalated to the PHSO (compared to one in 2020/21). Three of these complaints have been closed by the PHSO, as they decided not to investigate. Three complaints remain open with the PSHO.

From the 126 closed complaints during 2021/2022, the following shows our performance in relation to response times.

Closed within agreed timescales	26%
Closed after agreed timescales	50%
Ongoing (in time)	11%
Ongoing (late)	5%

Due to changes in data capture, it is not possible to provide a comparison to 2020/2021 figures.

Correlating Learning from Serious Incidents

Reporting against key performance indicators for serious incidents and complaints is managed by the Weekly Investigation Panel and this group focusses on the delivery of learning reports for the complaints and serious incidents and section 42 safeguarding enquiries.

There has been escalation to the serious incident process whenever appropriate and/or the involvement of safeguarding and other appropriate departments.

Risk of Admission Work was a key theme from incident huddle and complaints, specifically the ability to admit patients into an inpatient bed at the point of need. This does align with the significant increase in the level of complaints received whereby complainants feel that their care needs are not being adequately met as reported earlier in this report. The Clinical Quality and Safety Group have requested and received reports on the work underway within the acute and community directorate to understand and support appropriate triage of people `at risk of admission`. Monitoring of this patient safety issue will continue through the incident huddle and within the group as well as monthly through the Integrated Performance Quality Reporting (IPQR).

Equality Diversity and Inclusion

The complaints team has attended easy read training and the aim is to provide options for service users and members of the public to access easy read complaints material.

We currently do not collect data on the protected characteristics of complainants. This is an area of interest for the complaints team and we will undertake a piece of work with engagement colleagues to review the possibility of collecting information on a voluntary basis to understand any particular trends in utilising the complaints process by protected characteristics.

Learning from Complaints

SHSC is always striving to learn from complaints and we have implemented changes in response to complainant's concerns. Some of the changes we have introduced as a result of complaints are as follows;

In response to a complex clinical complainant raised by a relative, the use of body maps on admission has been put in place for all admissions and this is checked every week through an audit and reported to the clinical team meeting. Furthermore, we now have the ability to upload any documentation including discharge notes to the electronic patient record system whenever they are received from another organisation.

As a result of a service user's experience in which they felt their views were not being respected, the staff member offered to write to the complainant personally to share how they had reflected upon their feedback and also the service user was offered access to utilise primary care mental health services through their GP to enhance the level of support they could receive.

In relation to poor communication concerning waiting times and day service programme changes, the issues raised in the complaint were taken to the relevant Clinical Governance Meeting to make sure there was clearer communication with GPs about physical health monitoring, as well as with service users about timetable changes.

Benchmarking

Nationally, SHSC has a moderate complaints rate. Similarly to last year, we are still ranked 15 (joint 15) out of 47 mental health trusts. The table below shows the level of complaints which have been received within Q1 and Q2 by each of the Mental Health trusts within the region, according to NHS Digital.

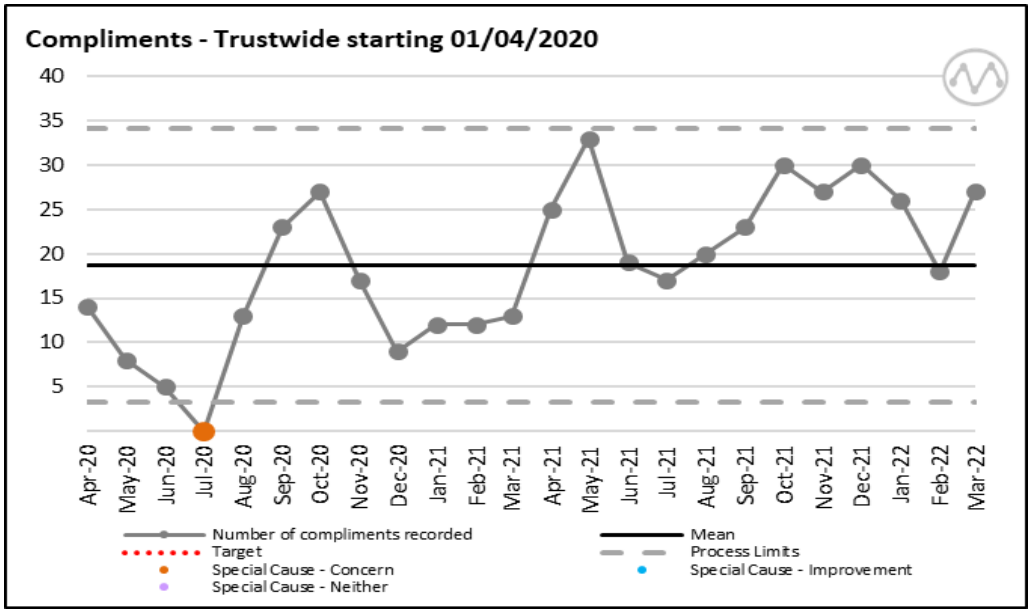
Regional Overview of complaints received during Q1 and Q2 2021/22

Mental Health Trust	NHS Digital Q1 and Q2 Complaints
Rotherham, Doncaster and South Humber NHS Foundation Trust	26
Sheffield Health and Social Care NHS Foundation Trust	42
Leeds and York Partnership NHS Foundation Trust	45
Bradford District Care NHS Foundation Trust	11
South West Yorkshire Partnership NHS Foundation Trust	50

Service User Feedback

The complaints team logged 295 compliments during 2021-2022 in comparison to 153 in 2020/2021. During the past year, guidance has been provided to services on what counts as a compliment and a template has been created to make it easier for services to report compliments. We have also introduced a generic 'compliments' email box to make it easier for staff to report these through.

The chart below shows the level of compliments we received from 1 April 2020 to 31 March 2022.



Here are some compliments which were received during 2021/2022

I wanted to say thank you for being so calm and patient during the appointment. I've had a lot of professionals (in mental health sectors or GPs) not take the time to listen and make me feel like a burden for asking for help, so I was very nervous for my appointment. But you allowed me the safe space I needed to be honest about what I had experienced and validated those experiences. So thank you, it makes me feel a lot more positive moving forward to know that there are people that will listen and do their best to help.

Single point of Access/Emotional Wellbeing Service

Thank you to everyone at East Glade - you have literally saved my life. People are quick to complain but never say thank you so he wanted to say thank you.

Recovery Service South

I just wanted to say a massive thank you for all of your responses to what was a very risky and challenging (in all respects) situation yesterday. Even being very much on the sidelines of the situation – it felt so supportive, safe and most importantly caring in the way that you all responded – so quickly and with ultimate care and compassion for the client and her family.

Huge appreciation for all of you – all of you were calm, containing, and caring 😊 And I just felt I needed to say that!!

Complaints Received by Department

The tables below provide information on the complaints which were received by each team within 2020/2021 alongside 2021/2022. The number of complaints received for the North and South recovery teams in 2021/22 more than doubled for both teams in comparison to complaints received previously in 2020/2021.

In summary, the level of complaints received for South Recovery doubled and the number of complaints received for Single Point of Access also doubled. Complaints relating to the SAANS service also increased significantly, which is likely due to the longer waiting times.

Complaints Received 1 April 2020 - 31 March 2022 - broken down by Department/Year

Department	2020/21	2021/22
AMHP Function	-	2
Autism And Neurodevelopmental Service	2	10
CERT	-	1
CLDT	-	1
Decisions Unit	-	1
Dovedale	1	1
Dovedale 2 Ward (Burbage)	-	4
Early Intervention Service	1	2
Eating Disorders Service	-	3
ECT Suite	-	1
Endcliffe Ward	-	3
Flow Coordinators	-	5
Forest Lodge	1	5
G1 Ward	2	2
Gender Identity Service	2	9
Home Treatment Team	-	6
IAPT	2	7
IT Informatics & Architecture	1	-
Liaison Psychiatry	5	3
Maple Ward	3	6
Memory Service	-	2
Mental Health Recovery Team (North)	3	17
Mental Health Recovery Team (South)	11	23
Out Of Hours Team	1	1
Perinatal Mental Health	1	1
Specialist Psychotherapy Services	2	3
SPA / EWS	9	19
Stanage Ward	6	6
START Alcohol and Opiates Services	1	4
Wainwright Crescent	1	-
Woodland View	-	1
Grand Total	**55**	**149**

4. Implementing Learning from Complaints

SHSC is continuing its journey to get 'back to good' in relation to its management of complaints and the Trust has made positive progress to implement and progress the associated complaints improvement plan over the last 12 months. The Trust is committed to minimising the opportunity for harm to patients and staff. In keeping with our open and honest culture, staff are encouraged to report adverse events in a timely manner so that they can be investigated to identify opportunities for future learning and improvement.

We are committed to continually improving our services and acknowledge that whilst we do not always get it right, we believe that this report demonstrates some of the learning and changes we make as a direct result of feedback from our service users, their carers and loved ones. The Trust would like to apologise to all those people who have had cause to raise concerns. We thank our staff for their openness and candour when undertaking investigations.

This section of the annual report details examples of learning and change as a direct result of feedback received from complaints and concerns.

Directorate and Team	Learning	Actions
Acute and Community, Endcliffe Ward	Communication with relatives and carers on resolving concerns.	Action taken by the staff on acute wards to improve communication and recognise complaints. A new procedure for investigation of complaints has been put in place.
Rehabilitation and Specialist, Liaison Psychiatry	Patient Care - Enhanced learning in clinical risk and suicide prevention across multi agency disciplines.	The training delivered for clinical risk and suicide prevention has been reviewed to reflect practitioners have this knowledge and encourage professional curiosity. Where patients are admitted out of area (if identified) the bed flow manager to ensure all information pertinent to that person is shared within the boundaries of confidentiality and data protection legislative framework.
Acute and Community Memory Service	Patient Care, inadequate risk assessment.	The service has made some changes and they are now seeing more service users in person and a 'meet and greet' facility enables people to enter the building and wait in a safe socially distanced manner.

Acute and Community, Mental Health Recovery Team North	Values and Behaviours	Staff member became aware that they had caused service user to become upset and wrote a letter of apology and offered reassurance and encouragement to ask that they continue to attend future appointments with them and the service.
Acute and Community, Mental Health Recovery Team South, Eastglade.	Patient Care - Inadequate Support provided to service user.	Service user felt unsupported while they awaited allocation of care -coordinator. The service organised a one-off visit from the team to discuss options for community intervention and information on community activities, homecare and befriending. The service also looked into a review for a social care assessment.
Rehab and Specialist, Eating Disorder Service.	Access to Treatment and Drugs	The concerns raised within the complaint were reviewed at the Clinical Governance Meeting to make sure there is clearer communication with GPs about physical health monitoring, as well as with service users about timetable changes for the Day Service. The Trust recognises it should not make significant changes without consultation with our service users and will ensure they are consulted going forward.
Acute and Community, Crisis Resolution	Patient Care – Support with nutritional needs.	The Trust is piloting a new approach called Purposeful Inpatient Admissions (PIPA), which aims to ensure that the ward and community team are in regular contact, from the first day of admission, focusing on the treatment that individuals require and planning the discharge similarly. Inclusion of carers and loved ones is central to this process and it aims to ensure a positive outcome.
Rehab and Specialist Gender Identity Service	Access to Treatment or Drugs.	The complaint was discussed with the Multi-Disciplinary Team and an action plan was created. The associated actions were progressed and a referral was made to the National Referral Support Service for funding consideration and an appointment arranged for the service user to be seen by a clinician to discuss surgery.

5. Risks

There is a risk that if we do not improve how we identify and act upon learning from complaints that we will continue to receive complaints related to specific aspects of care and treatment within SHSC. We could receive a further regulatory notice from the CQC.

There is also a risk that we do not demonstrate to complainants that we have listened and that we are willing to make changes where it is appropriate to do so. This will result in people feeling SHSC is not a place they are able to receive safe and appropriate care.

There is a risk that staff feel overwhelmed with complaints and that they are not allocated to appropriate staff who are trained and confident in speaking with complainants.

There are risks in relation to specific types of complaints and services, which results in a small number of staff responding to similar themes in large quantities, for example our specialist services receiving complaints about waiting times. These waiting times are out with the service line control in many cases and an alternative approach is required to manage these complaints without depersonalising the experience of people waiting.

6. Conclusion

An increased level of complaints has been received this year which provides more opportunities for us to learn and improve. Early resolution remains our focus and we have resolved an increased level of complaints this year through the informal complaints process which is beneficial for the complainant and SHSC.

During the year we have achieved greater consistency in our data quality and recording through better utilisation of the Ulysses risk management system. Whilst this report clearly highlights a number of data inconsistencies from previous years, we are confident that a more accurate comparison will be seen in future years' reports.

We recognise waiting lists can cause frustration for service users and this increases further when long periods of time lapse without receiving any communication from us. SHSC is improving the frequency of communication and improving information on our website, to ensure that we can provide helpful and clear information to manage expectations.

Learning from complaints requires strengthening and is our top priority for 2022/23. We are addressing this through a number of ways:

- Agile mindset work with Executive Directors to look at how we promote learning from complaints at the beginning of the process.

- Complaints training package is being delivered via Patients Association, which will increase the confidence of complaint investigators to work with complainants and identify learning.

- Proposed work on understanding complainants by ethnicity.

- Consideration of how experts by experience can influence learning and improvement from complaints.

We endeavour to have a greater understanding of our communities and people who access our services and we will be inviting complainants to share more information with us when they raise a concern so that we have richer knowledge and reporting data so we can identify any trends around unfair treatment and discrimination so that can be investigated and resolved at the highest level within the Trust.