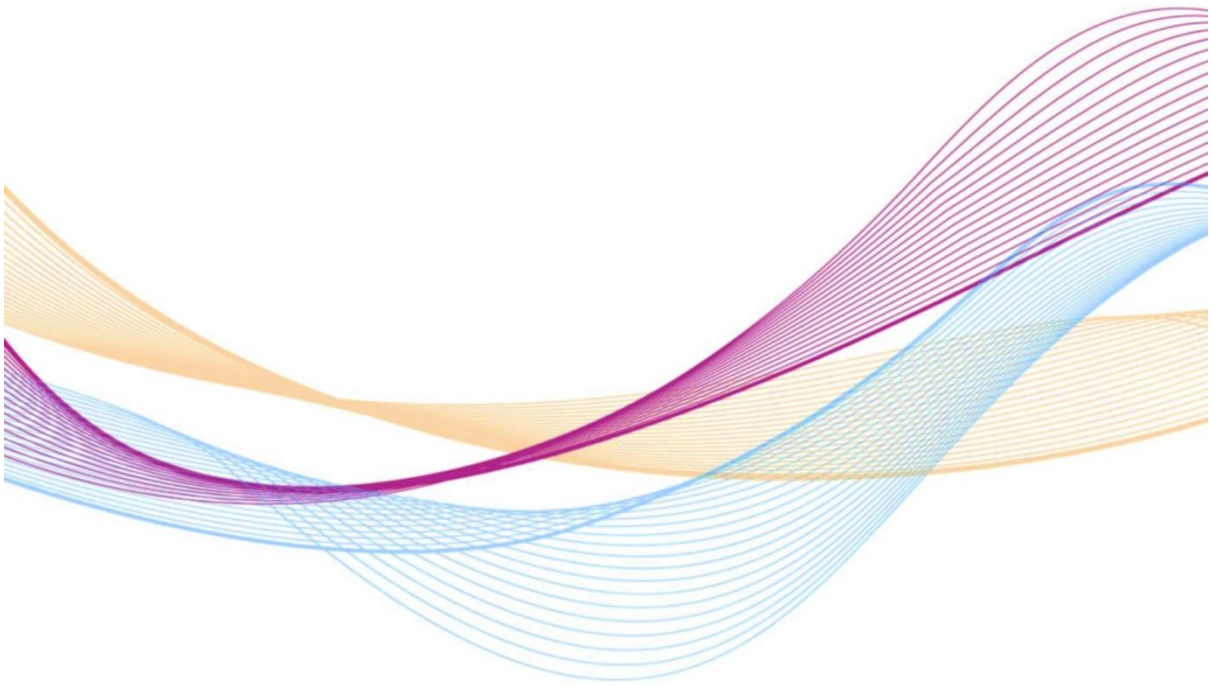
South Essex Partnership University NHS
NHS Foundation Trust

Complaints Annual Report 2016-2017



Chief Executive's Foreword

I am pleased to present our Complaints & Compliments Annual Report for 2016/17 for the period 1 April 2016 to 31 March 2017.

This is the final Complaints Annual report for the South Essex Partnership University NHS Foundation Trust (SEPT) as we merged with North Essex Foundation Trust (NEP) on 1 April 2017 to become Essex Partnership University NHS Foundation Trust (EPUT).

SEPT always aimed to make continuous improvements to its handling of complaints to ensure they are fit for purpose and encompass the diversity of Mental Health and Community Services. I intend for this culture to continue in the new organisation.

I am pleased to say that much work has taken place over the year to honour the Commitment in last year's report to:

- Ensure all key staff are trained to deal effectively and efficiently with complaints and concerns.

- Analyse final reports from the Parliamentary and Health Service Ombudsman (PHSO) to see where improvements can be made to complaint responses with a view to reducing the number of referrals.

- Continue work on refining and building on the complaints handling process.

A new complaints training pathway was developed and is continuously rolled out across the Trust to ensure that management as well as current and new complaints investigators have the knowledge and skills to undertake robust investigations and identify learning for the Trust.

The recommendations from the PHSO, final reports have been presented to, and discussed, at the Learning Lessons Oversight Committee to promote Trust wide awareness. Both the learning from the PHSO reports and that of completed complaints investigations have been monitored quarterly to ensure the same issues are not replicated.

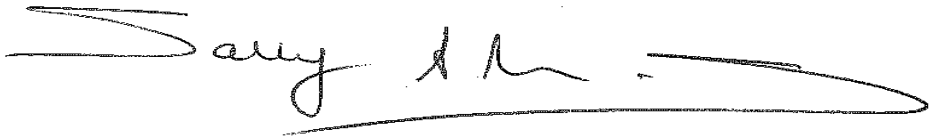
A more proactive approach has been taken by the Complaints Team in ensuring that all concerns raised have been fully addressed and answered.

I believe that focussing on these three commitments has led to an improvement in the quality and standard of complaint responses; fewer complaints have been reopened this year, (15 as opposed to 35 last year), and fewer referrals to the PHSO, (5 this year, 11 last year).

Although this has been a positive report, I am not complacent about the need to make further improvements, particularly in the area of identifying learning from those complaints that are either upheld or partially upheld. Improvements can be made in ensuring that the implementation of learning is across all services and wards, not just confined to one particular area.

It is important to me that individuals feel that they have been treated with respect and receive an open, honest and timely response to their concerns within agreed timescales. Complaint response times continue to be monitored by the Executive Team and any themes or trends are monitored by the Patient Experience Steering Group. Our Non-Executive Directors undertake monthly independent reviews of the complaints handling process to provide assurance that the Trust is providing high quality investigations and responses, and appropriate learning actions are identified. All of these actions will continue into the new organisation.

Finally, I would like to use this opportunity, as in previous years, to thank everyone who takes the time and trouble to send in compliments about our staff and services. Positive feedback is always welcome; it is good to hear when we have got it right as well as hearing when perhaps this has not been the case. All feedback helps us to learn from and improve our services for our patients, carers and relatives.



Sally Morris
Chief Executive

SEPT COMPLAINTS ANNUAL REPORT 2016/2017

1.0 INTRODUCTION

This is the Complaints Annual Report for South Essex Partnership University NHS Foundation Trust (SEPT) for the period 1 April 2016 to 31 March 2017.

SEPT provides Mental Health Services to people in South Essex and Forensic Services in Bedfordshire and Luton. The Trust also provides Community Healthcare in South East Essex, West Essex and Bedfordshire.

This is the fourth consecutive year that the Trust has seen a reduction in complaints for the services we provide.

The complaints function is overseen and monitored by the Corporate Governance Directorate, however, complaints and their prompt and effective management are everyone's responsibility. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or in her absence, her designated signatory.

Every year the number of compliments the Trust receives far outweighs the number of complaints about the services the Trust provides. Although there has been a reduction in the number of compliments from patients, their relatives, and carers from last year, the Trust has still received a significant number. A small selection of compliments is shown on page 20, appendix 1.

The time limit for making a complaint, as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant. However, the Trust will consider complaints outside of this timescale, on an individual basis, to see if it is still possible to investigate robustly and provide a response.

All complaints are acknowledged within 3 working days in line with Department of Health regulations. The Trust takes every complaint seriously and aims to respond to all complaints in an honest, open and timely manner.

SEPT continuously looks at ways of improving response times to complaints. For this year the Trust has achieved 99% for complaints closed within agreed timescales with the complainant. Data from the NHS Benchmarking Club showed that on average fewer than 80% of complaints were closed within agreed timescales across all Mental Health Trusts.

The Trust aims to remedy complaints locally through investigation and meetings if appropriate. However, if the complainant remains dissatisfied they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) as the second and final stage of the complaints process.

This year, the Trust had five complaints referred to the PHSO, which is a decrease of six from last year. One of the Trust's aims for 2016/17 was to "Analyse final reports from the PHSO to see where improvements can be made to complaint responses with a view to reducing the number of referrals". All recommendations from the

PHSO final reports have been shared with Executive and Service Directors as well as being discussed at the Learning Lessons Oversight Committee to ensure the learning is shared Trust-wide.

It should be noted that the figures stated in this report from point 3, (and those reported in the Trust's Quality Account) do not correspond with the figures submitted by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust's internal reporting (and thus the Quality Report / Account and Annual Complaints Report) is based on the complaints **closed** within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints **received** within the period.

2.0 NUMBER OF FORMAL COMPLAINTS RECEIVED

A total of 207 formal complaints were received by the Trust during 2016/2017. This figure indicates a decrease of 30 from the overall total of the previous year. 3 complaints were withdrawn by the complainants.

This decrease has been Trust wide with the exception of West Essex Community Health Services which remains the same as the previous year.

At year end 2015/16, 23 complaints were still under investigation, they were therefore added to the 2016/17 received total of 207 (230), the 208 closed complaints were deducted from that total, leaving 22 active complaints at year end. All active complaints are on target to be responded to within their agreed timescale, by the end of May 2017.

Table1: Number of Complaints Received by Trust area

Area	Number of Complaints Handled	
	2016/17	**2015/16**
Mental Health – South Essex	139	147
Forensic - Bedfordshire & Luton	5	6
Total Mental Health	**144**	**153**
Community - Bedfordshire	20	29
Community – South East Essex	18	28
Community - West Essex	25	25
Community – Suffolk N/A for 2016/17	0	2
Total Community	**63**	**84**
Total Complaints Received	**207**	**237**
Total Complaints closed	**208**	**247**

The following figures illustrate the number of complaints received by Directorate during 2016/17.

Figure 1: Numbers of Complaints received by Directorate

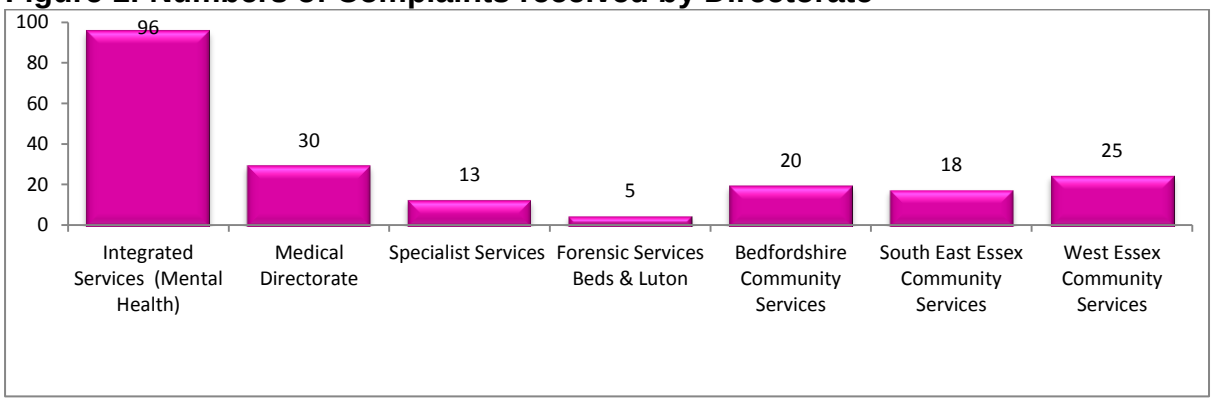


Figure 2: Percentage of Complaints received by Directorate

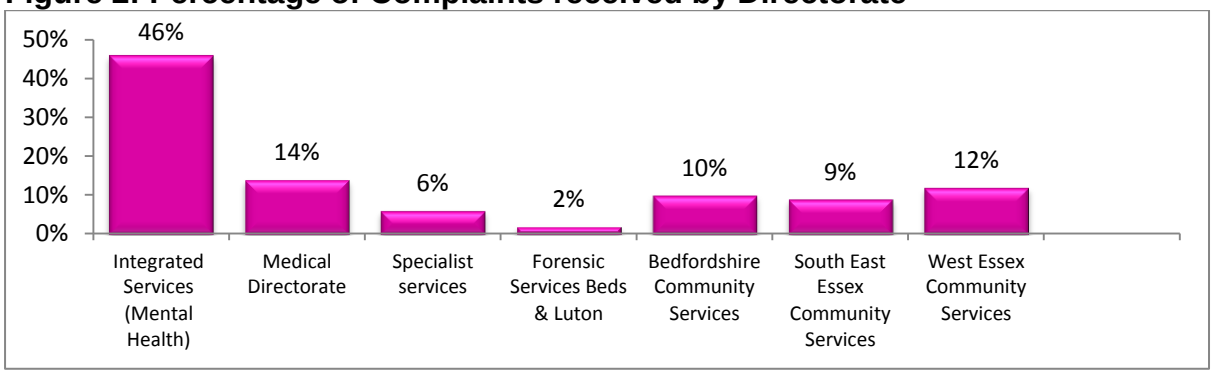
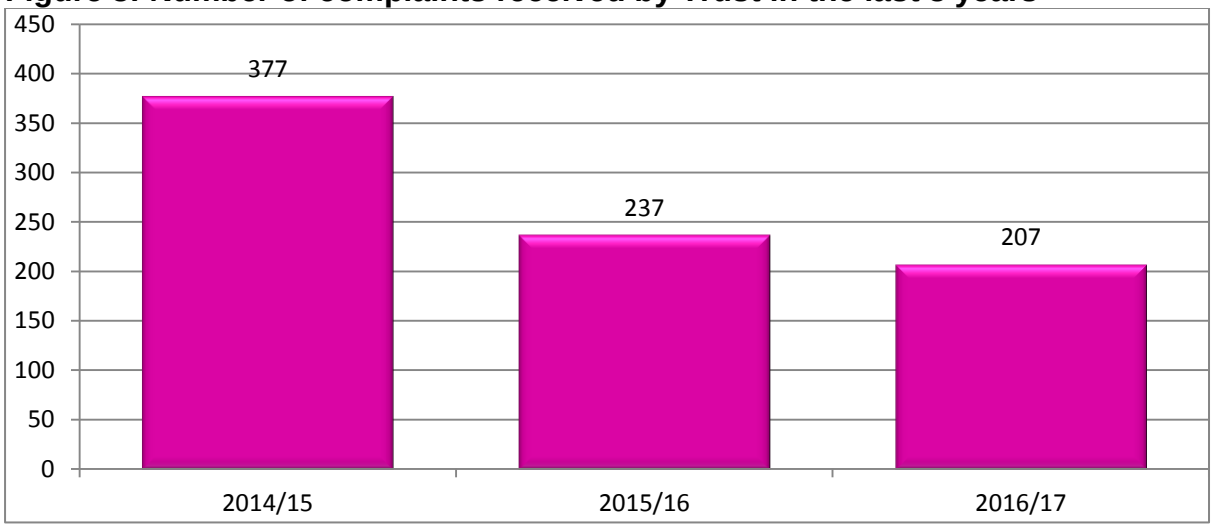


Figure 3: Number of complaints received by Trust in the last 3 years



It should be noted that Bedford and Luton Mental Health Services transferred to another organisation at the end on 2014/15, and Suffolk Community Services transferred in October 2015. Therefore a direct like for like comparison is not viable.

3.0 NUMBER OF COMPLAINTS UPHELD/PARTIALLY UPHELD

A total of 208 complaints were closed during the year and 3 were withdrawn.

The outcome of these complaints is shown below.

Upheld	Partially Upheld	Not Upheld	Total
29	121	47	197

The remaining 11 comprise:

- 5 not investigated (consent withheld)
- 3 withdrawn
- 2 conduct and capability
- 1 locally resolved

If a complaint has several issues raised, it is recorded as partially upheld if one element is upheld, even if most elements are found not to be upheld. Last year's figures are shown for comparison.

Table 2: Complaints Outcome by service/locality

Area	Number of Complaints Upheld		Number of Complaints Partially Upheld		Not Upheld		Total	
	2016 /17	2015 /16	2016 /17	2015/ 16	2016 /17	2015/ 16	2016 /17	2015/ 16
Essex Mental Health	**16**	9	**72**	78	**37**	59	**125**	146
B&L Forensic	**1**	0	**4**	2	**3**	1	**8**	3
Community – Bedfordshire	**3**	3	**15**	17	**3**	7	**21**	27
Community – South East Essex	**3**	5	**14**	18	**2**	5	**19**	28
Community – West Essex	**6**	1	**16**	19	**2**	1	**24**	21
Community – Suffolk	**-**	0	**-**	3	**-**	1	**-**	4
Total	**29**	18	**121**	137	**47**	74	**197**	229

4.0 NUMBER OF COMPAINTS RESOLVED WITHIN AGREED TIMESCALE

Table 3 below illustrates the percentage of complaints closed within the agreed timescale with the complainant. As outlined in section 1, Data from the NHS Benchmarking Club showed that on average fewer than 80% of complaints were closed within agreed timescales across all Mental Health Trusts.

Overall this year the Trust responded to 99% of complaints within agreed timescales, this is a 1% increase on last year's figure. The average number of days taken to respond to complainants is shown in the table below. It should be noted that 2 complaints under Bedfordshire and Luton Forensic Services, (Bedfordshire prison) contained complex issues that took 50 days to resolve.

Table 3: Closure of Complaints within Agreed Timescales

.Area	Closed within agreed timescale	Percentage	Average time taken to respond
Mental Health – Essex	135	99%	37 days
Bedfordshire & Luton Forensic	8	100%	43 days
Community – Bedfordshire	22	100%	22 days
Community – South East Essex	19	100%	23 days
Community – West Essex	24	100%	23 days

5.0 NUMBER OF COMPLAINTS REFERRED TO THE PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

If the complainant remains dissatisfied with the response they receive from the Trust and feel that all avenues to resolve it locally have been exhausted, they can ask the Ombudsman to independently review their complaint.

During 2016/17 a total of 5 complaints were referred to the PHSO which is a decrease of 6 from the previous year. The PHSO discontinued their investigation in 1 case as the complainant could not confirm the scope of the investigation.

To date, there are 3 active cases with the PHSO. Table 4 below, illustrates the area of the Trust from which the complaints were referred to the PHSO and their current status.

Table 4: Complaints Referred to the Ombudsman

Area	Number of Complaints Referred	Comments
Mental Health - Essex	2	1 partially upheld. Recommendation that the Trust should: • write to the complainant and acknowledge the failings that the Trust did not locate and examine all the relevant evidence before responding to complainant, and apologise for the impact this had on him. • prepare an action plan which describes what the Trust has done to ensure that it has learnt lessons from the failings identified and detail what the Trust has done and/or plans to do, including timescales, to avoid a recurrence of these failings in the future. 1 was discontinued as the complainant could not confirm the scope of the investigation. No active referrals.
Community Health Services – Bedfordshire	1	1 is active
Community Health Services– South East Essex	2	2 are active

At the end of last year (2015/16), 6 complaints were still under investigation by the PHSO; 3 relating to Essex Mental Health Services, 1 for West Essex Community Healthcare, 1 for Suffolk Community and 1 for Bedfordshire Community.

The outcomes were:

Area	Number of Complaints Referred	Comments
Mental Health – Essex		• 1 discontinued investigation as complainant withdrew complaint. • 2 were partially upheld, in 1 case the Trust paid £70 for replacement glasses and to review the patient property policy. In the second case an action plan was completed.
West Essex Community	1	Not upheld
Suffolk Community	1	Partially Upheld, letter of apology no further actions.
Bedfordshire Community	1	Partially Upheld. • Trust paid £1500 and provided an action plan in relation to Doppler Tests.

6.0 NATURE OF COMPLAINTS RECEIVED

The top three themes for complaints for both mental health and community during 2016/2017 were dissatisfaction with treatment, staff attitude and communication. These are consistently the top three themes for the Trust, and also apply nationally across the spectrum of health services.

Emerging trends or themes are monitored regularly as complaints are received, and any areas of concern are highlighted to the Executive Team. In addition, a quarterly thematic report is produced and discussed by the Patient and Carer Experience Steering Group.

Of the 208 closed complaints, 92 were recorded within the top three themes. Of these, 65 were either upheld or partially upheld. The table below shows the upheld and partially upheld figures for the top 3 themes. Last year's figures are shown for information.

Table 5: Top Three Complaint Themes

Top Three Complaint Themes	Total number of Complaints closed (2015 / 2016)		Upheld		Partially Upheld		Total of Upheld/ partially Upheld	
	2016/17	2015 /16	**2016/17**	2015 /16	**2016/17**	2015 /16	**2016/17**	2015 /16
Unhappy with treatment	**23**	47	**1**	3	**15**	31	**16**	34
Staff Attitude	**43**	41	**3**	3	**26**	19	**29**	22
Communication	**26**	29	**5**	1	**15**	27	**20**	28

The remaining number (27) were either not upheld, withdrawn or not investigated as consent was withheld.

As these figures include services no longer managed by SEPT it is not possible to make direct comparisons with last year's figures.

It should be noted that the category 'unhappy with treatment' covers a wide spectrum. In some cases, complainants have certain expectations; however, these can be contrary to their clinical need. The Trust has therefore, been limited in providing solutions to these complaints.

7.0 NUMBER OF RE-OPENED COMPLAINTS

During 2016/17, of the 208 complaints closed, a total of 15 complaints were reopened as the complainant was dissatisfied with the Trust's response to their complaint. The Trust had a 58% decrease in the number of reopened complaints this year compared with last year. There was a 61% decrease in reopened complaints for Mental Health Services compared to last year.

The most common cause for complainant dissatisfaction is disagreement with the content of the Trust's response, this applied to 7 of the reopened cases. 5 further complainants cited that their response letter had contained factually incorrect information; two stated that agreed outcomes had not been implemented; and one felt that aspects of the original complaint had not been addressed.

Table 6: Reopened Complaints

Area	Number Closed	Number Re-opened	Percentage
Mental Health - Essex	135	9	6%
Forensic Bedfordshire & Luton	8	0	0%
Community - Bedford	22	4	18%
Community – South East Essex	19	2	10%
Community – West Essex	24	0	0%
Total	208	15	7%

8.0 NUMBER OF COMPLAINTS REVIEWED BY NON-EXECUTIVE DIRECTORS

The Non-Executive Directors have continued to provide an important and valuable part of the complaints process by providing independent reviews of randomly selected completed complaints. During 2016/17 a total of 56 reviews were undertaken, which is 12 more than last year.

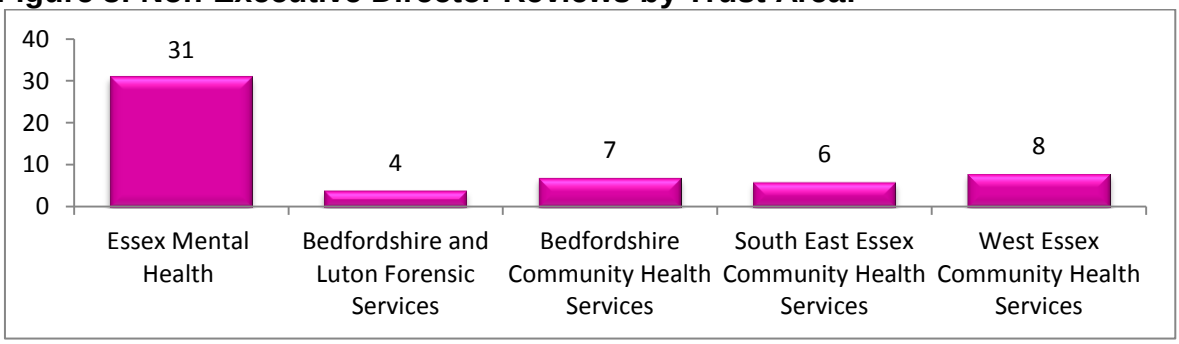
The reviewer will take into consideration the content and presentation of the responses and scrutinise the investigation report to seek assurance that a robust, open and fair investigation has been undertaken.

If the Non–Executive Director has any concerns or questions about the complaint they have reviewed they will arrange to meet with the Executive Director or Director of the service to discuss. The Non-Executive Directors held 5 such meetings to either clarify points or suggest further learning which could be taken from the complaint they had reviewed. Once reviews have been completed, they are signed off by the Trust's Chair and circulated to Directors to view the comments.

In addition, the Council of Governors receive regular reports on the number of complaints and provide an additional level of assurance in monitoring the Trust's performance.

The number of complaints reviewed is shown below by Trust area.

Figure 3: Non-Executive Director Reviews by Trust Area:



9.0 NUMBER OF LOCAL RESOLUTIONS RECORDED

The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. This timely intervention can prevent an escalation to a formal complaint. This year, the complaints training to staff has reiterated the benefits to both staff and complainants by locally resolving complaints where possible.

There was a total of 208 locally resolved concerns recorded for the year. This total includes 33 enquiries from MPs on behalf of their constituents. MP queries have slightly increased this year, these are recorded as local resolution and the table below illustrates the area for which they were received.

Figure 4: Local resolution by Trust area (excludes MP queries):

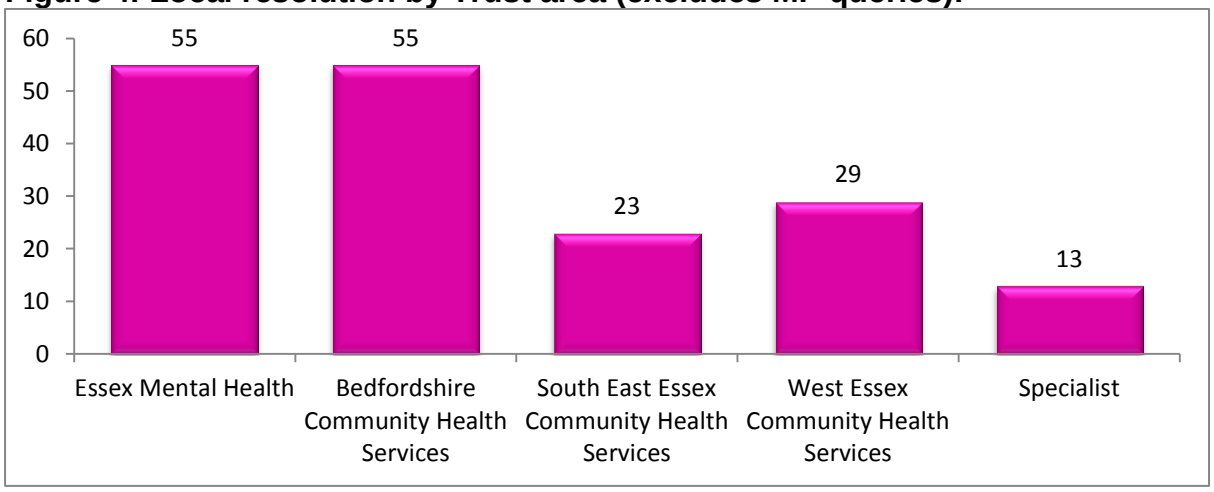
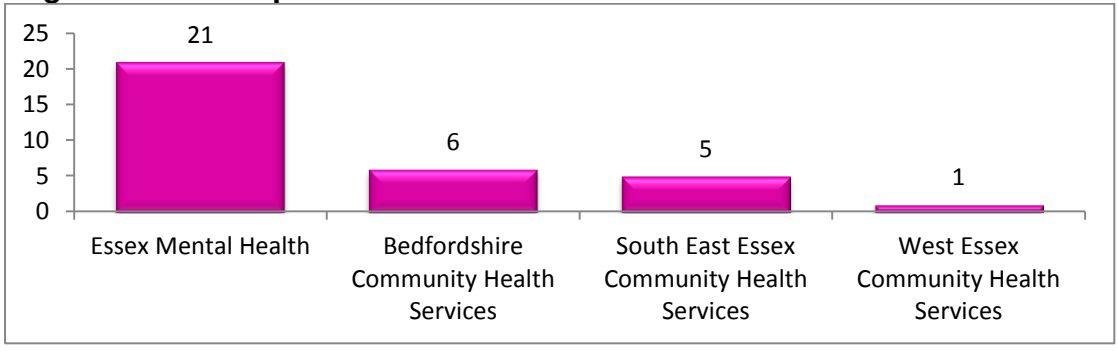


Figure 5: MP enquiries on behalf of Constituents



10.0 Triangulation of Complaints, Serious Incidents and Claims

All complaints are logged onto the Datix reporting system, and are cross referenced with the incident module; this will highlight any incidents relevant to the complaint. During 2016/17, 18 such cases were recorded. Of these, 2 complaints were linked to serious incidents and 1 to a critical incident.

A detailed root cause analysis is undertaken for the serious incident and the final report used to inform the complaint response. The joint learning from the serious incident and the complaint will be discussed at the Learning Oversight Steering Group for dissemination across the Trust.

A total of 9 complaints became the subject of claims this year. 2 claims were closed with no damages, 1 case is at the settlement stage and 6 cases are on-going.

Complaints are also linked to any recorded safeguarding concerns for information, the Safeguarding Team take these forward through their own processes.

11.0 ETHNICITY OF PATIENTS

The Department of Health no longer collects data in relation to ethnicity. However, the Trust continues to send out an equal opportunities form with the acknowledgement letter to complainants.

In the majority of cases either the form is not returned or the complainant chooses not to state their ethnicity. The data collected relates to the patient concerned and not the complainant.

Table 7 below illustrates the information received by area.

	Beds & Luton Forensic Services	Essex Mental Health Services	Bedfordshire Community Services	South East Essex Community Services	West Essex Community Services	Total
White – British	3	108	3	5	6	125
White – other white	0	7	0	1	0	8
Mixed white & black Caribbean	1	3	0	0	0	4
Other Mixed	1	2	0	0	0	3
Indian	0	1	0	0	0	1
Pakistani	0	0	1	0	0	1
Black African	0	3	0	0	0	3
Chinese	0	0	0	0	0	0
Not Stated	0	15	16	12	19	62
Total	5	139	20	18	25	207

12.0 FEEDBACK ON COMPLAINTS PROCESS

A complaint handling questionnaire is sent to complainants approximately 6 weeks after the closure of their complaint. This feedback form asks how easy the complaints process is to access and understand and if the complainant is happy with the handling and outcome of their complaint.

Last year's report noted that the response rates to the complaints questionnaires was disappointing. This year the response rate remains low, however there has been a slight increase. Of the 130 questionnaires sent out only 35 were completed (27%).

Questionnaires were not sent to complainants where consent to investigate was withheld or those complaints closed in March which will receive their feedback forms in May 2017.

Overall the results were as follows:

- Positive experience 18 responses.
- Negative experience 15 responses.
- Mixed experience 2 responses.

Of the 35 returned surveys, 25 people felt that the staff who dealt with their complaint were helpful and polite. 9 of the people who had a negative experience felt they had not been kept fully informed throughout the complaint investigation. 9 people expressed dissatisfaction with the timescale for a response, although all had been responded to within an agreed timescale with the complainant.

The comments provided on the returned forms are shared with the relevant Director.

13.0 INTERNET FEEDBACK

During the year, the Trust has monitored and responded to feedback posted on NHS Choices. This is an important source of feedback for us. As the comments are mostly anonymous, it is not always possible to identify which service or staff members the person is referring to. Every effort is made to respond, and contact details of our PALS and Complaints Departments are posted to encourage the writer to contact us directly so that we can address their concerns through the complaints process. However, none of the authors of the comments have contacted the Trust therefore, although their concerns are passed to the relevant Director to make them aware, they are not included in the complaints numbers. Compliments have also been posted and recorded when the service/area has been identified.

A total of 9 comments and 2 compliments were posted on the site. Of the 9 comments, 5 were not SEPT services, they related to other services held in clinics or hospitals that SEPT also delivered services from. 3 were left anonymously and did not respond after being invited to contact us directly so that we could obtain more information to investigate their concerns, although a generic response was posted by the Trust. 1 was already the subject of a formal complaint.

14.0 ACTIONS TAKEN TO IMPROVE SERVICES AS A RESULT OF THE COMPLAINTS RECEIVED

The Trust recognises the importance of lessons that can be learnt from complaints, and the Trust wide value in sharing these with appropriate members of staff.

To ensure organisational learning from complaints, any recommendations made following investigation of a complaint are recorded and monitored.

The Trust has a Lessons Learned Oversight Committee which ensures that any learning is taken forward and implemented within service delivery. The feedback loop for sharing learning has continued to improve over the past year, with learning from complaints being regularly discussed in Management and Team meetings across the Trust.

The commissioners of SEPT's services also receive a quarterly report on the lessons learned from complaints originating from their specific geographical areas.

The lessons learned process is reviewed on a regular basis and identified learning is followed up on a quarterly basis to provide assurance that learning from complaints is both captured and embedded in everyday practice. In addition, the lessons are reviewed quarterly to ensure that there are no recurring themes either within the same service or another service. This is also discussed at the Learning Oversight Committee to ensure Trust wide learning.

Table 8 below highlights a selection of some of the lessons learned from complaints over the past year.

Table 8: Lesson Learned

What our patients said	What we did
Patients wife asked clinician for help in getting her husband into the treatment chair but felt she was ignored.	Clinical staff have been reminded to clarify the mobility status of service users when calling them from the waiting room to ensure that adequate assistance is provided as required
Unable to leave a telephone message about an appointment unless a Clinician is at the clinic.	The service to see if it is possible to install an answer phone.
A letter had been received about a 2-3 Year old Children's Development Assessment. The letter invited patients/relatives to call if they had any questions but did not provide a telephone number. They found a number but could not get through.	All staff have been reminded of the importance of thoroughly checking letters to ensure they are complete. Senior Manager to discuss with NHS Property services the telephone cover/answerphone facility at the Clinic.
Concerns about the change of Consultants without prior knowledge. The patient had felt comfortable with their Consultant but found out that they had moved to another base. Another Consultant was allocated but they also left after a short period. Their current	Improve communication to ensure patients are kept informed if there is a Trust re-structure resulting in change of their Psychiatrist or Care worker.

Consultant is retiring soon. The complainant is concerned as they need stability to recover and because of the Consultant changes has to repeat themselves.	
An inpatient had missed three of their arranged podiatry appointments because staff were unaware of the appointments as they do not open the patient's mail, and instead this is usually done with the support of their visitors.	Team to review arrangements for opening post and ensure a robust process is in place to support service users.

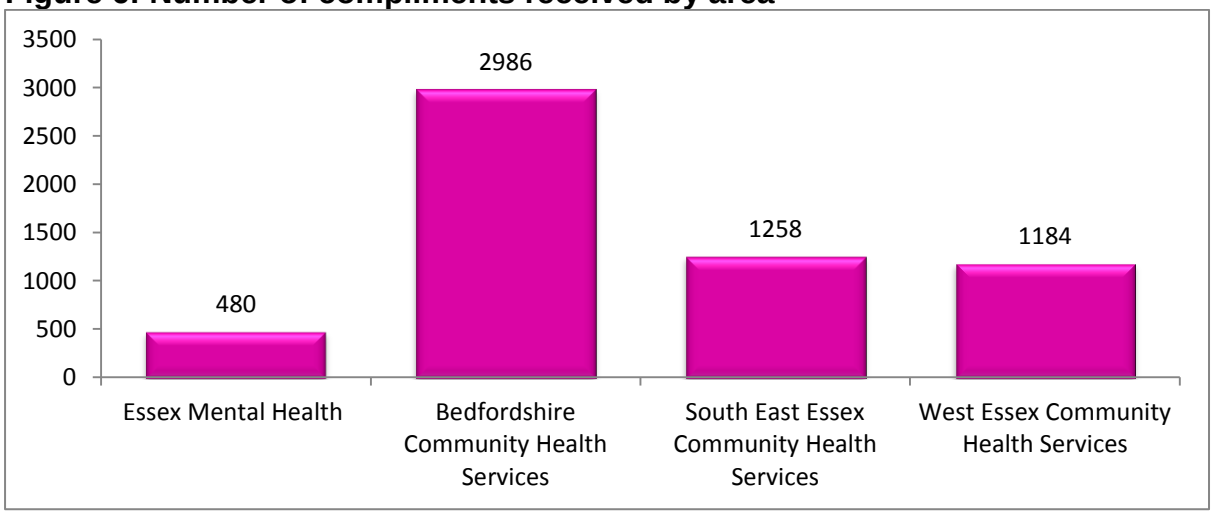
15.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 5908 compliments were received during 2016/17. This equates to 480 for Mental Health Services and 5428 for the Community Health Services. All areas have experienced a decrease in the number of compliments received this year. However some of the services previously under SEPT, who received compliments in previous years, have transferred to other Trusts. In addition to the letters and cards of appreciation sent directly to services or the Complaints Department, compliments are also recorded from the Friends and Family Test forms and hand hygiene audit forms (community).

All staff are encouraged to share any compliments they receive either individually or as teams. It is important that positive feedback is shared with staff and services across the Trust. A selection of compliments is published regularly in the internal newsletters. The table and figures below show the compliments received by the Trust and last year's figures for comparison. A selection of the compliments received is shown in appendix 1 of this report.

Table 9: Compliments Received Area	2016/17	2015/16
Mental Health - Essex	480	496
Community - Bedfordshire	2986	3525
Community – South East	1258	1547
Community - West Essex	1184	1310

Figure 6: Number of compliments received by area



16.0 COMPLAINANTS' STORIES

Each of the complainants whose stories are shown below, has given consent to include them anonymously in this report.

Story 1

Complaint:
Mrs G is part of a military family who move quite frequently. Concerns had been raised by Clinicians in Scotland about her son's speech. A relative who is a teacher of many years standing and specialises in Special Educational Needs (SEN) had also voiced concerns about the child's speech. Mrs G attended a drop in centre and an issue with speech was noted, she was told to return when her son was older. Mrs G went to another drop in centre in Biggleswade just after her son started school. Mrs G was told her son would be referred as a delay could now be identified with his speech. Her son was assessed again by a Speech Therapist two months later and she was told her son would be put on a list to commence one to one therapy.

As she did not hear anything for some time she attempted to speak to the Speech Therapist, the answer machine told her to leave a message, which she did on at least 5 occasions. She also emailed twice and became very frustrated that she was not getting a response. After calling again a while later she was informed that the staff member was on maternity leave. No one had told Mrs G the situation and she had not received an out of office reply to her email and therefore thought it had been ignored. Mrs G spoke with another staff member and asked what was being done about her son's referral. The staff member suggested arranging an assessment at Biggleswade. This would be her son's third assessment. Mrs G stated that the issue was now having an impact on her son's education and literacy schooling. Mrs G found the delays unacceptable.

Trust Response:
The Trust apologised to Mrs G that she had tried to contact the service several times and was not informed that the therapist was on maternity leave until the last call. Mrs G should have been advised of this on her first contact to the service after the therapist went on leave. Apologies were also given that Mrs G and her son had had to wait longer than we would have expected. She was advised that the reason for this was due to the high number of staff vacancies in the team and not being able to source suitable temporary registered therapists as an interim solution.

Outcome:
Assurances were given that the trust has taken steps to prevent occurrences such as this in the future; the receptionists will be made fully aware of staff departures, and the service will ensure staff use out of office messages on their emails and voicemail. The service also undertook a robust recruitment drive, which they anticipated would improve the staffing situation in the near future.

During the complaint investigation Mrs G met with the team lead and received an appointment where plan were made for future sessions for her son's therapy.
The complaint was upheld.

Story 2

Complaint:
Mr X said he was unhappy with the Improving Access to Psychological Therapies (IAPT) Service. He self-referred in and was signed up for phone therapy but 3 month son had heard nothing.

Mr X had signed up for 'Beating the Blues' but as he had not heard from the service, he contacted them and received an apology but was told they were busy and he would be contacted in due course. Mr X left five messages for the Service and each time was told he would be called back. Eventually he was left a message on his phone with a mobile number to contact. He was unable to get through on this number, despite trying numerous times and at different times of the day and there was no voicemail facility.

Mr X received a letter from the Service which upset him as he felt the content of the letter contained factually incorrect dates and tried to make it look like his fault. He was told he had not kept an appointment at Basildon Hospital, however he stated that he had not been advised of the appointment and also that he is house bound which he advised the staff were aware of, hence his request for telephone therapy. Mr X said the staff member he spoke to had been very helpful but he was unable to gain a great deal of information on record and what was on record was inaccurate.

Trust Response:
The Trust was sorry that Mr X had felt unsupported by the Service and experienced a delay in being contacted by a therapist following initial telephone assessment and having to contact the service several times. The Trust was also very sorry that a letter received by Mr X from Therapy For You was unhelpful in tone, contained inaccuracies regarding his contacts with the service and that this had led to an increase in his anxiety, causing unnecessary further distress. The investigation had identified areas for improvement and training which would be implemented straight away. The response letter thanked Mr X for noticing that the Therapy For You service had been omitted from the national IAPT website and for bringing this to the Trust's attention.

Outcome:
It was noted that although the therapist concerned is no longer with the Service, the communication issues raised would be discussed at the next team meeting to remind staff of service procedures and processes. Specific refresher training sessions for the administration team would also be organised. The Communications Department would also address the omission of the Therapy for You Service from the national IAPT website.

The complaint was upheld.

Story 3

Complaint:
Miss Y raised concerns about Mrs J's inpatient stay on Plane Ward, St Margaret's Hospital. Mrs J was admitted following two strokes and a mild heart attack, she was unable to walk without assistance and needed regular 24 hour care. Because of Mrs

J's age (94) and condition it was agreed that any matter concerning her would be agreed with Miss Y prior to any action being taken. Miss Y was concerned that the nurses did not assist her to the toilet at night. Mrs J was receiving 'Oromorph' but Miss Y was not given an adequate explanation of why. Miss Y received a call from the discharge team advising Mrs J was being transferred to the care home that day at 10 am. Miss Y was not aware of this and had not been advised of the intended move that day. She had been previously informed that Mrs J was not well enough to be transferred. The care home were concerned about Mrs J's presentation and called the doctor to assess her. The doctor suggested an immediate transfer to PAH in Harlow. On arrival, Mrs J was given emergency treatment as she was in a very poorly suffering pneumonia, kidney infection, severe dehydration and sepsis. An ultrasound later that week found a mass in her epigastric region and a cystic mass over one kidney. Mrs J sadly passed away 4 days later. Miss Y asks how the Plane Ward Doctors could have passed Mrs J as medically fit enough to be transferred to the care home and believes they failed to diagnose her physical problems.

Trust Response:
A Meeting was held with Miss Y, Medical Clinical Director, Acting Consultant, Hospital Matron and Head of Integrated Community Services to discuss Miss Y's concerns. Apologies were given at the meeting for the failure of the staff on Plane Ward in relation to the care given to Mrs J and with regard to the poor communication regarding her discharge and medication.

Outcome:
Miss Y's experience was discussed at a reflective meeting with all staff who work on Plane Ward, facilitated by the Matrons. With immediate effect, no patients will be discharged on a Monday morning to ensure that there is a full medical review prior to all patient discharges.
The Matron overviewed the ward rotas ensuring that agency staff always work with a permanent member of staff. All nursing staff on duty during weekends will ensure that any concerns regarding a patient are escalated to a Senior Nurse on site and the Sunday Doctor. If a patient is prescribed an Opiate such as Oromorph, this must be communication to the family with rationale or prescription. The Matron wrote to Miss Y confirming that all of the actions had been implemented.
The complaint was partially upheld.

16.0 AIMS FOR 2017/2018

During the next year we will:

- Configure Datix to highlight any complaints relating to a patient's death as these now need to go through detailed case note review under national mortality review guidance.

- Continue to improve identification of lessons learned from complaints.

- Continue to explore ways in which to improve the complaints feedback form response rate.

- Continue to promote meetings with complainants at an early stage of investigations, as a beneficial method of sensitively addressing concerns. Direct discussions and explanations can lead to increased understanding and resolution.

- To undertake all necessary work on refining and building on the complaints handling process for the new Trust.

17.0 CONCLUSION

SEPT aims at all times to provide the best possible service to patients but when we do not meet their expectations, we strive to put things right by:

- acknowledging our mistakes and apologising where appropriate;
- providing honest evidence-based explanations;
- learning from the feedback;
- ensuring we have handled our patient's complaint in a positive, sensitive and timely manner.

The complaints handling process provides an opportunity to improve our customer service and make our patient's and relatives/carer's experience better in the future. We have embedded a 'duty of candour' across the Trust thereby ensuring transparency and honesty in our complaint investigations and responses.

All complaint timescales and progress of open complaints are closely monitored. Each Executive Director receives a weekly situation report for their services. In addition, the report is discussed at the Executive Team meeting fortnightly, so that any areas of concern can be highlighted, and appropriate and immediate action taken.

Although this is a positive report, with fewer complaints and many compliments received this year, we recognise from complaints received, that we do 'get it wrong' sometimes and need to continue to make improvements. We need to ensure staff communicate more effectively with relatives and carers about discharge arrangements, and care plans; we need to ensure that when there is a genuine need to cancel appointments at short notice, a robust system is in place to ensure patients are advised whenever possible of the cancellation before they embark on a needless journey. We need to ensure all of our communication, whether verbal or written, is clear and understood by our patients.

We will continue to build on the well-developed complaints systems already in place and seek continuous improvement in complaints handling and identifying learning so that we can put in measures to prevent the same thing happening to others.

Pam Madison
Head of Complaints and
Customer Service
Improvement.

Nigel Leonard
Executive Director of Corporate Governance

May 2017

Appendix 1

Selection of compliments received 2016/17

Good afternoon lifesaver! Thank you for coming into my life when I was lonely and shattered. Thank you for supporting me when I was abandoned by the world and society. Thank you for understanding me when no one was even willing to listen. Thank you for accepting me just for what I am and just the way I am. You supported me when I needed it the most and I will never forget this. I am eternally grateful for your commitment to my recovery and for enabling my future.	I cannot praise the staff highly enough, I feel they all went over and above the call of duty. I have spent 9 months in the hospital and feel blessed to have had such compassionate people looking after me. I feel as though I have been reborn and I am so grateful to you all. I also have to mention the receptionist who has been nothing but helpful to me and my family. I sincerely thank each and everyone one of you from the bottom of my heart.
To all members of the team who regularly visited our home. We would like to say a big thank you. We found you were always encouraging which gave us a positive approach, you treated us with dignity and we both looked forward to our daily visits. Thank you everyone for the part you have played in my husband's recovery.	Thank you for the excellent care and compassion you are showing dad. It is a large weight off our shoulders to know that he is in a safe place. You are all so kind, considerate and well trained to treat his needs. He has only been in your care for six weeks and already we can see how much more settled he is. We could not ask for more patience and understanding than what you have all shown him and so generously given.
I was finding it all overwhelming but then I met a staff member who was kind, understanding and easy to talk to. Nothing is ever too much trouble for any of the patients she cares for. She makes me feel safe. She listens to me and makes time to hear me out.	To all the wonderful district nurses who looked after my mum until the end. I will always remember the kindness you showed to my mum and I know she thought the world of you all. Be proud of the good work you do for those people in need, for you are all special.
Just to say a huge thank you for everything you do you have no idea how grateful people are and what high esteem you are held in. I would like you to keep this card when times are grim as I'm sure they are at times, and remember you are making a difference and the world is a better place because of you. Thank you.	To the amazing District Nurses who helped my Aunt and I keep my lovely mum at home to the end. We cannot thank you enough - there simply aren't the words. You who not only looked after mum but who looked after us as well. We simply could not have given mum the peaceful death she had without you, and we will remember your tender care forever. Thank you.

I wish to say a massive thank you to all the staff on the ward for the caring, loving & respectful way in which mum was cared for. It was sad that she died, but comforting to know that she did so in a place that cared for her, not just as a patient, but as an individual. I spent 4 lovely last hours with Mum & I held her hand & had plenty of time to say goodbye. Even after she passed, they didn't rush us. Mum had a very dignified death because of the staff & I thank them for that. What fabulous, caring staff you have.	Thank you to the staff at the unit for the care my mum received whilst an in-patient. I was amazed at the professionalism, compassion and patience shown by the staff towards not only my mum but other patients as well. You are a credit to the NHS. I am most grateful to all the members of staff that helped my Mum. Nothing was too much trouble; they always came when they said they would; they communicated with my mum and my family very well. Overall, they never failed to be professional and they are a credit to this wonderful team.
Words cannot express how truly thankful I am for all your care, time and patience that you have shown not only myself but my husband. We really have appreciated your advice help and finally the operation to put my foot back to normal again. The treatment I have received from yourself is so far above what we expect to normally receive on NHS and if there was a prize given you would be a winner.	The care I received was first class, nothing was too much trouble. The food was lovely, all home cooked. The whole place was kept immaculately clean. What would I have done without that facility? There were people in there who had had falls, strokes etc, everyone was encouraged to be as independent as possible. Many thanks to all the staff for their unfailing care.
After the recent sad death of my husband, I felt I had to write to express my thanks to you all. What wonderful people you are - the help and support you gave to us and our family was just outstanding. Nothing was too much trouble for any of you, from arranging practical matters, to listening to our doubts and fears; I just cannot thank you all enough. Keep up your brilliant work and thank you all again from the bottom of my heart.'	I have been most fortunate to receive the care, support and encouragement from the START team for 4 weeks. The therapeutic assessments, setting of goals, provision of equipment and advice has proved to be of a very high standard. I also admired the diligence and swiftness of response demonstrating that your service should be rightly regarded as a centre of excellence. I cannot thank you enough. My daughter and son in law would also like to send their grateful thanks."
Thank you to all the staff for caring for us in your special way for 3 years and 3 months it was a joy to meet you all and even in my husband's last hours you were there for him and me which was comforting and supportive. Thank you so much, and thank you for the lovely flowers.	The staff were extremely helpful and I found the session therapeutic, eased the stress levels on my mind and aided my condition. I cannot wait for the next session I thoroughly enjoyed myself. I learnt a lot of new skills and coping techniques too, like breathing exercises. Thank you so much."