



Essex Partnership University  
NHS Foundation Trust

# Complaints Annual Report

2021-2022



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## **1.0 PURPOSE**

This annual complaint report has been produced by the Head of Complaints and is based on the PALS requests, Complaints, and Compliments that have been received during the year from April 2021 to March 2022. The PALS and Complaints data has then been through a process of thematic analysis in order to find common themes and trends to which EPUT should focus their effort on improving for the year ahead. This report should be used to provide an overview of the past year and fundamentally feed into quality improvement and learning for 2022-2023.

## **2.0 SUMMARY**

Essex Partnership University NHS Foundation Trust (EPUT) provide services to 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk. We are a large employer in the East of England with more than 9000 staff working across over 200 sites. We also provide services in people's home and community settings.

The PALS and Complaints service is managed by a central team within the People and Culture Directorate and offers an extremely powerful mechanism for the Trust to receive feedback on our services and of the experiences of them for those that use them. However, it is vitally important to note that 'PALS and Complaints', whilst managed by a central team, are all of our responsibility to ensure that we provide a prompt and effective response that meets the needs of the person that has taken the time to provide feedback on their experiences of our services where reasonable. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in his absence, a designated signatory. Although, as we move into the year ahead we want to make PALS and Complaints much more about driving quality improvement across our services, with demonstrable outcomes, and feeding into our learning culture.

The Covid-19 pandemic continued to affect EPUT last year, increasing pressure on our services as we prioritised the need to keep our patients and staff safe whilst continuing to deliver essential services within our community and inpatient settings. At times, this decision has affected our ability to respond effectively to complaints, which saddens us immensely. We had to adapt our complaints process, balancing the need to reduce the pressure on our clinical teams with continuing to provide a process to address and respond to concerns raised by our service users.

We have focussed on locally resolving complaints where we feel this would provide a quicker and more effective resolution for the person raising the complaint, and we introduced a “Rapid Response” process for responding without a formal investigation, where complaints were not complex, and the person agreed.

At the start of 2022 we launched a coproduction project to review and redesign our end-to-end complaints process. The Patient Experience team is supporting this project, and the coproduction collaborative is made up of complainants, complaint investigators, and the complaints team. We believe that this will enable us to have PALS and Complaints driving improvement and feeding into our learning culture, whilst giving the most effective outcomes for those that use our services.

### **Key highlights from the Annual Report:**

- The volume of complaints received has increased by 37% on the previous year’s figure to 376.
- 92% of complaints were closed within agreed timescales, however only 59 (20%) were resolved within the 40-working day target.
- 4 complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) which is 1.3% of the total number of complaints closed (295).
- The top category for Formal Complaints, Rapid Responses and MP complaints was “Lack of Community Support”, and this was also the 4<sup>th</sup> highest PALS enquiry category.
- The number of compliments the Trust received outweighed the number of complaints about the service by over 5:1

*N.B It should be noted that the figures in this report from point 3, (and those reported in the Trust’s Quality Account) do not correspond with the figures sent 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 while the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints received within this same period.*

### 3.0 FORMAL COMPLAINTS

#### Number of Complaints Received

Total Complaints carried forward from 2020/21	Total Complaints Received 2021/22	Total Complaints Closed 2021/22	Total Complaints carried forward to 2022/23
59	376	295	140

376 formal complaints were received by the Trust during 2021/2022, which is an increase of 37% on the previous year's figure (275). Important to note that we do not see this increase as a negative, but as a positive because it means that more of those that use our services are taking time to provide feedback and find opportunities to improve.

Having said that, the increase in formal complaints is in part because of the following:

- The launch of the Covid vaccination programme in January 2021, which saw EPUT administer half a million vaccinations to people across Essex and Suffolk within the first 6 months (27 complaints received)
- The previous year's number of complaints was lower because of a temporary process we adopted in quarter 1 (Apr-Jun 2020). Because of the Covid-19 pandemic and the pressures that were facing our service, where right, concerns raised during this time were dealt with by PALS or responded to directly by the service, rather than being formally investigated. There were 39 complaints dealt with under this process, which would otherwise have been logged as formal complaints.
- The activity and publicity around the public enquiry has encouraged increased feedback on EPUT's services.

#### Received by Area

Mental Health Services saw the most significant increases, with an overall increase of 29% compared with last year.

Area	2020/21	2021/22	% change
Mid and South Essex STP	116	162	+ 40%
North East Essex STP	42	63	+ 50%
West Essex STP	22	38	+ 73%
Medical – Trust-wide	50	48	- 4%
Specialist – Trust-wide	20	12	- 40%
<b>Total Mental Health</b>	<b>250</b>	<b>323</b>	<b>+ 29%</b>
Community - South East Essex	16	11	- 31%
Community - West Essex	9	15	+ 67%
<b>Total Community Health</b>	<b>25</b>	<b>26</b>	<b>+ 4%</b>
Covid Vaccination Programme	-	27	
<b>Grand Total Received</b>	<b>275</b>	<b>376</b>	<b>+ 37%</b>

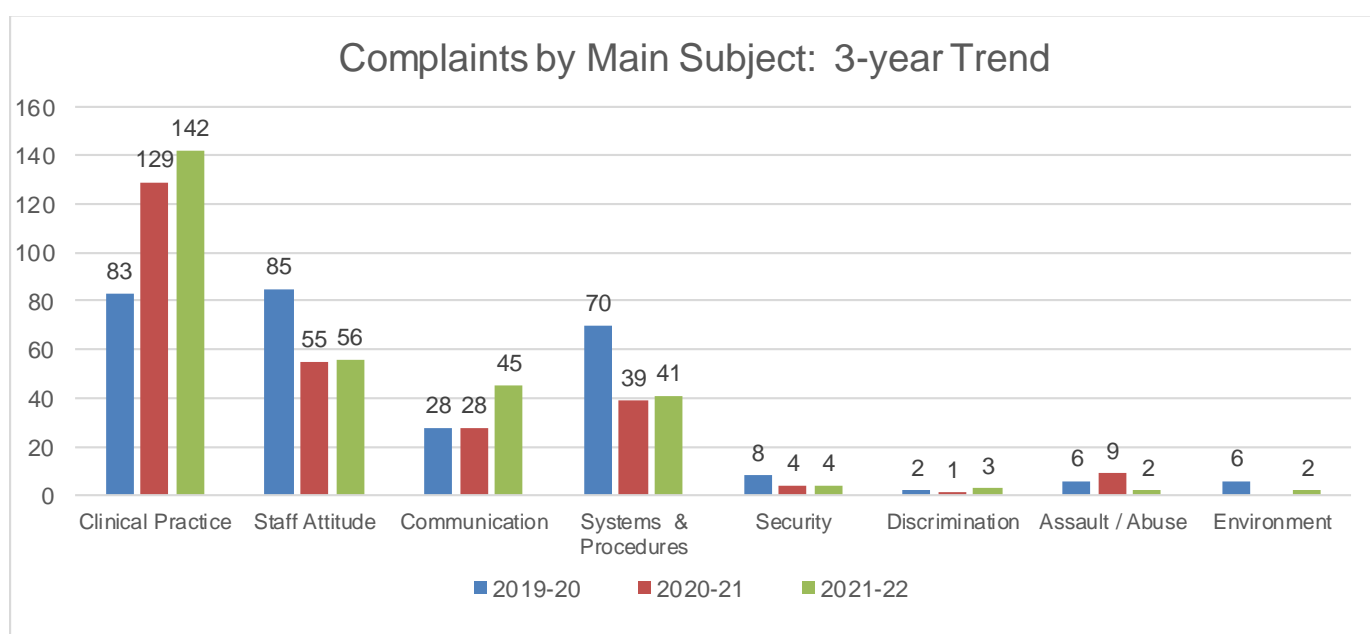
## Complaint Outcomes

295 formal complaint investigations were completed and responses sent during the year, with two thirds being either upheld or partially upheld.

	Not Upheld	Upheld	Partially Upheld	Not Investigated	Withdrawn	Resolved locally	Grand Total
Mid and South Essex MH	35	13	61		3		112
North East Essex MH	15	9	27			1	52
West Essex MH	7	3	18		3		31
Medical	15	5	18	2	1		41
Specialist Services	6	1	5				12
South East Essex Community Health Services	1	3	8				12
West Essex Community Health Services	1	3	7				11
Covid Vaccination Programme	8	6	9		1		24
<b>Grand Total</b>	<b>88</b>	<b>43</b>	<b>153</b>	<b>2</b>	<b>8</b>	<b>1</b>	<b>295</b>
<b>% of Total</b>	<b>30%</b>	<b>15%</b>	<b>52%</b>	<b>1%</b>	<b>3%</b>	<b>0.3%</b>	<b>100%</b>

## Complaint Themes

Closed complaints are sorted according to their category or 'theme'. The chart below shows the 3-year trend of these complaint categories.



Below are some of the trends we have seen when comparing the data across the last 3 years:

- Clinical Practice stays the highest category for the second consecutive year.
- Staff Attitude complaints are still at the same level as last year, having dropped from being the highest category in 2019-20.
- Complaints relating to Communication have increased by 61% compared to the previous 2 years.

### Top ten Sub-categories of Complaint Themes

Under each Main category, there are a number of “sub-categories”. The top ten sub-categories make up nearly half (48%) of the total closed complaints in 2021-21 (142 out of 295), as follows:

Main Subject	Sub-category	Number closed	% of Total Complaints
Clinical Practice	Lack of Community Support	30	10.2%
Clinical Practice	Unhappy with Treatment	14	4.7%
Clinical Practice	Assessment & Treatment	14	4.7%
Clinical Practice	Covid Vaccination	14	4.7%
Clinical Practice	Medication	13	4.4%
Staff Attitude	Unhelpful	13	4.4%
Communication	Communication breakdown with relatives	12	4.1%
Staff Attitude	Inappropriate behaviour	12	4.1%
Communication	Communication breakdown with patient	10	3.4%
Staff Attitude	Rude on telephone	10	3.4%
<b>Total</b>		<b>142</b>	<b>48%</b>

### Re-opened Complaints

Complainants are encouraged to let us know if they still are dissatisfied after receiving our response, so that we can try to resolve any outstanding concerns.

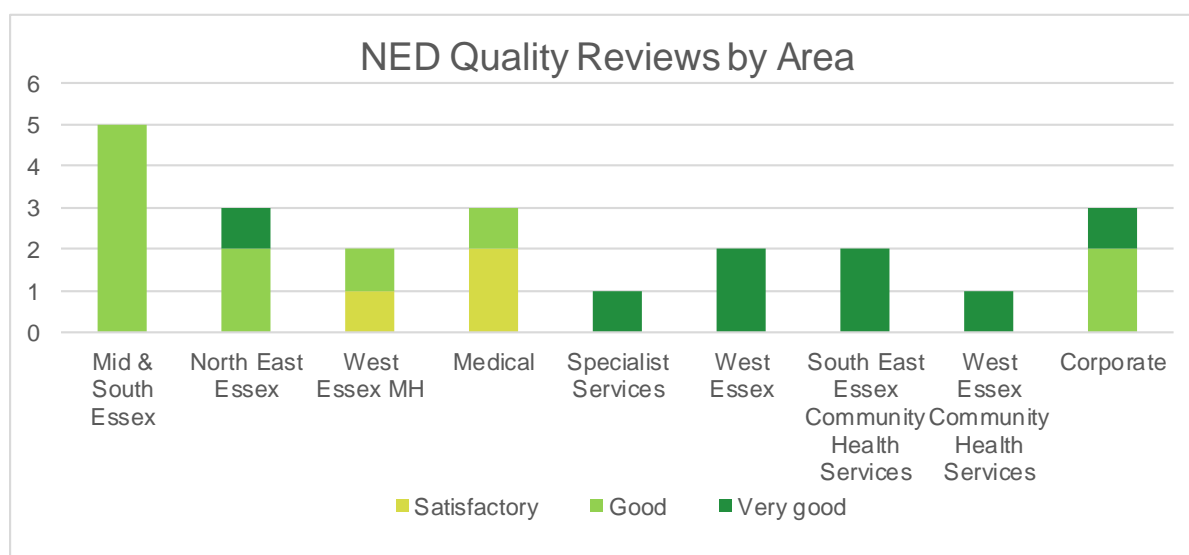
Of the 295 complaints closed in 2021/22, a total of 23 (8%) were reopened as the complainant was dissatisfied with the Trust’s first response.

The reasons given for requesting the complaint to be re-opened are detailed below.

Reason for Re-opened Complaint	Number of complaints
Disagrees with response	8
Unhappy with outcome	6
New questions/ information	5
Complaint not fully addressed	2
Dissatisfied with investigation	2
<b>Grand Total</b>	<b>23</b>

### Non-Executive Director Complaints Quality Reviews

The Trust's Non-Executive Directors (NEDs) provide an important and valuable part of the complaints process by undertaking independent quality reviews of randomly selected complaints that are marked as complete. This adds an extra level of assurance in the Trust's complaints performance. During 2021/22, 23 reviews were completed for Q1-Q3, and a further 7 complaints closed during Q4 are due for NED review. This totals 30 NED complaint reviews, which is 10% of the all closed complaints in the whole year (295). Of the complaint responses that were reviewed by the NED's, 8 were considered 'Very Good' (36%); 11 'good' (50%); and 3 were 'Satisfactory' (14%). None were considered as below 'Satisfactory'.





#### 4.0 COMPLAINTS RAPID RESPONSE APPROACH

In 2021, we introduced a Rapid Response approach to Complaints that met specific criteria and not complicated. We recognise a complicated complaint as one spanning multiple teams, services, and often multiple organisations.

#### Rapid Response Complaints By Area

118 complaints received by the Trust in 2021/22 were logged as “Rapid Responses”. As at year-end, 87 were resolved and 31 carried forward into 2022/23.

Rapid Responses	Received	Resolved
Mid and South Essex STP	66	51
North East Essex STP	19	16
West Essex STP	3	2
Medical – Trust-wide	8	5
Specialist – Trust-wide	5	2
<b>Total Mental Health</b>	<b>101</b>	<b>76</b>
Community - South East Essex	9	4
Community - West Essex	1	1
<b>Total Community Health</b>	<b>10</b>	<b>5</b>
Covid Vaccination Programme	7	6
<b>Grand Total Received</b>	<b>118</b>	<b>87</b>

#### Rapid Response Complaint Themes

Half of all the 87 Rapid Response complaints were logged within the top 6 sub-categories. The top sub-category was “Lack of Community Support”, which was the same as the top sub-category for Formal Complaints.

Main Subject	Sub-category	Number closed	% of Total Complaints
Clinical Practice	Lack of Community Support	12	14%
Clinical Practice	Unhappy with Treatment	10	11%
Clinical Practice	Covid Vaccination	6	7%
Clinical Practice	Medication	6	7%
Clinical Practice	Poor care on ward	5	6%
Communication	Communication breakdown with patient	5	6%
		<b>44</b>	<b>50%</b>

## 5.0 MP COMPLAINTS

The Trust received 84 enquiries from MPs on behalf of their constituents, which was one more than the previous year, and the top three topics of the MP enquiries were as follows:

- Lack of Community Support (19)
- Covid Vaccination concerns (12)
- Access to Treatment (7)

## 6.0 LOCALLY RESOLVED COMPLAINTS

Wherever possible, all EPUT staff are encouraged to try to resolve complaints locally when they are first raised and at the earliest opportunity. The details of any complaints resolved in this way should then be passed to the Complaints Team, so that any actions taken and lessons learned can be recorded, along with the details of the complaint. This not always the case and we are aware that many issues are resolved locally without ever being recorded. On one hand this is good, as it prevents unnecessary escalation but on the other it also inhibits us from capturing and sharing lessons learned, so the team are looking at how we can make it easier for teams to self-log this activity.

There was a total of 35 locally resolved complaints recorded for 2021/22, by the following areas:

Area	Resolved Locally
Mid and South Essex MH	14
North East Essex MH	4
West Essex MH	1
Specialist Services	6
South East Essex Community Health Services	6
West Essex Community Health Services	3
Corporate Services	1
<b>Grand Total</b>	<b>35</b>

## **7.0 COMPLAINTS RESPONSE TIMES**

### **Formal Complaints Response Times**

The Trust aims to investigate and respond to formal complaints within 40 working days and where this is not achievable; we endeavour to keep the complainant updated with our investigation and planned response date. The increased operational pressure on our services caused by Covid-19 has continued to impact on our responsiveness to complaints, as investigations were delayed where we have had to prioritise immediate clinical duties.

Out of 295 complaints closed in 2021/22:

- 59 (20%) were resolved within 40 working days.
- The average time taken to respond was 75.5 working days (compared with a pre-pandemic average of 44 working days in 2019-20)
- 92% of complaints were closed within the agreed extended timescale

Based on the information above, we recognise that this means that 80% of formal complaints have not met our internal target of 40 days, with 4 out of 5 complaints delayed and timescales extended. Although we are meeting our national targets, we know that this is not good enough. This is why we have initiated a coproduction project to review and redesign the complaints process end to end, with the key objectives of improving response times and making the complaints process more user-friendly.

### **Rapid Response Complaints Response Times**

As highlighted above, the Rapid Response process is for less complex complaints that usually just involve one area. If the complainant wishes, these types of complaint can be responded to directly by the relevant Service, without a formal investigation. We aim to resolve these complaints within 15 working days.

Out of the 87 Rapid Response complaints closed in 2021/22:

- 47 (54%) were resolved within 15 working days.
- The average time taken to respond was 23 working days

Based on the information above, generally, this approach has been effective and we will now work with teams to ensure they can meet the 15 working days target for responding.

## 8.0 PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

If a complainant is dissatisfied with the response they receive and feels that all avenues to resolve it with the Trust have been exhausted, they can ask the Parliamentary & Health Services Ombudsman (PHSO) to conduct an independent review of their complaint.

### PHSO Referrals

During 2021/22 a total of 4 complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO). All 4 cases are awaiting assessment by the PHSO, who will advise the Trust if they are going to proceed with an investigation. There were no new complaint cases accepted for investigation by the PHSO this year.

### PHSO Investigations

A total of 4 PHSO investigations were closed during 2021/22, and all were partly upheld by the PHSO. A brief summary of these is supplied below.

**ESSEX MENTAL HEALTH (NORTH EAST), Ardleigh Ward**  
**Date of PHSO Final Report: May-21**  
**Final Decision: Partly Upheld**

The PHSO found a failing in the Trust not following its plans to update the complainant on his wife's progress before discharging her, and when she was in seclusion and did not give her anti-ligature clothing. The Trust's Seclusion Policy was amended in July 2019 to include the use of anti-ligature clothing together with rationales and guidance for the use of this.

**ESSEX MENTAL HEALTH (MID & SOUTH), Medical (Thorpe Ward)**  
**Date of PHSO Final Report: May-21**  
**Final Decision: Partly Upheld**

Complaint about the standard of care received following patient's discharge from hospital in Sep-18. PHSO partly upheld the complaint, and found there was a shortfall in ensuring that CPA processes and the patient's aftercare plan under Section 117 were properly assessed and recorded. The Trust now has a robust system in place to ensure that we capture and monitor those patients needing CPA and Section 117 aftercare, especially after a period of admission to hospital.

**ESSEX MENTAL HEALTH (MID & SOUTH), Inpatient - Basildon Mental Health Unit**  
**Date of PHSO Final Report: Aug-21**  
**Final Decision: Partly Upheld**

Patient died 3 days after being discharged, due to a heart condition. The complainant feels that the Trust missed opportunities to notice her son's deterioration and should have taken proper action. The PHSO found the care and treatment the Trust provided to the patient to be right and in line with guidance. However, failings were found in that the Trust did not update the patient's clinical record in line with its records management policy. The Trust were recommended to apologize and provide evidence explaining the steps it will take to ensure staff complete patient records in line with its records management policy.

**ESSEX MENTAL HEALTH (MID & SOUTH), Inpatient – Hadleigh Unit (South)**  
**Date of PHSO Final Report: Oct-21**  
**Final Decision: Partly Upheld**

The PHSO found that the Trust failed to refer patient for trauma therapy in 2016, and it did not take sufficient action to appropriately collaborate with her to set out her preferences for how her care should be delivered. Additionally, the Trust failed to do all the things it should have done after complainant was involved in fights with another patient. Awareness of the links and overlaps between EUPD and trauma have been raised with our clinical staff and they are able to provide Personality Disorder-specific treatments and trauma treatments. We are now more focused on negotiated goals for treatment and service user choice. £500 paid in compensation and letter of apology sent to patient.

## 9.0 LEARNING FROM COMPLAINTS

The Trust has a strong and developing culture of learning, and recognises Complaints as a valuable source of feedback from which we can learn and improve our services. As part of the complaints investigation process, we always consider the actions needed to prevent errors from reoccurring, or to minimize the risk. Where learning is identified as part of a complaint investigation, the Complaints Team follow up with the relevant service to provide assurance that improvement actions have been taken forward and embedded into everyday practice. Although we know this can (and will) be strengthened during the year ahead as we work closely with the Quality Improvement and Learning Culture teams.

Lessons found are presented monthly at the Learning Oversight Committee to help Trust-wide dissemination. The Commissioners of EPUT's services also receive a report on the lessons learned from complaints for their specific geographical areas. Some examples of lessons learned from complaints over the past year are supplied below.

### Examples of learning from Formal Complaints

Below are just some of the examples of learning from Formal complaints although there are many more, which are available on request.

Service: Dementia Memory Service, The King's Wood Centre	
Brief Complaint Description	Brief Summary of Learning
<p>Patient's daughter complained about a letter received about her mother's diagnosis of dementia. The letter had many inaccuracies, and the diagnosis based on this inaccurate information.</p> <p>There is no reference in the letter to any comparison of a recent MRI to one done in 2017.</p> <p>The patient's daughter would like this investigated as she disputes the diagnosis.</p>	<p>Outcome: <b>UPHELD</b></p> <p>Case explored through MDT forum and discussion in supervisions/ team meetings with memory assessment nurses.</p> <p>Now embedded into the process to check for any earlier scans at the point of screening referral and completing MRI safety questionnaire with patient/ family.</p>

<b>Service: Community Nursing (District Nurses), St Margaret's Hospital</b>	
<b>Brief Complaint Description</b>	<b>Brief Summary of Learning</b>
<p>Daughter of patient complained to West Essex CCG, she was advised the district nurses would attend her father's home to teach her how to support him and to manage his catheter, but they did not arrive.</p> <p>Daughter was trying to get support from physiotherapy, ulcer clinic and the memory clinic, this was not carried out either.</p>	<p>Outcome: <b>PARTIALLY UPHELD</b></p> <p>During conversations with the complainant she suggested the creation of a leaflet in regards to catheter care, aimed at families and carers.</p> <p>Community services do have patient information leaflets for catheter care and all community nursing teams will be reminded to share with patients/family and carers.</p> <p>We are working with Princess Alexandra Hospital to improve the discharge journey for patients, family and carers with a focus on supplying correct information of what ongoing care and referrals have been made.</p>

<b>Service: Community Mental Health Team (CMHT), Coombewood, Rayleigh</b>	
<b>Brief Complaint Description</b>	<b>Brief Summary of Learning</b>
<p>Father of patient is complaining about the way his son has been treated by the community mental health team at Coombewood, his appointments keep getting cancelled last minute, they do not call him to advise and letters are sent out after the appointment date</p>	<p>Outcome: <b>UPHELD</b></p> <p>More text messages will be send to patients when the notice period for an outpatient cancellation is 7 days or less.</p>

<b>Service: Acute Treatment Ward, The Crystal Centre</b>	
<b>Brief Complaint Description</b>	<b>Brief Summary of Learning</b>
<p>Patient's "Care and Recovery Plan" was lost. Patient has raised several concerns about other patients on the ward as she feels she is not listened to and the issues raised have not been looked into or taken seriously.</p>	<p>Outcome: <b>PARTIALLY UPHELD</b></p> <p>Ward Manager has now introduced a new system where the "My Care and Recovery Plan" documents can <i>only</i> be handed over to ward administrators to ensure that they are uploaded on our system straightaway to prevent a similar situation from happening again.</p>

## Examples of learning from Local Resolutions (informal complaints)

Below are just some of the examples of learning from locally resolved informal complaints although there are many more, which are available on request.

<b>Service: Therapy For You (SEE), Pride House, Landon</b>	
<b>Brief Complaint Description</b>	<b>Brief Summary of Learning</b>
Patient wanted to know why a discharge letter was sent to his GP when he missed his appointment on 27/11/20 at 3.30 when he called in explaining he had not heard his phone that day. Patient has since been booked a follow up appointment but did not receive an apology for the letter being sent.	The therapist to leave a message for the client should an appointment be missed. The therapist to wait 24 hours for contact from clients engaged in treatment missing an appointment before sending discharge letters.

<b>Service: District Nursing Team, Rochford Hospital</b>	
<b>Brief Complaint Description</b>	<b>Brief Summary of Learning</b>
Patient's daughter rang to complain her father's insulin was missed at 7am.	Following a discussion with the District Nurse, he admitted this was due to human error and he had missed the task from the day service for an early call. Matron made a follow-up phone call to the patient's daughter to explain and apologise. The night service will now check all tasks when they come on duty

<b>Service: Specialist Community Mental Health Team, Herrick House</b>	
<b>Brief Complaint Description</b>	<b>Brief Summary of Learning</b>
Patient's former care co-ordinator did not inform patient of her leaving date. Care Co told patient that she would be leaving at some point in January 2021, but patient was never informed of the date. One day on calling the service, patient was told that her care co had already left.	The importance of effective communication with patients, particularly where there are changes to the professionals involved in their care and treatment.  Discussed at team meeting as case study.



## **10.0 TRIANGULATION OF COMPLAINTS, PSI'S AND CLAIMS**

### **Complaints linked to Patient Safety Incidents**

All complaints are logged onto the Datix reporting system and are cross-referenced with the incidents, to highlight any incidents that are connected to the complaint. Where there are complaints that are also being investigated as a Patient Safety Incident (PSI), the Complaint Investigator works collaboratively with the Patient Safety Team, ensuring that all elements of the complaint are investigated without conflict or duplication. The complainant is kept informed throughout this process.

During 2021/22, there were 24 complaints that were linked to an incident recorded on Datix. Of these, 7 were linked to a Patient Safety Incident.

A detailed root-cause analysis is undertaken for a PSI, and the final report is used to inform the complaint response. The joint learning from the serious incident and the complaint is discussed at the Learning Oversight Steering Committee.



### **Legal Claims related to complaints**

There was 1 claim received by the Trust that related to a formal complaint this year, which is an alleged Clinical Negligence claim. A total of 2 claims were closed, with joint damages of £145,415.00.






## **11.0 FEEDBACK ON COMPLAINTS PROCESS**

We send a survey link with our complaint responses, to gauge satisfaction with our complaints process. In 2021/22 we received 34 responses to the survey, and the results are shown below. This data has been used as part of the co-productive redesign project to understand our current position.






### 1. Did the investigator make contact with you at the start of the process?

Answer Choices		Response Percent	Response Total
1	Yes		63.64% 21
2	No		36.36% 12
		answered	33
		skipped	1






### 2. Were all aspects of your complaint addressed?

Answer Choices		Response Percent	Response Total
1	Very satisfied		12.12% 4
2	Fairly satisfied		15.15% 5
3	Neither satisfied nor dissatisfied		3.03% 1
4	Fairly dissatisfied		18.18% 6
5	Very dissatisfied		51.52% 17
		answered	33
		skipped	1






### 3. Were the reasons for the outcome of your complaint fully explained?

Answer Choices		Response Percent	Response Total
1	Very satisfied		9.38% 3
2	Fairly satisfied		15.63% 5
3	Neither satisfied nor dissatisfied		6.25% 2
4	Fairly dissatisfied		25.00% 8
5	Very dissatisfied		43.75% 14
		answered	32
		skipped	2

#### 4. Was your complaint dealt with in a reasonable timescale?

Answer Choices			Response Percent	Response Total
1	Very satisfied		6.06%	2
2	Fairly satisfied		12.12%	4
3	Neither satisfied nor dissatisfied		9.09%	3
4	Fairly dissatisfied		15.15%	5
5	Very dissatisfied		57.58%	19
			answered	33
			skipped	1

#### 5. Do you believe the complaints process is fair and would you have confidence to use it again if necessary?

Answer Choices			Response Percent	Response Total
1	Very satisfied		12.12%	4
2	Fairly satisfied		12.12%	4
3	Neither satisfied nor dissatisfied		6.06%	2
4	Fairly dissatisfied		9.09%	3
5	Very dissatisfied		60.61%	20
			answered	33
			skipped	1

There are some themes to the survey, which we hope to resolve as part of the co-productive redesign project:

- Not meeting the expected outcome
- Perceived to be unfair therefore resulting in a lack of confidence
- General dissatisfaction with response times

## **12.0 COMPLAINANTS' STORIES**

### **Story 1**

Following the development and administration of the Covid-19 vaccination, EPUT received many enquiries relating to the recording of the vaccinations, through the helpline, Patient Advice and Liaison Service (PALS) and the Complaints Department.

In this instance, the complainant had received their first vaccination; however, when trying to rearrange the second vaccination this was not appearing as it should, leaving the complainant unable to rebook through the National Booking System. The complainant felt that there was insufficient information available to guide people to the correct department to enable their concerns to be heard and rectified which caused stress. EPUT recognised this as a source of frustration.

In response to the complaint, immediate contact was made by a representative of the service who explained the reason for the first vaccination not being added was due to the system being in its infancy and there was a backlog of errors. New staff were in place to rectify the issues. It was subsequently confirmed that their vaccination had been recorded; however, it would take a period of time to show correctly.

The complainant highlighted the inconvenience and frustration of having to contact several departments and they advised that there was a lack of communication despite promises of return calls. The Trust acknowledged that this was not acceptable; we require telephone calls to be returned as promised and it was disappointing that this was not facilitated. This was raised with the manager of the service for them to address directly with staff where expectations were reiterated. The complainant was advised that their feedback had allowed improvements to be made to the service to enhance the experience of future patients.

## Story 2

The service user contacted their usual team expressing concern and panic about medication for addiction that was not available to collect from the pharmacy. The service users usual prescribers were absent from work on the day of the telephone call and instead they were given an alternative telephone number to call. They explained that on contacting the team they were given a date for a further appointment which would leave them without medication for 8 days leading to withdrawal and vulnerability.

Having been made aware of the situation, the prescribers acted at once to rectify the issue and arranged for provision of medication. A full investigation was completed to find what went wrong and how the risks of reoccurrence could be mitigated.

It was found that although staff did follow the correct procedure, the level of anxiety of the service user was not recognised. It would have been more proper for a return telephone call to have been made in this circumstance to gain further details and allow the service user to be heard. It was also agreed that this particular case should have been managed differently and going forwards clinicians will be approached for advice in the event that the service user makes contact.

It is important that service users feel supported and listened to, especially in instances where there is added concern about potential withdrawal due to lack of medication. Staff have been requested where possible, to call clients back, instead of asking them to call another number. This will ensure that the frustration and stress of the service user is minimised.

The staff involved were invited to attend a customer service training session. This session was also made available to all staff so that service users are placed at the centre of their care and that our staff are supported/empowered to respond on an individual needs led basis showing care and compassion.

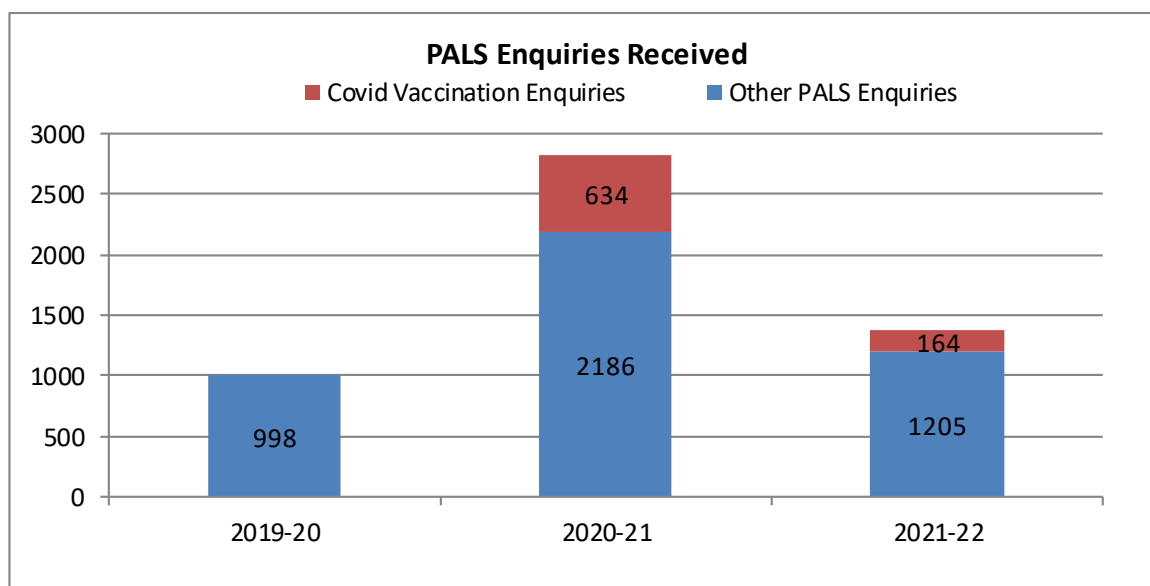
### 13.0 PATIENT ADVICE AND LIAISON SERVICE (PALS)

The PALS service sits alongside the Complaints Team, and serves as a first point of contact for enquiries and concerns, which are received and responded to by telephone and email. Our PALS service supplies confidential advice, support and information about all aspects of EPUT services, primarily to patients, their families and their carers.

PALS logged 1369 enquiries during the year 2021-22, which was a decrease of 51% from the previous year's total of 2820.

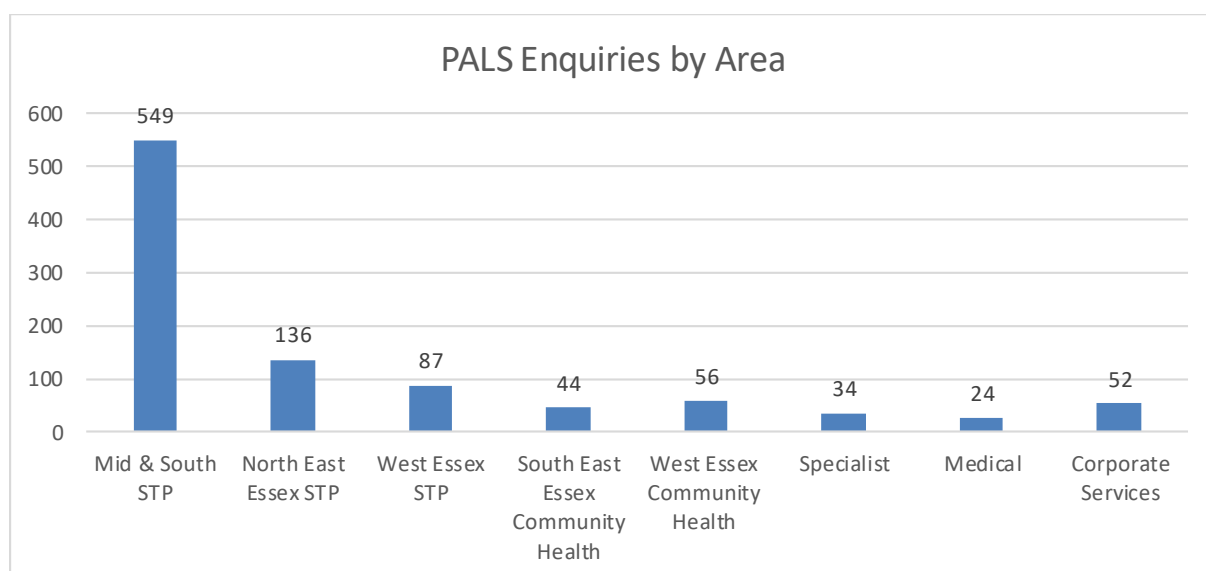
This reflects the spike in the volume of enquiries we saw in 2020-21 when the Covid Vaccination programme was first launched, and the impact the pandemic had on other services that prompted enquiries.

We continue to receive enquiries related to Covid vaccinations, however the volume of these has considerably decreased.



The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal complaints investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 17 (1.2%) were passed to the Complaints Team as formal complaints and 232 (17%) were signposted to other organisations.

The below chart shows where the PALS enquiry was referred to a specific area.



The top 10 themes for PALS enquiries in 2021/22 made up 58% of the total enquiries for the whole year (1369). These are shown in the table below as a percentage of the total number of enquiries received.

Top 10 PALS Categories	Number of Enquiries	% of Total Enquiries
Clinical Practice: Covid Vaccination	158	12%
Request for Information	158	12%
Communication breakdown with patient	117	9%
Lack of Community Support	87	6%
Unhappy with Treatment	73	5%
Communication breakdown with relatives	52	4%
Referrals / Appointments	48	4%
Access to treatment	35	3%
Medication	32	2%
Care	29	2%
<b>TOTAL</b>	<b>789</b>	<b>58%</b>

## 14.0 COMPLIMENTS

1,936 compliments were logged by the Trust in 2021/22. Services directly received 1479 compliments and 457 compliments were taken from comments made within the Friends and Family Test (FFT) feedback.

The breakdown of this was:

- 1487 for Mental Health Services
- 397 for Community Health Services
- 52 compliments were received for Corporate Services – mainly relating to the Covid Vaccination Programme.

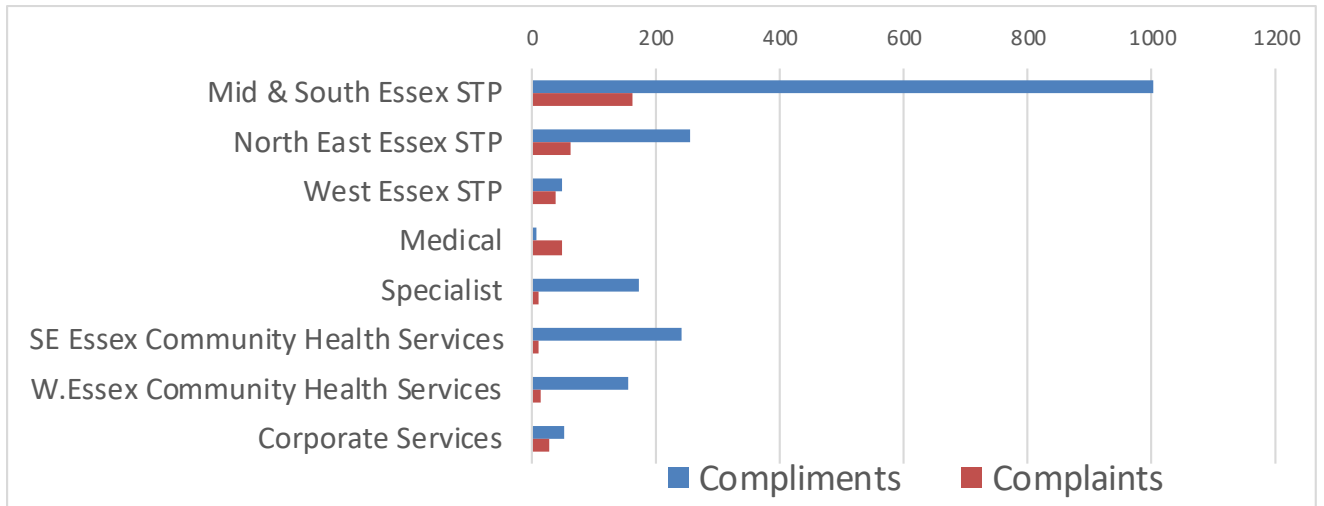
Compared to last year's total figure of 1,000, the Trust has seen a significant increase in compliments received. The low figure the previous year was a direct result of the FFT being paused during the pandemic.

A selection of compliments are published regularly in our internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas.

Area	Compliments Received
Mid & South Essex STP	1004
North East Essex STP	256
West Essex STP	47
Medical Specialist	7
	173
<b>Total Mental Health</b>	<b>1487</b>
South East Essex Community Health Services	241
West Essex Community Health Services	156
<b>Total Community Health</b>	<b>397</b>
Corporate Services	52
<b>Total</b>	<b>1936</b>



There were over 5 times as many compliments received than complaints during the year, and this comparison is illustrated on the chart below by Area.



*N.B. It is not always possible to work out when a compliment relates to the Medical Directorate, therefore these may be captured under other areas.*

## 15.0 UPDATE ON PRIORITIES FOR 2021/22

Please find an update on the priorities set in the annual report for 2021/22 in the table below.

Priorities set for 2021/22	Status	Action Taken
Update our Complaints training to align with the PHSO Complaint Standards, which is a model Complaints Handling Procedure and guidance, due to be published this year	Complete	<b>This is incorporated within MDP Training</b>
Build on the work already in place to learn lessons from Complaints, ensuring that our new complaints process is robust in supporting the identification, proper sharing and embedding of lessons across the Trust.	Complete	<p><b>We have improved our process in the following ways:</b></p> <ul style="list-style-type: none"> <li>• <b>We have a robust process for following up monthly on lessons found through complaints to ensure that actions are completed, and lessons are embedded.</b></li> <li>• <b>We have included lessons found from locally resolved complaints into our monthly reporting so that these are now shared Trust-wide</b></li> </ul>
Supply support to the operational areas and improve adherence to agreed timescales by centralising the process of monitoring impending due dates and keeping complainants updated within the Complaints Team	Complete	<b>This process is now managed within the Complaints Team, and it has improved adherence to agreed timescales and kept us on track with updating people about their complaint.</b>
Develop a process to provide information of complaints and compliments made about specific staff members for inclusion in reviews and annual appraisal	Outstanding	<b>Carried forward.</b>
Explore ways to promote and publicise compliments received to the Trust.	Ongoing	<b>We are continuing to publicise compliments widely and have plans to work with Communications this year to promote positive stories from across all aspects of the Trust internally and externally.</b>

## **16.0 PRIORITIES FOR 2022/23**

- Redesign our Complaints Process to improve satisfaction with outcomes and reduce unnecessary delays and extensions.
- Improve the way that Complaints and PALS drives learning and quality improvement across EPUT.
- Enhance PALS accessibility by creating a network of volunteers onsite within our services to provide support and advice, and proactively seek feedback from our service users.
- Improving the self-logging facilities for staff and service to log informal complaints and compliments
- Develop a process to provide information about complaints and compliments made about specific staff members for inclusion in reviews and annual appraisal
- Explore ways to promote and publicise compliments received to the Trust.

### **Report produced by:**

Claire Lawrence  
Head of Complaints and PALS

### **On behalf of:**

Sean Leahy  
Executive Director of People and Culture  
May 2022