Essex Partnership University
NHS Foundation Trust

Complaints Annual Report

2019-2020

Chief Executive's Foreword

I am pleased to present Essex Partnership University NHS Foundation Trust's (EPUT) Complaints and Compliments Annual Report for 2019/20 for the period 1 April 2019 to 31 March 2020.

Like other Trusts, we have had to make unprecedented adjustments to our normal complaints processes due to the Coronavirus pandemic. The Trust was operating on a major incident footing at year end, and as our clinicians, who would normally investigate complaints, focused all their time on delivering patient care, a decision was made to pass any new complaints to the Service Team Lead/Manager to address through appropriate channels and take learning from the concerns. A shorter response than normal was provided. All complaints that were already under investigation at the time, either received a response or were extended with the complainant.

During this year, we also changed our reporting criteria to fit with the Trusts Sustainability and Transformation Partnership areas (STP's). It is therefore not feasible to provide direct comparisons to the previous year's complaints and compliments within this report.

This year has seen changes to the way the Parliamentary and Health Service Ombudsman (PHSO), has reviewed complaints by introducing an "assessment stage" in which they make a decision as to whether to investigate further or not. EPUT has logged all complaints when placed at the assessment stage, thus increasing the overall number of PHSO contacts for the Trust This is reported in full in section 5 of the report.

I have always believed that all complaints should be taken seriously and the complainant deserves open and honest answers to their concerns. I recognise the value of timely, good quality and honest complaint responses, especially for the complainant, but also for the Trust to understand where improvements need to be made, and for us to learn from our patient's and relative's experiences.

We have a rolling complaint training programme for new and existing complaints investigators to provide them with the tools to undertake robust complaint investigations and highlight any lessons learned from the complaint, whilst also looking for continuous improvement in the services we deliver.

Our Non-Executive Directors continue to provide an important service by undertaking 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. Our chair, Professor Sheila Salmon, views and signs off these reviews. The process is currently being assessed to focus more on the learning from complaints

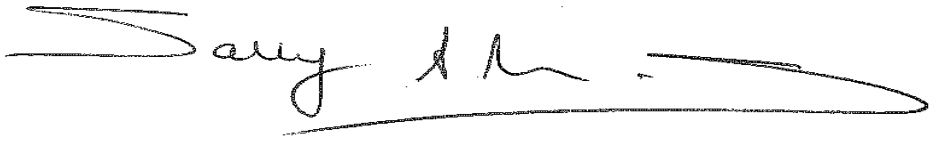
EPUT publishes all learning from complaints and recommendations from the PHSO investigations on our website so they are available for anyone to view. In addition, learning and any identified themes or trends are discussed at the Learning Oversight Committee as well as the Patient and Carer Experience Sub Committee, for dissemination to Service Leads to share with their staff to promote Trust -wide awareness and best practice.

We monitor the feedback posted on NHS website, and make every attempt to respond individually. However, most comments are left anonymously; we therefore encourage the writer to contact our Patient Advice and Liaison Service (PALS) or Complaints team to enable us to investigate their concerns and respond accordingly.

The staff and I are very pleased that people have also taken the time to leave some very heartfelt compliments for care they have received from a particular service or individual. These, as well as the concerns raised, are all communicated to the Executive Team and Service Directors.

The Trust continues to receive a far greater number of compliments than concerns, with a ratio of more than 14 compliments per complaint. A selection of these are displayed on the Trust website throughout our service pages so everyone can share the sincere and often moving sentiments of appreciation expressed to staff.

Finally, I would like to use this opportunity to reiterate how much the staff appreciate positive feedback, especially during these challenging times, and to thank everyone who takes the time to send in compliments about our staff and services. As Chief Executive, it is heartening, to hear when we have got it right as well as hearing when, perhaps, this has not been the case. Constructive feedback helps us to improve our services for our patients, carers and relatives.



Sally Morris
Chief Executive

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST'S (EPUT) COMPLAINTS ANNUAL REPORT 2018/2019

1.0 INTRODUCTION

EPUT provides community health, mental health and learning disability services for a population of approximately 1.3 million people throughout Bedfordshire, Essex, Suffolk and Luton. We employ over 5,000 members of staff across 200 sites.

The Trust is required to compile an annual complaints report which is subsequently approved by the Board of Directors and displayed on the Trust website. We are also required to provide evidence to NHS Improvement that the document was approved by the Board and was submitted as part of the annual report process.

The complaints function is overseen and monitored by the People and Culture 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, the Deputy Chief Executive or an Executive Director designated signatory.

We try to reflect the Trust values of; Open, Empowering and Compassionate in our response letters to complainants.

As in previous years the number of compliments the Trust has received far outweighs the number of complaints about the services the Trust provides, with a ratio of more than 14 compliments per complaint. A small selection of compliments is shown on page 22, 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.

The Trust has achieved 100% for complaints acknowledged within 3 working days in line with Department of Health complaints regulations. Although the Trust has internal targets for complaint responses, the appointed complaint investigator will agree a timescale for completion with the complainant. This will be a realistic timescale based on certain factors, such as the complexity of the complaint. This year the Trust has achieved 93.2% for complaints closed within agreed timescales with the complainant. This is an improvement on last year's figure of 80.1% and just below the Trust's target figure of 95%.

EPUT 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 19 complaints referred to the PHSO, which is 6.48% of the total number of complaints received. As the PHSO decided not to investigate 10 of these cases, just over 3% of the total number of complaints received this year, were investigated further by the ombudsman.

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 this same period.

2.0 NUMBER OF FORMAL COMPLAINTS RECEIVED

A total of 293 formal complaints were received by the Trust during 2019/2020. The total figure represents 8 more complaints than the previous year. A total of 8 complaints were subsequently withdrawn, 10 complaints were not investigated as consent was withheld. Although a formal response cannot be provided to the complainant where consent is withheld by the patient, the complaint is still seen by the Service Director and taken forward as necessary; in some cases a generic response can be provided.

At the end of the financial year, 49 complaints remained under investigation and have been carried forward to 2020/21. Due to the Coronavirus pandemic, these complaints may take longer to respond to than normal. All complainants have been contacted to advise them that complaint investigators are focussing on their clinical duties at this time, and all have agreed to an extended response date.

Table1: Number of Complaints Received by Trust area

Area	Number of Complaints Handled
	2019/20
Mid and South Essex STP	**114**
North East Essex STP	**61**
West Essex STP	**15**
Medical – Trust-wide	**54**
Specialist – Trust-wide	**17**
Total Mental Health	**261**
Community – South East Essex	**21**
Community - West Essex	**11**
Total Community	**32**
Total Complaints Received	**293**
Total Complaints Closed	**288**
Total carried forward to 2020/21	**49**

Last year Mental Health Services received 259 complaints, and Community Health Services 26. Therefore this year has seen an increase of 2 for Mental Health Services and an increase of 6 for Community Health Services. The following figures illustrate the number of complaints received by Directorate during 2019/20.

Figure 1: Numbers of Complaints received by Directorate

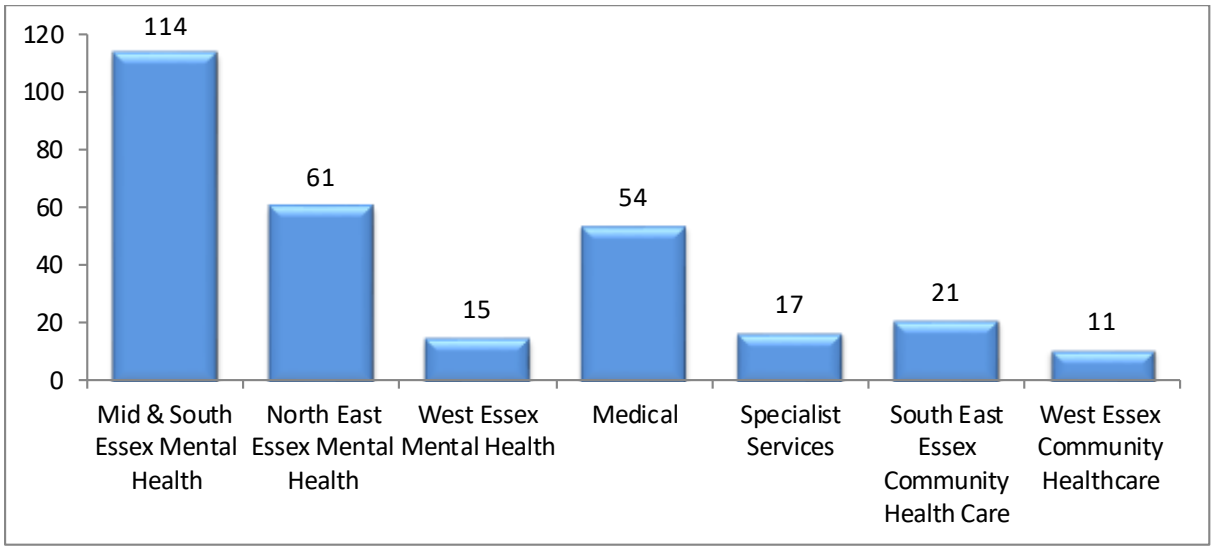
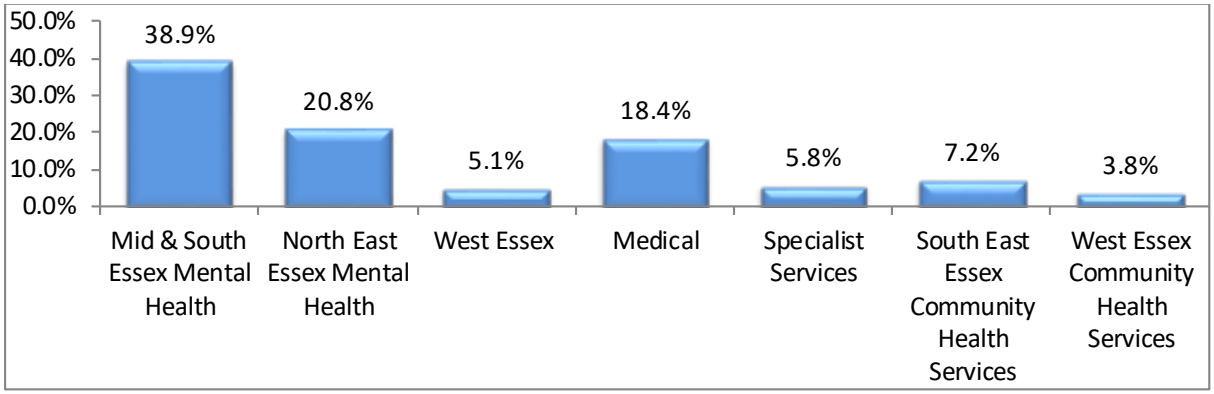


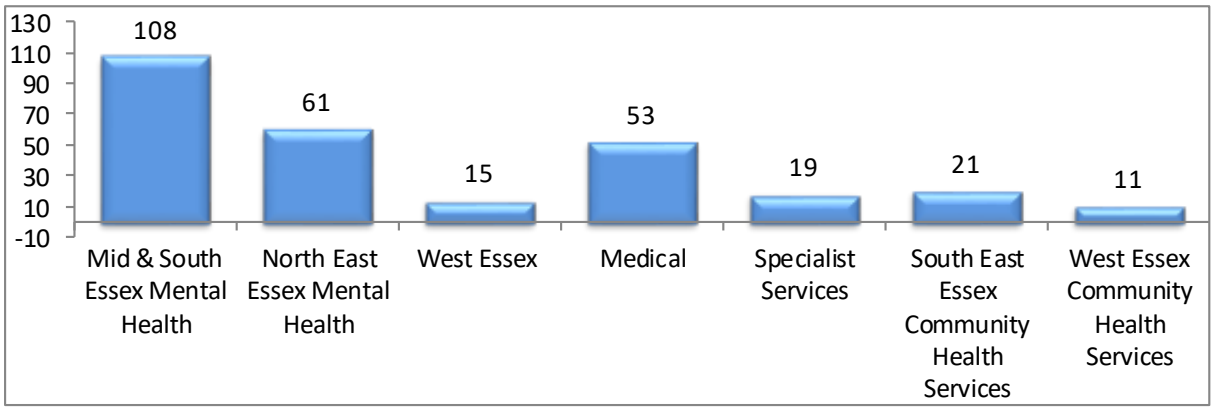
Figure 2: Percentage of Complaints received by Directorate



3.0 NUMBER OF COMPLAINTS CLOSED AND OUTCOMES

A total of 288 complaints were closed during the year.

Figure 3: Numbers of Complaints closed by Directorate



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.

Table 2: Complaints Outcome by Service/Locality

Area	Number of Complaints Upheld	Number of Complaints Partially Upheld	Not Upheld	Not investigated	Withdrawn	Total
Mid and South Mental Health	**4**	**74**	**24**	**3**	**3**	**108**
North East Essex Mental Health	**5**	**39**	**11**	**4**	**2**	**61**
West Essex Mental Health	**2**	**11**	**1**	**0**	**1**	**15**
Medical	**6**	**25**	**19**	**2**	**1**	**53**
Specialist Services	**0**	**13**	**6**	**0**	**0**	**19**
South East Essex Community Health Services	**2**	**9**	**8**	**1**	**1**	**21**
West Essex Community Health Services	**5**	**6**	**0**	**0**	**0**	**11**
Total	**24**	**177**	**69**	**10**	**8**	**288**

4.0 NUMBER OF COMPAINTS RESOLVED WITHIN AGREED TIMESCALE

The Trust responded to 93.2% of complaints within agreed timescales with the complainant. The average time taken to respond to complaints is 46 days for Mental Health Services and 30 days for Community Health Services.

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 conduct an independent of their complaint as the final stage in the complaints process.

During 2019/20 a total of 19 complaints were referred to the PHSO. This represents an increase of 10 from the previous year; however, it should be noted that the PHSO has changed the way in which they review cases, introducing an “Assessment Stage” which is used to decide whether to investigate further or not. Of the 19 referrals, the PHSO decided not to investigate 10 of the cases as they felt the Trust had responded fully. No complaints were fully upheld; 2 of the 19 referrals were partially upheld which is less than 1% of the total number of complaints received.

At the time of this report, there are 9 active cases with the PHSO. This figure includes 2 cases from the previous year and 1 from this year where final reports are

awaited. Table 3 below, illustrates the areas of the Trust from which the complaints were referred to the PHSO this financial year, and their current status.

Table 3: Complaints referred to the Ombudsman

Area	Number of Complaints Referred	Status
Mental Health – Mid and South Essex	11	4 cases were assessed and not investigated. 1 draft report received, awaiting final report. 2 cases under investigation. 2 cases at assessment stage 2 cases partially upheld with financial redress of £500 & £100 respectively.
Mental Health – North East Essex	4	2 cases were assessed and not investigated 1 case is under investigation 1 case is at assessment stage
West Essex	2	2 cases were assessed and not investigated
Specialist Services	1	Assessed and not investigated
South East Essex Community Health Services	1	Assessed and not investigated

5.1 PHSO referrals received in 2018/19 and concluded in 2019/20

A total of 5 cases from 2018/19 remained open at the start of this year. 3 have now been closed. Draft reports have been received for the remaining 2; the Trust is awaiting final reports for these. In addition, one case referred from the previous North Essex Trust prior to the formation of EPUT was upheld with recommendations.

Table 4: Complaints final reports and findings

Area	Number of Complaints Number of cases	Findings and Recommendations
Mental Health – South Essex	1	1 draft report received awaiting final report.
Mental Health – North Essex	3 cases	1 partially upheld Recommendations: Trust to carry out a root cause analysis to identify what led to the failing in the assessment (full assessment not undertaken), and produce an action plan to address the issues.

		1 case not upheld 1 draft report received awaiting final report.
Community Health Services – West Essex	1	1 case upheld Recommendations: As a pressure ulcer risk assessment and full skin assessment was not carried out by the Community Nurse, there was further deterioration which may have been prevented. The impact caused to the patient was significant enough to warrant a financial remedy of £1,000.

6.0 NATURE OF COMPLAINTS RECEIVED

The top three themes for complaints for both mental health and community during 2019/2020 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 as well as the Compliance, Serious Incident and Safeguarding Teams as appropriate. In addition, a quarterly thematic report is presented at the Patient and Carer Experience Sub Committee, chaired by the Chief Executive, who will discuss areas of concern to action with her Director Team.

Of the 288 closed complaints, 137 were recorded within the top three themes. Of these, 103 were either upheld or partially upheld.

Table 5: Top Three Complaint Themes 2019/20

Top Three Complaint Themes	Total number of Complaints closed (2019 / 2020)	Upheld	Partially Upheld	Total of Upheld/ partially Upheld
Unhappy with treatment	24	1	17	18
Staff Attitude	85	5	56	61
Communication	28	6	18	24
Total	137	12	91	103

6 Staff Attitude complaints were withdrawn and 2 were not investigated due to consent issues. Both the categories Unhappy with Treatment and Communication had 1 complaint each not investigated, also due to consent being withheld. A total of 24 complaints were not upheld.

Table 6: For comparison Top Three Complaint Themes 2018/19

Top Three Complaint Themes	Total number of Complaints closed (2017 / 2018)	Upheld	Partially Upheld	Total of Upheld/ partially Upheld
Unhappy with treatment	45	2	31	33
Staff Attitude	52	6	34	40
Communication	39	5	28	33
Total	136	13	93	106

Each category had 3 withdrawals (9.) A total of 21 were not upheld.

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 is therefore limited in providing solutions to these complaints.

7.0 NUMBER OF RE-OPENED COMPLAINTS

During 2019/20, of the 288 complaints closed, a total of 28 complaints were reopened as the complainant was dissatisfied with the Trust's response to their complaint. This equates to 9.7% of complainants being unhappy with the response received to their complaint.

The most common cause for complainant dissatisfaction is disagreement with the content of the Trust's response; this applied to 9 of the reopened cases; 7 further complainants cited that their response letter had contained factually incorrect information; 7 sought clarification around some of the answers provided in the response letter to their concerns and 5 said not all of their concerns had been addressed.

8.0 NUMBER OF COMPLAINTS REVIEWED BY NON-EXECUTIVE DIRECTORS

The Non-Executive Directors, (NEDs) provide an important and valuable part of the complaints process by undertaking independent reviews of randomly selected completed complaints. They provide an extra level of assurance in monitoring the Trust's complaints performance.

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 NEDs have any concerns they raise this with the appropriate Service Director; this happened in 2 cases. Once reviews have been completed, they are signed off by the Trust's Chair and circulated to Directors and the appropriate investigator to view the comments.

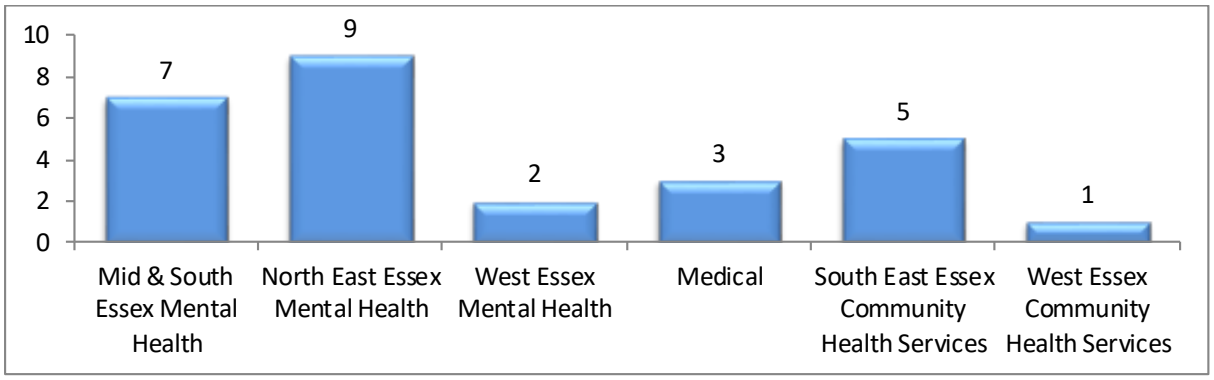
During 2019/20, a total of 27 reviews were completed. This represents 9.3% of the total number of closed complaints and a decrease of 50% compared to last year.

A number of mitigating factors have led to the decrease in the number of reviews; the recent Coronavirus Pandemic has meant that the NEDS have been unable to attend Headquarters to undertake complaint reviews. In addition, the NEDs decided

to reflect on and discuss, the current review process, to enable them to concentrate more on the impact the complaint had had on the complainant, and the learning for the Trust, as well as agreeing on what percentage of complaints should be reviewed.

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

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



9.0 Patient Advice and Liaison Service (PALS)

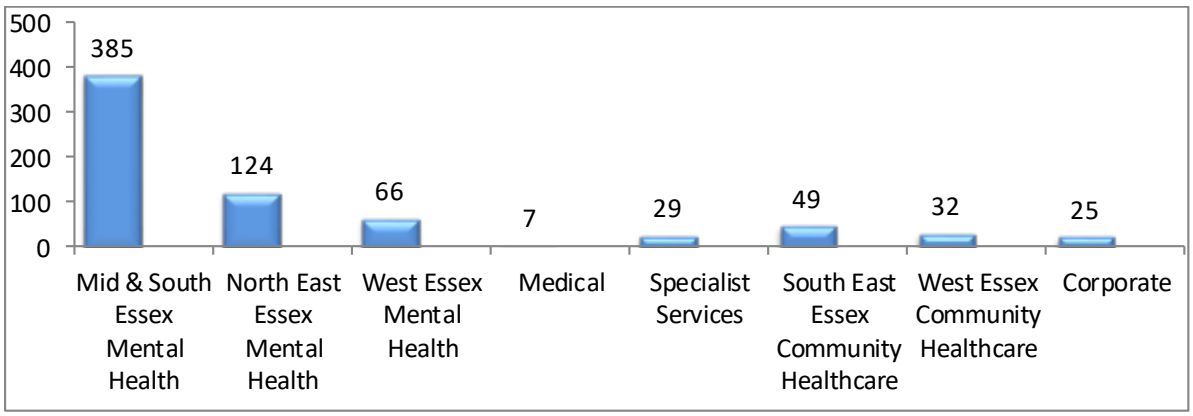
This year PALS have been integrated into the Complaints Team; this has enabled PALS to become both a triage service for complaints and reduce the number of duplications between the teams.

PALS provide confidential advice, support and information on health-related matters, to patients, their families and their carers.

PALS received 998 enquiries during the year. This is an increase of 138 from last year's total of 860. Trends are identified in point 11 of this report.

The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 32 complaints were passed to Complaints (3.3%). A total of 281 contacts were signposted to other organisations, (28.16%) as EPUT did not provide the services the enquiry related to. Figure 4 shows which areas the enquiries were received for.

Figure 4: PALS Enquiries



10.0 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 provides the opportunity to listen and discuss the concern and can prevent an escalation to a formal complaint. Local resolutions are recorded on a "Local Resolution Monitoring form" by staff and recorded electronically by the Complaints Team.

There was a total of 124 locally resolved concerns recorded for the year. In addition, the Trust received 46 enquiries from MPs, (13 less than the previous year), on behalf of their constituents; these are also recorded as local resolutions. The table below illustrates the areas from which they were received.

Figure 5: Local resolution by Trust area (excludes MP queries):

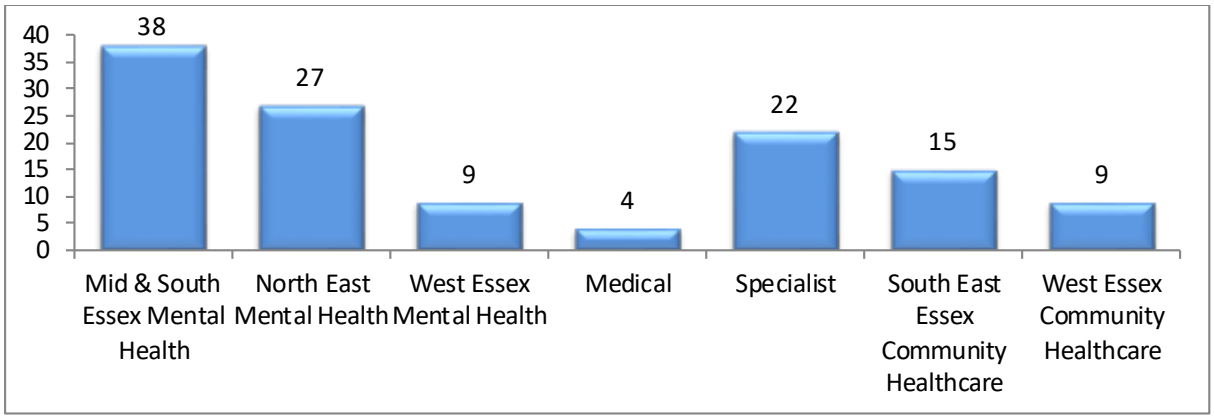
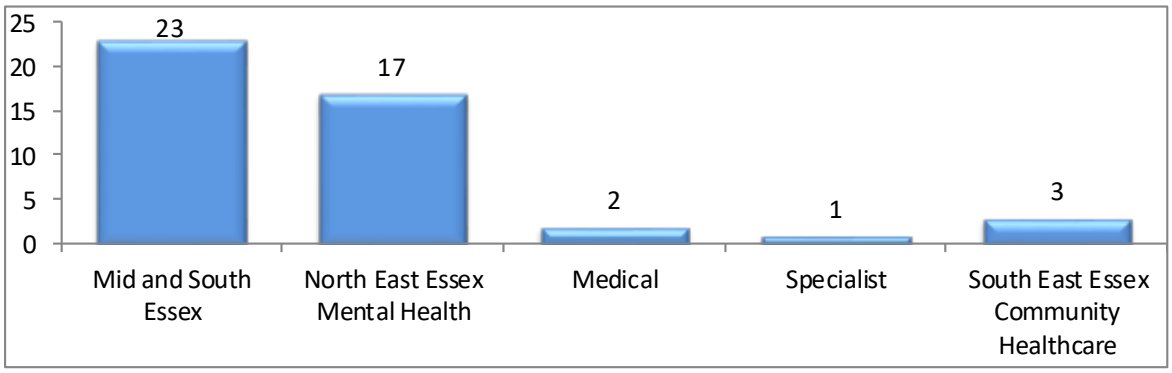


Figure 6: MP enquiries on behalf of Constituents



11.0 THEMES AND TRENDS

It has been reported in the Thematic Report throughout the year that staff attitude complaints have experienced a steady rise, up 33 on last year's figure. Where the staff member/s are named in the complaint, it is recorded on the complaints Datix system to enable close monitoring of potential multiple incidences. Where this has happened and the investigation has shown foundation, the complaint can be referred to the Trust's internal Human Resources procedures.

The themes/trends from complaints and PALS enquiries have been the same. Identified trends are:

- Communication to relatives/carers regarding patient discharge arrangements and inconsistent information from different staff members..
- Patient's belongings becoming lost on in-patient wards or during transfer to other wards.
- Length of wait for referrals and appointments.

Complaints are monitored continuously for any emerging trends or themes and reported to the Executive team for immediate action if required.

As a result of the number of complaints regarding patient's missing property, safes have been installed in ward areas. Since the completion of this work, the number of complaints regarding missing property has fallen significantly.

Trends and themes are highlighted in a quarterly Thematic Report and discussed at the Patient and Carer Experience Sub-Committee as well as at the Learning Oversight Committee.

12.0 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 2019/20, 27 such cases were recorded. Of these, 4 complaints were linked to serious incidents. No complaints were linked to a critical incident.

A detailed root-cause analysis is undertaken for both serious incidents and critical incidents 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.

A total of 6 complaints became the subject of claims this year; which is double the number from the previous year. A total of 3 claims, carried over from the previous year were closed, 2 of which had no damages awarded and 1 had damages awarded of £115,000.

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

13.0 ETHNICITY OF PATIENTS

Although the Department of Health no longer collects data in relation to ethnicity, the Trust includes an equal opportunities form with the acknowledgement letter to complainants and retains an electronic record.

The vast majority of patients the complaints related to are white British; however, in 29 cases the patient chose not to state their ethnicity. The data collected relates to the patient concerned and not the complainant.

Table 5 below illustrates the ethnicity information received by area.

	Mid & South	North East Essex	West Essex STP	Medical	Specialist Services and contracts	South East Essex CHS	West Essex CHS	Total
White – British	100	56		47	14	7	4	228
White - Irish			13	1	1			15
White – other white	4		1	1				6
Mixed white & black Caribbean	1	1					1	3
Indian				1	1			2
Pakistani								
Other Asian	1						1	2
Other Ethnic Category		1	1					2
Other Black				2				2
Other Mixed	1							1
Black African	3							3
Not Stated	3	4		2	1	14	5	29
Total	113	62	15	54	17	21	11	293

14.0 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. The form helps us to audit how complainants rate our complaints process.

The Trust sent out 189 Complaints Handling Questionnaires for complaints closed between 1 April 2019 and 30 November 2019. Questionnaires were not sent to complainants where consent to investigate was withheld or those complaints closed between December 2019 to March 2020; these will receive their feedback forms from May/June 2020.

Of the 189 surveys only 30 were returned fully completed (2 for West Essex Community Health Services, 5 for South East Essex Community Health Services, 7 for Mid & South Essex Mental Health, 3 for West Essex Mental Health, 9 for North

Essex Mental Health & Learning Disability and 4 for South Essex Mental Health & Learning Disability). The percentage return rate was 17.34%. Out of the 30 surveys returned 7 were positive, 4 were mixed and 19 were negative.

Of the 30 returned surveys, 16 people felt that the staff who dealt with their complaint were helpful and polite; 13 of the people who had a negative experience felt they had not been kept fully informed throughout the complaint investigation; 15 people expressed dissatisfaction with the timescale for a response. However, all but 2 had been responded to within an agreed timescale with the complainant; 12 people thought the complaints process was easy to access and understand.

The Trust has looked at various ways to improve the response rate to the complaints feedback forms but it remains a challenge.

15.0 INTERNET FEEDBACK

The Complaints Department monitors and responds to feedback posted on NHS Website, (formally NHS Choices). The majority of the comments are left anonymously; it is, therefore, not always possible to identify which particular service the person is referring to. However, every effort is made to respond individually, but where this is not possible, contact details of our PALS and Complaints Departments are posted to encourage the writer to contact us directly to enable us to respond more fully to their specific concerns. As the base is usually identifiable, the relevant Director is contacted to make them aware of the comments. These are not included in the complaints numbers. Compliments have also been posted and responded to as well as being recorded and sent to the service.

Due to connectivity changes made to NHS website, EPUT was unable to access the site for some months to respond to comments. Once this was rectified all postings were responded to.

A total of 16 negative comments and 9 compliments were posted on the site. Of the 16 comments, 4 were not EPUT services, but related to other services held in clinics or hospitals that EPUT also deliver services from.

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

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

As noted in section 12, the Trust has a Lessons Learned Oversight Committee which ensures that any learning from complaints and the PHSO's investigations is taken forward and implemented within service delivery. Some learning which has significant impact across the Trust is published in EPUT's internal Learning Portfolio Newsletter. In addition, all learning from complaints, including any recommendations received from the PHSO, are published on the Trust's website.
https://eput.nhs.uk/about-us/safe-quality-care/lessons-learned/

The lessons learned process is reviewed on a regular basis and identified learning is followed up with the relevant service on a quarterly basis to provide assurance that learning from complaints is both captured and embedded in everyday practice. In addition, the lessons are analysed 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.

The Commissioners of EPUT's services also receive a report on the lessons learned from complaints for their specific geographical areas.

The following table highlights a selection of some of the lessons learned from complaints over the past year.

Table 6: Lesson Learned

What our patients said	What we did
Whilst taking part in pulmonary rehabilitation programme, I wasn't shown how to use the equipment properly. As a result of this, I hurt my leg. I am now in pain; how can you make sure this doesn't happen to someone else?	An information sheet with details of the safety precautions will be shared with all participants before commencement of treatment. Clinicians delivering the sessions will remind all participants at the start of each session of the safety precautions for the gym equipment; furthermore, posters detailing safety precautions will be prominently displayed in the gym areas.
I was unable to get through to anyone on the Dementia Helpline when I really needed extra support. I would like to know why? The Social Worker who I left the message with also did not know who to contact.	The Social Worker was unaware who to contact in the North East as Social Care Teams in Mid and North East Essex work to different geographical boundaries. This has now been remedied and staff names and key roles have been shared with the team and a flow chart provided to ensure there is 24 hour assistance.
Why was there blood in my catheter, resulting in me having to attend A & E.	The team realise the importance of explaining to patients the possible causes of blood found in a blocked catheter; a Catheter Care Passport will be introduced by March 2020, to all catheter patients, to facilitate patient user information.
My family member was made a subject of Deprivation of Liberty Order (DOLs) and during a previous Care Programme Approach (CPA) meeting, there was no mention of any change to their circumstances. We were not given any information when, or why, this occurred.	The Gate Keeping Team have ensured that details are explained and a copy of DOLs leaflet given to relatives. All issues will be discussed and agreed at CPA meetings with a complete follow-up meeting or telephone call to offer them the opportunity to clarify any issues.
What did you do about my child's safety from another patient when they were on the ward following an incident? They are scared it will happen again	The adjoining door will now be kept closed at all times. This was implemented with immediate effect.

Appointment was cancelled after a 2/3 month's wait but I was not informed before arriving for the appointment. A voicemail advising of the cancellation was not received.	The team have implemented a follow up letter with regards to appointments that are cancelled to ensure clearer communication.

17.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 4,269 compliments were received by the Trust in 2019/20. Services directly received 1,726 compliments and 2,543 compliments were taken from the Friends and Family Test. This equates to 2,140 for Mental Health Services and 2,105 for Community Health Services. In addition, 24 compliments were received for Corporate Services. Compliments are also recorded from NHS feedback websites and are included in the figures above. Compared to last year's figure of 4,223, the Trust has seen an increase of 46 compliments.

A selection of compliments is published regularly in the 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 as appropriate.

The table and figures below show the compliments received by the Trust and the ratio of compliments to complaints. Overall, there are almost 15 compliments to each complaint. A selection of the compliments received is shown in appendix 1 of this report.

Table 7: Compliments received by area

Area	Number of Compliments Received
Mid & South Essex Mental Health	1135
North East Essex Mental Health	620
West Essex Mental Health	175
Medical	4
Specialist Services	206
South East Essex Community Health Services	1203
West Essex Community Health Services	902
Corporate Services	24

Figure 7: Ratio of Complaints to Compliments

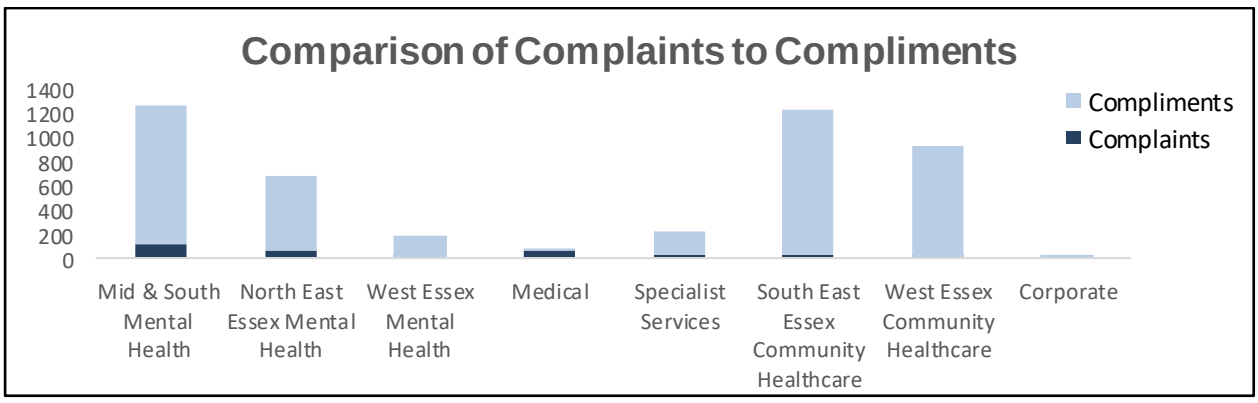


Table 8: Ratio of Compliments to Complaints

Compliments by Area	Number of compliments Received	Number of complaints received
Mid & South Essex Mental Health	1135	114
North East Essex Mental Health	620	61
West Essex Mental Health	175	15
Medical	4	54
Specialist Services	206	17
South East Essex Community Healthcare	1203	21
West Essex Community Healthcare	902	11
Corporate	24	0

18.0 COMPLAINANTS' STORIES

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

Story 1

Complaint:
Patient A is in the early stages of Alzheimer's. They attended an appointment with the doctor at the Emerald Centre as stated on their appointment letter. They had been there before for a previous appointment. They were surprised to see that the centre was in darkness and there was a notice on the door directing people to the Kingswood Centre. On arrival, the patient noticed that this too was in darkness. After walking around, they managed to find a member of staff, who told them the Emerald Centre had closed. Patient A told them that they were not happy that there was nobody there to greet them for their appointment, and they had felt safe at the Emerald Centre.

Trust Response:
A meeting was arranged with the Clinical Matron for Dementia Services, who showed patient A around the Emerald Centre, as they had been so concerned that it may have been closed; specifically pointing out the sensory room and the garden. Apologies were given for the letter stating that the patient should attend the Emerald Centre and not the main Kingswood Centre. It was explained that it was an administrative error and assurance was given that it had been raised with staff to understand the impact of the error on patient A.

It was also explained that the Emerald Centre had not closed but there had been changes to the way the reception services operate; therefore, appointments are now undertaken in the main Kingswood Centre.

Outcome:
Patient A was reassured to hear that the Emerald Centre was not closing and also that their complaint would be discussed at the next Quality Meeting to ensure staff awareness of the learning points.
The complaint was partially upheld.

Story 2

Complaint:

Patient B was taken to the Community Hospital by ambulance, but after routine medical checks was transferred to the Acute Trust with their personal belongings. The following day they were transferred back to the Community Hospital. During patient B's stay they noticed that a sum of money was missing as well as various bank cards. Patient B reported this to staff but says no action was taken. They said their bank had contacted them to say the cards had been used. The patient informed the police.

Trust Response:

The Trust apologised that the nurse had not reported the loss in accordance with Trust Policy as at the time they had been busy with clinical handover. During the investigation, both staff on the wards and domestic staff, were interviewed and were not aware that patient B had a large sum of money or bank cards on them. It was noted that upon admission the patient had said they had a lower amount of money but declined for staff to put it in the safe, preferring to give it to a friend to look after.

Outcome:

Following investigation and in conjunction with the police, it was not possible to determine who was responsible for the missing money. The patient later reported in a meeting, that they had their bank cards on them. It was therefore not possible to identify how they could have been fraudulently used as reported. The response highlighted that in future patient B should declare all monies at the point of admission as a disclaimer policy was in place to provide peace of mind and safeguard staff, visitors and patients by having a record of all personal property and valuables.

The complaint was not upheld.

Story 3

Complaint:

Patient C had been feeling anxious and depressed as they said they had been waiting for some weeks to be seen by the Mental Health Services. Following attendance at Accident and Emergency, it was decided that the patient should be seen at home by the Crisis Team who referred the patient to the Home Treatment Team. On the day of the arranged assessment, patient C was told that the care worker could not see them and would refer the patient to someone else.

The patient was later admitted to the Assessment Unit but says they had a long wait before being assessed, during which time they raised several issues about the lack of communication from staff, the lack of cleanliness of the unit and the bad internet signal.

Trust Response:

The investigation found that several attempts had been made to contact the patient by telephone; when this was unsuccessful a letter was sent with an appointment that the patient was unable to attend as they could not get time off work. Unfortunately the member of staff who was to complete the assessment had left the team and their caseload was passed to someone else. This did lead to a delay in obtaining an appointment and the Trust apologised for this.

Explanation was given as to why there is no Wi-Fi facility on the ward although patients can use their own devices. The long wait for assessment was acknowledged, explaining that there had been high demands on the medical staff at that time.

Outcome:
The concerns around lack of communication on the ward were discussed with the Matron and Manager of the ward who raised it at the next business meeting. A structured handover takes place so that staff get to know who the patients are and their reason for admission; they can then be supported accordingly. In addition, the ward holds daily community meetings providing the opportunity for patients to raise concerns and the staff to provide feedback on any actions taken.
The complaint was partially upheld.

19.0 AIMS FOR 2020/2021

During the next year we will:

- Build on the work already in place to promote locally resolving complaints as they arise and to encourage meeting with complainants at an early stage of investigations, as a beneficial method of sensitively addressing concerns.

- Work with Non-Executive Directors to support them in undertaking their complaint reviews electronically, as well as in person.

- Continue to monitor staff attitude complaints, and provide quarterly reports to Service Directors on multiple incidences involving the same staff member.

- Continue to look at ways to improve highlighting learning from complaints.

- Continue with the rolling programme of complaints training for current and new complaint investigators.

- Be more proactive in ensuring that the complaints team works with complaint investigators to improve complaint response times.

- Undertake further work to ensure all service leads receive a quarterly report of the compliments received.

20.0 CONCLUSION

EPUT is always looking for ways in which to improve the complaints process for people who are dissatisfied with any of the services we provide. Complaints and compliments are used as a barometer to see what is going well and what needs improvement.

During this year as last year, a great deal of work has taken place to improve the quality and timeliness of complaint responses; there has been an overall improvement but there remains further room for improvement.

Following feedback from complainants, improvements have been made in communicating with complainants both at the beginning and during the investigation process, where appropriate, to ensure they are kept fully informed of progress as per Department of Health guidelines. Complainants have also advised that they prefer the appointed complaint investigator to contact them by telephone extending complaint response times, when necessary, rather than receiving a letter. This is highlighted to all investigators on commencing investigations into complaints.

Each Service Director receives a weekly situation report for their complaints, displaying timescales and extensions. 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.

The number of complaints relating to Staff Attitude has increased from last year. Although this has been analysed throughout the year, close monitoring will continue.

Report produced by:

Pam Madison
Head of Complaints and
PALS

On behalf of:

Sean Leahy
Executive Director of People and Culture
May 2020

Appendix 1

Selection of compliments received 2019/20

End of Life Care South East Essex. The work you do is amazing and more often than not it probably goes unnoticed. Believe us when we say your work has definitely not gone unnoticed here and we will be forever grateful for your kindness, compassion, at times humour but most of all your honesty to us all. We couldn't have done it without you.	***Peter Bruff Ward, The Kingswood Centre.*** I would like to praise the staff for the high quality of care I have received whilst on the Peter Bruff ward. My admission was done in a calm and caring way. The staff will always make time to speak to me if I need support. I have found only positivity in my care. I have always been treated with respect and kindness. Peter Bruff is a shining example of how to care for people with mental health issues and I wish all mental health units could be the same.
Gallywood Ward, The Linden Centre I am very thankful for the help I got here. It changed my life for the better. I am a new person now. I can see what is important in life. The staff, the way they care is remarkable and amazing. They inspired me and my husband for new plans for the future. Thank you all.	***CAMHS, Larkwood Ward, North Essex*** A huge thank you for everything you've done. Thank you for taking the time to sit and talk to me, making me feel cared for and understood. It's been a long journey in which there have been highs and lows but you always took the time to make sure I was alright. I will never forget you or this place.
Clifton Lodge Nursing Home Dad and I just wanted to say thank you for all your amazing kindness, professionalism, care and joy you brought into our lives during the year Dad has been lucky enough to be staying under your care. He couldn't have been more settled and rested at Clifton, which has been a great relief. Thank you for all the wonderful activities and parties. What fun we both had.	***Rawreth Court Nursing Home.*** Thank you all so very much for the kindness, care, patience and humour shown to our mother during her stay with you. You helped to make her final days and weeks as comfortable as possible and there was no doubt as to how comfortable and 'at home' she felt at Rawreth Court; something we will always remember. Many thanks
Christopher Unit (PICU) The Linden Centre. I wouldn't be where I am today without all your help! Thank you all for helping me get to where I am. I didn't know why I was here and you all showed me that life can be worth living and you're right - it is! I'm so thankful for the hard work you all put in to help me recover. You should all be proud to be who you are because	***Therapy for you, Mid and South*** I was initially unsure of therapy, but I believe that the time I had with you has been extremely beneficial. Through speaking with staff, I've become more confident in speaking to others about my anxiety, which has helped me to cope better and realize that having anxiety isn't a weakness.

I'm proud that I met some amazing, brilliant staff members, thank you.	
Stort Ward, Derwent Centre We would like to thank all the staff who looked after our relative. From their first contact with the Derwent Centre Outpatients Department, the care for them has been exemplary. It would be unfair to single out any individual staff as all of them, from the day to day care staff on the ward, the outpatient clinicians, Doctors, Psychologists and Psychiatrists have shown superb care, consideration and quiet determination to get our relative better again.	***Paediatric Community Nursing – South East*** We would like to say a massive thank you for taking care of us and listening to our troubles, and just being there every day. You all do an amazing job looking after the sick. All of you have been there for us both at this horrible time in our lives, and I can honestly say if we didn't have you, we would not have been able to cope.
Speech and Language Therapy South East Essex. I would just like to say what an amazing course Talking Toddlers is and how amazing the staff **are**. My child's first day she cried and clung to me, she didn't like the attention, noise or joining in. Move forward five weeks and she's a different child, clapping her hands, popping bubbles and saying 'Go' after the ladies say 'ready, steady'. The course and the ladies are amazing. I can't thank you enough.	***Integrated Care Team West Essex*** I am writing to show my appreciation to all your nursing staff who have been attending me in dressing my leg and foot over the last seven to eight weeks. They are all so kind and sincere, always a smile on their faces and they put me at my ease. I cannot thank them enough. I must not forget the nurse who takes my INR every week. She, comes in the same category as the above nurses. Thank you all so very much.
Rainbow Unit, Linden Centre The kindness and support I have felt on the Rainbow Unit will never be forgotten. The nurses go above and beyond to try and guide us mums through the worst of times. I have had my eyes opened to the beauty of humanity, and feel humbled by the level of compassion and grace the the nurses have imparted. a very deep heartfelt thank you to everyone who supported me. I shall be forever grateful.	***Meadowview Ward, Thurrock Hospital*** When my relative came to you they had been in a state of anger and distress for a very long time. This was a terrible situation for her and, of course, very difficult for those caring for them. We really thought all was lost, and were amazed at the transformation you achieved in such a short time. They are now content with their life and no-one can wish more than that for someone they love.

Compliments are also received from students on placements:

Topaz Ward, Broomfield: Thank you for making the last four months so lovely. I have had a great time working here and have been really impressed and touched by the level of care and dedication you show to patients.

Dementia Intensive Support Team: The team are so kind and supportive. They always found time to explain matters to me despite being busy. I enjoyed so much a placement where staff work in partnership, supporting each other, showing care and compassion not only to patients but each other as well.