

# Complaints Annual Report

2020-2021



# 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 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 his absence, a designated signatory.

We endeavour to always reflect the Trust values of 'Open, Empowering and Compassionate' in our response letters to complainants. This year we have focussed in particular on improving how we detail any lessons learned and actions taken within our response letter, to provide assurance to the complainant that we have listened to and acted on their concerns.

The year has seen unprecedented challenges to the health service due to the Covid-19 pandemic. In EPUT we have worked under extreme pressure, prioritising the need to keep our patients and staff safe whilst continuing to deliver essential services within our community and inpatient settings.

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. During quarter 1, at the beginning of the first National lockdown, we introduced a temporary pause in the formal investigation process and resolved complaints informally wherever possible.

We were able to resume formal investigations by the beginning of quarter 2, but we have retained the focus of locally resolving complaints where we feel this would provide a more efficient resolution for the complainant.

As in previous years, the number of compliments the Trust received far outweighed the number of complaints about the service. Overall the number of compliments received was lower than previous years due to the pause of the Friends & Family Test feedback, because of Covid-19. But despite this we still received almost 4 times more compliments than complaints.

The Trust achieved 92.5% for complaints closed within agreed timescales with the complainant. This is below the Trust's target figure of 95%, and we have plans underway to improve our response times for this year.

If a complainant is dissatisfied with our response to their complaint, they have the right to refer to the Parliamentary and Health Service Ombudsman (PHSO) as the second and final stage of the complaints process. This year, the Trust had 9 complaints referred to the PHSO, which is 3.3% of the total number of complaints received (275).

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 275 formal complaints were received by the Trust during 2019/2020. The total figure represents 18 fewer complaints than the previous year (293). A total of 6 complaints were subsequently withdrawn, 1 complaint was not investigated as consent was withheld, and another was not investigated as it related to a Patient Safety Incident (PSI), for which the PSI Team investigated and provided a full report addressing the concerns raised.

In quarter 1 (Apr-Jun 2020), as a result of the Covid-19 pandemic and the pressures that were facing our service, the Trust introduced a temporary complaints process. Where appropriate, 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, and these were logged as "not investigated".

At the end of the financial year, 59 complaints remained under investigation and were carried forward to 2021/22.

**Table 1: Total Number of Complaints Received and Closed**

Total Complaints carried forward from 2019/20	Total Complaints Received 2020/21	Total Complaints Closed 2020/21	Total Complaints carried forward to 2021/22
49	275	265	59

The table below shows the distribution of the 275 complaints received by Trust Area:

**Table 2: Number of Complaints Received by Trust area**

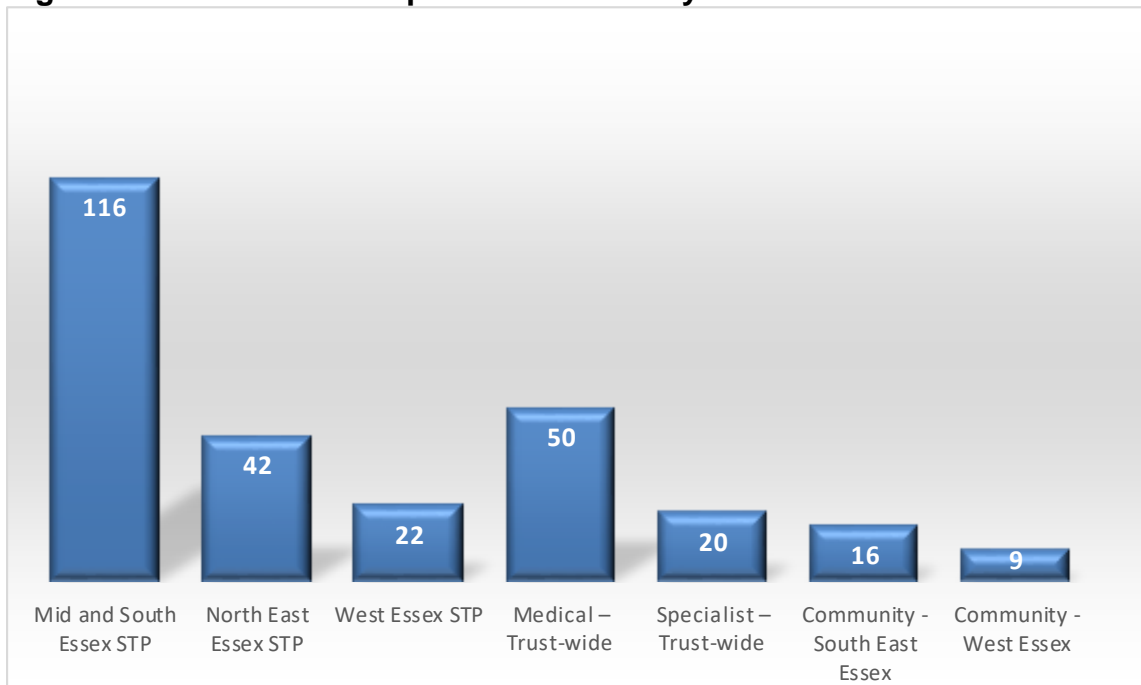
Area	Formal Complaints Received
Mid and South Essex STP	116
North East Essex STP	42
West Essex STP	22
Medical – Trust-wide	50
Specialist – Trust-wide	20
<b>Total Mental Health</b>	<b>250</b>
Community - South East Essex	16
Community - West Essex	9
<b>Total Community</b>	<b>25</b>
<b>Grand Total</b>	<b>275</b>

The number of Mental Health Services complaints has decreased by 11 (- 4%) from last year's total of 261 complaints.

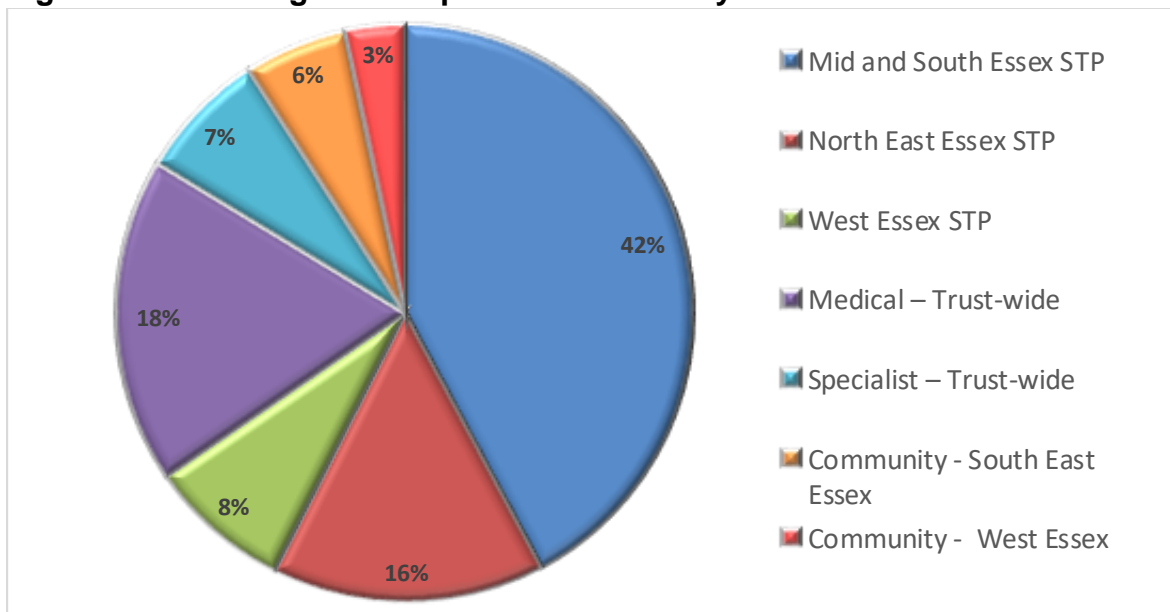
The number of Community Health Services complaints has decreased, by 7 (- 22%) from last year's total of 32 complaints.

The following charts illustrate the number of complaints received by Area during 2020/21.

**Figure 1: Numbers of Complaints received by Area**



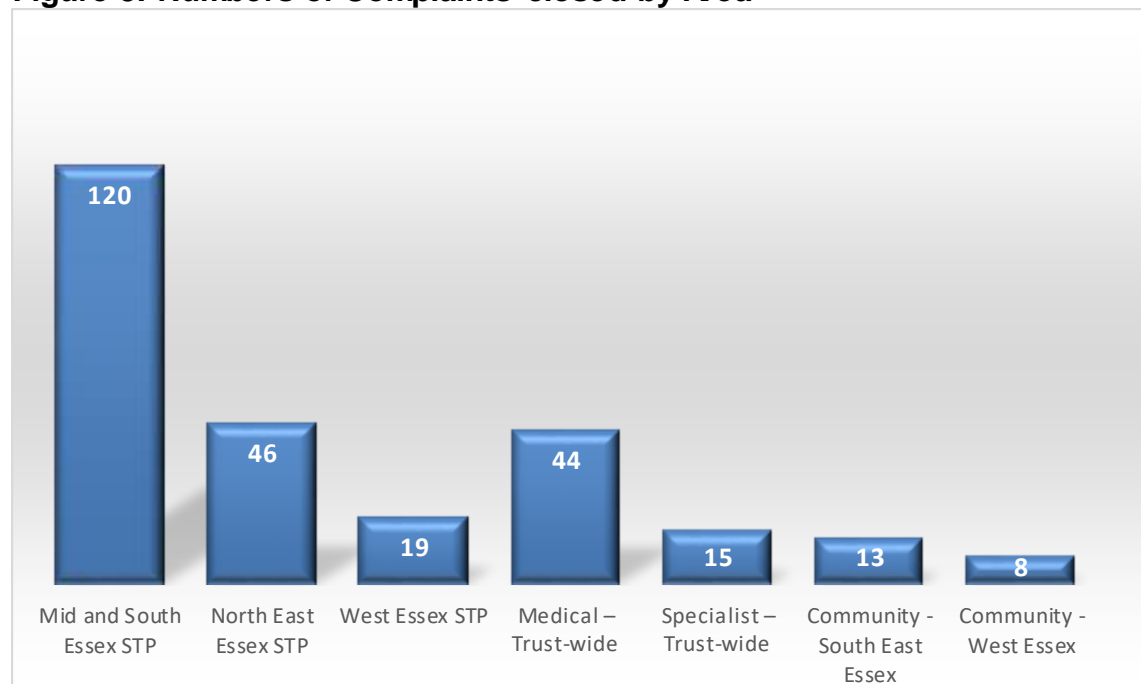
**Figure 2: Percentage of Complaints received by Area**



### 3.0 NUMBER OF COMPLAINTS CLOSED AND OUTCOMES

A total of 265 complaints were closed during the year.

**Figure 3: Numbers of Complaints closed by Area**



#### Complaints Outcomes

Each separate complaint point is recorded by the Investigator as either 'upheld' or 'not upheld'. Where there are a combination of upheld and not upheld points within the same complaint investigation, the overall outcome of the complaint is recorded as 'partially upheld'.

**Table 3: Complaints Outcome by Area**

Area	Upheld	Partially Upheld	Not Upheld	Not Investigated	Withdrawn	Total
Mid and South Essex STP	12	66	21	19	2	<b>120</b>
North East Essex STP	2	26	7	8	3	<b>46</b>
West Essex STP	1	14	1	2	1	<b>19</b>
Medical – Trust-wide	3	17	19	5		<b>44</b>
Specialist – Trust-wide		10	3	2		<b>15</b>
Community - South East Essex	2	6	1	4		<b>13</b>
Community - West Essex	1	6		1		<b>8</b>
<b>Total</b>	<b>21</b>	<b>145</b>	<b>52</b>	<b>41</b>	<b>6</b>	<b>265</b>
<b>% of Total</b>	<b>8%</b>	<b>55%</b>	<b>20%</b>	<b>15%</b>	<b>2%</b>	<b>100%</b>

#### **4.0 COMPLAINTS RESOLVED WITHIN AGREED TIMESCALE**

The Trust responded to 92.5% of complaints within agreed timescales with the complainant. The average time taken to respond to complaints was 42.4 working days for Mental Health Services and 26.1 working days for Community Health Services.

#### **5.0 COMPLAINTS REFERRED TO THE PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)**

If the 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 Ombudsman to conduct an independent review of their complaint.

It should be noted that the PHSO paused work on NHS complaints on 26 March 2020 to help the NHS focus on tackling the Covid-19 pandemic, and restarted accepting new NHS complaints and progressing existing ones on 1 July.

During 2020/21 a total of 9 complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO) which is a decrease of 10 from the number received in the previous year (19). Of these 9 referrals:

- 1 case the PHSO decided not to investigate
- 1 case the PHSO have confirmed they are investigating (still under investigation)
- 7 cases are still awaiting assessment

The table below illustrates the areas of the Trust from which the 9 complaints were referred to the PHSO this financial year, and their current status.

**Table 4: Complaints referred to the Ombudsman – by Area**

<b>Area</b>	<b>Number of Complaints Referred</b>	<b>Status</b>
Mental Health Mid and South Essex	7	1 assessed and now under investigation 1 closed - not investigated 5 awaiting assessment
Mental Health North East Essex	1	1 awaiting assessment
Community Health West Essex	1	1 awaiting assessment

#### **PHSO Complaints Closed**

A total of 2 PHSO investigations were closed during 2020/21, and both were partially upheld by the PHSO. A brief summary of these is provided in the table below.

**Table 5: PHSO final reports and findings**

Area	Date of PHSO Final Report	Findings and Recommendations
Mental Health Mid and South Essex	01/07/2020	<b>Partially Upheld</b> This was a joint case with Essex County Council relating to a delay in carrying out a Care Act assessment. The Trust had a significant role in these events, however the Council retained statutory responsibility, and were instructed to pay the financial redress (£750)
Mental Health North East Essex	15/10/2020	<b>Partially Upheld</b> The Trust was required to pay £500 in recognition of failings in care: including not completing a care plan on the patient's departure from the ward.

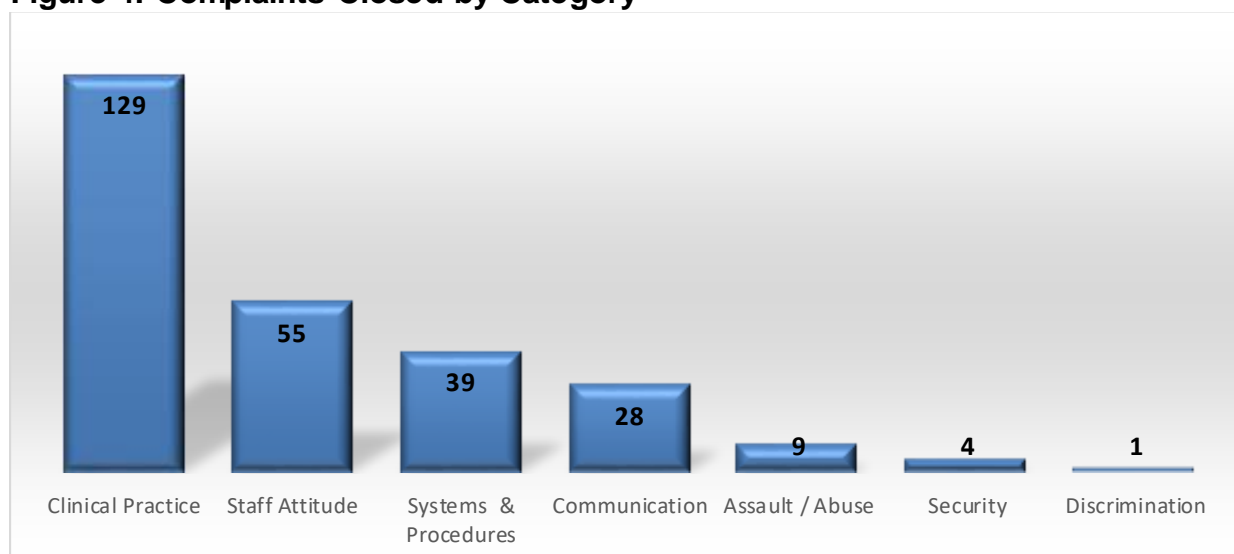
As at year-end 2020-21, there are 12 active cases with the PHSO: 4 cases being investigated by the PHSO, and 8 still awaiting assessment. This figure includes 4 cases that were carried forward from the previous year.

## 6.0 COMPLAINTS THEMES

### Nature of complaints:

The top three complaint categories for complaints closed in 2020/2021 were Clinical Practice, Staff Attitude, and Systems and Procedures.

**Figure 4: Complaints Closed by Category**



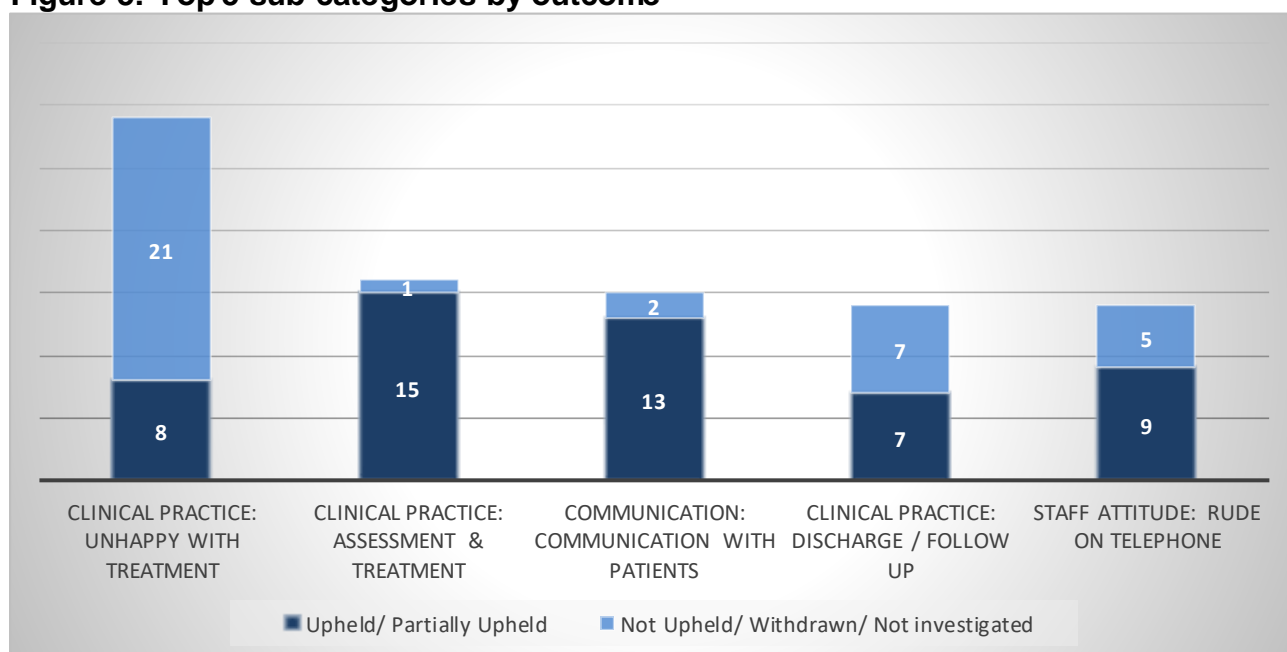
Under each main complaint category, there are a number of “sub-categories”. The top five sub-categories made up a third of the total closed complaints in 2020-21 (265), and were as follows:

**Table 6: Top 5 Sub-Categories**

Complaint Sub-Category	Number of Complaints	% of Total Closed Complaints
Clinical Practice: Unhappy with Treatment	29	11%
Clinical Practice: Assessment & Treatment	16	6%
Communication: Communication with Patients	15	6%
Clinical Practice: Discharge / Follow Up	14	5%
Staff Attitude: Rude on telephone	14	5%
<b>TOTAL</b>	<b>88</b>	<b>33%</b>

The number of the top 5 sub-category complaints that were upheld or partially upheld is shown on the chart below.

**Figure 5: Top 5 sub-categories by outcome**



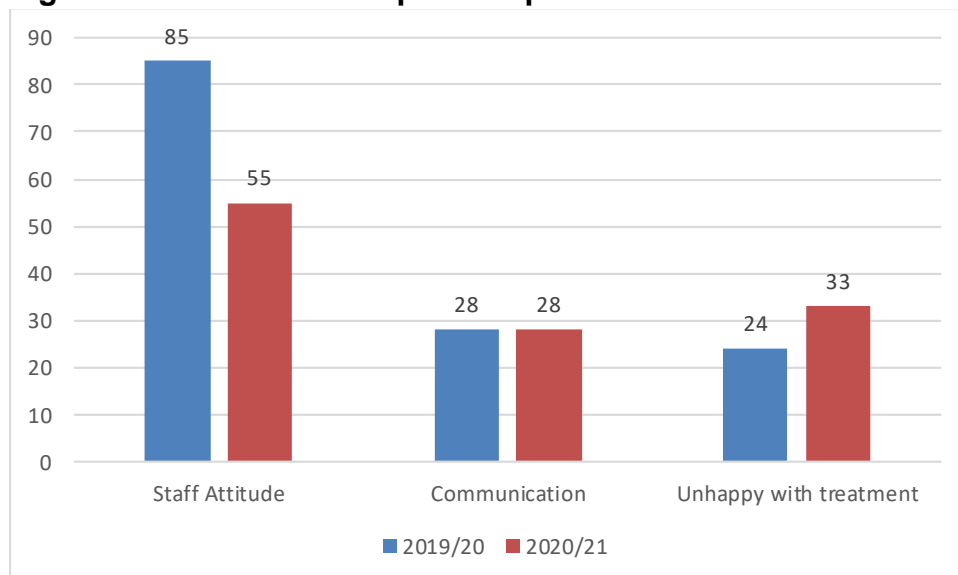
Nationally, the three main complaint themes for health services are:

- Dissatisfaction with treatment
- Communication
- Staff Attitude

These themes are reflected in our top 5 sub-categories. Compared to the previous year, complaints about Staff Attitude have decreased by 35%, whereas the number of complaints raising dissatisfaction with treatment increased by 37%. Complaints about Communication stayed the same, at 28 for both years.



**Figure 6: Three main complaint topics**



The Trust's complaints data is analysed to identify emerging complaint trends or themes, and 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.

Of the 265 complaints closed in 2020/21, 116 (44%) were recorded within these three main themes. Of these, 67 (58%) were either upheld or partially upheld.

## **7.0 RE-OPENED COMPLAINTS**

During 2020/21, of the 265 complaints closed, a total of 35 complaints were reopened as the complainant was dissatisfied with the Trust's response to their complaint. This equates to 13% of complainants being unhappy with the response received to their complaint.

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

**Table 7: Reasons for Re-opened Complaint**

<b>Reason for Re-opened Complaint</b>	<b>Number of complaints</b>
Disagrees with response	12
Dissatisfied with investigation	7
New questions raised/ information provided	6
Inaccurate response	5
Unhappy with Covid process	3
Unhappy with outcome	2
<b>Total</b>	<b>35</b>

## 8.0 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.

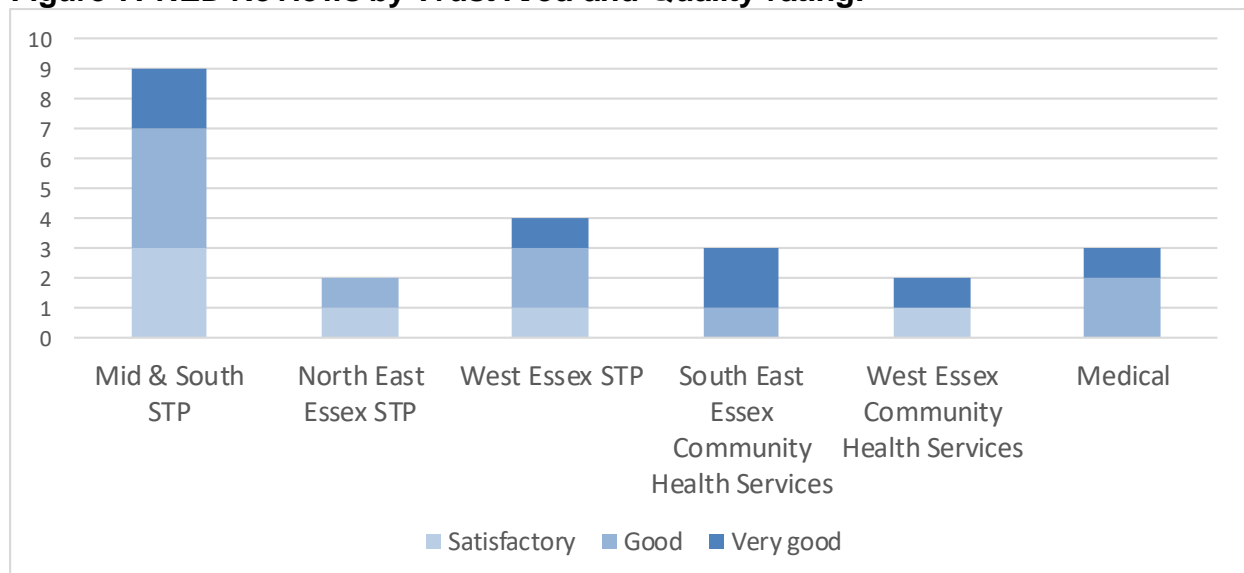
During 2020/21, 23 reviews were completed in Q1-Q3, and a further 6 reviews are underway for Q4 at the time of writing this report. The total of 29 reviews represents 11% of the number of closed complaints in the year (265).

Due to the Covid-19 pandemic, the process for the NED reviews was adapted, and these are now carried out remotely by a paperless process.

Of the 23 complaint responses that were reviewed: 7 were deemed 'Very Good'; 10 'good' and 6 were 'Satisfactory'. None were deemed 'Fair' or 'Poor'.

In answer to the question "Do you feel the Trust has done all it could have to resolve the complaint satisfactorily?" the response was "Yes" in over 95% of the cases reviewed.

**Figure 7: NED Reviews by Trust Area and Quality rating:**



## 9.0 PATIENT ADVICE AND LIASION SERVICE (PALS)

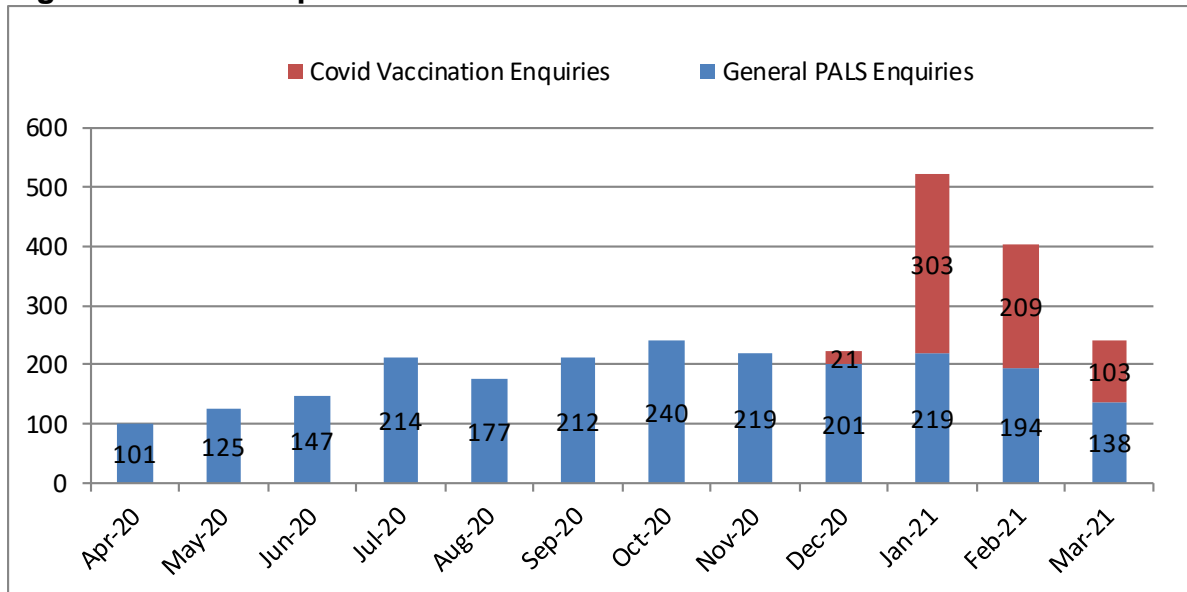
The PALS service sits within the Complaints Team, and serves as a first point of contact for enquiries and concerns, which are received and responded to by telephone and email. PALS provide confidential advice, support and information regarding all aspects of EPUT services, primarily to patients, their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

In November 2020 EPUT was appointed one of three lead providers in the East of England region for the COVID-19 vaccination programme, and PALS supported this programme by responding to enquiries from the general public relating to vaccinations.

PALS received 2820 enquiries during the year 2020-21, which was an increase of 182% from the previous year's total of 998.

613 (22%) of these enquiries related to Covid-19 vaccinations. The number of other 'general' enquiries (2,207) was more than double the previous year's figure, and can be attributed to the additional pressure placed on the service by the pandemic.

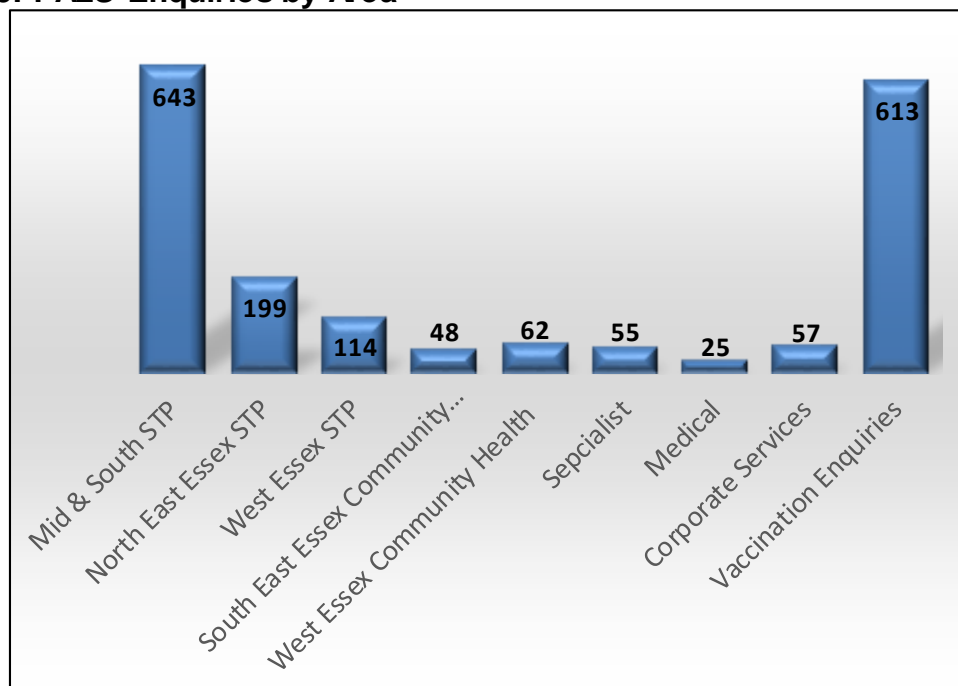
**Figure 8: PALS enquiries received 2020/21:**



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 47 (1.6%) were passed to the Complaints Team to resolve and 1205 (43%) were signposted to other organisations.

The chart below shows which areas the enquiries were received for.

**Figure 9: PALS Enquiries by Area**



The top 5 themes for PALS enquiries in 2020/21 made up almost exactly 50% of the total enquiries for the whole year (2820). These are shown in the table below as a percentage of the total number of enquiries received.

**Table 8: Top 5 PALS Sub-Categories**

Sub-Category	Number of Enquiries	% of Total Enquiries
Clinical Practice: Covid Vaccination	613	22%
Communication breakdown with patient	342	12%
Request for Information	207	7%
Communication breakdown with relatives	139	5%
Access to treatment	112	4%
<b>TOTAL</b>	<b>1413</b>	<b>50%</b>

## 10.0 LOCAL RESOLUTIONS

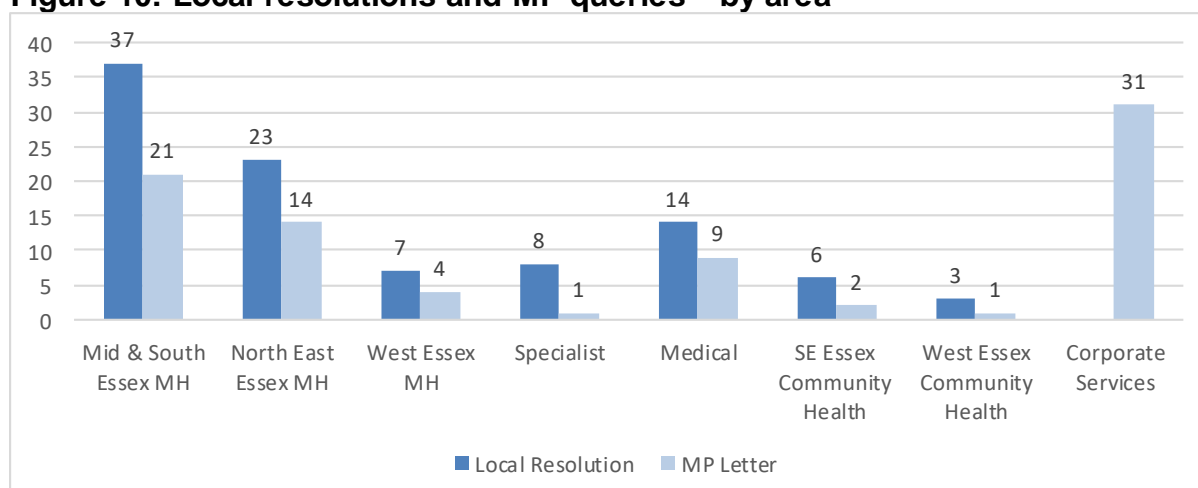
The Trust encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. A timely intervention can provide the opportunity to listen and discuss the concern and can prevent an escalation to a formal 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 98 locally resolved concerns recorded for the year.

### MP Enquiries

The Trust received 83 enquiries from MPs on behalf of their constituents, which was 37 more than the previous year. This increase can be mainly attributed to enquiries regarding Covid-19 vaccinations, of which there were 31.

The chart below illustrates the areas for which the Local Resolutions and MP enquiries were received.

**Figure 10: Local resolutions and MP queries – by area**



## 11.0 TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

All complaints are logged onto the Datix reporting system and are cross-referenced with the incident module; 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 2020/21, 27 complaints cases were recorded. Of these, 6 complaints were linked to a PSI.

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

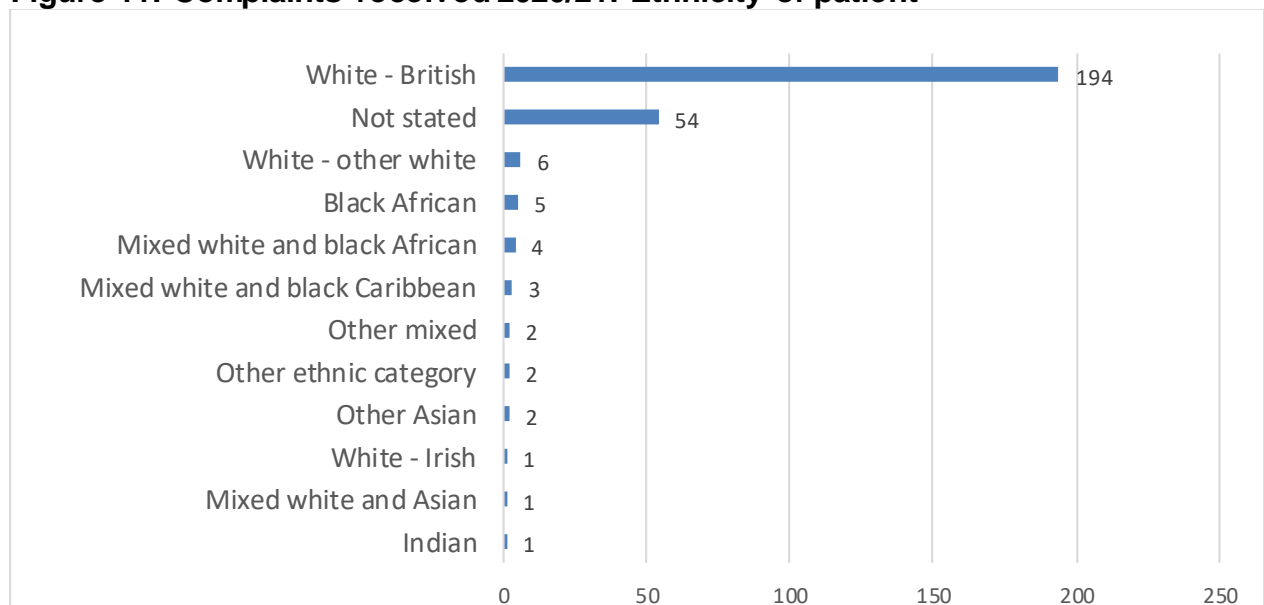
There were 4 claims received by the Trust that related to complaints this year, which is 2 fewer than the previous year. A total of 3 claims were closed, with combined damages of £29,500.

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

## 12.0 ETHNICITY OF PATIENTS

The Trust retains an electronic record of a patient's ethnicity, and this is recorded within the complaint record for statistical purposes. In 54 cases the patient has not stated their ethnicity.

Figure 11: Complaints received 2020/21: Ethnicity of patient



### **13.0 FEEDBACK ON COMPLAINTS PROCESS**

In previous years The Trust has sent a questionnaire to complainants approximately 6 weeks after the closure of their complaint, asking for feedback on how the complaint was handled.

In April 2020, following changes made to the complaints process due to the pressure of the Covid-19 pandemic, we stopped sending this survey.

We have taken the opportunity to consider how we can increase the survey response rate to maximise the feedback we receive. We have reviewed the survey contents, reducing the number of questions from 11 to 6. We have made it easier for people to respond by creating an electronic survey that complainants can complete online (via a link we email to them), as well as paper surveys that we post to complainants who correspond by letter.

The revised Complaints Survey was implemented for complaints closed from April 2021, and the new questions are as follows:

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

Yes  No

How satisfied were you with the following: (Very Satisfied/ Fairly Satisfied/ Neither satisfied nor dissatisfied/ Fairly dissatisfied/ Very dissatisfied)

2) Were all aspects of your complaint addressed?

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

4) Was your complaint dealt with in a reasonable timescale?

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

6) How satisfied are you overall with the handling of your complaint?

### **14.0 ONLINE FEEDBACK**

The Complaints Department monitors and responds to feedback posted on the 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. We endeavour to respond to comments individually, and where appropriate we provide the contact details of our PALS and Complaints Departments and 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. In 2020/21, a total of 15 comments were received: 11 negative, 3 positive and 1 not related to EPUT services.

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

The Trust recognises the importance of learning from Complaints to continuously improve our service. This year we adapted our Complaints Investigation Report template, to include a prompt for the Complaint Investigator to consider if it would be beneficial to share any lessons learned from the complaint Trust-wide.

As mentioned in section 12, the Trust has a Learning Oversight Committee which ensures that any learning from complaints and the PHSO’s investigations is taken forward and implemented within service delivery. Additionally, some learning which has significant impact across the Trust is published in EPUT’s internal Learning Portfolio Newsletter.

Where learning has been identified as part of a complaint investigation, the Complaints Team follow up with the relevant service on a quarterly basis to provide assurance that improvements have been taken forward and embedded in everyday practice. In addition, the lessons are analysed regularly 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 9: Lesson Learned**

What our patients said	What we did
<p>When I was discharged from the service I didn’t receive a discharge letter, and neither did my GP. The contact numbers I was provided for the Crisis Line were incorrect and there was a delay in accessing the service.</p>	<p>The Contact Centre systems were undergoing migration of networks and this caused some issues with the service - these issues are fixed, and all letters following assessments are completed the next working day. The Contact Centre is actively working on improving the experience of callers, and will be reviewing calls from start to finish to ensure that the best and most appropriate support is being given.</p>
<p>I live abroad, and had problems contacting my mother who was a patient. I feel that the communication equipment and infrastructure are inadequate for a modern ward, and this is compounded by the lack of communication between staff.</p>	<p>A walkabout telephone is now available for patient use, and this has been communicated to all staff. Communication equipment and infrastructure on the ward is being addressed with the IT Department; additional booster boxes have been installed to give everyone wi-fi access. The Trust is also providing access to Skype (or similar) which can be accessed via a computer allowing patients to chat with loved ones.</p>

<p>I received a letter advising that my son was being discharged from your service due to lack of engagement and non-attendance of appointments.</p> <p>Due to my son's ADHD, he cannot retain information as his racing thoughts move onto the next thing so quickly. This is why I had requested to be made aware of and involved in his appointments, to ensure attendance. This agreement was not adhered to which is why he did not attend.</p>	<p>We apologised because the patient's mother had previously made it clear that she needed to be informed of appointments, and we had failed to do this.</p> <p>An anonymised summary of this complaint was included in the August 2020 Learning From Complaints report; and the importance of establishing clear communication systems with patient/carers in line with their preferred method of communication was highlighted to all staff.</p>
<p>I received a telephone call from the First Contact Practitioner (FCP) in which I was given MRI results and a diagnosis for a life changing condition. This caused me great distress, during an already difficult time. I feel a phone call was inappropriate and I should have been given a face to face appointment, or at the very least a video call appointment.</p>	<p>As a result of this complaint, additional supervisions will be held with staff regarding patients who receive a diagnosis of Cauda Equina and the life changing impact of this syndrome.</p> <p>Patients will be offered the option of telephone/video consultation in the first instance, followed by face to face appointments where clinically indicated.</p>
<p>My son was sectioned and taken to Rochford Hospital for assessment, then moved to a ward in Colchester near where we live. I have found out that that he has now been moved to a ward in Harlow, but nobody had told me.</p> <p>The Ward Manager was unable to explain why he had been moved.</p>	<p>The Complaint Investigator found that, following a Sitrep meeting, the patient was admitted to the most local hospital to his home address. However, the address we held for the patient was incorrect.</p> <p>We have communicated to staff to check before making transfers back to the home area that the address we hold is correct.</p>

## 16.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 1,000 compliments were received by the Trust in 2019/20. Services directly received 811 compliments and 189 compliments were taken from the Friends and Family Test (FFT).

This equates to 712 for Mental Health Services and 262 for Community Health Services. In addition, 26 compliments were received for Corporate Services.

Compared to last year's figure of 4,269, the Trust has seen a significant decrease in compliments received. This is a direct result of the FFT (which is typically our greatest source of compliments) 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.



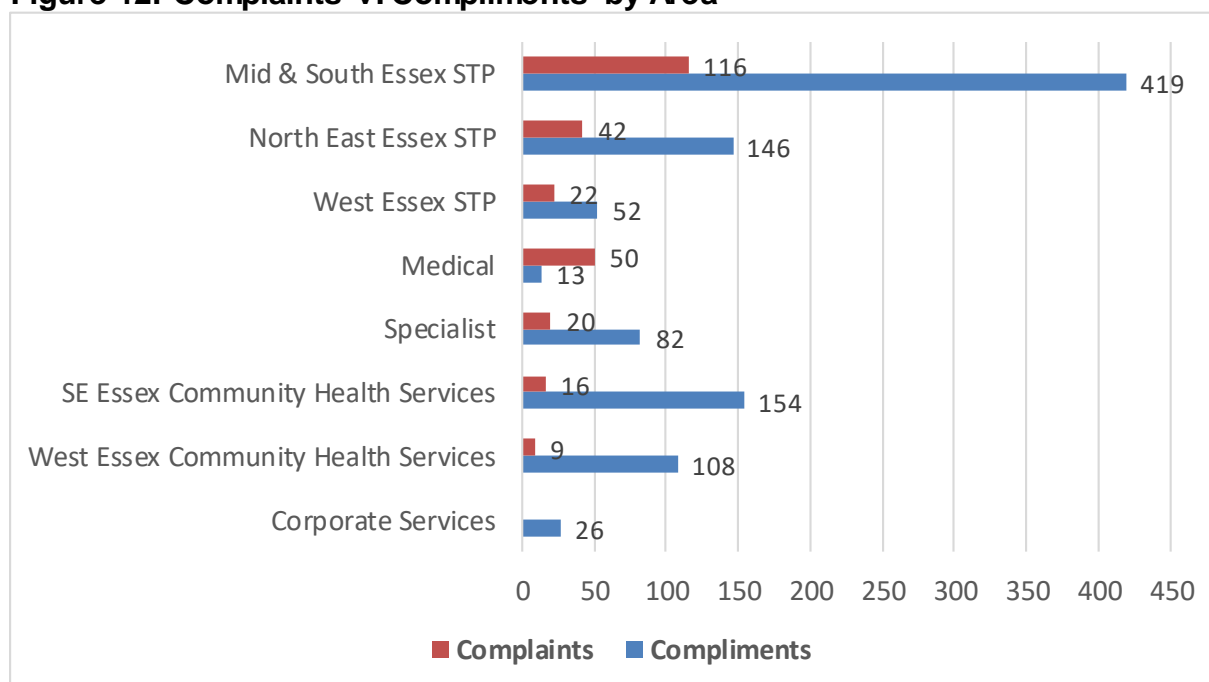
The table and figures below show the compliments received by the Trust and the ratio of compliments to complaints. Overall, there are almost 15 compliments to each complaint. A selection of the compliments received is shown in appendix 1 of this report.

**Table 10: Compliments received by area**

Area	Compliments Received
Mid & South Essex STP	419
North East Essex STP	146
West Essex STP	52
Medical	13
Specialist	82
<b>Total Mental Health</b>	<b>712</b>
South East Essex Community Health Services	154
West Essex Community Health Services	108
<b>Total Community Health</b>	<b>262</b>
Corporate Services	26
<b>Total</b>	<b>1000</b>

There were almost 4 times as many compliments received than complaints during the year, and the comparison is illustrated on the chart below by Area.

**Figure 12: Complaints v. Compliments by Area**



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

## 17.0 COMPLAINANTS' STORIES

### Story 1

The service user was diagnosed with Emotionally Unstable Personality Disorder and was under the care of CAMHS for seven weeks before being transferred to an adult inpatient psychiatric unit when she turned 18 in 2020. The service user wrote to her MP expressing concerns around her transition from a children's unit to an adult unit, which she felt was extremely terrifying and challenging.

The service user made a number of suggestions on how to make this transition easier for patients. This included being given the opportunity to visit the adult ward before being transferred and being given the opportunity to speak to other patients and/or staff on the wards. The service user also suggested being given leaflets or a website with more information on the adult ward; this could include pictures, videos and key information about the ward layout and key staff members. Overall, the service user felt that the transition process would have been much easier had she been given more information beforehand. The lack of information before the transition had a negative impact on the service user's mental health.

The issues raised by the service user via her MP were dealt with via the complaints procedure. As a result of the complaint, the Associate Director for CAMHS met with clinical leaders from both CAMHS and the Adult Services to address the concerns raised. The services will be conducting a joint review of the transition process and operational policies which they would like to co-produce with the service user and other young people who may be going through a similar situation. The Associate Director has assured the Patient Experience Team that they will include and update the team as part of the co-production work going forward.

### Story 2

The service user was a 22 year old man who throughout his childhood had been in contact with children's mental health services. He was referred to the West Specialist Mental Health Team in June 2020 by his GP due to deteriorating mood, anxiety, generalised stress, insomnia, anger outbursts and paranoid ideation. This was on the background of him using both Cocaine and Ketamine as a form of self-medication.

In July 2020, the service user was assessed via telephone by a Community Psychiatric Nurse. His mother was present at the time. On 20 August 2020, the team received a telephone call from the service user's mother at which time she expressed her concern that the outcome letter they had received following the assessment was not only grammatically poorly written but also did not reflect on any level what concerns/issues had been discussed at the time of the assessment. Essentially, she expressed that they had neither been listened to nor heard. His mother expressed further concerns as some details within the outcome letter were so factually incorrect that she felt it was a defamation of the service user's father's character. At the time of this initial conversation, the team apologised and advised the service user's mother that they would arrange a face to face assessment for the service user.

The team received further telephone calls from the service user's mother during which she made the team aware of further deterioration in his mental state: including physical aggression towards his partner and also high use of illicit substances. In response to these concerns, the team arranged an urgent face to face assessment for that week. This appointment was attended by the service user, his partner and also his mother. The appointment lasted for well over an hour and it was agreed that medication would be commenced. The team also arranged on the same day for a physical health check and blood

investigations as his mother had serious concerns about his physical health. The service user's mother texted the team the following day thanking them for their help and support and expressed gratitude for the urgent meeting:

*"I'm texting to just say it again, because I am beyond grateful for all your help and kindness over the past few days. The meeting yesterday was more than I could have wished for - pls thank ... for me again as well - what an incredible team you make - I can honestly say in all the years we have been in and out of counselling, GP visits, social services etc etc, never before have we experienced such a thorough, professional and caring consultation. You listened, you heard, you understood and you truly cared. .... wants to feel different. He cried yesterday, that really doesn't happen very often...almost like he took a huge sigh of relief that finally he felt understood. Thank you thank you"*

## **18.0 AIMS FOR 2021/2022**

During the next year we will:

- 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.
- Build on the work already in place to learn lessons from Complaints, ensuring that our new complaints process is robust in supporting the identification, appropriate sharing and embedding of lessons across the Trust.
- Provide 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.
- Develop a process to provide information regarding 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.

## **19.0 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 provide valuable insight into what is going well and what needs improvement.

Each Service Director receives a weekly situation report for their complaints, displaying timescales and extensions. In addition, a complaints update is discussed at the Executive Team meeting every month, so that any areas of concern can be highlighted, and appropriate and immediate action taken.

During this year, despite the unprecedented challenges presented by Covid-19, a great deal of work has taken place to improve the quality and timeliness of complaint responses.

Highlights of work that has been done in 2020/21 are:

- The complaints process has been improved, and now delivers greater consistency in the quality of complaint responses, and faster responses to less complex complaints.
- The Complaints process is now entirely paperless, with all files stored electronically. Additionally, the independent complaint reviews carried out by the Non-Executive Directors are also now completed electronically. This is a more efficient way of working, and better for the environment too.
- The Complaints Satisfaction Survey has been revised and can now be completed online.
- The PALS and Complaints team have supported the Mass Vaccination Programme by handling and responding to general enquiries and concerns from the general public, whilst also continuing to deliver a responsive service in all other aspects of their work.

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