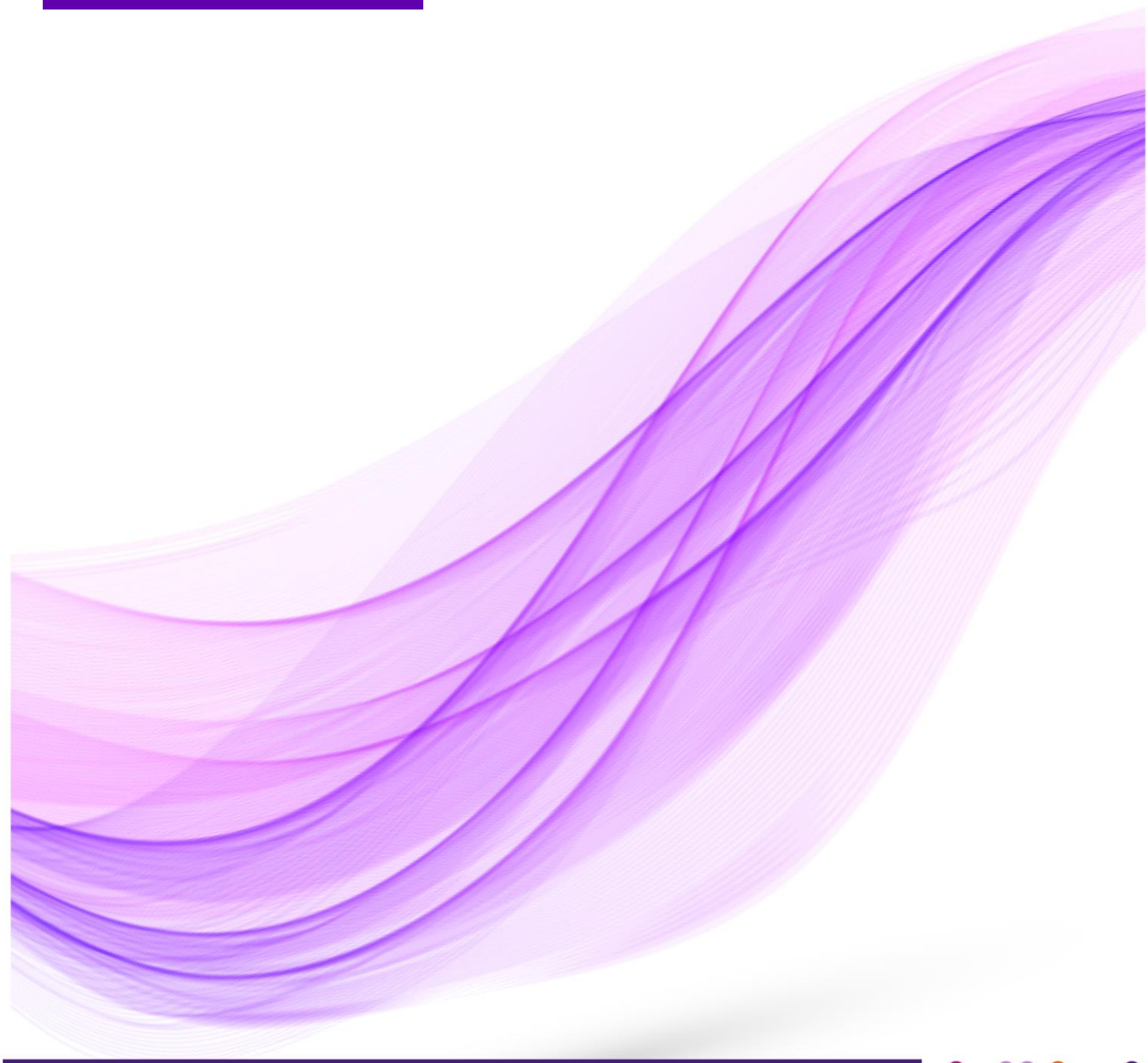
Essex Partnership University
NHS Foundation Trust

Complaints Annual Report

2018-2019



Chief Executive's Foreword

I am pleased to present Essex Partnership University NHS Foundation Trust's (EPUT) Complaints and Compliments Annual Report for 2018/19 for the period 1 April 2018 to 31 March 2019.

This is our second year as a merged Trust, between the former South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Partnership University Foundation Trust, (NEP). We are therefore able to provide comparisons to the previous year for our complaints and compliments within this report.

In the current changing and often challenging NHS service provision, I appreciate that we do not always get it right, which gives cause for patients, their relatives or carer's to raise concerns.

I firmly believe that all complaints should be taken seriously and the complainant deserves open and honest answers to their concerns. Recognising the value of timely, good quality complaint responses, the Executive team has undertaken a lot of work this year, to improve this aspect of our complaints process. In addition, my Complaints Team have proactively provided an ongoing complaints training programme to investigators and managers across the Trust to assist in providing robust investigations and responses.

This year we have introduced an electronic complaint form to the complaints page on our website; this is being utilised, as an additional means of submitting a complaint to the Trust.

As a learning Trust, we continuously look for ways to improve, identifying any learning from complaints and building that learning into improving the services we provide to patients in our Mental Health and Community Healthcare services. We have mechanisms in place to monitor implementation of learning from our complaints and any recommendations the Trust receives from the Parliamentary and Health Service Ombudsman. These are published on the Trust website.

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 continue to monitor the feedback posted on websites such as NHS website and Healthwatch. Most of the comments are left anonymously, however every attempt is made to respond individually. If this is not possible we encourage the writer to contact our Patient Advice and Liaison Service (PALS) or Complaints teams to enable us to investigate their concerns and respond accordingly.

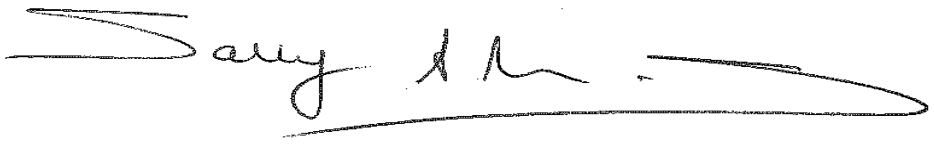
I am very pleased that people have also taken the time to leave some very heartfelt compliments for care they have received from a particular service or individual. These, as well as the concerns raised, are all communicated to the Executive Team and Service Directors.

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 Trust continues to receive a far greater number of compliments than concerns. 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.

In line with the Parliamentary and Health Service Ombudsman's "principles of good complaints handling", EPUT seeks continuous improvement in our handling of all complaints we receive. We will continue to listen to people's concerns, address them and learn from them.

Finally, I would like to use this opportunity, to thank everyone who takes the time to send in compliments about our staff and services. Positive feedback is always very welcome; it is good for me, as Chief Executive, and certainly to the staff providing services, 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 Corporate Governance and Strategy 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.

The number of compliments the Trust has received far outweighs the number of complaints about the services the Trust provides, with a ratio of nearly fifteen 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 80.1% for complaints closed within agreed timescales with the complainant. This is a decrease on last year's figure of 90%.

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

This year, the Trust had nine complaints referred to the PHSO, which is 3% of the total number of complaints received.

It should be noted that the figures stated in this report from point 3, (and those reported in the Trust's Quality Account) do not correspond with the figures submitted

by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust's internal reporting (and thus the Quality Report / Account and Annual Complaints Report) is based on the complaints **closed** within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints **received** within the period.

2.0 NUMBER OF FORMAL COMPLAINTS RECEIVED

A total of 285 formal complaints were received by the Trust during 2018/2019. The total figure represents 27 fewer complaints than the previous year. However, this was attributable to a decrease in the number of complaints for the Community Health Services in South East Essex and West Essex and the transfer of Bedfordshire Community Health Services to another provider. The number of complaints for Mental Health increased by 15 (South Essex) and 10 (North Essex). A total of 12 complaints were subsequently withdrawn, 1 complaint was not investigated as consent was withheld and 1 complaint was investigated under internal policy.

At the end of the financial year, 55 complaints remained under investigation and have been carried forward to 2019/20. All active complaints are on target to be responded to within their agreed timescales.

Table1: Number of Complaints Received by Trust area

Area	Number of Complaints Handled	
	2018/19	2017/18
Mental Health – South Essex	**128**	**113**
Mental Health – North Essex	**129**	**119**
Bedfordshire Specialist Mental Health	**2**	**6**
Total Mental Health	**259**	**238**
Community – South East Essex	**13**	**20**
Community - West Essex	**13**	**29**
Total Community	**26**	**49**
Total Complaints Received	**285**	**312**
Total Complaints Closed	**300**	**284**
Total carried forward to 2019/20	**55**	**59**

Last year's (2017/18) figure of 23 for Bedfordshire Community Services has been omitted from the above chart, the received and closed figures are therefore correct. The following figures illustrate the number of complaints received by Directorate during 2018/19.

Figure 1: Numbers of Complaints received by Directorate

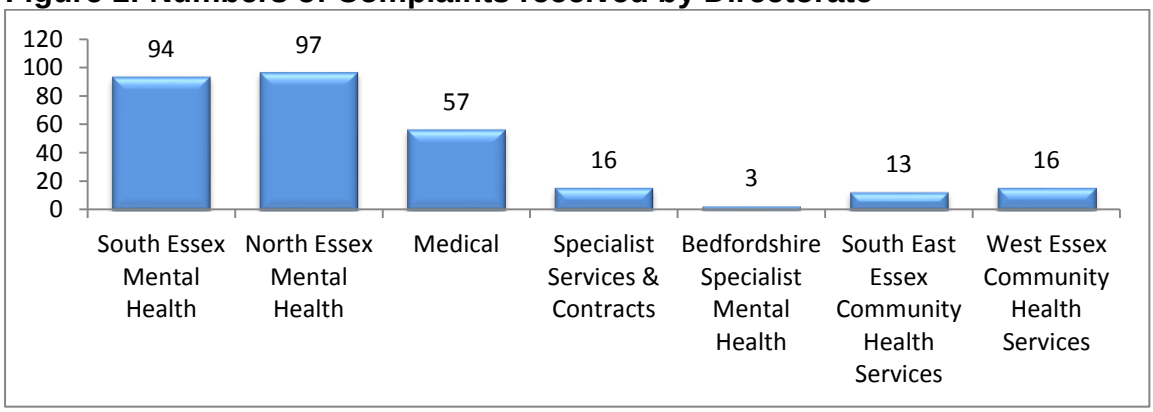
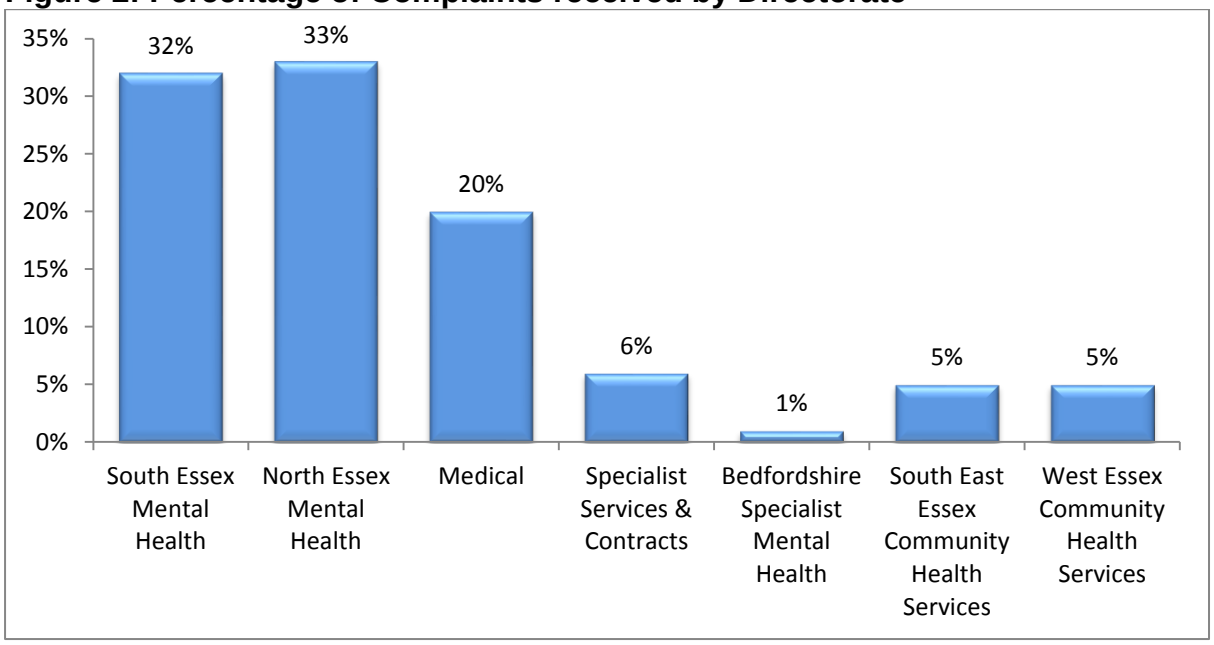


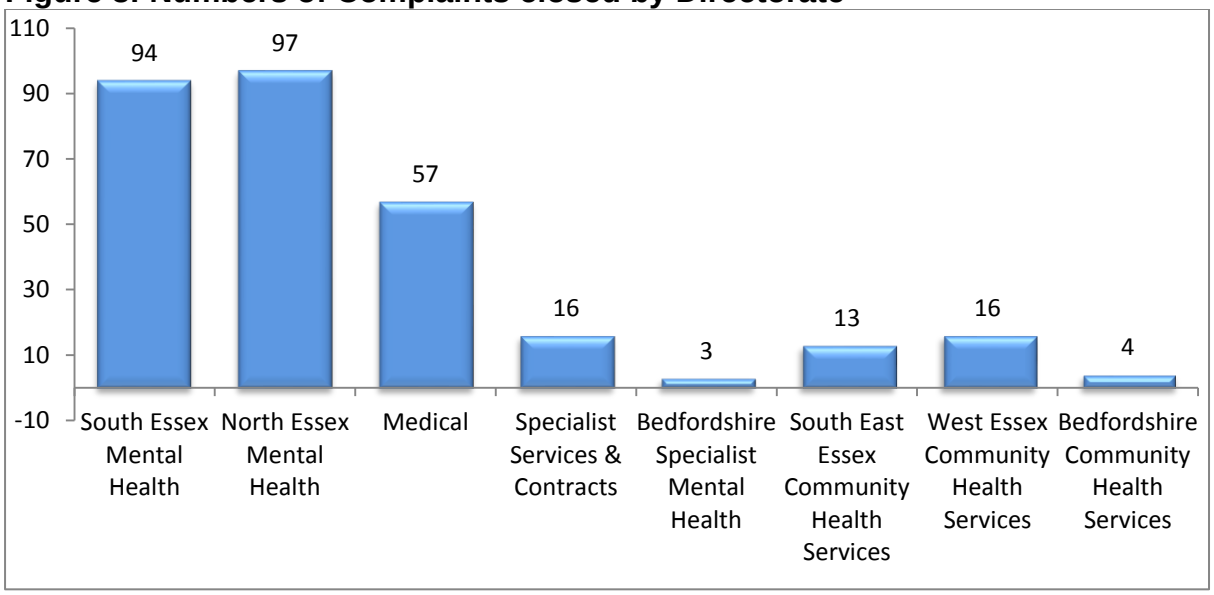
Figure 2: Percentage of Complaints received by Directorate



3.0 NUMBER OF COMPLAINTS CLOSED AND OUTCOMES

A total of 300 complaints were closed during the year.

Figure 3: Numbers of Complaints closed by Directorate



The 4 complaints closed for Bedfordshire Community Health Services were received prior to their transfer to another provider.

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		Total	
	2018/19	2017/18	**2018/19**	2017/18	**2018/19**	2017/18	**2018/19**	2017/18
South Mental Health	**5**	6	64	50	**18**	14	**87**	70
North Mental Health	**8**	11	**74**	47	**12**	15	**94**	73
Medical	**7**	9	**28**	21	**19**	14	**54**	44
Specialist Services & Contracts	**0**	0	**10**	8	**5**	6	**15**	14
Bedfordshire Specialist Mental Health	**0**	0	**3**	0	**0**	2	**3**	2
Bedfordshire Community Health Services	**0**	3	**3**	12	**1**	5	**4**	20
South East Essex Community Health Services	**1**	3	**11**	10	**1**	5	**13**	18
West Essex Community Health Services	**3**	8	**8**	15	**5**	5	**16**	28
Total	**24**	40	**201**	163	**61**	66	**286**	269

4.0 NUMBER OF COMPAINTS RESOLVED WITHIN AGREED TIMESCALE

The Trust responded to 80.1% of complaints within agreed timescales with the complainant. The average time taken to respond to complaints is 43 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 independently review their complaint as the final stage in the complaints process.

During 2018/19 a total of 9 complaints were referred to the PHSO. At the time of this report, there are 6 active cases with the PHSO. This figure includes 1 case from the former NEP where a final report is awaited. Table 3 below, illustrates the area 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 – South Essex	3	2 cases were assessed and not investigated. 1 case under investigation.
Mental Health – North Essex	5	2 cases were assessed and not investigated 3 cases under investigation
Community Health Services – West Essex	1	1 case under investigation

5.1 PHSO referrals received in 2017/18 and concluded in 2018/19

A total of 5 complaints referred to the PHSO the previous year were finalised during the timescale of this report and are shown in table 4 below.

Table 4: Complaints final reports and findings

Area	Number of Complaints Closed	Findings and Recommendations
Mental Health – South Essex The partially upheld complaints were for the former South Essex Partnership Trust (SEPT)	3	1 not upheld 2 partially upheld with recommendations: The Trust, with the council, to review their procedures for carrying out carer's assessments. Financial redress for the impact of the faults on the complainant, £750 (this was declined by complainant) The Trust to change letter templates to make clear if a patient is discharged from a ward or a section.
Mental Health – Former North Essex Trust (NEP), (included another NHS Trust and a Council)	1	Upheld Recommendations: To consider whether the respective complaints procedures adequately reflect the need for, and enable, joint investigations. Where there are joint meetings, it should be recorded who will carry out the actions and by when. Financial redress of £1,000 for avoidable distress and harm caused to family and legal costs of £2,520.
Community Health Services – South East Essex	1	Not upheld

6.0 NATURE OF COMPLAINTS RECEIVED

The top three themes for complaints for both mental health and community during 2017/2018 were dissatisfaction with treatment, staff attitude and communication. These are consistently the top three themes for the Trust, and also apply nationally across the spectrum of health services.

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

Of the 300 closed complaints, 136 were recorded within the top three themes. Of these, 106 were either upheld or partially upheld.

Table 5: 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.

Table 6: For comparison Top Three Complaint Themes 2017/18

Top Three Complaint Themes	Total number of Complaints closed (2017 / 2018)	Upheld	Partially Upheld	Total of Upheld/ partially Upheld
Unhappy with treatment	54	4	35	39
Staff Attitude	36	3	21	24
Communication	42	9	25	34
Total	132	16	81	97

The remaining number (50) were either not upheld, withdrawn, or not investigated as consent was withheld.

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 2018/19, of the 300 complaints closed, a total of 24 complaints were reopened as the complainant was dissatisfied with the Trust’s response to their

complaint. This equates to 8% 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 12 of the reopened cases; 5 further complainants cited that their response letter had contained factually incorrect information; 5 sought clarification around some of the answers provided in the response letter to their concerns and 2 said not all of their concerns had been addressed.

8.0 NUMBER OF COMPLAINTS REVIEWED BY NON-EXECUTIVE DIRECTORS

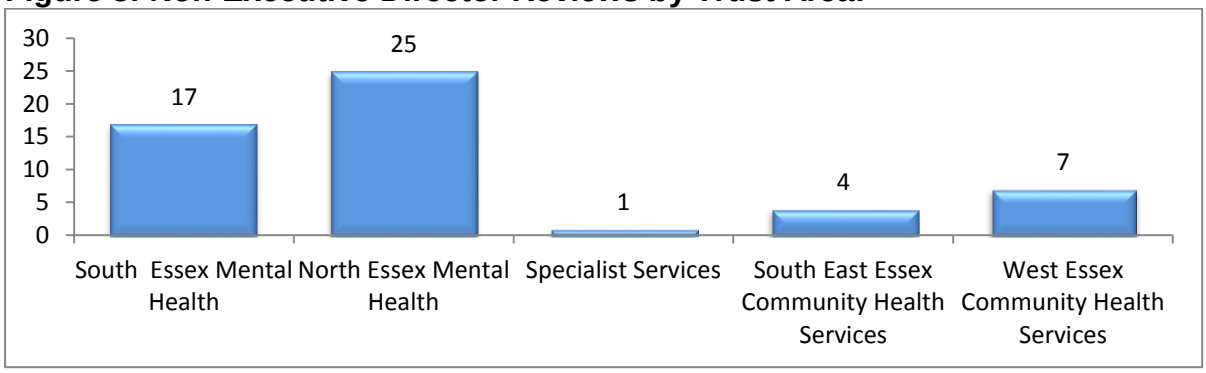
The Non-Executive Directors provide an important and valuable part of the complaints process by undertaking independent reviews of randomly selected completed complaints. During 2018/19 a total of 54 reviews were completed. They provide a level of assurance in monitoring the Trust's complaints performance.

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.

The reviewing Non–Executive Directors raised concerns or questions about 3 of the complaints they have reviewed with the Director of the service in order to obtain assurance that action plans had been completed. 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.

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)

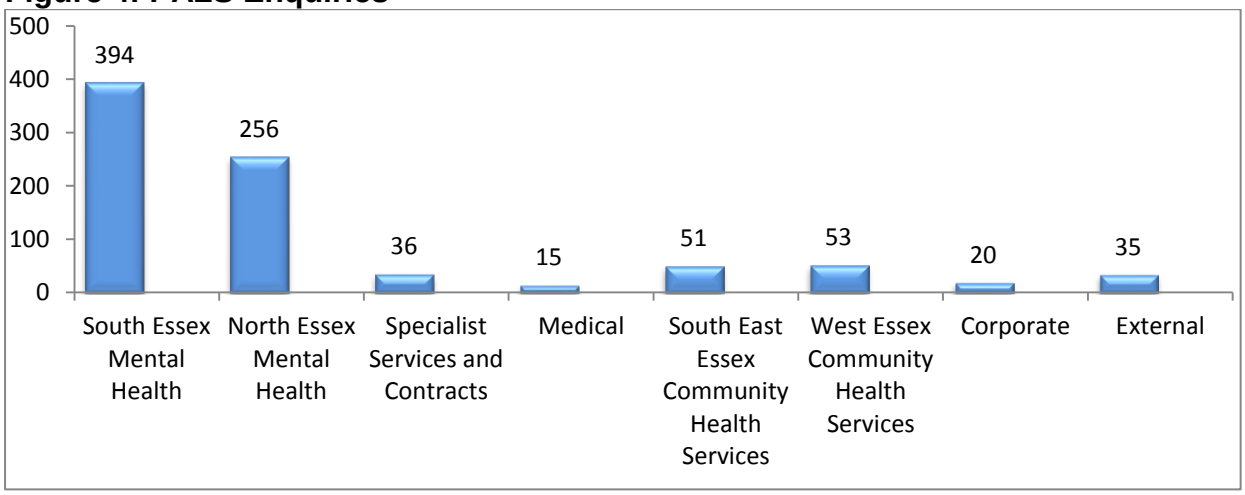
PALS provide confidential advice, support and information on health-related matters, to patients, their families and their carers.

The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires an investigation it is passed to the Complaints Team to action through the Trust's complaints process.

PALS received 860 enquiries during the year. This is a decrease of 409 from last year's total of 1269. Trends are identified in point 11 of this report.

Figure 4 shows which areas they 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 354 locally resolved concerns recorded for the year, which is the same as last year. In addition, the Trust received 59 enquiries from MPs, (6 less than the previous year), on behalf of their constituents; these are also recorded as local resolutions. The table below illustrates the area for which they were received.

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

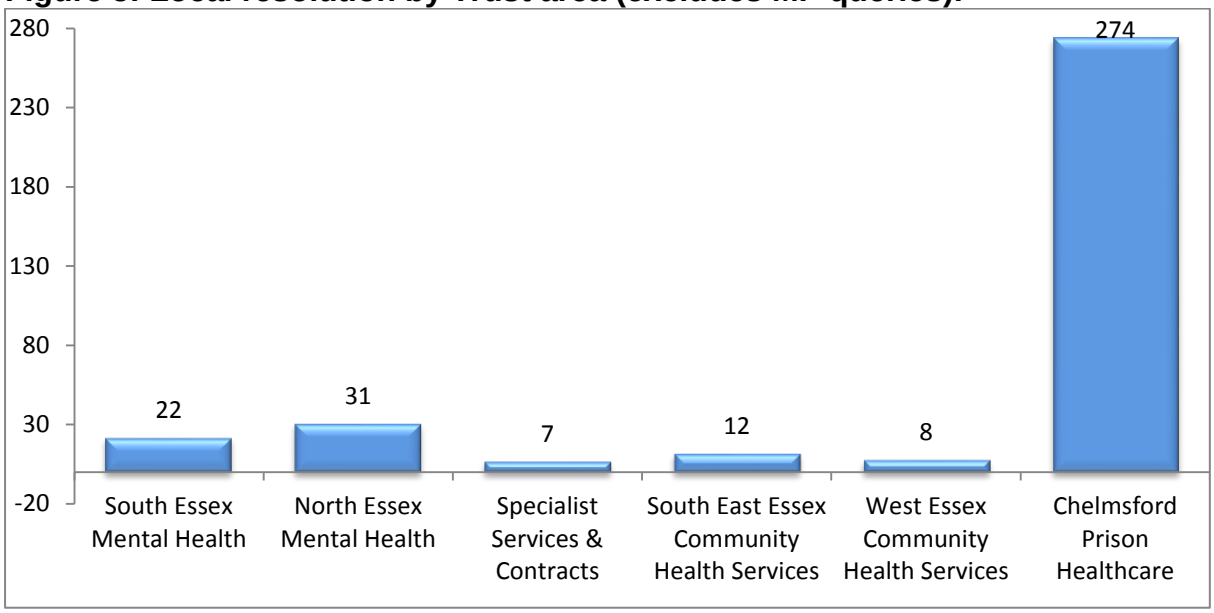
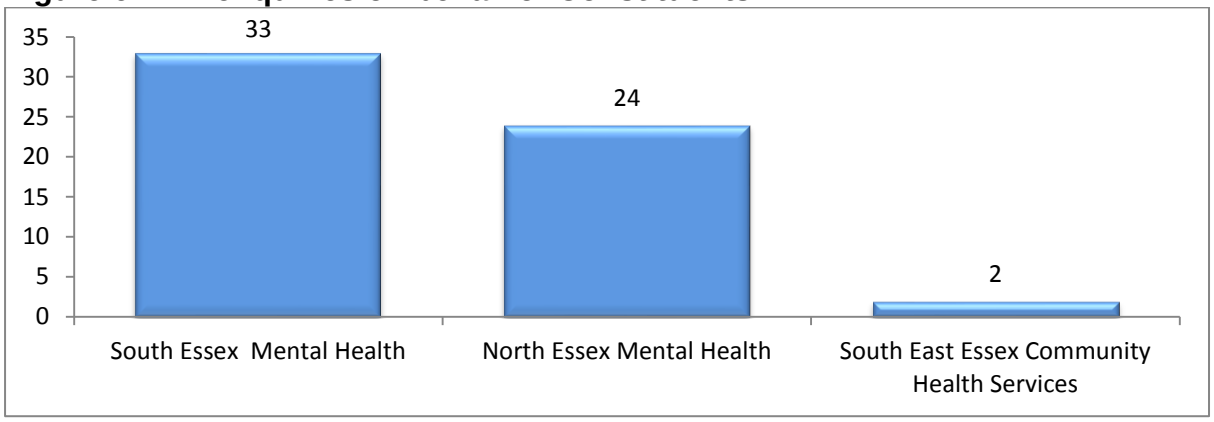


Figure 6: MP enquiries on behalf of Constituents



11.0 THEMES AND TRENDS

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

- Communication to relatives/carers regarding patient discharge arrangements.
- Lack of Community Support for Mental Health patients.
- Patient's belongings becoming lost on in-patient wards or during transfer to other wards.

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 rise in complaints about staff attitude, the complainant's thoughts on how certain comments or attitudes made them feel have been built into the Trusts Customer Service Training to give clear insight into how staff actions can be perceived.

Trends and themes are highlighted in a quarterly Thematic Report and discussed at the Patient and Carer Experience Sub-Committee as well as 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 2018/19, 31 such cases were recorded. Of these, 2 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 3 complaints became the subject of claims this year; which is half the number from the previous year. A total of 5 claims, carried over from the previous year were closed; 1 had no damages awarded, the remaining 4 had damages totalling £89,800.

Complaints are also linked to any recorded safeguarding concerns for information; 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 majority of patients the complaints related to are white British; however, in 41 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.

	South Essex Mental Health	North Essex Mental Health	Medical	Specialist Services and contracts	South East Essex CHS	West Essex CHS	Total
White – British	79	77	50	10	4	2	222
White - Irish	1	1	0	0	1	0	3
White – other white	2	1	1	0	0	0	4
Mixed white & black Caribbean	1	0	0	1	0	0	2
Indian	0	0	1	0	0	0	1
Pakistani	1	0	0	0	0	0	1
Other Asian	1	0	0	1	0	0	2
Other Ethnic Category	1	0	0	0	0	0	1
Other Black	0	1	0	3	0	0	4
Black African	1	1	2	0	0	0	4
Not Stated	5	12	2	3	8	11	41
Total	92	93	56	18	13	13	285

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 191 Complaints Handling Questionnaires for complaints closed between 1 April 2018 and 31 January 2019. Of these surveys 49 were returned fully completed (two for West Essex Community Health Services, four for South East Essex Community Health Services, one for Bedfordshire Specialist Mental Health Services, 23 North Essex Mental Health & Learning Disability and 19 for South Essex Mental Health & Learning Disability. The percentage return rate was 25.7%. Out of the 49 surveys returned 17 were positive, four were mixed and 28 were negative.

The results of the survey questions were calculated on 46 surveys (West Essex Community Health Services & Bedfordshire Specialist Mental Health Services were not included as their sample size was too small).

Questionnaires were not sent to complainants where consent to investigate was withheld or those complaints closed between January to March; the closed complaints in March will receive their feedback forms in May 2019.

Of the 49 returned surveys, 27 people felt that the staff who dealt with their complaint were helpful and polite; 22 of the people who had a negative experience felt they had not been kept fully informed throughout the complaint investigation; 23 people expressed dissatisfaction with the timescale for a response, although all but one had been responded to within an agreed timescale with the complainant; 19 people thought the complaints process was easy to access and understand.
Overall the results were as follows:

2018/2019		*2017/2018*	
Category	Number of Responses	*Category*	*Number of Responses*
Positive Experience	17	*Positive Experience*	*18*
Negative Experience	28	*Negative Experience*	*8*
Mixed Experience	4	*Mixed Experience*	*1*

The Trust has looked at ways to improve the response rate to the complaints feedback forms; previously all forms had been posted to complainants. This year where possible, the forms have been emailed. As a result the response rate has improved on last year's figure of 27 by 22 returns (over 80% increase). Although the response rate has improved, the number of complainants reporting a negative experience of their complaint handling has risen considerably.

As the main issue has been that complainants did not feel the investigator of their complaint, had contacted them either at the start of the complaint or kept them adequately informed of progress; this will be an area that the Trust will be looking to improve during this year.

15.0 INTERNET FEEDBACK

The Complaints Department monitors and responds to feedback posted on NHS Website, (formally NHS Choices) and the Healthwatch websites. The majority of the

comments are left anonymously; it is therefore not always possible to identify which particular service the person is referring to. 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.

A total of 18 negative comments and 10 compliments were posted on the site. Of the 18 comments, 3 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 lessons discussed at this committee are published in EPUT's internal Learning Portfolio Newsletter.

The lessons learned process is reviewed on a regular basis and identified learning is followed up on a quarterly basis to provide assurance that learning from complaints is both captured and embedded in everyday practice. In addition, the lessons are 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 Trust also uploads the learning from complaints onto the Trust website in the same format as Table 6 below.

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
The patient's parent requested a copy of the forms completed on two separate visits to clinic. The parent noticed that some of the answers had been changed without their knowledge or consent.	If a practitioner makes any changes to the scores on the Ages and Stages form, they will ask the family to initial the change to show they have been informed
The date of discharge to patient's own home was not discussed or communicated to the complainant, so arrangements were not in place for appropriate equipment to be available.	All wards will include in the standard operating protocol for discharge that where appropriate and consented by the patient, family and carers will be informed of the estimated discharge date within 24 hours of admission and updated if the discharge is re-arranged.

I was seen by several doctors and given incorrect advise about self-referral; it was corrected, but the new referral was not communicated to me.	Patients will be routinely copied into referral letters. This will help to improve the communication between different teams and our patients. Staff now routinely log calls from patients on the electronic records, to improve communication within teams.
A patient was upset at being transferred from a ward they had settled into, as it was being changed from an admission ward to a mental health assessment unit. The new ward had not been expecting them.	Contacting the ward receiving a patient being transferred has now become part of standardized practice. When patients are being transferred to wards in other parts of the Trust, the Nurse in Charge of the shift will record that they have telephoned the other ward giving details of the patient and the reason as to why the transfer is necessary.
Patient's belongings were mislaid during transfer to another ward. The suitcase and belongings that arrived with them were not theirs. A relative attended the previous ward and was given the correct suitcase but it was empty.	New patient's property list and folder is now in use. The option to employ housekeepers to assist with property management for patients is being explored. Part of their duties will be the recording, monitoring and management of patients' property, which should assist in reducing incidents of this type in the future.
The appointment service was unable to accommodate specific requests with the same doctor for several weeks.	A group was set-up to look at increasing the productivity of the outpatient clinics; the work will help to identify capacity issues, as well as improve the management of patients who fail to attend appointments, developing a system where these appointments can be offered to others at short notice.

17.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 4223 compliments were received by the Trust in 2018/19. Services directly received 1329 compliments and 2894 compliments were taken from the Friends and Family Test. This equates to 1606 for Mental Health Services and 2597 for Community Health Services. In addition, 20 compliments were received for Corporate Services. Compliments are also recorded from NHS feedback websites and included in the figures above.

Compared to last year's figure of 4733 compliments, it appears that the Trust has experienced a decrease of 510 compliments this year. However, as Bedfordshire Community Services (no longer part of the Trust), received 1703 of that figure, the Trust has actually seen an increase of nearly 40%.

The Trust logged compliments against the Trust values of Open, Compassionate and Empowering; the numbers are shown below;

Open	26
Compassionate	1000
Empowering	119

Compliments from the Friends and Family Test, which produced a total of 2,894 compliments are not included in the values above.

Staff always appreciate positive feedback; to ensure good practice is shared across the Trust. A selection of compliments is published regularly in the internal newsletters, and uploaded on to 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. A selection of the compliments received is shown in appendix 1 of this report.

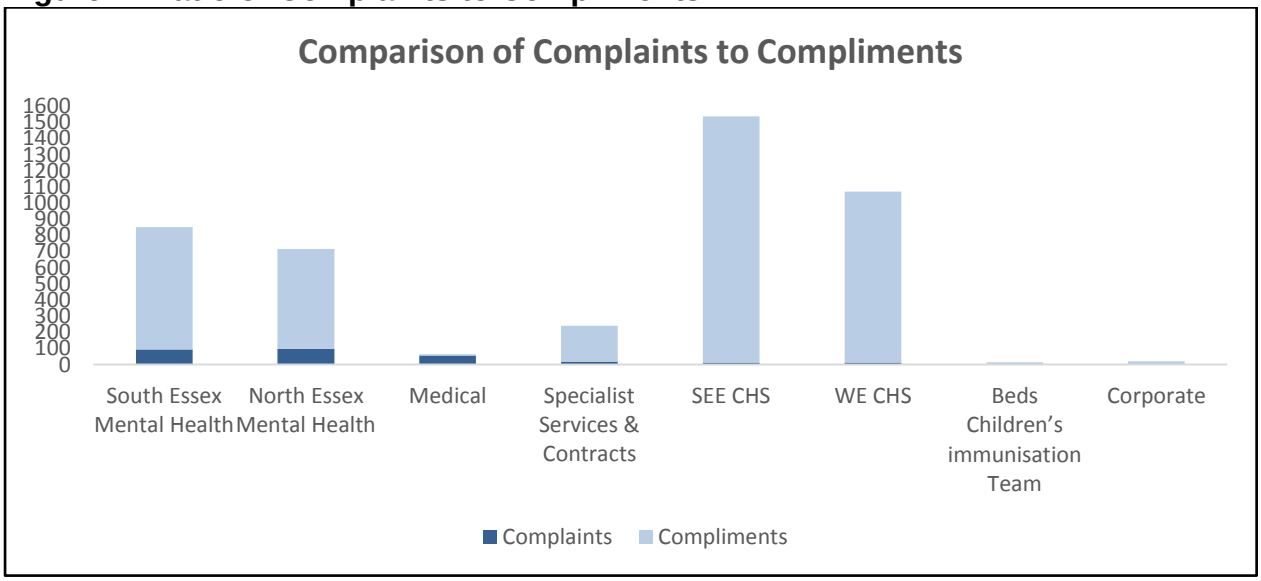
Table 7: Compliments received by area

Area	Number of Compliments Received
South Essex Mental Health	757
North Essex Mental Health	620
Medical	8
Specialist Services and Contracts	221
South East Essex Community Health Services	1524
West Essex Community Health Services	1059
Bedfordshire Immunisation Team	14
Corporate Services	20

Table 8: Ratio of Complaints to Compliments

Compliments by Area	No. Rec'd	Ratio Complaints to Compliments	Complaints by Area	No. Rec'd
South Essex Mental Health	757	0.12	South Essex Mental Health	94
North Essex Mental Health	620	0.16	North Essex Mental Health	97
Medical	8	7.13	Medical	57
Specialist Services & Contracts	221	0.09	Specialist Services & Contracts	19
SEE CHS	1524	0.01	SEE CHS	13
WE CHS	1059	0.01	WE CHS	13
Beds Children's immunisation Team	14	0.00	Beds Children's immunisation Team	0
Corporate	20	0.00	Corporate	0

Figure 7: Ratio of Complaints to Compliments



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:

The parents of a patient contacted the Trust to raise concerns regarding patient B's Multi-Disciplinary Team (MDT) meeting. They believed that patient B was not assessed fairly and they sent an email the following day highlighting this. They said that the assessor did not look at the daily or night time logs that were available. They felt that input should have been supplied by the care workers who keep patient B stable with a lot of timely preventative actions including long period of time spent persuading the patient to take food. On the assessed level of needs section 2, patient B's mobility had been graded as medium but there had been slow deterioration, not improvement, over the years, which the parents felt proved the need for professional care assessment at this review and not just the parents and patient's input.

Trust Response:

The complainant was contacted by a senior manager, who discussed the complaint with them, and acknowledged that the initial assessment team appeared unclear in explaining both their role and the process. The complainant was advised that staff had not followed the Continuing Health Care (CHC) NHS Framework.

The complainant was thanked for bringing their concerns to our attention and apologies were given for any distress the process had caused. It was recognised that there are improvements to be made and assurances were given that action has been taken by the Trust **and** West Essex Clinical Commissioning Group (CCG) to develop a standard operating protocol to support clinicians to adhere to the CHC framework

Outcome:
Complainant was pleased to hear that the trust's expectation and that of the Clinical Commissioning Group (CCG) was in line with their own; and that the review should have been completed sensitively, professionally and holistically and should have included input from all agencies and care providers that support patient B.

The Community Matron reviewed the care plan and assurance was given that a CHC review would take place. The Complainant was reassured and happy that a senior manager had taken the time to call and discuss their concerns.
The complaint was resolved locally and upheld.

Story 2

Complaint:

Complainant raised concerns about the length of time taken for their relative to be seen and assessed. Once assessed, a decision was made to sectioned patient C, but the parents had no say in this. They could also not understand why medication was not given to calm patient C down.

Patient C was admitted to the Assessment Unit, and subsequently transferred to another ward. The complainant felt there was an apparent lack of communication between the two wards regarding medication, with Lorazepam not being given on the ward, yet was effective on the Assessment Unit. The complainant said they were neither informed of the transfer to another ward, which had differing visiting times, nor informed of what medication was being given to the patient. The complaint also queried why patient C was asked to sign a consent to share form, when they were not mentally fit.

The complainant also raised concerns regarding the lack of support since the Carer Link Worker had left their role. In addition, they found it difficult to cope with patient C following discharge.

Trust Response:
The Trust explained that the delay in arranging a Mental Health Assessment (MHA) was due to the logistics of necessary staff, the Trust was satisfied the Approved Mental Health Professional (AMHP) had acted promptly and explained that they could not progress the MHA until the doctors were present.

Reassurance was given that every effort was made by the Psychiatrist to provide the patient with the appropriate medication to calm them down.

The Trust apologised for the parents not being informed of patient C's transfer to another ward and explained that the parents were not advised of what medication was being given to patient C as this is not generally discussed with family members; in addition, there was no consent to share information.

Outcome:
The Care Co-ordinator met with the complainant and arranged a carer's assessment and discussed support options such as Therapy for You to help the complainant cope better. A carer's leaflet and a list of supporting organisations was also provided.
The complaint was partially upheld.

Story 3

Complaint:

Patient D (the complainant), was referred to an in-patient ward as a health professional thought they had a Mental Health issue; patient D said they had a severe UTI instead.

The complainant said they were not permitted to make any telephone calls for a few weeks; a member of staff had broken patient D's watch, and they were refused pain relief medication. The patient also complained that they had been made to rush their Christmas dinner. The complainant said they had been discharged from the ward, with no care package in place.

Trust Response:
The investigation found that patient D's watch was broken because the patient had thrown it onto the floor; staff had picked up the broken pieces and held them in the ward safe for safe-keeping. The patient often arrived late to the canteen, which has a designated and fixed time to be open as it is shared with another ward. Patient D therefore had less time to finish their meal.

There was no record of any staff refusing pain medication, nor was this raised by patient D whilst on the ward.

Outcome:
Confirmation was given that a suitable and acceptable home care package had been arranged between the patient and the care provider prior to discharge.
The complaint was not upheld.

19.0 AIMS FOR 2019/2020

During the next year we will:

- Build on the work already in place by the Complaints Team to mitigate recurring themes. The Complains Team has worked closely with the Compliance Team where emerging trends or themes have been identified in complaints; this enables spot checks on wards to be carried out where appropriate.

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

- Continue to improve Identifying learning from complaints, and ensuring this is disseminated across the Trust.

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

- Build into complaints training, the importance of investigators making initial contact with complainants and also keeping them updated throughout the investigation.

- Undertake further work to promote the many compliments received by services.

- Review our Complaints Policy and Procedure to reflect the changes made to our quality checking process.

20.0 CONCLUSION

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

We are always looking at ways to improve our complaints pathway for complainants. The introduction of an on-line complaints form requesting pertinent information, has reduced the number of email exchanges prior to a full investigation

Complaint timescales and progress of open complaints continue to be closely monitored, always seeking improvement. Each Executive Director receives a weekly situation report for their services, 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. As a result, redacted complaints received in this category, are used in Customer Service training, so that staff can see and understand the impact some comments or actions have on patients, their relatives and carers. The number of complaints and PALS enquiries relating to patient's missing property has also been of concern; several improvements have been put in place to try to mitigate these events.

It is clear from the complaint feedback forms that improvements must be 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.

Report produced by:

Pam Madison
Head of Complaints

On behalf of:

Nigel Leonard
Executive Director of Corporate Governance and Strategy
May 2019

Appendix 1

Selection of compliments received 2018/19

Palliative Care Team South East Essex Community Healthcare. We just wanted to say thank you for everything you have done for our mum. She thought the world of you and we honestly don't know what we would have done without you. We will always remember your professionalism, kindness, compassion and in the end, dignity you showed our mum. Thank you forever.	***CAMHS, Larkwood Ward, North Essex*** You have all helped me so much. This is honestly the best hospital I've been to and that's thanks to all of you. You are all heroes because you all save lives. I hated this place when I came but now I don't want to say goodbye. You all helped make this experience easier. I can't thank you enough because you helped me realise that I have so much to live for.
Clifton Lodge, Care Home, South Essex My heartfelt thanks for your warm reception and generous hospitality. My family are so grateful for the loving care you and your staff gave mum. I could not have wished for a better place to end her days.	***Eating Disorders North Essex Mental Health.*** To the most caring bunch of people I've ever met. You are all stars in my eyes. I couldn't wish for better support. Thank you for putting up with me and being there when I've needed you. This really is a special place. Thank you all.
Specialist Psychosis Team North Essex Mental Health. Absolute heroes: I have had ongoing mental health problems my whole life. Since being with my CPN, consultant and Psychologist my life is completely different. The team have worked tirelessly over the last 4 years and the continuity of care I have received has really made the difference. You are amazing and despite recent budget cuts and a high demand on the service the quality has never changed. Keep doing what you do and thank you all.	***Beech Ward, Rochford. South Essex Mental Health.*** A massive thank you to all the doctors, nurses and staff involved in our mother's treatment, care and recovery. The night staff, canteen staff and cleaners and particularly the Nurses, all gave our mother the most amazing care, compassion and attention to bring our mum back to her old self. Sadly we only hear the bad bits from within the NHS, but the care and service our mum received on Beech Ward, was a shining example of the NHS at its very best.
Rainbow Unit, North Essex Mental Health Rainbow staff were all outstanding going the extra mile to ensure that patients felt welcome, supported and valued. It was fabulous to be supported by such an amazing team and even more fabulous to be with my precious baby while unwell. The time we were separated was intolerable and my recovery is owed to the staff at Rainbow and being reunited with my baby.	***Mental Health Assessment Unit South Essex Mental Health*** From the bottom of my heart many, many thanks for your art activities. You make people feel like they belong somewhere,, my confidence has grown. You have allowed me to have headspace in the art I have done for four days. The brightness of the colours has given me gracefulness and to believe I can get better. Thanks for your kindness, patience and laughter. I wish you well!

Children's Immunisation Team – Bedfordshire. Your nurses were fabulous as they assisted with an incident in school, which ended up requiring an ambulance with a child. They were very professional and knowledgeable and a pleasure to have in school.	***District Nurses, South East Essex Community Healthcare.*** Sincere thanks for your professional care of my mother and all your kindness and consideration towards her; it made all the difference to her, and thus to me also. The NHS is blessed to have you all and we are most fortunate to have your care in our local community.
Home Treatment Service North Essex Mental Health. I cannot praise enough, the help my son received after a mental health crisis. The home Treatment Service members visited him from the following day and every day for the next couple of weeks until he was well enough to be discharged back to his own GP. When a young person harms themselves and is in the depths of despair, it affects the whole family. I felt everything possible was done for him and I was also informed of how to seek help if required for myself, his dad and his siblings.	***Rawreth Court, Care Home, South Essex*** We were so impressed with the unit and the staff there. The little touches like the street names, vintage style posters on the walls, door decorations (which I loved) and personalised boxes outside of the rooms really made it feel less like a nursing home and more like a community, the unit is absolutely spotless. Every member of staff who passed us said hello or smiled. When we left the staff included nan in the singing and made sure she was settled and not upset when we left.
Avocet Ward, West Essex Community Healthcare We are writing to express our appreciation of the amazing and caring staff working on Avocet Ward. Our mother recently transferred to Avocet Ward from another Hospital after a very negative experience. The sense of relief and gratitude we felt was palpable when we realised what a brilliant hospital Saffron Walden is. The care and commitment of all the staff was exemplary.	***Meadowview Ward, South Essex Mental Health*** My lovely dad who spent many weeks with you in your excellent care has sadly passed away. He is finally at rest from that terrible disease called dementia. You will remember how much he loved to sing and dance so the angels are set for one big party now. Thanks to every one of you for helping him in his last tormented months and helping him so much to get through each day without hurting anyone. Keep doing what Angels do on earth.

Compliments are also received from professionals from other Trusts; the sentiments below were expressed to the Paediatric Community Nursing Team & Specialist Nurses Willow Ward, South East Essex Community Health Services, by staff from Neptune Ward Southend Hospital.

I wanted to make you aware of the fantastic team work and to hear positive feedback regarding your team with a patient. Your nurses responded to the request for support with professionalism and compassion to not only the family, but to the ward staff.

The family were extremely grateful to see all the team and this also enabled my team to undertake the medical actions and ensure that the family had continuous emotional support during the time your team were here. On a personal note, each member of the team asked after my wellbeing and my band 5 nurses during the afternoon and I feel that compassion such as this is humbling and a credit to our profession.