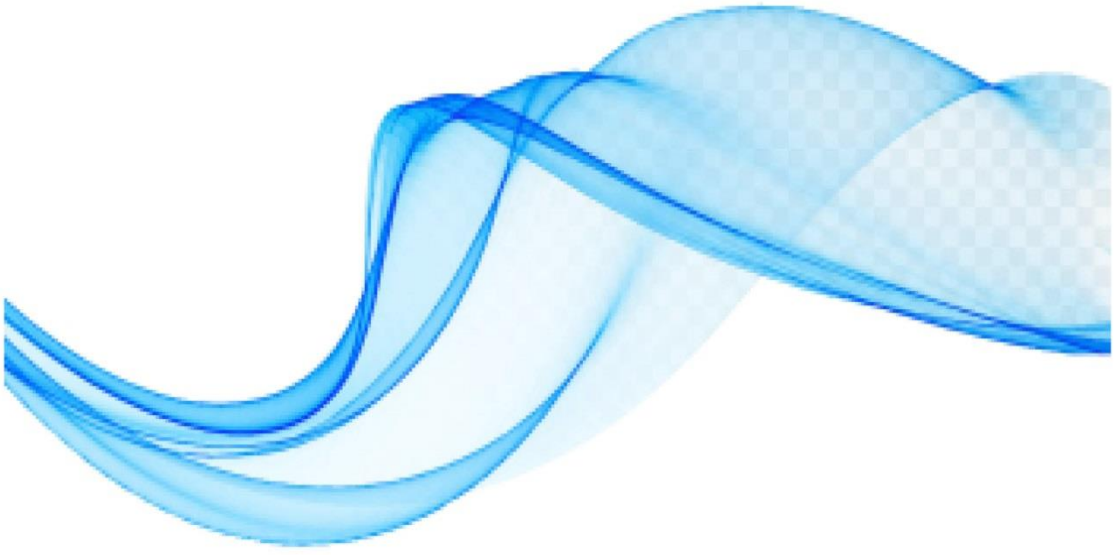
Essex Partnership University
NHS Foundation Trust

Complaints Annual Report

2017 - 2018



Chief Executive's Foreword

I am pleased to present our Complaints & Compliments Annual Report for 2017/18 for the period 1 April 2017 to 31 March 2018.

This is the first Complaints Annual Report for Essex Partnership University NHS Foundation Trust (EPUT). The Trust was formed with the merger of the former South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Foundation Trust (NEP) on 1 April 2017.

Due to this being our first year as a new organisation, there will not be the usual comparisons to previous year's statistics throughout this report. Going forward, however, we will build a picture year on year to understand where improvements need to be made.

Complaints are a valuable source of feedback for the Trust; they are taken seriously and are responded to appropriately on an individual basis. We monitor the feedback posted on websites such as NHS Choices and Healthwatch. Some very pleasing compliments have been left for services, and these, as well as the concerns raised, are communicated to the Executive Team and responded to on the relevant sites. Where concerns have been left anonymously, the author is encouraged to contact our Patient Experience Team as we would like the opportunity to be able to respond directly to them.

It is very important to me that individuals feel that they have been treated with respect and receive an open, honest and timely response to their concerns. Complaint response times are monitored by the Complaints Department and the Executive Team. Any themes or trends noted are discussed at the Patient and Carer Experience Steering Group.

EPUT is a learning Trust and I am committed to making continuous improvements to both the timeliness of responses to complainants, ensuring we learn from people's experiences, and use that learning to improve the services we provide, in both Mental Health and our Community Healthcare Services.

As a way of ensuring Trust-wide learning, any recommendations and actions taken from the Parliamentary and Health Service Ombudsman's (PHSO) reports on referred cases are discussed at our Learning Oversight Committee with a view to making improvements and reducing repeat concerns.

EPUT has a robust and rolling complaints training programme in place to help and support current complaint investigators, as well as those new to investigating complaints, to deal effectively and efficiently with complaints and concerns.

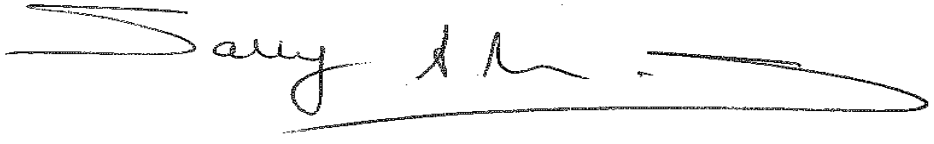
Our Non-Executive Directors provide an important service in undertaking monthly independent reviews of the complaints handling process to provide assurance that the Trust is providing high quality investigations and responses, and appropriate learning actions are identified.

We have introduced a "you said, we did" section to our website so that staff and the public can view the concerns raised and what the Trust has put in place to improve matters.

Compliments are also being displayed on the website through our service pages so everyone can share the sincere and often moving sentiments of appreciation expressed to staff.

Although the Trust has received a greater number of compliments than concerns, I am not complacent about the need to make further improvements. We are a large new Trust and there have been challenges in seamlessly harmonising services from the previous two organisations, however, 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 and trouble to send in compliments about our staff and services. Positive feedback is always welcome; it is good to hear when we have got it right as well as hearing when, perhaps, this has not been the case. All feedback helps us to learn from and improve our services for our patients, carers and relatives.



Sally Morris
Chief Executive

EPUT COMPLAINTS ANNUAL REPORT 2017/2018

1.0 INTRODUCTION

EPUT provides Mental Health and Learning Disability Services and Community Health Services for a population of approximately 2.5 million people throughout Bedfordshire, Essex, Suffolk and Luton; staff provide services 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 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. A small selection of compliments is shown on page 20, appendix 1.

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

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

This year the Trust has achieved 90% for complaints closed within agreed timescales with the complainant. Data from the latest NHS Benchmarking Club (2016), showed that on average fewer than 80% of complaints were closed within agreed timescales across all Mental Health Trusts.

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

This year, the Trust had ten complaints referred to the PHSO, which is less than 4% of the number of investigations undertaken.

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 312 formal complaints were received by the Trust during 2017/2018. 5 complaints were subsequently withdrawn and 9 complaints were not investigated as consent was withheld.

At the end of the financial year, 59 complaints remained under investigation and have been carried forward to 2018/19. 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
Mental Health – South Essex	**113**
Mental Health – North Essex	**119**
Forensic - Bedfordshire & Luton	**6**
Total Mental Health	**238**
Community - Bedfordshire	**23**
Community – South East Essex	**20**
Community - West Essex	**29**
Total Community	**72**
Other - Corporate and GP practice	**2**
Total Complaints Received	**312**
Total Complaints Closed	**284**
Total carried forward to 2018/19	**59**

- **A total of 31 complaints closed this year were complaints received prior to merger of the 2 previous Trusts and carried forward to 2017/18.**

The following figures illustrate the number of complaints received by Directorate during 2017/18.

Figure 1: Numbers of Complaints received by Directorate

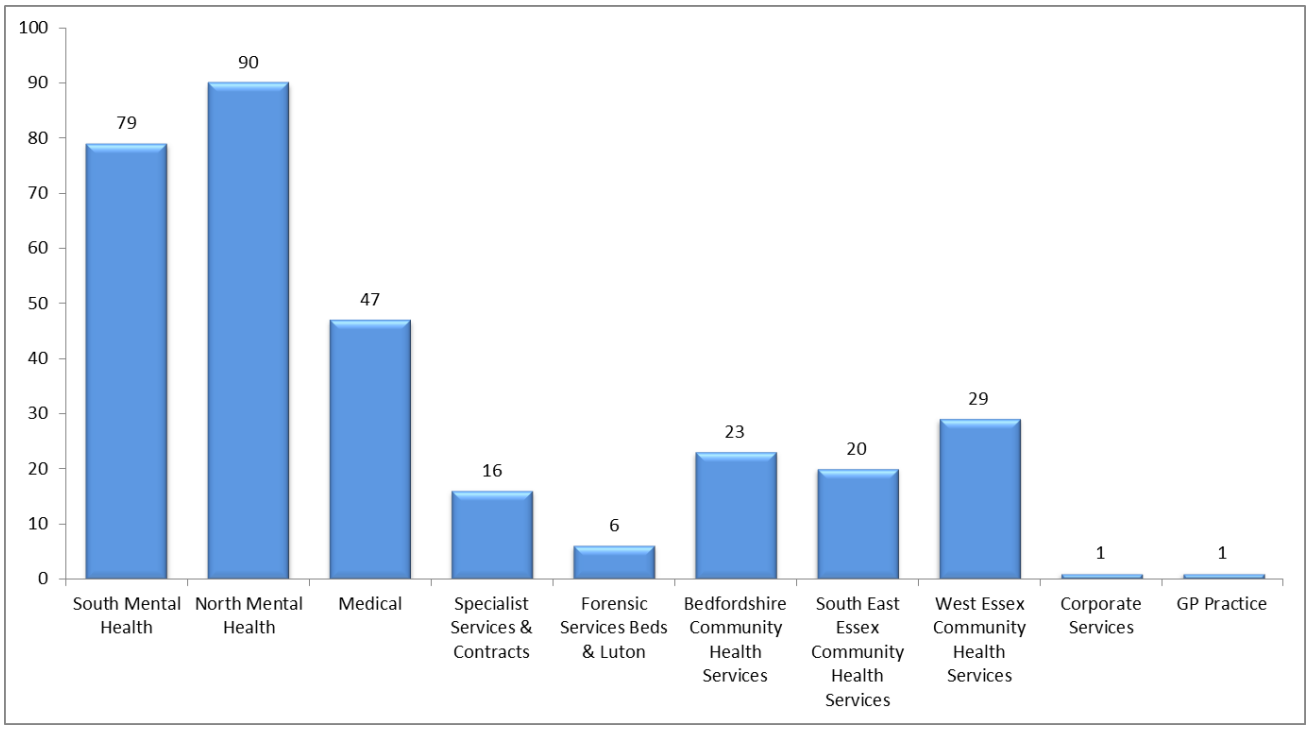
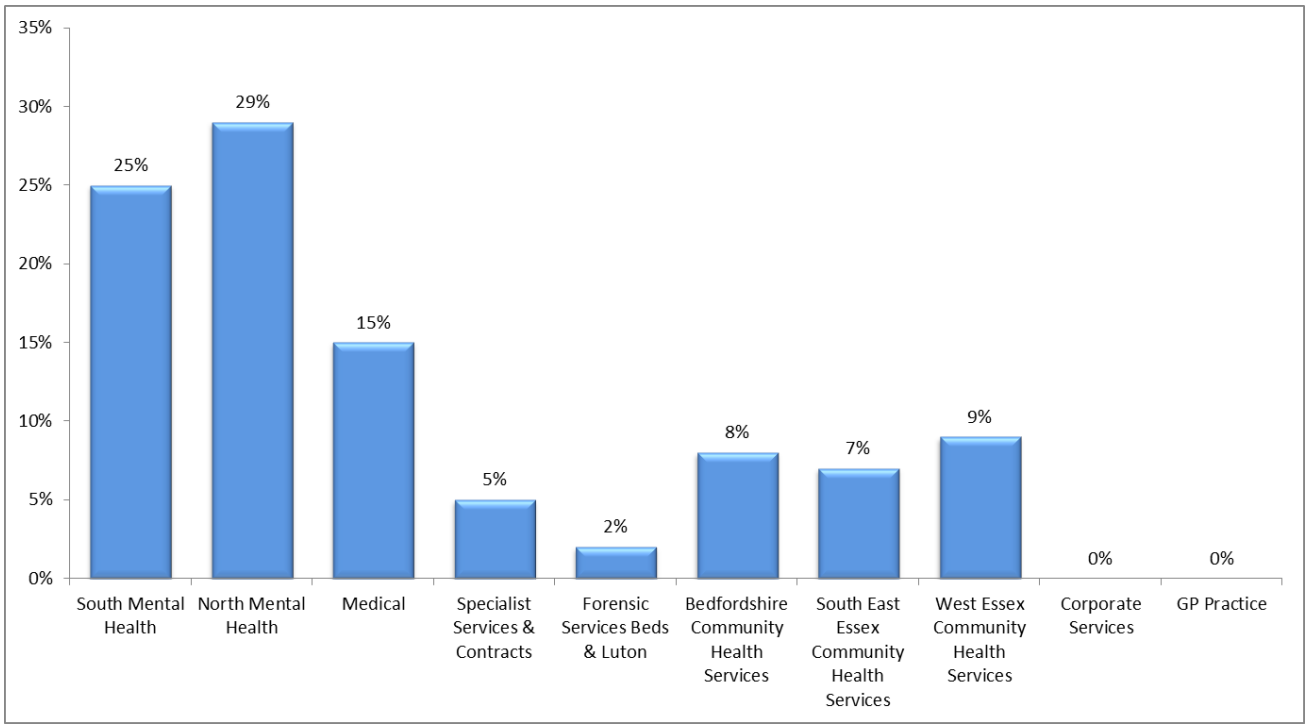


Figure 2: Percentage of Complaints received by Directorate



3.0 NUMBER OF COMPLAINTS UPHELD/PARTIALLY UPHELD

A total of 284 complaints were closed during the year.

South Mental Health	North Mental Health	Forensic Bedfordshire	Bedfordshire Community	South East Essex Community	West Essex Community	Total
91	95	4	19	18	26	253

In addition, 22 complaints were closed for the former SEPT and 9 for the former NEP. The outcome of these complaints is shown below.

Upheld	Partially Upheld	Not Upheld	Total
40	163	66	269

The remaining 15 comprise of:

- 9 not investigated (consent withheld)
- 5 withdrawn
- 1 conduct and capability

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
South Mental Health	6	50	14	70
North Mental Health	11	47	15	73
Medical	9	21	14	44
Specialist Services & Contracts	0	8	6	14
Forensic Services Beds and Luton	0	0	2	2
Bedfordshire Community Health Services	3	12	5	20
South East Essex Community Health Services	3	10	5	18
West Essex Community Health Services	8	15	5	28
Total	40	163	66	269

4.0 NUMBER OF COMPAINTS RESOLVED WITHIN AGREED TIMESCALE

The Trust responded to 90% of complaints within agreed timescales with the complainant. The average time taken to respond to complaints is 44 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 2017/18 a total of 10 complaints were referred to the PHSO.

To date, there are 7 active cases with the PHSO. This figure includes 4 cases from the former Trusts. 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	Comments
Mental Health – South Essex	4	1 case was discontinued. 1 draft report received. 2 active cases.
Mental Health – North Essex	3	1 upheld – Trust paid £500 for the impact failings had on complainant. Action plan completed to address failings. 2 not upheld
Community Health Services – Bedfordshire	1	1 not upheld
Community Health Services – South East Essex	2	1 not upheld 1 active case

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 Steering Group.

Of the 284 closed complaints, 147 were recorded within the top three themes. Of these, 109 were either upheld or partially upheld.

Table 4: Top Three Complaint Themes

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 2017/18, of the 284 complaints closed, a total of 14 complaints were reopened as the complainant was dissatisfied with the Trust's response to their complaint. This equates to less than 5% 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. 2 further complainants cited that their response letter had contained factually incorrect information; 2 sought clarification around some of the answers provided in the response letter to their concerns and 1 said not all of their concerns had been addressed.

8.0 NUMBER OF COMPLAINTS REVIEWED BY NON-EXECUTIVE DIRECTORS

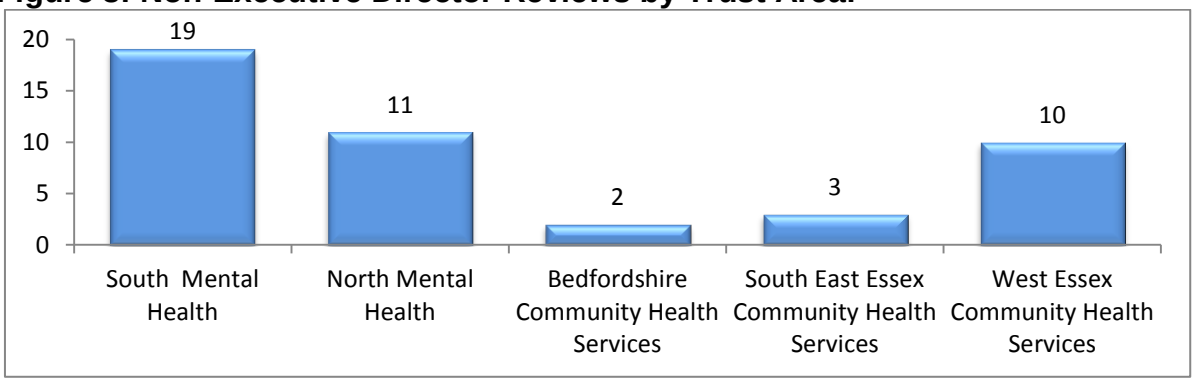
The Non-Executive Directors provide an important and valuable part of the complaints process by undertaking independent reviews of randomly selected completed complaints. During 2017/18 a total of 45 reviews were completed. They provide a level of assurance in monitoring the Trust's complaints performance.

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 4 of the complaints they have reviewed with either an Executive Director or Director of the service. 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.

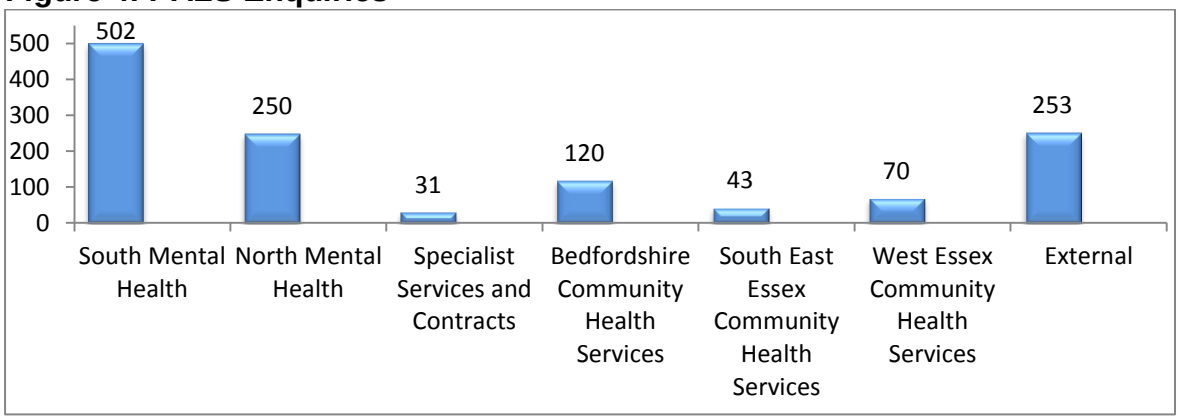
Figure 3: Non-Executive Director Reviews by Trust Area:



9.0 Patient Advisory Liaison Service (PALS)

PALS received 1269 enquiries during the year. 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 can prevent an escalation to a formal complaint. This year, the complaints training to staff has reiterated the benefits to both staff and complainants by locally resolving complaints where possible. Local resolutions are recorded on a "Local Resolution Monitoring form" by staff and forwarded to the Patient Experience Team to record electronically.

There was a total of 354 locally resolved concerns recorded for the year. In addition, the Trust received 65 enquiries from MPs 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):

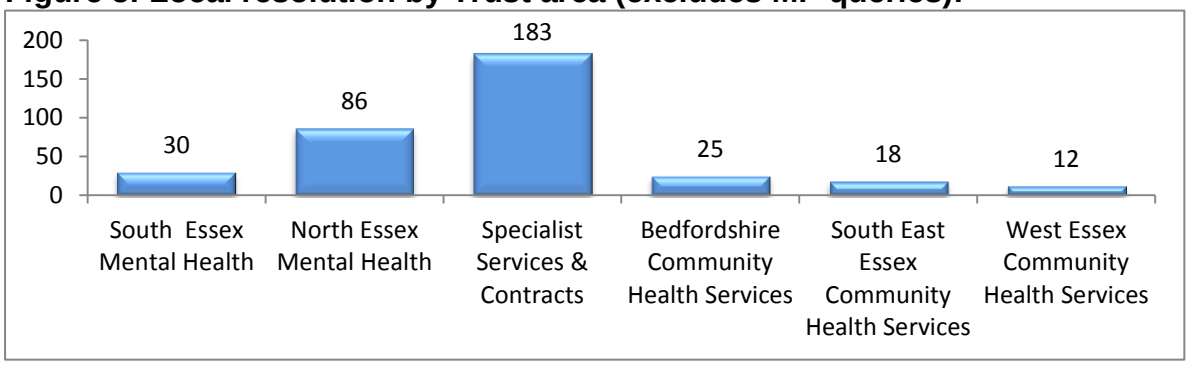
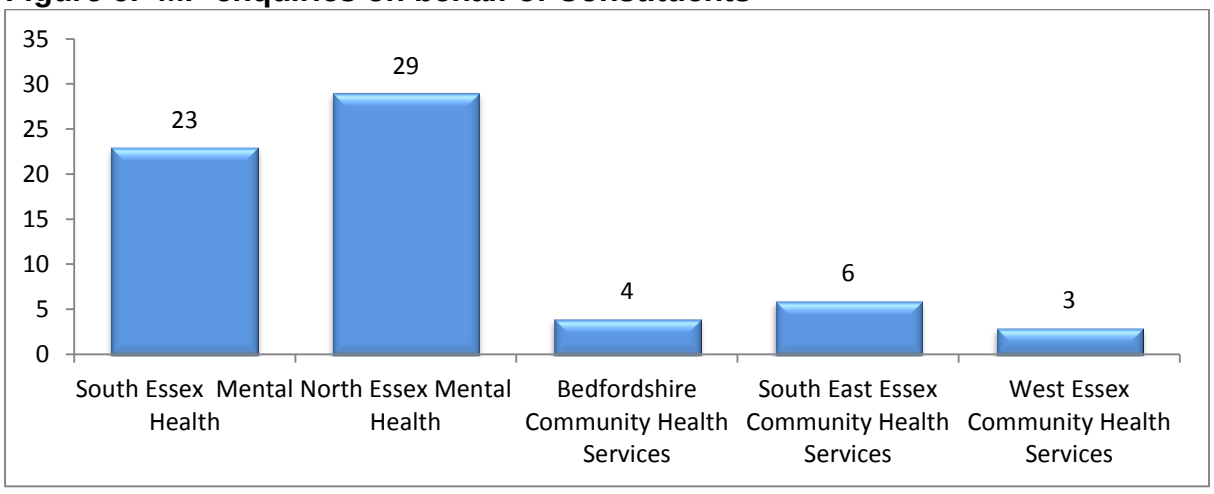


Figure 6: MP enquiries on behalf of Constituents



11.0 THEMES AND TRENDS

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

- 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.

Trends and themes are highlighted in a quarterly Thematic Report and discussed at the Patient and Carer Experience Steering Group.

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 2017/18, 30 such cases were recorded. Of these, 3 complaints were linked to serious incidents and 7 to critical incidents.

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 Group.

A total of 6 complaints became the subject of claims this year. All are currently ongoing.

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 141 cases the patient either did not return the form or they 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	Forensic Services Beds and Luton	Bedfordshire CHS	South East Essex CHS	West Essex CHS	Total
White – British	65	41	29	6	2	2	4	1	150
White – other white	3	1	1	0	1	0	0	0	6
Mixed white & black Caribbean	1	1	0	0	1	0	0	0	3
Other	1	1	0	0	0	1	0	1	4

Mixed									
Indian	0	0	1	0	0	0	0	0	1
Pakistani	0	1	0	0	0	0	0	0	1
Other Asian	0	0	1	0	0	0	0	0	1
Black African	3	1	0	0	0	0	0	0	4
Black Carribean	1	0	0	0	0	0	0	0	1
Not Stated	7	45	15	10	1	20	16	27	141
Total	81	91	47	16	5	23	20	29	312

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.

Despite trying different ways to improve the response rates, such as emailing, the response rate to the complaints questionnaires is disappointing. The Trust sent out 165 Complaints Handling Questionnaires for complaints closed between 1 April 2017 and 31 January 2018. Of these surveys 27 were returned fully completed (5 for West Essex Community Health Services, 4 for Bedfordshire Community Health Services, 2 South East Essex Community Health Services, 11 North Essex Mental Health & Learning Disability and 5 for South Essex Mental Health & Learning Disability. The percentage return rate was 16%. Out of the 27 surveys returned 18 were positive, 1 was mixed and 8 were negative.

The results of the survey questions were calculated on 21 surveys (Bedfordshire Community Health Services & South East Essex Community Health Service 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 in March which will receive their feedback forms in May 2018.

Overall the results were as follows:

- Positive experience 18 responses.
- Negative experience 8 responses.
- Mixed experience 1 response.

Of the 27 returned surveys, 18 people felt that the staff who dealt with their complaint were helpful and polite; 7 of the people who had a negative experience felt they had not been kept fully informed throughout the complaint investigation; 9 people expressed dissatisfaction with the timescale for a response, although all 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 comments provided on the returned forms are shared with the relevant Director.

15.0 INTERNET FEEDBACK

The Complaints Department monitors and responds to feedback posted on NHS Choices and the Healthwatch websites. This is another important source of feedback for the Trust. The majority of the comments are anonymous; it is therefore not always possible to identify which service or staff members the person is referring to. Every effort is made to respond individually, and 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. However, none of the authors of the comments have contacted the Trust, therefore, although their concerns are passed to the relevant Director to make them aware, they are not included in the complaints numbers. All were responded to generically. Compliments have also been posted and responded to as well as being recorded and sent to the service.

A total of 19 negative comments and 18 compliments were posted on the site. Of the 19 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 learnt from complaints, and the Trust wide value in sharing these with appropriate members of staff.

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

As noted in section 12 the Trust has a Lessons Learned Oversight Committee which ensures that any learning is taken forward and implemented within service delivery. Some lessons discussed at this committee are published in EPUT's internal Learning Portfolio Newsletter. The feedback loop for sharing learning has continued to improve over the past year, with learning from complaints being regularly discussed in Management and Team meetings across the Trust. In addition, all learning is uploaded onto the Trust website for staff and the public to see.

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

The lessons learned process is reviewed on a regular basis and identified learning is followed up on a quarterly basis to provide assurance that learning from complaints is both captured and embedded in everyday practice. In addition, the lessons are reviewed quarterly to ensure that there are no recurring themes either within the same service or another service. This is also discussed at the Learning Oversight Committee to ensure Trust-wide learning. The Trust also uploads the learning from complaints onto the Trust website in the same format as Table 8 below.

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 school and parents had to chase the Paediatrician's letter of discharge to adult services which should have taken place around patient's 18th birthday.	Reviewed transition points out of the service (Paediatric Service Review) with an anticipated process change to highlight Young People transitioning out of children's services and into adults. The community service to explore the provision of a new case manager nursing role to oversee transitions.
Inpatient experienced dental problems but there was a long delay before they sourced a community dentist who would visit the ward.	The contact details of a community dentist have been secured to allow a more responsive service in future for similar situations.
Patient saw a different clinician at each appointment and didn't understand how a decision could be made to discharge back to GP.	Ensured a full and proper explanation of the process of transfer to GP and the rationale behind it to be done by all clinicians.
Complainant concerned that they were not asked to sign in when attending admittance of their relative to ward.	Visitor's signing in book is now available for use during out of hours of the reception being open and manned.
Had difficulty accessing building with non-automated doors, as one needed to be held open whilst opening the second door.	Improvements to the entry doors (access via a ramp and carpeted areas) to be addressed and in the meantime, reception staff have been advised that when the buzzer is operated, to assist upon request, anyone who needs additional help to enter the building.
Communication issues between agencies impacted on application for Continuing Care.	EPUT ops managers to support more joint working and communication between physical and mental health, mental health teams to join community integrated team meetings across all 3 localities in the west. To share contact numbers to support improved communication.

17.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 4733 compliments were received during 2017/18. This equates to 1367 for Mental Health Services and 3366 for the Community Health Services. In addition to the letters and cards of appreciation sent directly to services or the Complaints Department, compliments are also recorded from the Friends and Family Test forms, NHS Choices website and hand hygiene audit forms (Community Health Care).

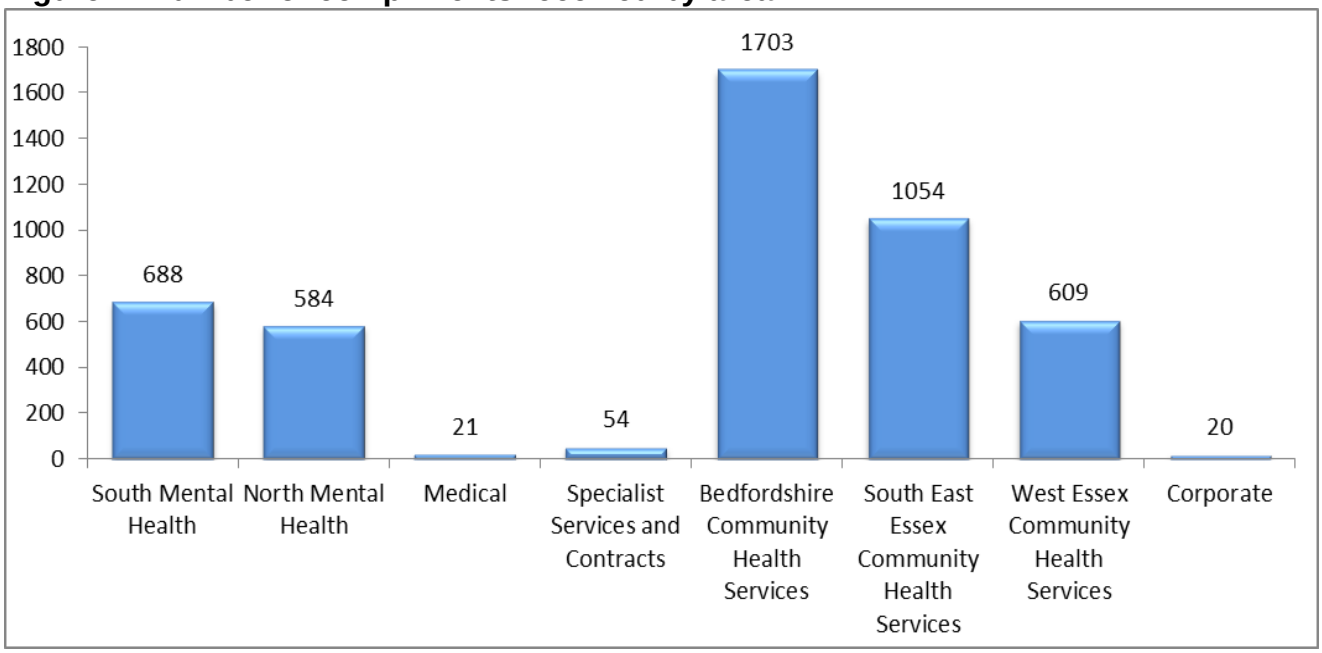
This year the Trust has logged compliments against the Trust values of Open, Compassionate and Empowering; the numbers are shown below;

Open	89
Compassionate	972
Empowering	53

Compliments from the Friends and Family Test, which produced a total of 3,619 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. The table and figures below show the compliments received by the Trust and last year's figures for comparison. A selection of the compliments received is shown in appendix 1 of this report. The final compliment was received from a child, using symbols.

Figure 7: Number of compliments received by area



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:
Mrs X's husband complained that there was a lack of involvement in the care provided to his wife resulting in the prescription of a medication which they felt could be harmful, as it was contraindicated and had been discussed in a review appointment when the doctor wanted to prescribe it at that time. It was also felt that the prescribing doctor did not take into account the concerns they had as a couple.

Trust Response:
The investigation found that the doctor was aware of the medical condition diagnosed by a Neurology Team, and had made a clinical decision to prescribe the medication after weighing up the benefits against potential adverse effects. The doctor expressed regret that their action caused distress in that the patient did not feel their views were taken into account. The Doctor had intended to address the concerns raised during Mrs X's next appointment but did not feel that the Consultation was an appropriate avenue to discuss the complaint.

Outcome:
The Medical Director communicated to all Doctors to ensure that they are aware of their responsibility under General Medical Councils "Good Medical Practice" to seek and gain informed consent for all aspects of care delivery to patients, in particular when it comes to changing medicines.
The complaint was upheld.

Story 2

Complaint:
Mr B's relative complained that the memory team did not assess the patient whilst they were an inpatient in the Acute Trust. The complainant had concerns about his father's memory but felt nothing was being done about it. They said the patient had already had a referral accepted by the Community Team and did not understand why this could not be used to access the Acute Memory Service Clinic.

The complainant stated that a referral had been sent to the Rapid Assessment, Interface and Discharge (RAID)Team by the ward on three occasions before the team responded.

The complainant felt there was a lack of communication between services and Mr B's referral to the RAID Team.

Trust Response:
It was unclear what information the complainant had been given, but the response explained that EPUT have only one memory assessment service in the patient's area. This is a community facing service which does not offer an in-reach into inpatient wards.

It was acknowledged, however, that memory assessment can be provided by a number of different services; the RAID Team have the expertise to provide a basic memory assessment but a more comprehensive memory assessment may not be achievable within the timescale of a person's hospital admission.

With regard to the referral being sent three times, the Trust acknowledged this was unacceptable, however, the records indicated that only one referral was received and the patient was assessed within 24 hours.

Outcome:
Following investigation of the complaint the Clinical Lead met with the Ward Manager to look into ways of avoiding such incidents in the future. It was agreed that the referring team will ensure that receipt of referrals will be confirmed by the referrer. The RAID Team will work proactively with the hospital wards to ensure regular communication between the services. The RAID Team are also reviewing the referral process to ensure it is robust.
The complaint was partially upheld.

Story 3

Complaint:
Mr H had attended his annual Diabetic check at his GP practice and received a referral to the Podiatry service to see if he qualified for toenail surgery to remove the ingrowing nails. Mr H attended an appointment for an initial check and a further appointment to have a Doppler ultrasound to estimate the blood flow in his feet to aid the healing following surgery.

The Podiatrist was unable to undertake the scan as it was found that the new battery they had requested be fitted had not been. This meant that Mr H had to make another appointment for this procedure. At this appointment the Doppler ran out of power and again, Mr H had to make another appointment. Mr H asked why the equipment was not checked to ensure it is working prior to appointments.

Trust Response:
The Trust apologised to Mr H for the standard of service being below what is expected. The response explained that as part of an equipment updating scheme new Doppler's had been introduced in a number of clinics.

The devices required batteries that were not available on the Trust's standard order form and therefore not routinely available from stock which created a delay between the time the equipment was discovered to be not working and a new battery becoming available.

Outcome:
Mr H had a successful appointment where the Doppler was used on this foot pulses. As a result of the complaint, the service has updated the order process to include all of the battery types needed for devices, and also ensured there is a spare battery in all clinics.
The complaint was upheld

19.0 AIMS FOR 2018/2019

During the next year we will:

- 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. Direct discussions and explanations can lead to increased understanding and resolution for both complainants and staff.

- Continue to build on the work already undertaken to improve identification of lessons learned from complaints ensuring they are shared Trust-wide.

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

- Undertake further work to ensure complainants receive a timely response to their concerns.

- The Complaints Team have customised the electronic complaints system to enable the recording and reporting of protected characteristics when mentioned within complaints for 2018/19.

20.0 CONCLUSION

During the first year of EPUT, there have been several challenges in complaints; harmonising policies from the two former Trusts; for some investigators, adapting to a different way on processing complaints; co-ordination across a large area. It is recognised that our response rates need to improve to provide timely responses; the latter months of the year have seen improvement in this area, but there remains room for improvement.

EPUT follows the PHSO 's principles of Good Complaint Handling and as such, we strive to put things right by:

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

Complaints provide us with an opportunity to improve our customer service and increase our patient's and relative's/carer's experience of the services we provide.

All complaint timescales and progress of open complaints are closely monitored. 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.

We need to improve communication between staff and patients/relatives/carers, whether verbal or written, ensuring it is clear and has been understood. Concerns have also been raised over the year, around communicating discharge arrangements to patients and relatives; lessons have been learned and will be monitored going forward to ensure we are getting it right.

We have a good complaints system in place and seek continuous improvement in complaints handling and identifying learning to enable us to mitigate the same thing happening to others and thus ensuring a positive experience for our patients.

Pam Madison
Head of Complaints

Nigel Leonard
Executive Director of Corporate Governance and Strategy

May 2018

Appendix 1

Selection of compliments received 2017/18

I attended an appointment for nail surgery today at Addison House Harlow. At a time when the NHS is often criticised, I wanted to thank the staff involved in my treatment for the excellent service I received. I arrived early and as a consequence was seen before my appointment time. The two members of staff who treated me for an in-growing toenail took the time to explain the procedure to me, answer my questions and made me feel very comfortable before the minor operation started. The operation itself was completed quickly without causing me any discomfort and I was told what to expect at each stage of the process. Afterwards my follow up treatment was explained and an appointment made for me to have my toe re-dressed. At all times the staff were very professional and caring in their approach and they always took the time to ensure I knew what to expect and was happy to proceed. I am very grateful to the staff involved for their kind attention.	To all the nurses, healthcare assistants and staff on Henneage Ward. I have so much gratitude in my heart for you all - you've looked after my dad with such amazing care, compassion, humour and love over the past six months. From the bottom of my heart thank you so very much. I know that he will have found it difficult being in hospital for such a long time. I am so thankful he was somewhere where he was looked after by such kind-hearted and skilled people. So many of you have told me that impact my dad made on you too. I'm so glad. He was certainly a very dignified gentleman with a heart that wanted to care for others. My massive thanks go to absolutely everyone on the ward - you've all been so wonderful. Thank you all so much. I will never forget you all and all your kindness. God bless you all very much.
Thank you all so very much for all the help and encouragement you gave me during my stay with you. I am sincerely grateful to every member of staff for helping me get my life back on track. Since I last saw you, I have gained over a stone in weight and feel much better for it. I am enjoying my life to the full and don't take anything for granted the way I used to before I became unwell. I feel extremely fortunate that my doctors and consultant placed me on Gloucester Ward. I cannot imagine a more caring and professional ward with such a lovely atmosphere and I feel sure that I speak on behalf of my fellow patients.	To Roding Ward staff: I would like to commend the care of the Deputy Ward Manager who spoke with me when I visited my mother who is in the end stages of dementia and this nurse dealt with me so compassionately. She had time for me and specifically asked me about how I was feeling and took time to sit and listen to me even though she must have been busy. Her care for me as a grieving relative was exceptional and when I have told friends about how she was, they have been so impressed at her compassion which was over and above what you'd expect from someone with so many demands on her time. She has a beautiful way about her which was an absolute gift to me on such a difficult day.

To the loveliest nurses around. Thank you so much for all you lovely ladies did for me during my recovery. During those first few dark days the way you all helped, talk to me, and understood what I was going through really made me feel better and you all honestly helped me get through a terrible time. You do an amazing job, help people and make them feel human and normal when they are at their worse. Thank you so much. Excuse my writing I've broken my finger swinging drunkenly on my commode.	In these days of endless wooden spoons being awarded for poor service and customer care, I thought it only right to take the opportunity to praise the most professional, consistent and faultless treatment I have ever received, in my 74 years from the NHS. The nurses of the leg ulcer clinics have continued to provide a service, second to none, week after week and they deserve the highest of rewards for their dedication to their profession. Well done to them all. I will always be full of gratitude for everything that you continue to do and have done for me in the past - and I'm sure that there are many who feel the same.
We just wanted to send a note to thank you, and all the staff on Beech Ward, for the excellent and compassionate treatment you gave our mother over the last few weeks of her life. The NHS often gets poor press but your ward and team were professional, caring, informative and kind. We couldn't fault anything from the day she arrived on the ward until her departure in the early hours of Sunday morning. You kept us informed, enabled us to be with her, made sure she was comfortable and wasn't distressed. We couldn't have asked for more. Thank you once again, you should be very proud of the work you and your team do every day.	To the District Nurses; we have all witnessed personally your frequent visits to my Mum's home to dress her legs and monitor her sores etc. We really appreciate the encouragement and guidance you gave to Mum as well as your kindness and support. You are all a credit to the NHS and my mum was fortunate to have you looking after her at home, nursing her needs. As you know Mum passed away recently, but we know for sure that Mum would have fully supported our desire to pass on our sincere thanks to you and your team for looking after her.
The Contact Centre; you all do make a difference and should be proud. Your effort in dealing with calls, showing empathy, and supporting the clinicians in managing behaviours and preventing relapse for their clients is excellent.	To staff at Meadowview Ward; We just wanted to say a big thank you. Sometimes as a family we need that extra special care that only staff like you can give. We found that in each and every one there. It eased our worries as we knew our loved one was well cared for. So thank you from each one of us for the care you gave to our loved one.
Clifton Lodge; I would like to thank each and every one of you for the kindness and caring you showed my husband. He always looked so happy and well dressed. It always made me laugh when I used to do those walks with him as he always smiled when he met you all walking round and round even though he sometimes saw the same person over and over again. I shall miss those	To the sister of MS & Parkinsons Nursing Team. At long last I find myself free to thank the 'hidden heroes' who made my dear wife's long and agonising suffering endurable and always hopeful. She would brighten just to hear that you and your ladies were in the nursing home. As you know, my wife was herself a nurse, professionally proud of her vocation and she had a special place in her circle of

moments but shall never forget them as long as I live as they were very special as he loved to walk. Those treasured memories of sitting there beside him not very long ago when I visited him; he was so happy smiling and laughing, he held my hand, hugged and kissed me goodbye, when I left him; are sealed in my heart forever.	duties for the dear people with long term, wasting illnesses. Wherever you went your attitudes, disciplines and skills could not fail to have an improving influence on local staff nurses and carers.
Cumberlege Intermediate Care Centre. I cannot fault the care, support and encouragement from all the staff at CICC. They work together very well as a team with excellent communication and camaraderie between them. This became even clearer on the days when they were shorter staffed than usual. Another important aspect of care was the in-house kitchen, which meant that the food was freshly prepared, hot, nutritious, and edible. It also meant that the chef was able to be flexible and accommodate different dietary requirements. I am very clear that had I not gone to CICC between discharge and hospital and going home, I would not have managed. Having been too ill to get out of bed for three days, they helped me learnt to walk again and begin to rebuild my strength. I cannot thank them enough.	Perinatal Mental Health Service (South) You have been an incredible support to me over the past few months. I really feel you have equipped me to get myself out of a very dark and difficult place. Thank you so much, I am so grateful for your care, compassion and insightful guidance. You showed genuine empathy - Feeling fully listened to, you 'got me' and never made me feel stupid or inadequate for the way I felt. You never 'told me what to do' rather helped me organise my feelings, thoughts and anxieties. You made suggestions about things I felt able to try differently. You made me feel it wasn't my fault I was behaving/feeling like I did, and made it clear you wasn't here to 'fix me' and that I wasn't a problem to sort out. Instead she was here to support me through this awful time until I felt equipped to manage again. There was no tick boxes or standard medical questions! I felt like an individual with a personalised approach being taken. Thank you again - words fail me when I'm trying to express how much help you have been!
The help given by the eating disorders service is excellent. They listened to my views on my treatment, in particular what I thought I would find helpful and what wouldn't help and then adapted the service to suit my needs. This doesn't always happen in mental health services and it has been refreshing to come across such caring, skilled and helpful practitioners. As a result I have found the service really helpful. In particular their psychologist and Service Manager have gone out of their way to help me.	I wish to thank all staff within Basildon Mental Health Unit for all the courteous and respectful care that I received. The standard of care was excellent and of a very high standard. This for me was a very difficult and stressful time. They showed me how to help myself through patient centred approach plans. I was able to express myself in a way that was acceptable and acknowledged to be insightful; I didn't expect it to be this way. So therefore I think there are no concerns of a negative nature. All your staff treated me with a high level of respect and mutual care. Yours with many thanks.

Compliments are received by services in various ways, the compliment below was sent by a young person who is involved in an arm support case study in Community Healthcare. The symbols are used to help the child to read using a “communicate in print” tool.