NHS
Essex Partnership University
NHS Foundation Trust

Complaints & Compliments

Annual Report 2023/2024

May 2024

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PURPOSE

The purpose of this report is to provide an overview of complaints, concerns and compliments that were received by the Trust throughout the year from 1 April 2023 to 31 March 2024 (this period is referred to as "2023/24" throughout the report). As well as data relating to volumes, response times and themes of complaints, it will review the impact of our new complaints process. The report also includes examples of lessons learned from complaints and compliments and provides an update on the priorities we identified last year and sets out our priorities for 2024-2025.

SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provides services to more than 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk. With more than 5,500 staff working across over 200 sites, we also provide services in people's home and community settings.

The Complaints Team is part of the Patient Experience portfolio, and provides a Complaints Service and Patient Advice and Liaison Service (PALS) for people who use the Trust services. This includes current and past service users or patients, carers, friends and relatives. We are there to help provide resolutions and rebuild relationships.

This year's annual report (2023/24) will be the first to look at a full 12 months of working with our new complaints process, which was launched in January 2023 after a co-produced re-design project. The changes to the process have had a positive impact on the service we deliver, and on the experience of our service users and staff.

We are taking a complainant-led approach to complaint resolution, by focussing on the desired outcome of the person raising the complaint, and agreeing together the best route to resolving the issues raised. This approach has allowed us to resolve a greater proportion of concerns informally through the PALS service. Our PALS officers have liaised with the clinical services to provide much faster and more direct responses to the less complex concerns. As a result, the number of formal complaint investigations has fallen by nearly a third.

The table below shows the volume of complaints and concerns logged by type, compared with the previous year. Please also note the increase in locally resolved complaints, which is a positive indicator that services are resolving more issues raised directly with them, thereby preventing the escalation of issues to a formal complaint. Overall, there has been a reduction of 5% in total complaints raised.

	2022/23	2023/24	+/-
Formal Complaints	397	275	**-31%**
PALS Concerns	470	537	**+14%**
MP Complaints	71	69	**-3%**
Locally resolved complaints	48	60	**+25%**
Grand Total	**986**	**941**	**-5%**

Report Highlights

- The trust received 941 complaints and concerns in 2023/24 which is a 5% decrease compared to the previous year (986).
- 275 were formal complaints investigated by the Complaints Team; 537 were concerns raised and resolved informally via the PALS service; 69 were complaints raised and resolved via a local MP, and 60 were raised directly to the relevant service and resolved locally by them.
- Only 96 formal complaints (29%) were resolved within the Trust's target of 60 working days.
- However, 94.8% of formal complaints were closed within agreed timescales (this includes keeping the complainant updated with extended timescales)
- We closed more formal complaints (332) than we received (275) which led to the total caseload of open investigations decreasing by over a third from 157 as at 31 March 2023 to 100 as at 31 March 2024.

- The top category for Formal Complaints was "Assessment & Treatment (Clinical Practice)", however the top theme of complaints received via MPs was "Lack of Community Support" for the third consecutive year.
- Lessons were identified from 172 (52%) of the 332 formal complaints closed during the year, and many were shared Trust-wide in our Learning Lessons Newsletter.
- We increased the response rate for our Complaints Feedback Survey to 14% by including a QR code with a link to the survey on our response letters.
- Of the 19 Quality Assurance reviews completed so far by the Non-Executive Directors, 100% were rated positively for the 'quality of the response letter'
- 9 cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant was unhappy with the response received from the Trust.
- We resolved 14% more concerns via the PALS service compared to last year, which has helped to reduce the number of Formal Complaints by nearly a third.
- There was a 2% increase in the number of compliments received directly to EPUT services this year.

Although we have made substantial improvements to our complaints service, we do continue to have some challenges. Constrained resource, and limited capacity in the frontline teams to support the complaints liaison team provide an ongoing challenge to meeting targets for response times. We continuously review the way we work to improve efficiency, and we will continue to consider ways to do this in the coming year.

We are pleased to have improved the response rate for our Complaints Feedback Survey this year: however, the scores and comments received have given us a lot to think about. Despite receiving some very positive feedback directly from people that have used our complaints service this year, the clear message from people completing the complaints survey is that they do not have faith in our complaints service, with only one fifth of respondents saying they believe it is fair.

Our focus for the year ahead will be on building trust with our service users, by listening to their feedback and taking positive action to improve confidence in our service.

FORMAL COMPLAINTS

Complaints that are received directly into the Trust's Complaints Team are allocated to a Complaints Liaison Officer (CLO) within the Complaint Team. The CLO will attempt to contact the complainant to discuss their concerns and agree together how to proceed with resolving the issues raised.

A formal complaint investigation is likely to be the recommended route if:

- The concerns relate to a past event (rather than an ongoing situation which requires immediate/ urgent action).
- The complaint is complex, and cannot be reasonably addressed without a formal investigation into what happened.

The CLO carries out the formal investigation liaising with the complainant and a clinical advisor from the service as necessary. When their investigation is complete, a Formal Response Letter is sent to the complainant to explain how the complaint was considered and the outcome of the investigation.

Where we have found failings in our service we explain what happened, take accountability and set out what action we have taken to put matters right. We detail any lessons identified and improvement actions that were taken as a result of the complaint investigation, and we notify the complainant of their right to refer the complaint for an independent review by the Parliamentary and Health Service Ombudsman (PHSO).

Received and Closed

Carried forward from 2022/23	Received 2023/24	Closed 2023/24	Carried forward to 2024/25
157	275	332	100

275 formal complaints were received by the Trust during 2023/2024, which is a decrease of 31% on the previous year's figure (397). This reduction reflects our focus on resolving complaints informally via the PALS service wherever it is appropriate – i.e. if the concerns raised relate to an ongoing issue that requires prompt action and/or are low complexity and do not require a formal investigation to address them.

Received by Area

Our complaints reporting system (Datix) is now aligned to the Trust's Care Units, and the below table shows formal complaints received by Trust Care Unit in 2023/24.

	2023/24
Community Delivery Mid and South Essex	88
Community Delivery North Essex	30
Community Delivery West Essex	34
Inpatient and Urgent Care	89
Psychological Services	21
Specialist Services	10
Corporate / Business Units	3
Grand Total	**275**

Comparative data is not available for the previous year by Care Unit, as complaints were logged under the Trust's old organisational structure in 2022/23. Therefore, for comparative purposes the data is also presented below by area under the old structure.

Area	2022/23	2023/24	% change
Mid and South Essex STP	132	102	-23%
North East Essex STP	56	46	-18%
West Essex STP	29	22	-24%
Medical – Trust-wide	68	40	-41%
Specialist – Trust-wide	20	10	-50%
Psychology Services	21	16	-24%
Total Mental Health	**326**	**236**	**-28%**
Community - South East Essex	42	17	-60%
Community - West Essex	16	19	+19%
Total Community Health	**58**	**36**	**-38%**
Corporate Services	13	3	-77%
Grand Total Received	**397**	**275**	**-31%**

Received by Patient Contacts

Due to the different volume of services delivered within these localities, the number of patient contacts vary significantly. Data for patient contacts in 2023/24 are shown below:

Area (MH Services)	Total Formal Complaints	Total Patient Contacts	Complaints per 1000 patient contacts
Mid & South MH	102	361,511	0.28
North Essex MH	46	171,334	0.27
West Essex MH	22	124,719	0.18
TOTAL MH Services	**170**	**657,564**	**0.26 ***
Community - South East Essex	17	608,483	0.03
Community - West Essex	19	504,429	0.04
TOTAL Community Services	**36**	**1,112,912**	**0.03**
Grand Total	206	1,770,476	0.12

* In the previous year (2022/23) the number of complaints received per 1,000 patient contacts constituted between 0.5 and 0.6 complaints across all 3 localities for Mental Health Services.

Trend Analysis by Area

The comparative data demonstrates a reduction in formal complaints received in all areas, with the exception of West Essex Community services. The 19% uplift in that area represents a difference of 3 complaints. Two complaints were logged in 2023/24 for the Virtual Hospital service, which was a new service launched in December 2022.

The most significant decreases in formal complaints are seen in Corporate Services (-77%) and South East Essex Community (-60%).

Of the 13 complaints logged in 2022/23 for Corporate Services, 10 related to covid vaccinations. The Trust’s covid vaccination programme has now been significantly scaled down, and we did not receive any complaints for this service in 2023/24.

The 60% reduction in formal complaints logged for SEE Community can be attributed to service improvements made at The Lighthouse Centre in Southend. EPUT took over the management of children's services at The Lighthouse Child Development Centre in Southend from Mid and South Essex NHS Foundation Trust in March 2022, and 22 formal complaints relating to this service were logged in that year relating to:

- Access to treatment
- Referrals / Appointments
- Medication
- Communication

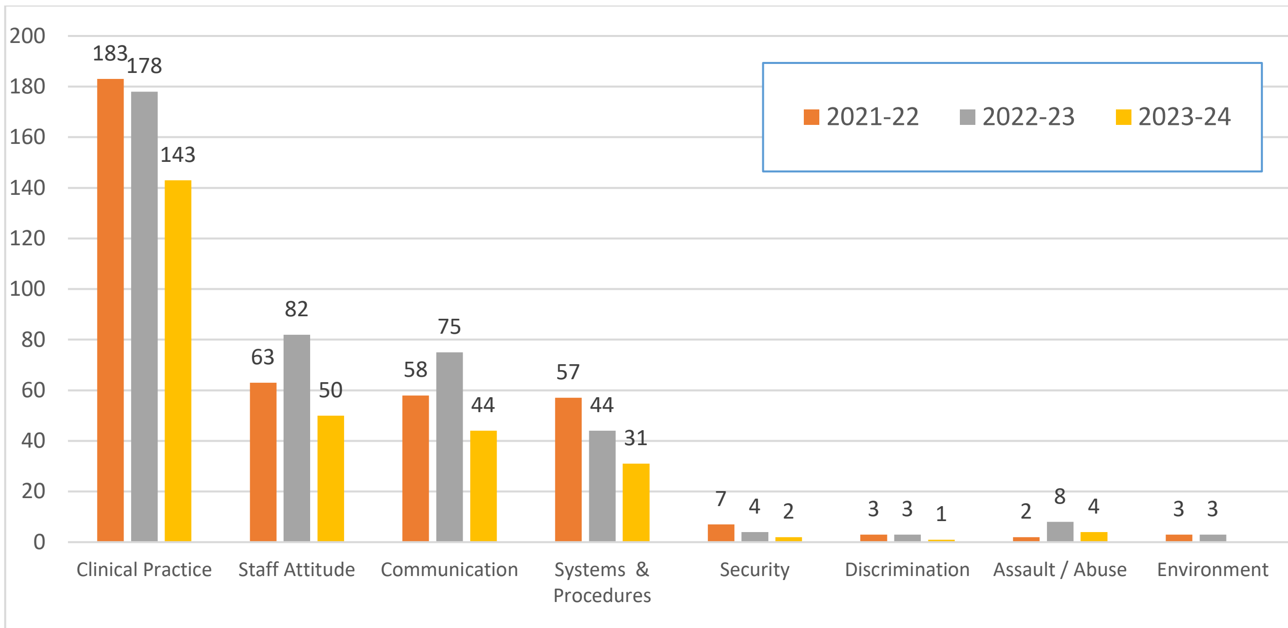
The service worked closely with the Patient Experience Team and local partners, including commissioners, councils, schools, GPs, parent carer forums, and families to improve services at The Lighthouse. This has been a great example of how we can use patient insight and information from PALS, Complaints, and I Want Great Care, to drive improvements.

We set up a new nurse-led ADHD service, which provides various diagnostic assessments for children with suspected ADHD, and treatment. We also now have more doctors working with us, and we have recruited additional administrative staff to answer phones more quickly, to support with referrals and booking appointments.

These changes are providing families with a better experience at The Lighthouse, and we didn't receive any formal complaints for The Lighthouse Centre in 2023/24.

Complaint Categories

Complaints are categorised according to the main theme of the issues raised. The chart below shows the 3-year trend of formal complaints received in these categories.



- Clinical Practice remained the highest category in 2023/24, although the number of complaints logged within this category fell by 35 (20%) from the previous year.
- Complaints about Staff Attitude and Communication both increased last year, but both decreased below the 2021/22 level in 2023/24.
- All complaint categories have decreased compared to last year.

Top ten sub-categories

Under each main category, there are a number of sub-categories, which drill down further the theme of the complaint. The top ten sub-categories made up 54% of the total formal complaints received in 2023/24 (149 out of 275), as follows:

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Assessment & Treatment	29	11%
Communication	Communication breakdown with patient	23	8%
Clinical Practice	Unhappy with Treatment	17	6%
Clinical Practice	Discharge / Follow Up	17	6%
Clinical Practice	Medication	14	5%
Clinical Practice	Poor care on ward	11	4%
Staff Attitude	Rude face to face	10	4%
Staff Attitude	Inappropriate behaviour	10	4%
Staff Attitude	Unhelpful	9	3%
Systems & Procedures	Waiting Lists/Times	9	3%
		149	**54%**

Common themes in the complaints that were categorised under 'Assessment & Treatment' were:

- Patients unhappy with their diagnosis, feeling that the assessment was not thorough/ correct
- Patients feeling unsupported and not knowing what is happening
- Appointments being cancelled, leading to delays in assessment/ treatment

Many of these complaints also link to communication. Complaints are regularly discussed in team meetings to reinforce how important it is to maintain good communication with patients and families.

Complaint Outcomes

When a formal complaint is investigated, a review is carried out to establish if something has gone wrong with the care or service provided. The investigation seeks to confirm what happened, and considers this against what *should have* happened according to relevant regulations, standards, and policies or published guidance.

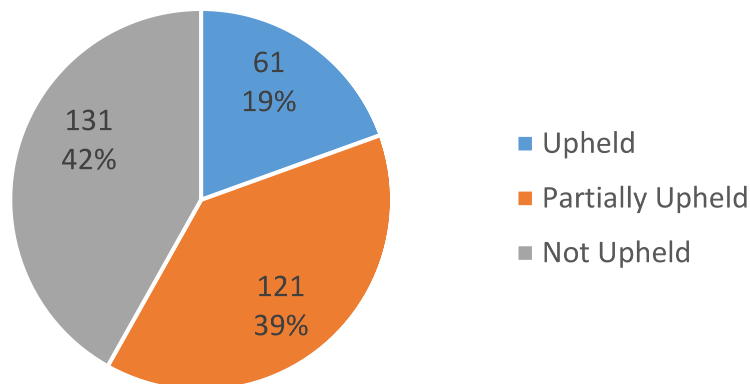
If the evidence demonstrates a difference between what happened and what should have happened, the complaint is recorded as 'upheld.' If the investigation finds that the care or service provided was in accordance with expected standards, the complaint is recorded as 'not upheld'.

If there are multiple points raised within one complaint, each point is considered separately and each one is either upheld or not upheld. Where there is any combination of upheld/ not upheld complaint points, the overall complaint outcome is logged as 'partially upheld'.

332 formal complaints were closed during 2023/24, but a formal investigation was not completed for 19 (6%) cases for the following reasons:

- 2 were withdrawn by the complainant after being logged.
- 6 were initially logged as formal complaints, but were subsequently resolved informally by the service (with the agreement of the person who raised it) to achieve a faster resolution.
- 11 were closed with no investigation for various other reasons, e.g. a Patient Safety Incident Investigation (PSII) was looking at the same issues so the complaint was closed in agreement with the complainant; a lack of patient engagement made it impossible to complete one investigation; another complaint was re-directed to a different Trust after discussion with the complainant.

Of the 313 formal complaint investigations that were completed by the Trust's Complaints Team in 2023/24, the outcomes were recorded as follows:



Re-opened Complaints

We encourage people to let us know if they remain dissatisfied after receiving our response to their complaint, so that we can continue to seek resolution on any outstanding concerns for the complainant.

Of the 332 formal complaints closed in the year, 7% (23) were subsequently reopened. The reasons given for requesting the complaint to be re-opened are categorised below, alongside the previous year's data for comparison.

Reason for Re-opened Complaint	2022/23	2023/24
New questions/ information	3	8
Disagrees with response	1	6
Dissatisfied with investigation	10	5
Unhappy with outcome	8	3
Complaint not fully addressed	5	1
Grand Total	**27/380 (7%)**	**23/332 (7%)**

A recurring theme is a mistrust of the information provided to the complaints investigator by the service. Comments from the file include:

- *"Complainant is accusing staff of submitting false statements and making up information on records"*
- *"Complainant is unhappy with outcome of complaint, feels the information given by the service was not correct"*
- *"Complainant unhappy with response and disagrees with much that has been said. States assessments were not completed, feels accusations have been made and would like to know where these have come from."*

Under our new complaints process, formal investigations are conducted by a Complaints Liaison Officer (CLO) within the Complaints Team, rather than by an investigator allocated from within the service that the complaint is about - a change that was made (in part) to improve the transparency and integrity of the investigation process.

The CLO's investigation necessarily involves reviewing records made by the service and taking statements from staff about their recollection of events, but it is crucial that we balance this by also speaking to the complainant, taking their recollection of events into account and providing them the opportunity to be heard and involved in the investigation process.

Since launching our new process we have taken further steps to increase the objectivity of the complaint response. Previously, the Complaints Liaison Officer would conduct their independent investigation and then draft a response letter to be approved and signed by the service director for the area the complaint was about. Following direct feedback from complainants we changed this approach, and now the CLO writes the response letter directly to the complainant, explaining the outcome of their investigation.

We know that fairness must be at the heart of any complaints process in order for people to use it with confidence. The challenge when delivering an internal complaints service is not only to ensure that the process is as impartial and fair as possible, but also to provide assurance of this to the service user. We are determined as a service to strengthen our service users' trust in our complaints process, and we will continue to focus on this challenge in 2024/25.

Non-Executive Director Complaint Quality Reviews

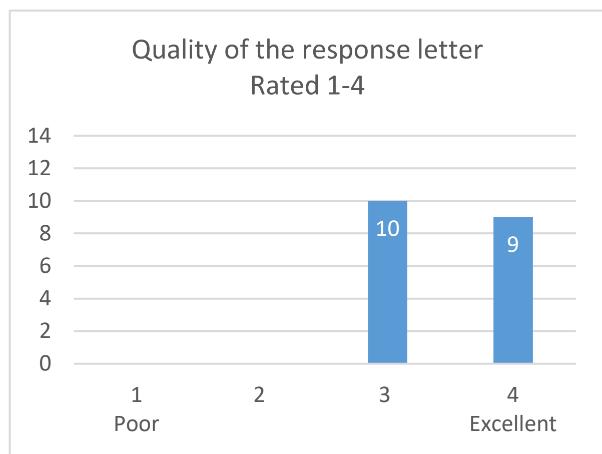
The Trust's Non-Executive Directors (NEDs) provide an important and valuable quality review of 10% of complaints that are closed each quarter.

The reviewer rates the quality of the investigation and the response, and considers whether the Trust has done all it can to resolve the complaint and if appropriate lessons were identified and taken forward.

A total of 19 reviews have so far been completed for Q1-Q2 2023/24, which represents 6% of the total formal complaints closed in the whole year (332). A further 15 reviews will be completed, to ensure that a total of 10% are reviewed.

Of the 19 reviews that have been completed:

- 89% were rated positively for 'how the investigation was handled'
- 100% were rated positively for the 'quality of the response letter'



Along with scoring the quality of the complaint files, the Non-Executive Directors provide comments that are shared with the Complaints Team as feedback to take on board for future. Some examples from this year are below.

The language in the response letter could have been simpler. e.g. the term "in line with presenting needs" is not used in everyday language outside the NHS.

It was not clear despite the investigation how Mrs X would get the right incontinence pants that she needed. In addition, the Trust ends up blaming the ICB in the response letter…we should own the commissioning responsibility.

We should always aim to be replying sooner, but it was a reasonable turnaround. Clear and concise investigation.

MP COMPLAINTS

The Trust received 69 complaints from MPs on behalf of their constituents, down by 3% compared with the previous year (71). The top 4 topics for MP complaints were as follows:

- Lack of Community Support (12)
- Assessment & Treatment (8)
- Unhappy with Treatment (7)
- Access to Treatment (6)

LOCALLY RESOLVED COMPLAINTS

All EPUT staff are encouraged to resolve concerns or complaints directly at the point they are first raised wherever this is feasible, because it provides a much better patient experience. A sincere apology and prompt resolution by the service when something has gone wrong can prevent matters from escalating, and also save the person raising the concern a lot of time and worry.

It is important that we capture the details of complaints that are resolved locally, so that we are aware of emerging issues, and any lessons learned can be recorded and shared as appropriate. Until last year, staff were required to complete a manual form and pass it to the Complaints Team for logging if they resolved a complaint locally. We felt this manual process was deterring staff from reporting locally resolved issues, so we devised a more efficient process.

Following a systems development in 2023, complaints resolved locally by the services can now be logged directly on the complaints reporting system (Datix) by any member of staff – and this appears to have had a positive effect on the numbers that are being reported.

There were 60 locally resolved complaints recorded on Datix for 2023/24, which is an increase of 25% compared to the previous year's total (48). The numbers logged are shown below by area.

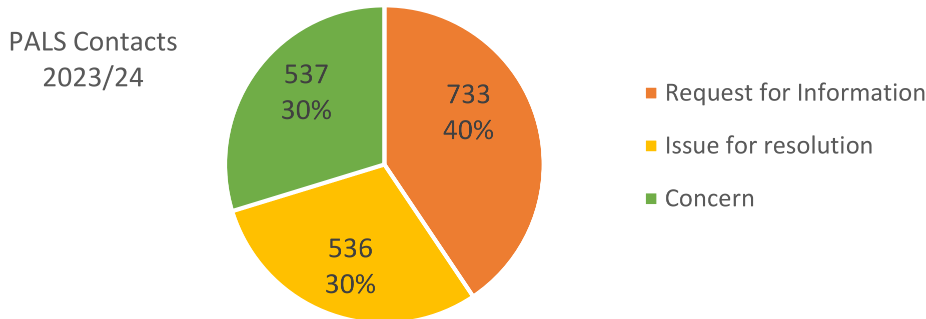
	2023/24
Community Delivery Mid and South Essex	37
Community Delivery North Essex	12
Community Delivery West Essex	4
Inpatient and Urgent Care	6
Corporate / Business Units	1
Grand Total	**60**

PATIENT ADVICE AND LIAISON SERVICE (PALS)

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

The majority of contacts to PALS are either resolved by a PALS Officer at the point of contact, or passed to the relevant service to contact the enquirer and resolve the issue raised.

PALS received 1,806 contacts during the year 2023/24, which was an increase of 35% on the previous year (1,337). A breakdown of the type of enquiries received is shown below.



In addition, PALS Officers signposted 1,686 enquirers for help to other services/ organisations.

Concerns

Concerns that the PALS service typically manage are where the issue relates to an ongoing or current patient situation which requires immediate action and/or the issues raised are not complex and can be resolved promptly by liaising with the relevant service without carrying out a formal investigation.

If the issues raised are complex and require a formal complaints investigation in order to provide a resolution, this would be discussed with the person raising the concerns and, with their agreement, passed to the Complaints Team to manage through the Trust's complaints process. In total, 37 concerns (2% of PALS contacts) were passed to the Complaints Team to be investigated as formal complaints in 2023/24.

We remain focussed on resolving issues informally via the PALS service wherever this is likely to provide the best outcome for the person raising the concerns, and we saw a 14% increase in the number of concerns resolved via PALS in 2023/24.

The top 10 sub-categories for PALS concerns in 2023/24 make up 78% (419) of the total for the year (536).

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Care	167	31%
Communication	Communication breakdown with patient	96	18%
Communication	Communication breakdown with relatives	35	7%
Clinical Practice	Unhappy with Treatment	26	5%
Clinical Practice	Referrals / Appointments	25	5%
Clinical Practice	Lack of Community Support	19	4%
Clinical Practice	Discharge / Follow Up	18	3%
Clinical Practice	Medication	12	2%
Communication	Sharing of Information/Record Keeping	11	2%
Staff Attitude	Inappropriate behaviour	10	2%
		419	**78%**

Some brief summaries of PALS concerns from last year are provided below:

Concern sub-category	Concern Raised	Outcome
Care	Daughter unhappy with her mother's treatment and lack of care on the wards. Mum now being told she will be discharged on Monday and daughter does not believe she should be. Would like it looked into.	Consultant has responded to enquirer regarding their concerns and invited them to attend the review on Monday to discuss discharge.
Communication breakdown with patient	Enquirer (service user) unhappy as received a telephone call on Friday from Brentwood Resource Centre to their home telephone number and have not given permission for this to be used. All calls should go to their mobile telephone number. Would like home telephone number removed from all records.	Email sent to service from PALS who responded to enquirer. PALS confirmed telephone number has been removed from system and patient summary record before closing.
Communication breakdown with relatives	Enquirer not happy that someone from Memory Monitoring came to see his wife (who has memory issues) and he was not aware of it so was not present. Wife then cannot remember what was said and gets upset.	PALS liaised with service who confirmed they would contact Enquirer when wife has appointment so that they can be present.

RESPONSE TIMES

Formal Complaints

Completed within agreed timescale (Target 95%)

In line with the NHS Complaints Regulations (2009), we investigate Formal Complaints as quickly and efficiently as possible, keeping the complainant updated with progress.

Every formal complaint is allocated to a Complaints Liaison Officer (CLO) who makes contact with the complainant as soon as possible to discuss the issues raised. The CLO explains how their investigation will be taken forward, and, based on the complexity of the case, provides a likely timescale for completion.

If we are unable to meet the original timescale provided, the CLO is responsible for keeping the complainant updated regarding the revised timeframe.

In 2023/24 we completed 94.8% within the agreed timescale, which was an increase compared to the previous year (91%).

Completed within internal service level (Target = 90% within 60 working days)

Although complaint response timescales inevitably vary based on the complexity of the case, we also measure our performance against a fixed internal service level of 60 working days (3months) for responding to formal complaints.

Out of the 332 formal complaints closed in 2023/24, 62 (19%) were legacy complaints that were investigated and responded to under the old process. There is a significant variation compared with the response times for the 270 complaints managed under the new process, as shown below:

Complaints Process	Number Closed in 2023/24	% Closed within 60 working days	Average Response Time (working days)
Old Process (received <2023)	62	0% (0)	197
New Process (received ≥01/01/23)	270	35% (96)	78
Total	**332**	**29% (96)**	**100**

The new complaints process has demonstrated an improvement of 16% (15 working days) compared with the previous year’s average response time of 93 working days for formal complaints.

PALS Concerns

Completed within internal service level (Target =90% within 15 working days)

We work to a service level of 15 working days (3 weeks) for low level concerns raised through PALS. These concerns are sent via PALS to the service to address directly, or to respond to the patient via the PALS team.

In 2023/24:

- 74% of PALS concerns were closed within 15 working days.
- The average response time was 15.3 days

PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

If a person is dissatisfied with the response they receive and the Trust's complaints process has been exhausted, they can refer their complaint to the Parliamentary & Health Services Ombudsman (PHSO) to conduct an independent review. We inform complainants of this right within our response letter.

The PHSO conduct an initial assessment of the complaint to decide whether to investigate it. They consider several things, including whether there are signs that the Trust potentially got things wrong that have had a negative effect on the person, that haven't already been put right by the Trust's internal complaint process.

PHSO Referrals

During 2023/24, 9 cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant was unhappy with the response received from the Trust. Of these 9 referrals:

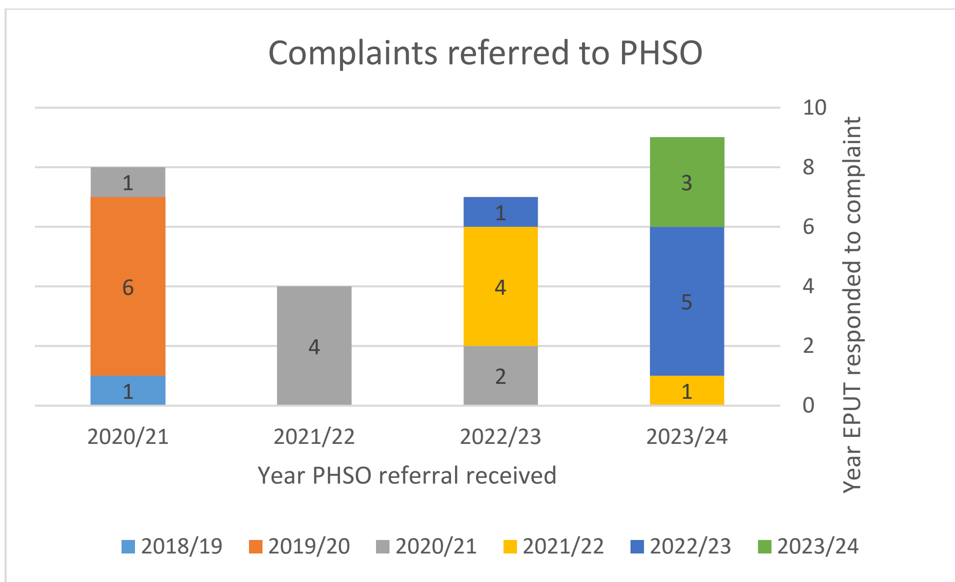
- 2 were closed without further investigation after an initial assessment by the PHSO.
- 7 referrals are still awaiting an initial assessment at the time of writing this report.

Only 3 of the 9 referrals were complaints that had been responded to by EPUT in 2023/24.

The other 6 were complaints we had responded to under the old complaints process in the previous 2 years: 5 in 2022/23 and 1 in 2021/22.

The PHSO has suffered from a backlog of cases since the start of the Covid pandemic, both due to the organisation briefly pausing the processing of complaints at the start of the pandemic and a reduced capacity in the NHS to deal with complaints when it resumed casework.

The below chart shows how 6 complaints that were closed by EPUT in 2020/21 and referred to the PHSO (indicated in grey), filtered through to us gradually across 3 years. The number of referrals received in 2023/24 is the highest since the pandemic, reflecting that the PHSO are catching up on their backlog.



PHSO Investigations

One PHSO investigation was completed during 2023/24, and the case was partially upheld by the Ombudsman. This case is summarised below.

The complainant (Mrs W) was unhappy that her mother had an unwitnessed fall during an inpatient stay on Meadowview Ward in 2020. Specifically, Mrs W's complaint was that EPUT failed to:

- complete the necessary risk assessments or put appropriate risk measures in place despite knowledge of her mother's falls and self-harming history
- ensure Level 3 observations were consistently provided to her mother
- involve her as her mother's representative and Legal Power of Attorney (LPA) during discussions with her mother about 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR)
- provide appropriate care to meet her mother's physical health needs throughout the admission.
- investigate her mother's unwitnessed fall as a Serious Incident

PHSO findings:

The first 4 points were not upheld, however the PHSO upheld the last complaint point, stating:

"*We think Essex Partnership should have identified what happened as a Serious Incident, completing a report in line with the CCG's directive, implemented in March 2020*".

The PHSO recommended that EPUT send a letter to Mrs W to acknowledge this failure and to apologise for the avoidable upset and distress this had caused her. The Trust wrote to Mrs W apologising for our failing to act in line with the Clinical Commissioning Group (CCG) directive in place at the time and to provide a 7-day report in place of a Serious Incident investigation.

We confirmed that we have since taken steps to improve our processes to reduce the likelihood of a similar situation occurring in the future by implementing the Patient Safety Incident Response Framework (PSIRF). We have also employed two Family Liaison Leads who support patients and families following patient safety incidents.

LEARNING FROM COMPLAINTS

The Trust has a strong culture of learning, and recognises complaints as a valuable source of feedback from which we can learn and improve our services. An integral part of the complaints investigation process is to consider if there are lessons we can learn and/or improvement actions we can take to minimize the risk of errors reoccurring. The Complaints Team follow up with the service to provide assurance that improvement actions have been taken forward and embedded into everyday practice.

Lessons identified are presented monthly at the Learning Collaborative Partnership meeting and circulated Trust-wide in the Lessons Identified Newsletter. Learning from complaints is also discussed at monthly Quality & Safety meetings, and the Commissioners of EPUT's services receive a quarterly report containing the lessons learned from complaints for their specific geographical areas. Some examples of lessons learned from complaints over the past year are supplied below.

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Examples of lessons learned

Lessons were identified from 172 (52%) of the 332 formal complaints closed during the year. Below are a few examples of learning from complaints.

1. Psychological Services, Therapy For You (South East):

A patient had to have surgery following a miscarriage. A few weeks later she received an invite from Therapy for You for a "Living well with your baby" 6-week programme and a breakdown of the topics covered, which was very distressing. The assessing clinician had incorrectly used the "perinatal" category with the intention of fast-tracking the patient. (The label is used for patients who are pregnant, expecting a child or have a child up to the age of 1 year old). The clinicians who run the "Living well with your baby" group had then sent letter invites out based only on the attached category, without screening them for suitability.

Learning identified:

Labels are no longer to be used for intervention allocation and the service policy has now been amended and shared with staff. Additionally, group clinicians have been made aware to read all referrals before invites to groups are sent out.

2. Specialist Mental Health Team, West Essex

A patient hand delivered a letter to Latton Bush regarding an appointment at the Derwent Centre. The security guard started to open the letter and the patient advised him not to as it was confidential and for medical staff only. The security guard took the patient and her son through the ward to a nurse so the letter could be hand delivered. The letter was handed to a nurse, but it never reached the Derwent Centre.

Learning identified:

This case was discussed at a wider management meeting (West Essex). A change of process was agreed for when forms are hand delivered. Self-addressed envelopes are to be included with forms and detail is now provided in the letter of where and when patients can hand deliver letters.

3. CAMHS, Longview Ward

Father unhappy that the transfer of ward was not discussed with him, as the patient has Autism and finds change difficult.

Learning identified:

Communication with the family could have been much better and a phone call should have been made on the morning the transfer took place, and then another call once the patient had left the Ward. Having to move a young person so quickly and at such short notice is something that the service should try to avoid. Especially a young person with ASD who needs time to process information. Discussed at Ward Meeting and Operational Meeting and shared via CAMHS Shared Learning System.

4. First Contact Practitioners Service, West Essex

Patient emailed with complaint regarding delayed diagnosis, treatment and physiotherapy causing more damage to their achilles and tears of the tendons.

Learning identified:

On their first appointment the patient was advised of exercises and advice for footwear. At this point the patient should have been referred for urgent imaging and to the fracture clinic. On their second appointment the patient reported having a further injury. Conservative management was advised and a physiotherapy referral was made. However, the patient should have had an urgent referral to the fracture clinic or imaging. Investigation concluded that the appropriate referrals were not made when they should have been. The pathway for managing this clinical presentation has been updated and shared with all MSK (Musculoskeletal) teams.

5. Mid Essex Immunisation team (Childrens Services)

A mother complained that her 12 year old son was given the HPV Vaccine with no consent at school. Her son was asked by the nurse if he had any allergies or medical conditions to which he replied no, when in fact he did have but was unaware of them.

Learning identified:

Investigation identified the consent form completed was for Year 9 cohort, which was the year group of the complainant's other son. As the signed consent form was over six weeks old, we should have sought confirmation that details were up to date and consent had not been withdrawn, this did not happen. Complaint discussed with staff. We now operate a guide of seeking consent a maximum of 4-6 weeks prior to a vaccination session, and a system development is being explored to email confirmation of consent and send text or email reminders.

TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

Complaints linked to Patient Safety Incidents

All complaints are logged onto the Datix reporting system and are cross-referenced with incidents that have been logged separately, to highlight any incidents that are connected to the complaint.

Where there are complaints that are also being investigated as a Patient Safety Incident (PSI), the Complaint Liaison Officer works collaboratively with the Patient Safety Team, ensuring that all elements of the complaint are investigated without conflict or duplication. The complainant is kept informed throughout this process.

During 2023/24 there were 58 complaints investigated that were linked to separate incidents that had been recorded on Datix. Of these, 7 were linked to a Patient Safety Incident.

Legal Claims related to Complaints

There were 10 claims opened in 2023/24 that related to complaints; 8 related to alleged clinical negligence, and 2 to alleged data breaches.

A total of 6 claims were closed that related to formal complaints (none of these were any of the above 10 claims, but were received prior to 2023/24).

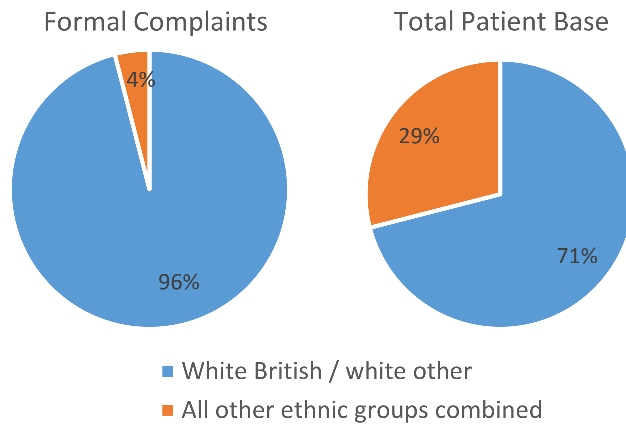
In two of the cases closed there were damages awarded, with a joint total of £67,500.

PATIENT DEMOGRAPHICS

Research published by the Care Quality Commission (CQC) in 2019 revealed that patients from ethnic minorities are less likely than those from a white British background to raise concerns about the standard of care they receive, particularly in relation to mental health. (*Ref: CQC Press Release, 12 June 2019*).

We record patient details on our complaint database (Datix) when logging a complaint, including their ethnicity where this is known. The patient ethnicity data recorded for formal complaints received in 2023/24 is presented below in a pie chart, alongside a pie chart showing ethnicity by our total patient base for comparison.

Ethnicity of patients 2023/24



Through the implementation of our Patient and Carer Race Equality Framework (PCREF), we aim to reduce inequalities in access, experience, and outcomes for racialised and ethnic minority communities.

Complaints are a vital source of knowledge for the Trust, from which we can learn and improve our services. Understanding who is complaining, and proactively seeking out feedback from those who do not, is key to ensuring that all patients have a voice.

In 2024/25 we will be improving how we collect and record demographic data for people who make complaints, so we can better understand which groups are not speaking up, and consider ways to improve access to our complaints service for these groups.

We also recognise that not everyone wants to make a formal complaint, so as a Trust we continue to develop our methods for engaging with the people and communities we serve. By encouraging and acting on informal feedback through patient surveys, NHS reviews, focus groups and workshops, we aim to provide everyone with opportunities to inform and shape our services.

FEEDBACK ON OUR COMPLAINTS SERVICE

Complaints Survey Results

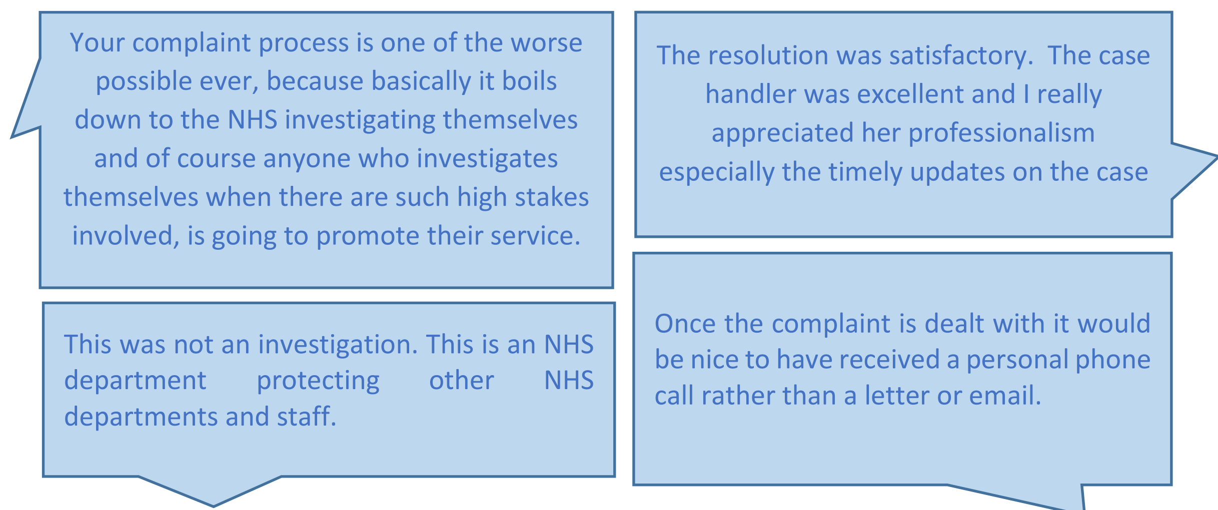
In 2023 we redesigned our Complaints Feedback Survey and introduced a QR code at the end of every response letter that provided a digital link to the survey. We also send a follow-up email with a link to the survey, several weeks after the response is sent.

This approach has been successful in increasing responses, and in 2023/24 we received 48 survey responses (v. 24 the previous year) which represents a response rate of 14%.

Summary of results 2023/24:

- 28% were satisfied that all aspects of their complaint were addressed (v.42% 2022/23)
- 21% believed the complaints process was fair (v. 29% 2022/23)
- 28% were satisfied with the timescale of the response (v.8% 2022/23)
- 22% were satisfied with the overall handling of their complaint (v.33% 2022/23)

The survey is anonymous, and there is a free-text field for any additional comments. Some verbatim comments we received are shown below:



Based on the feedback received, we shall be considering what actions we can take in 2024/25 to improve satisfaction and confidence in the integrity of our complaints process. Whilst our Complaints and PALS team have some degree of independence from the clinical teams, ultimately they are part of the Trust and our complaints process is internal. The responses received to our survey have highlighted that we need to do more to build trust with people using our service.

Direct feedback to Complaints Team

We received lots of positive feedback directly to the team from people that had used the complaints service in 2023/24. Some examples are given below:

"Dear Lisa [*Complaints Investigation Manager*] Just a note to say thank you for your visit with Tracy [*End of Life Lead*] a few weeks ago and for your follow-up letter. It was helpful to explain my concerns and thank you both for listening and taking them seriously. I hope others in a similar situation will benefit."

(Email received following a Complaint Resolution Meeting)

"Thank you for your assistance in getting my medication rectified. I am very grateful and really appreciate your help, thank you." (

(Email sent to Complaints Liaison Officer)

"Thank you for your letter and attachments, I appreciate the steps taken in this investigation. You have answered the points raised…I am happy that the complaint is now resolved and the matter can now be brought to a close."

(Email sent to Complaints Liaison Officer)

"I am grateful for the comforting words and empathy shown in your report and the fact that you intend to make improvements regarding communication. Thank you for giving time to investigate. I needed to do this to prevent other families experiencing the same."

(Email sent to Complaints Liaison Officer)

"As a family we wanted to thank you all for your help in moving my father's care forwards. We are all quick to complain when things go wrong but not so quick to thank everyone when things go really well, thus the reason for us writing again to you today. We will be writing to the team as well to thank them personally. Thanks again for the lovely help and service you all provided for my father, it felt like the NHS truly paid him back for all the years he devoted to them as a GP for all those years."

(Email sent to PALS mailbox)

"Thank you so much for taking the time to investigate and for all you have done to help me with my complaints… you always listen to me and even speaking with you this morning made me feel so much happier, you made me feel heard and I trust that you actually take on board my concerns."

(Feedback given verbally to Complaints Liaison Officer)

COMPLAINANT STORIES

Reflecting on complainant stories is valuable, because they provide greater insight and context to the complaints data. Case studies are a powerful tool that we use in team meetings and coaching to bring real complaints 'to life' and prompt discussion, reflection and learning.

Note: All names and some other minor details have been changed in these case studies to protect patient and staff confidentiality.

Story 1:

A complaint was received from Mrs J, the mother of an adult patient, Kelly, who had been referred to the Mental Health Crisis Team by their GP after experiencing symptoms of a psychotic episode, including hearing voices, having visual hallucinations and becoming suddenly non-verbal.

After an initial assessment at home the patient was referred for an appointment with the Psychiatrist Team, and following that, the patient was referred to EIP Service (Early Intervention Psychosis).

At her initial appointment with the EIP service, Kelly was further assessed and Mrs J was given a date by which they would be informed if her daughter met the criteria for EIP services. The date passed with no contact, but Mrs J chased it up, and was advised the following day that Kelly did meet the criteria, and a meeting was arranged for the following week.

Mrs J was happy with the support that was offered at this first meeting. It was explained to her that the patient would be under the EIP service for 3 years, and Mrs J was also offered support. However, there were soon problems. A meeting was arranged for the patient to meet her Care Co-ordinator, but when the day arrived Mrs J had to cancel the appointment as Kelly was too unwell to attend it. When Mrs J called to cancel, the receptionist told her that the Care Coordinator was not even in work that day and nothing was in the diary for Kelly to attend an appointment.

Following this, there were more poor experiences. On one occasion the Care Coordinator turned up with another member of staff, who was not introduced to them until they asked who she was. Kelly felt anxious and unnerved by this. Mrs J was left frustrated when numerous appointments were cancelled. This didn't make Kelly feel valued or cared for.

Mrs J repeatedly requested for the Care Coordinator to set a regular time and day for his visits with Kelly, because uncertainty heightened her anxiety. These requests were not responded to.

Mrs J eventually made a complaint after Kelly attended a further psychiatry assessment, where it was decided that she would be discharged from the EIP service. Mrs J was left confused after this appointment, not knowing what would happen with Kelly's care. She emailed Kelly's Care Coordinator and the service to ask for clarification, but received no response.

In her complaint Mrs J said that the uncertainty of the situation had a negative impact on Kelly's mood, and had left her feeling disengaged. She expressed her disappointment with the lack of consistency in Kelly's care, and the support that had been promised and then not delivered. She felt that if the early support had been better then Kelly would have been further along with her recovery. Mrs J requested a second opinion on Kelly's case.

All aspects of Mrs J's complaint were upheld.

We apologised for the poor communication, and the fact that many of her emails to the service were not responded to. Our investigation found that miscommunication between staff had led to this. Some tasks had been delegated within the service, but not followed up.

We apologised for the service provided by the Care Coordinator, which fell short of the standards we expect. He had failed to follow through with plans for regular, weekly support for Kelly. And when he suddenly left the service, a proper handover did not take place.

Our complaint response explained that Kelly was referred to the Early Intervention Psychosis (EIP) team for further assessment, and although intervention with EIP can be up to 3 years, this depends on the outcome of assessments. This should have been explained to Mrs J from the beginning.

We explained that the reason Kelly had been discharged from EIP was because the Consultant had concluded that her symptoms were related to anxiety, and her presentation did not support a diagnosis of psychosis. Therefore, it was determined that EIP was not the most appropriate care team for Kelly. The service recognised that staff could have better explained this to Mrs J and Kelly, and we apologised for this lapse.

We acknowledged that a decision had been made to refer Kelly to a Specialist Community Mental Health team, and this had now been discussed with Mrs J. It was agreed that, in the meantime, Kelly would still be supported and continue with psychology intervention until the referral was complete.

In accordance with Mrs J's request, a second opinion was arranged regarding Kelly's diagnosis and care plan.

This complaint was discussed with the teams involved, to reflect on the errors that were made and the impact that these had on Mrs J and on the patient's care.

Story 2:

A complaint was raised by Mrs B, the daughter of a patient, Olive, who lived in a Care Home and was under the Trust's Dementia Memory Service.

A member of the Dementia Service team attended the Care Home to complete monitoring appointments for a number of residents. On arrival, the member of staff was advised by the Care Home staff that Olive had been made palliative 3 days previously, and that all medication had been stopped by her GP. The patient was in bed with her family by her side, and it would be inappropriate for the planned assessment to go ahead.

The member of staff insisted that he still needed to see Olive, and Mrs B reported that she could hear the Care Home staff outside trying to stop him from entering the room. In addition, there was a butterfly symbol on Olive's bedroom door to indicate that she was on end of life care. Despite this, he entered the room, and began by incorrectly addressing the patient as 'Enid'. He explained that he was there to complete an assessment. Mrs B asked him to leave, but he insisted on explaining that he would be writing to the next of kin (at which point Mrs B informed him that she was the next of kin) and he confirmed that he would be sending Mrs B a letter to say that he had attended to complete the medication monitoring assessment and that she had denied him access. He explained this was part of the Trust's policy and procedure.

Mrs B was upset at the intrusion, and was left feeling that she had been 'told off'. Her mother was unsettled by what happened, and it made what was already an extremely difficult time much worse.

Olive passed away a week afterwards, and Mrs B wrote to the service to complain about what had happened. She questioned if the member of staff had followed the correct procedure by insisting on seeing her mother, and suggested that, if so, the policy should be changed as she would not wish for any other families to go through this ordeal.

The complaint investigation quickly established that there was no policy in place to state that the visit needed to be made. At the time of the appointment, the service were unaware that the patient was now under palliative care and that the visit was not required, which highlighted an issue with communication between our services and those in the community.

As a result of this complaint, the admin staff that book monitoring appointments will now check if patients are on End of Life care before booking in the appointments.

The learning from this complaint included the retraining of the staff member involved, and enrolling all staff in the Dementia Memory Service on 'End of Life care' training. It was also highlighted that the team were not all aware that a butterfly symbol on a patient's door signifies they are on end of life care, so this was communicated in a team business meeting.

In addition, the experience of this family was raised in an external 'End of Life' forum to highlight the impact of the identified communications issues and share learning.

A face to face meeting was held with Mrs B to apologise for the failings and to explain the lessons that had been learned from her complaint.

COMPLIMENTS

1,344 compliments were received directly to the services in 2023/24, compared with 1320 for the previous year. (+ 2%)

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

Received by Area

Area	Compliments Received
Mid & South Essex STP	516
North East Essex STP	151
West Essex STP	54
Specialist	265
Total Mental Health	**986**
South East Essex Community Health Services	189
West Essex Community Health Services	142
Total Community Health	**331**
Corporate Services	27
Total	**1344**

Learning from Compliments

Along with complaints, all compliments received by the Trust are analysed for potential learning that can be shared, as they can provide an excellent opportunity to highlight good practice.

Below are some examples of lessons learned from compliments that were shared Trust-wide in the monthly Lessons Identified Newsletter in 2023/2024:

1. **Basildon Mental Health Unit (MHU), Grangewaters:**

   "I have been a patient on the ward for almost 3 weeks. I would like to say how wonderful the staff have all been. I have been treated with respect, care and understanding. My risk assessment was done swiftly. The nurse (E) asked the sensitive questions in a hushed respectful manner. This made me feel less conscious... My care has been without doubt 100 % positive."

   Good practice shared: By demonstrating sensitivity in this moment we made the patient feel respected and cared for.

2. **rTMS, Brentwood Resource Centre**

   "The staff were kind, helpful, knowledgeable and supportive. They reduced fears and were very thorough. They showed interest in us as people. The treatment has been literally life changing, both for my husband and myself. It is a real joy to see him so able to cope with life. Thank you so much."

   Good practice shared: Taking a personal interest in our patients and their families helps build trust, engagement and shows that we care.

3. **St Margaret's Hospital, Admin**

   "I was enquiring about the progress of my referral yesterday and I was lucky enough to be put in contact with Karen. She listened attentively to my issue, unpicked all the confusion and even though I had been put through to her department by mistake, she spent a great deal of time explaining to me what information I needed to seek… she was patient, intelligent and gave up her time freely."

   Good practice shared: Effective listening skills are fundamental to providing a great service, and spending extra time to help provide clarity for someone can make a huge difference.

4. Plane Ward, Older Adult Inpatient (Community Health Services)

Letter received to thank staff for the care given to their father in his final days, before he passed away on Plane Ward. The family wanted to thank staff for the care and attention given not only to the patient but also the whole family at such a difficult and sensitive time. The letter from the patient's son ended *"The calm atmosphere of the ward and being told we could visit at any time was so important and even being offered a cup of tea by the ward team was a small but greatly appreciated act of kindness. We will never forget the excellent care our father received at your hospital".*

Good practice shared: In addition to delivering compassionate care and treatment to our patients, it is important to show kindness and understanding to their family/carers, recognising what a difficult time this can be for them.

5. South East Essex, Occupational Therapy

Telephone call from patient complimenting Community Occupational Therapist, Beverly, on her professionalism and caring attitude. The patient said that by providing the appropriate equipment to support and enable her at home, her condition is improving. She also added that Beverly asked about her wellbeing regarding her chemo treatment, and asked how she was feeling which the patient found very caring.

Good practice shared: Taking a whole person approach to treatment is understanding that health and wellness are not limited to physical health.

UPDATE ON PRIORITIES SET FOR 2023/2024

Please find an update on the priorities set in last year's annual complaints report in the table below.

Priority	Status	Action Taken
Embed new complaints process.	Complete	An evaluation of the re-designed Complaints Process was presented at Quality Committee in Dec-23.
Enhance PALS accessibility by creating a network of volunteers onsite within our services to provide support and advice, and proactively seek feedback from our service users.	In progress	A trial of this is planned in West and North East. A role description was advertised for volunteers and we have some applicants. Meeting planned to agree details of the role and book in some shifts.
Implement self-logging facilities for staff and service to log informal complaints and compliments.	Partially Complete	This facility has been delivered for self-logging compliments. The feasibility of extending this to locally resolved complaints is being reviewed.
Establish an effective feedback process (service user survey, and quality feedback from NEDs and Patient & Carer Forum) for the complaints process	Complete	Service User survey is now digital, with a QR code on every response letter, and a follow-up email sent with a link to the survey. The NED review process has also been reviewed so it is aligned with the new complaints process and is completed through MS Forms to make it a more efficient process. Advice was sought from Information Governance regarding consent required for quality reviews through the Patient & Carer Forum, and it was agreed we would need to gain the explicit consent of complainants to do this. We shall consider this as part of a wider review of the way we obtain and use consent for complaints

Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective .	Carried Forward	Due to operational pressures we have not yet started this review.
Engagement with Deputy Directors of Quality and Safety to implement effective feedback and follow up on lessons/ actions	Complete	An effective feedback process is now in place, and DDQS have been engaged to provide monthly feedback on lessons identified.
Review the information on the Trust website, make it more accessible and clearer regarding the PALS and Complaints services.	Complete	Information has been updated on the Trust website to provide clear guidance regarding the PALS and Complaints services. A directory has been added to the PALS page to provide contact details for alternative Trusts and ICBs, to reduce the number of “signposting” calls we receive in PALS.

PRIORITIES FOR 2024/2025

- Focus on maximising the integrity of our internal complaints service by:
    - Providing PHSO training for the whole Complaints Team (NHS Complaints Standards accredited course), to increase skills and confidence in conducting evidence-based investigations that are balanced and fair.
    - Minimising the potential for bias (and the perception of bias) by removing the requirement for the service to approve the response letter that is sent to the complainant following the CLO's independent investigation. Replace this with a requirement for senior approval of the clinical information provided for the Complaints Investigation Report.
- Build trust with complainants and improve their faith in our service by:
    - Sharing our investigation plan with them at the beginning of the process so that (a) the complainant is clear on our intended approach and can provide input and feedback at an earlier stage, and (b) it provides better context for our estimated timescale for completion, which is based on the complexity of the investigation.
    - Where it would be helpful, providing our 'initial view' to the complainant and the service prior to sending our final response letter, so that both parties can raise any concerns and provide any further information to be taken into account.
- Improve response times by providing more effective early dispute resolution, including resolving a greater proportion of concerns via the PALS service.
- Implement a robust process for capturing and sharing lessons learned from PALS concerns, to ensure that we are not missing learning opportunities when we resolve complaints informally.
- Improve the capture and reporting of the demographic breakdown of our complainants, so we may better identify if there are certain groups who are not speaking up.
- Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective (carried forward from last year).

Report produced by:

Claire Lawrence, Head of Complaints and PALS
Matthew Sisto, Director of Patient Experience

On behalf of:
Zephan Trent, Executive Director of Strategy, Transformation and Digital

May 2024