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Complaints & Compliments

Annual Report 2024/2025

May 2025

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PURPOSE

This report provides an overview of the complaints, concerns, and compliments received by the Trust between 1 April 2024 and 31 March 2025 ("2024/25"). It includes data on volumes, response times, and key themes, and highlights learning arising from both complaints and compliments. The report also presents findings from the quality reviews conducted by our Non-Executive Directors and our complaints satisfaction survey— both of which assess the quality of complaint investigations and response letters. Finally, it reviews progress against the priorities set for the previous year and outlines our priorities for 2025/26.

SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provides community health, mental health, and learning disability services to over 3.2 million people across Luton and Bedfordshire, Essex, and Suffolk. With more than 8,000 staff working across 145 sites, our services are delivered not only from Trust premises but also within people's homes and community settings.

The Complaints Team forms part of the Patient Experience portfolio and provides both the Complaints Service and the Patient Advice and Liaison Service (PALS) for people using Trust services. Our role is to support resolution, rebuild trust, and ensure concerns are listened to and acted upon.

While the Complaints Team investigates and responds to formal complaints received by the Trust, many concerns are raised and resolved informally by the services themselves, without a formal investigation. These informal concerns are an important way in which we remain responsive to feedback. They are typically handled through one of the following routes:

- **PALS concerns** – Raised via the Patient Advice and Liaison Service and passed to the relevant service for a direct response.
- **MP concerns** – Raised by individuals through their local Member of Parliament, and responded to directly by the appropriate service.
- **Locally resolved concerns** – Raised directly with a Trust service and resolved informally at a local level without involvement from the Complaints Team.

In some instances, concerns that are initially raised through one of these informal channels are later escalated to be investigated formally—for example, where the issues are particularly complex or where informal resolution is not possible. Regardless of the route taken, all concerns are logged and monitored so that learning can be captured and used to inform service improvements.

Our approach to complaints is complainant-led, focusing on the outcomes that matter most to the person raising the concern. By working in partnership with individuals to agree the most appropriate route to resolution, we have been able to address a greater proportion of concerns informally—enabling faster, more direct responses to less complex issues.

This approach is reflected in the table below, which presents the number of complaints and concerns received, compared with the previous year. Notably, despite a 5% increase in the overall number received, the number of formal complaints has reduced by 9%.

	2023/24	2024/25	+/-
Formal Complaints	275	249	**-9%**
PALS Concerns	537	603	**+12%**
MP Concerns	69	73	**+6%**
Locally resolved concerns	60	59	**-2%**
Grand Total	**941**	**984**	**+5%**

Table 1: Volume received, all types of complaints and concerns

Year Highlights

- Total complaints & concerns: 984 (up 5% from 941 in 2023/24)
- Formal complaints received: 249 (down 9% from 275)
- Formal complaints closed: 268, reducing open caseload from 100 to 81
- Formal complaints closed within 60 working days: 44% (up from 29%)
- Formal complaints closed within agreed timescales: 98% (up from 94.8%)
- Average formal response time: 85 working days (down from 100)
- PALS concerns managed informally: 603 (up 12% from 537)
- Top formal complaint category: Clinical Practice (147 complaints)
- Re-opened complaints: 13% (vs. 7%)
- Lessons identified: 130 (60%) of 218 formal complaints closed
- Total compliments received: 1,545 (up 15% from 1,344)
- Non-Executive Director review “quality of response letter” rated positively: 100%

While we have made significant strides in enhancing our complaints service, we recognise that some patients continue to feel our process lacks impartiality. Feedback from both the 2023/24 and 2024/25 Complaints Surveys indicates a recurring perception that our investigations can appear defensive and biased in the Trust's favour. This perception undermines confidence in our procedures, which aim to be fair, transparent, and focused on learning.

In 2025/26 we aim to address this issue by strengthening the transparency of our process and providing additional training for staff and investigators on unconscious bias and fair decision-making. Our aim is to ensure every complainant can have full confidence in the integrity and fairness of our complaints process.

FORMAL COMPLAINTS

Complaints Process Overview

Complaints received directly by the Trust's Complaints Team are allocated to a Complaints Liaison Officer (CLO), who acts as the primary point of contact for the complainant. The CLO will attempt to make contact with the complainant to discuss the concerns raised, with the aim of agreeing on a clear and appropriate way forward to resolve the issues.

Where appropriate, a formal complaint investigation may be recommended. This is particularly likely when:

- The concerns relate to a past event, rather than an ongoing issue requiring immediate or urgent intervention.
- The nature of the complaint is complex and cannot reasonably be addressed without a detailed investigation.

The Complaints Team conduct independent, evidence-based investigations, focused on providing a fair and impartial view of what occurred. The CLO leads the investigation process, working closely with the complainant and, where necessary, a clinical advisor from the relevant service area.

Once the investigation is complete, a Formal Response Letter is sent to the complainant. This letter outlines how the complaint was considered, the findings of the investigation, and the outcome.

Where failings in care or service have been identified, we acknowledge what went wrong, take accountability, and explain the actions taken to address the issues. The response also includes details of any lessons learned and service improvements implemented as a direct result of the complaint.

Complainants are informed of their right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) should they remain dissatisfied with the outcome.

Complaints Received, Closed and Carried Forward

Carried forward from 2023/24	Received 2024/25	Closed 2024/25	Carried forward to 2025/26
100	249	268	81

Table 2: Complaints received, closed and carried forward

During 2024/2025, the Trust received 249 formal complaints, representing a 9% decrease compared to the previous year's total of 275. This marks the second consecutive year in which the number of formal complaints has declined. The reduction reflects the positive impact of the new complaints process introduced in January 2023, which established a more patient-led approach to resolving concerns.

By working collaboratively with individuals to understand their desired outcomes and agreeing on the most appropriate route to resolution, we have been able to resolve more issues informally—particularly where concerns are related to an ongoing issue, require prompt action, or are of low complexity and do not require a formal investigation.

This is also the second year in a row that we have responded to more formal complaints than we received, leading to a reduction in our overall active caseload. This improvement highlights the efficiency of the revised process and our continued commitment to providing timely and meaningful responses to the people who use our services.

Response Times

Completed within agreed timescale (Target 100%)

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 2024/25 we completed 98% within the agreed timescale, which was an increase compared to the previous year (95%).

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

While complaint response times naturally vary depending on the complexity of each case, we also monitor performance against a standard internal target of responding within 60 working days (approximately three months). In 2024/25, of the 268 formal complaints closed, 119 (44%) were resolved within this timeframe.

	2023/24	2024/25
Formal Complaints Closed in 2023/24	332	268
Closed within 60 working days (Target 90%)	29% (96)	44% (119)
Closed within Agreed Timescale (Target 95%)	95%	98%
Average Response Time (working days)	100	85

Table 3: Formal complaints response times v. targets, compared with previous year

The results show continued improvement in response times for the second consecutive year. However, we remain some distance from achieving our target of responding within 60 working days in 90% of cases. Resource constraints remain a key challenge, but in 2025/26 we will continue to focus on streamlining our processes to improve efficiency, while ensuring the quality and integrity of our investigations and responses are maintained.

Received per Patient Contacts (by Mental Health and Community Health)

The table below presents the number of patient contacts made in 2024/25 across all Mental Health and Community Services, broken down by locality. Patient contacts refer to any recorded interaction between a patient and a healthcare professional, including face-to-face appointments, phone calls, and virtual consultations. Alongside this, the number of formal complaints received in each area is shown.

The volume of patient contacts provides important context for understanding the complaint figures, as the number of contacts varies significantly between localities due to differences in the scale and nature of services delivered.

Table 4: Formal complaints shown per 1000 patient contacts, by area.

Area (MH Services)	Total Formal Complaints	Total Patient Contacts	Complaints per 1000 patient contacts
Mid & South MH	141	302,960	0.47
North Essex MH	38	100,576	0.38
West Essex MH	22	65,949	0.33
TOTAL Mental Health Services	**201**	**469,485**	**0.43**
Community - South East Essex	9	703,103	0.01
Community - West Essex	13	465,452	0.03
TOTAL Community Services	**22**	**1,168,555**	**0.02**
Grand Total	**223**	**1,638,040**	**0.14**

In 2023/24 the total number of complaints received per 1,000 patient contacts was 0.12.

Received by Care Unit

The services provided by the Trust are organised into distinct Care Units, each responsible for a specific area of healthcare delivery. A Care Unit functions as a management structure, overseeing the performance and quality of services within its area of responsibility. Each Care Unit is led by a dedicated leadership team who work collaboratively to maintain high standards of care, support staff, and ensure the delivery of safe and effective services. Organising services in this way allows for clear accountability, informed decision-making, and a strong focus on both patient experience and service improvement.

The table below shows the number of formal complaints received by each Care Unit in 2024/25, alongside figures from the previous year for comparison.

	2023/24	**2024/25**	**+/-**
Community Delivery Mid and South Essex	88	87	**-1%**
Community Delivery North Essex	30	12	**-60%**
Community Delivery West Essex	34	26	**-24%**
Inpatient and Urgent Care	89	71	**-20%**
Psychological Services	21	37	**+76%**
Specialist Services	10	12	**+20%**
Corporate / Business Units	3	4	**+33%**
Grand Total	**275**	**249**	**-9%**

Table 5: Formal complaints received by Care Unit, compared with previous year

Trend Analysis by Care Unit

The comparative data shows that most areas experienced a reduction in formal complaints received. Significant reductions were seen in Community Delivery North Essex (a 60% decrease) and Community Delivery West Essex (a 24% decrease).

These improvements are largely the result of a stronger emphasis on the informal resolution of less complex concerns. Issues such as staff attitude or communication problems are now more often addressed effectively through direct engagement—such as a meeting between the complainant and the service—rather than through a formal investigation process.

Psychological Services was the only Care Unit to report a significant increase, with complaints rising by 76%—an increase of 16 compared to the previous year. The complaint sub-categories that accounted for the biggest increases for Psychological Services in 2024/25 compared with the previous year were:

- Referrals Appointments (+9)
- Waiting Lists/Times (+3)
- Access to ADHD/ASD Service (+4)

The rise in these categories is linked to a growing number of referrals for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD). Greater public awareness of ADHD and other neurodivergent conditions has encouraged more individuals to seek diagnosis and support, placing additional demand on mental health services.

Actions Taken by Psychological Services

The Trust recognises the rise in complaints about waiting times, referrals, and access to ADHD/ASD services, reflecting wider national challenges in neurodevelopmental care. Demand for assessments has grown with public awareness, but current capacity—set by local commissioning—has not kept pace. We are working with commissioners on immediate mitigations and longer-term service redesign, though solutions will take time.

In September 2024, a Quality Senate on Neurodivergence examined systemic pressures and explored needs-based approaches that can guide care without relying solely on full diagnostic assessments. We are also managing increased prescribing demand after many GP practices

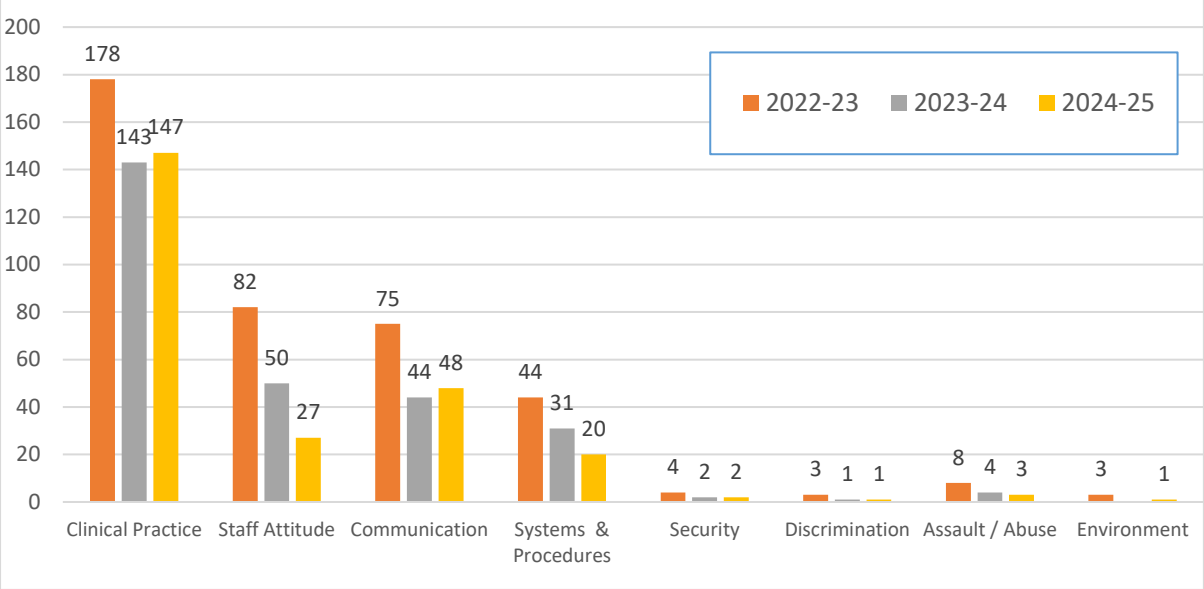
withdrew from shared care agreements for ADHD. Resources have been temporarily reallocated for prescribing, and capacity is under review. Ongoing discussions with Integrated Care Boards aim to secure sustainable service delivery.

These steps demonstrate our commitment to tackling root causes of complaints, even as capacity constraints persist locally and nationally.

Complaint Themes

On the Datix Complaints Database, each complaint is assigned to one of eight predefined categories based on its primary issue. The chart below illustrates the three-year trend in formal complaints received across those categories.

Figure 1: Formal Complaints received by main category (three-year trend)



- **Clinical Practice** remained the most frequently reported complaint category in 2024/25. The number of complaints showed only a slight increase from the previous year (147, up from 143), reflecting overall stability in this area.
- **Staff Attitude** complaints decreased for the second consecutive year, representing a 67% reduction compared to 2023/24.
- **Communication** complaints saw a modest rise (48, up from 44), but remain significantly lower than two years ago, when 75 were recorded in 2022/23.

- **Systems & Procedures** complaints also declined for a second year, with only 20 logged in 2024/25—less than half the number reported in 2022/23 (44).
- All other complaint categories remained low and demonstrated an overall downward trend.

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 57% of the total formal complaints received in 2024/25 (142 out of 249), as follows:

Table 6: Top ten sub-categories for Formal complaints

Main Theme	Sub-category	Number Received	% of Total Received
Clinical Practice	Discharge / Follow Up	20	8%
Communication	Communication breakdown with patient	19	8%
Clinical Practice	Medication	18	7%
Clinical Practice	Assessment & Treatment	16	6%
Clinical Practice	Lack of Community Support	14	6%
Clinical Practice	Referrals / Appointments	12	5%
Communication	Communication breakdown with relatives	12	5%
Systems & Procedures	Waiting Lists/Times	11	4%
Clinical Practice	Unhappy with Treatment	10	4%
Clinical Practice	Diagnosis	10	4%
		142	**57%**

Common themes in the complaints that were categorised under 'Discharge / Follow Up' were:

- **Inappropriate or Unsafe Discharge** – Patients discharged without notice, adequate follow-up, or while still unwell (e.g., suicidal or medically unstable).
- **Poor Communication** – Complaints highlighted unclear discharge decisions, lack of information for patients and carers, and missing or inaccurate documentation.
- **Service Accessibility & Continuity of Care** – Patients reported being discharged due to missed appointments despite valid reasons, or experienced gaps in care due to staff shortages or service limitations.
- **Lack of Compassionate or Person-Centred Care** – Concerns included not feeling listened to, especially during crises, and experiencing dismissive or apathetic interactions with staff.

Complaint Outcomes

When a formal complaint is investigated, a thorough review is undertaken to determine whether there were any shortcomings in the care or service provided. The investigation establishes the facts of what occurred and assesses this against what should have happened, based on relevant regulations, standards, policies, and published guidance.

If the evidence shows a clear discrepancy between the care provided and expected standards, the complaint is recorded as **upheld**. If the investigation concludes that the care or service met the appropriate standards, the complaint is recorded as **not upheld.**

In cases where a complaint raises multiple issues, each point is considered individually. Each is assessed on its own merits and recorded as either upheld or not upheld. Where the findings result in a mixture of upheld and not upheld elements, the overall outcome of the complaint is recorded as **partially upheld.**

268 formal complaints were closed during 2024/25, but a formal investigation was not completed for 50 (18%) cases for the following reasons:

- 6 were withdrawn by the complainant after being logged.
- 2 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.
- 42 were closed with no investigation for various other reasons, e.g. Patient consent was declined for a complaint made by a 3rd party; a Patient Safety Incident Investigation (PSII) was investigating the same issues so the complaint was closed in agreement with the complainant; complaint was re-directed to a different Trust after discussion with the complainant, a lack of patient engagement can make it impossible to complete an investigation.

The outcomes of the 218 formal complaint investigations completed by the Trust's Complaints Team in 2024/25 are shown in this pie chart:

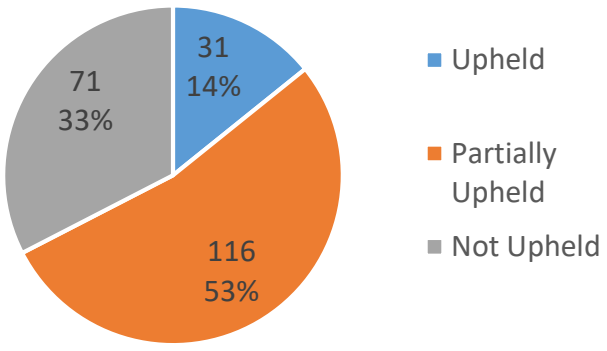


Figure 2:
Formal complaints investigations completed, by outcome

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 to any outstanding concerns for the complainant.

Of the 218 formal complaints that were investigated and responded to in the year, 13% (28) were subsequently reopened. The reasons given for requesting the complaint to be re-opened are categorised below in Table 7, alongside the previous year's data for comparison.

Table 7: Reasons for re-opened complaints, compared with previous year

Reason for Re-opened Complaint	2023/24	2024/25	-/+
Inadequate response/ not fully addressed	1	8	+7
Disputes information in response	6	6	-
New questions/ information	8	6	-2
Dissatisfied with investigation	5	6	+1
Unhappy with outcome	3	2	-1
Grand Total	**23/313 (7%)**	**28/218 (13%)**	**+5**

Overall the percentage of complainants that requested a further response has increased to 13%, from 7% the previous year. The number of individuals who felt the response letter was insufficient or failed to fully address their concerns now represents 28% of the reasons cited for re-opening complaints. Comments made include:

- *"Does not feel response letter has addressed the concerns raised"*
- *"Not happy with the level of detail provided"*
- *"Complainant does not feel her concerns have been answered in depth"*

The Complaints Investigation Manager personally reviews all re-opened complaints, and discusses feedback with the Complaint Liaison Officer that investigated and responded to the original complaint. We are committed to learning and improving from the feedback we receive, and the quality of our response letters will be an area of focus for 2025/26.

MP COMPLAINTS

The Trust received 73 concerns from MPs on behalf of their constituents, up by 6% compared with the previous year (69). The top 4 topics for MP complaints were as follows:

- Lack of Community Support (15)
- Unhappy with Treatment (11)
- Access to treatment (9)
- Access to assessment (7)
- Concern for others in the community (6)

LOCALLY RESOLVED COMPLAINTS

All EPUT staff are encouraged to resolve concerns 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 concerns that are resolved locally, so that we are aware of emerging issues, and any lessons learned can be recorded and shared as appropriate.

In 2024/25, 59 locally resolved concerns were recorded on Datix, representing a slight decrease of one compared to the previous year's total of 60. The numbers logged are shown below by Care Unit:

Table 8: Locally resolved complaints logged by Care Unit, compared with previous year

Care Unit	2023/24	2024/25	-/+
Community Delivery Mid and South Essex	37	35	-5%
Community Delivery North Essex	12	9	-25%
Community Delivery West Essex	4	7	75%
Inpatient and Urgent Care	6	4	-33%
Specialist Services	0	2	-
Psychological Services	1	2	100%
Total	**60**	**59**	**-2%**

The top nine concern topics accounted for 46 cases, representing 78% of all locally resolved concerns recorded.

Table 9: Top 9 topics of locally resolved concerns for 2024/25

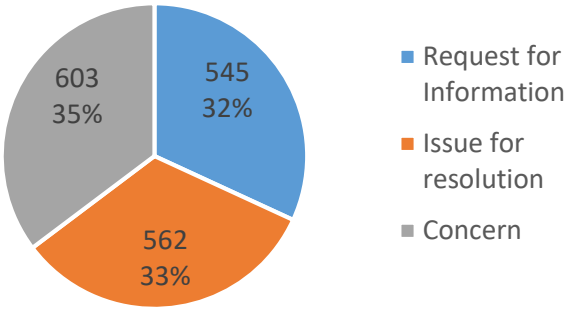
Concern Sub-category	Number received	%
Communication breakdown with patient	23	39%
Referrals / Appointments	4	7%
Inaccurate written records	4	7%
Communication with patients	3	5%
Poor communication between professionals	3	5%
Unhappy with Treatment	3	5%
Medication	2	3%
Consent	2	3%
Staff attitude (rude)	2	3%
Grand Total	**46**	**78%**

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 1,710 contacts during the year 2024/25, which was a decrease of 5% on the previous year (1,806). A breakdown of the type of enquiries received is shown below.

Figure 3: PALS contacts received, by type of enquiry



In addition, PALS Officers signposted 1,380 enquirers for help to other services/ organisations.

PALS 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, 25 concerns (1.5% of PALS contacts) were passed to the Complaints Team to be investigated as formal complaints in 2024/25.

We remain committed to resolving concerns informally through the PALS service wherever this is likely to achieve the best outcome for the individual raising the issue. In 2024/25, there was a 12.5% increase in the number of concerns managed through PALS, with a total of 603 logged during the year. Of these, the top 11 sub-categories accounted for 73% (439) of all the concerns raised:

Table 10: Top 11 sub-categories for PALS concerns

Main Theme	Sub-category	Number Received	% of Total Received
Communication	Communication breakdown with patient	111	18%
Clinical Practice	Unhappy with Treatment	103	17%
Clinical Practice	Referrals / Appointments	57	9%
Clinical Practice	Medication	37	6%
Communication	Communication breakdown with relatives	31	5%
Clinical Practice	Care	20	3%
Clinical Practice	Lack of Community Support	19	3%
Clinical Practice	Discharge / Follow Up	17	3%
Staff Attitude	Inappropriate behaviour	16	3%
Systems & Procedures	Assessment & Treatment	14	2%
Clinical Practice	Care planning	14	2%
	Total	**439**	**73%**

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

Concern sub-category & Care Unit	Concern Raised	Outcome
Care Psychological Service	Patient finds it difficult to leave his home, does not think he would benefit from therapy. He says calls and appointments with consultant are few and far between. He has contacted crisis on many occasions and is struggling.	PALS referred to service. Service responded putting a plan in place to do a home visit and see what is suitable for the patient.
Patient belongings Specialist Services, The Linden Centre	Patient emailed CQC to raise concern. He is unable to use his phone, as staff will not allow him to use it. Patient broke his TV remote, cannot watch TV as staff took the remote away. Staff have been into his room whilst he was in seclusion.	Clinical lead met with patient. Legal reasons prevent him from having a mobile phone on the ward, but he can use one under supervision during escorted leave. He damaged the remote control, and the reason for the room search was explained. Outcome shared with CQC by email.
Referrals/ Appointments Musculoskeletal Physiotherapy (MSK)	The patient is concerned about the time it has taken for an appointment to be made for them with the MSK service.	The MSK service had been trying to contact the patient and left several messages. The referral has been received and a face to face appointment has now been booked.

Response Times

Internal service level: Target =90% within 15 working days

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

In 2024/25:

- 69% of PALS concerns were closed within 15 working days, a slight decrease from 74% the previous year.
- The average response time improved to 14.3 days, down from 15.3 days in the previous year.

While the proportion of concerns closed within the target timeframe has fallen, the improvement in the average response time suggests that the overall handling of concerns has become more efficient. The decrease in cases meeting the 15-day target may reflect increased complexity or volume of concerns, but the shorter average turnaround time indicates that many concerns are still being addressed more promptly than before. We will continue to monitor both timeliness and quality to ensure a responsive and person-centred service.

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.

Table 11: Five-year summary of PHSO referrals and investigation outcomes (2020–2025)

	Number of referrals to PHSO	Cases accepted for investigation by the PHSO	PHSO investigation completed	PHSO Outcome
2020/21	39	1	1	Partly Upheld
2021/22	54	0	3	3 x Partly Upheld
2022/23	39	1	0	-
2023/24	64	0	1	Partly Upheld
2024/25	77	0	0	-

In 2024/25, 77 complaints were referred to the PHSO about EPUT services - an increase of 20% compared to the previous year. This increase may be influenced by a range of factors, including greater public awareness and ongoing publicity surrounding the Lampard Inquiry.

It is important to note that this rise does not necessarily reflect growing dissatisfaction with the Trust's complaint responses. In many instances, individuals contact the PHSO without first raising their concerns directly with the Trust. In fact, 20 referrals were not progressed to investigation by the PHSO last year for this reason.

Positively, for the second consecutive year, the PHSO did not accept any complaints for formal investigation.

This suggests that, despite external pressures and heightened scrutiny, the Trust's internal complaints handling process is effective in resolving concerns to a standard that satisfies independent review.

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 in 130 (60%) of the 218 formal complaint investigations closed during the year. Below are several examples of the key learnings from these complaints.

1. Poplar Ward, St Margaret's Hospital (West Essex)

Complaint Summary:
The complainant's mother, diagnosed with dementia, was admitted to Poplar Ward following a fall and surgery. During personal care, the patient, described as non-compliant, sustained a significant leg injury after rolling onto a crash mat and kicking against the bed frame. The family raised concerns regarding the severity of the injury, discrepancies in the explanations provided by staff, and additional bruising. The complainant questioned the overall standard of care and the adequacy of communication surrounding the incident.

Learning Summary:
Staff were reminded of the critical importance of accurately completing and updating body maps in both patient records and at the bedside to ensure effective monitoring of injuries. The importance of adhering to Trust policies, procedures, and communication protocols was emphasized. This learning was disseminated through team meetings and group supervision sessions to reinforce awareness and compliance among staff.

2. Adult Community Psychological Services - South West (Psychological Services)

Complaint Summary:
The complainant raised concerns about a Dialectical Behaviour Therapy (DBT) group therapy session conducted via Microsoft Teams. During the session, another participant was observed with friends present in the background, behaving inappropriately while others shared sensitive personal information. Although the facilitator eventually asked the participant to leave, this occurred halfway through the session, leading to the complainant feeling mistrustful and ultimately withdrawing from the DBT course.

Learning Summary:
Facilitators were reminded to clearly reiterate confidentiality rules and the group contract at the beginning of each DBT session to ensure all participants understand the expectations. An apology was offered for the distress caused, and this issue was addressed in subsequent team discussions to improve group session management.

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3. Basildon Mental Health Unit (MHU) (Inpatient & Urgent Care)

Complaint Summary:
An advocate raised concerns about a lack of understanding and support for a deaf inpatient on Grangewater Ward. The issues highlighted included poor staff awareness of the patient's communication needs, insufficient disability support, and a general lack of knowledge on interacting with individuals with hearing impairments. The advocate sought assurance that actions would be taken to improve both staff practice and the patient's experience.

Learning Summary:
In response, the Trust undertook a review of practices and took steps to improve accessibility and staff awareness. Deaf awareness training is being explored with the Training Department, and staff will receive appropriate training materials. Additionally, 'Accessible Information Standard' posters have been displayed in patient and staff areas to promote inclusive communication. These learning points were shared with staff and reinforced by updated ward signage.

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4. Tendring Specialist Community Mental Health Team Reunion House (North Essex)

Complaint Summary:
The complainant expressed dissatisfaction with communication failures during their care. They were not informed about a change in their care plan—originally, they were to be allocated a care coordinator, but this was changed to a referral for psychotherapy services without prior discussion. Additionally, they were not sent a copy of a letter shared with their GP, leading to confusion and unmet expectations.

Learning Summary:
Staff have been reminded that changes to a patient's care plan should always be discussed with the patient beforehand, whenever possible. If prior discussion is not feasible, patients must be promptly informed of any alterations. Consultants and administrative staff have been reminded to share any correspondence with the patient unless explicitly marked as confidential. These reminders were reinforced through staff meetings and one-to-one supervision.

5. Recovery and Wellbeing Southend, (Mid & South Essex)

Complaint Summary:
The complainant raised concerns about their care at the Taylor Centre, highlighting several issues. They were never allocated a care coordinator and were unsure of who their case worker was throughout their involvement with the service. The complainant also noted a lack of continuity, with different staff attending each contact, none of whom seemed familiar with their case. Furthermore, they cited long waiting times for appointments, averaging four to five months, which hindered effective support. The complainant requested an apology and assurances that future communication would be more person-centred.

Learning Summary:
Staff were reminded to review patient notes before appointments, especially when unfamiliar with the patient's history, and to respond appropriately to patient requests and preferences. The Trust reinforced its expectation of professionalism and compassion in interactions with patients and families. This feedback has been incorporated into both individual supervision sessions and team discussions to enhance patient care and communication.

6. Veterans Team, The Lakes (Specialist Services)

Complaint Summary:
The complainant and their husband raised concerns about delays in receiving therapeutic support, poor communication, and a loss of trust in the psychologist. They expressed that these issues adversely affected the patient’s mental health, and, as veterans, they were concerned that other veterans might experience similar challenges. They sought assurances that lessons would be learned to improve future services for veterans.

Learning Summary:
The following improvements have been made based on the complaint:

- Ensure all emails to patients and families are acknowledged, even if no update is available.
- Review the process for arranging medication reviews to prevent delays.
- Recognise and address delays in therapy or intervention early.
- Consider a phone call with patients before sending letters about removal from a psychologist’s caseload to reduce distress.

An action plan has been implemented to address these concerns, ensuring a more responsive and supportive service for veterans.

7. Specialist Mental Health Team, the Gables (Mid & South Essex)

Complaint Summary:
The complainant, writing on behalf of their brother, raised concerns about the lack of care planning and unprofessional conduct by a staff member at The Gables. The staff member had provided personal contact details, failed to attend appointments, and bought personal items for the complainant's brother. The complainant felt that a letter of apology was insufficient, and that accountability was necessary for the impact on their brother's mental health.

Learning Summary:
The investigation revealed that the staff member had blurred professional boundaries, which led to significant concerns. In response, all staff members will undergo internal training focused on reinforcing the importance of maintaining professional boundaries when interacting with service users. Additionally, the lack of comprehensive care planning was addressed, with an emphasis on ensuring that care coordinators create and share meaningful care plans with service users. This learning has been incorporated into ongoing clinical supervision to ensure continuous improvement in practice.

TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

Complaints Linked to Patient Safety Incidents

All complaints are recorded on the Datix reporting system and cross-referenced with any related incidents to ensure that links between complaints and incidents are identified.

Where a complaint relates to a Patient Safety Incident (PSI), the Complaint Liaison Officer works closely with the Patient Safety Team to ensure a coordinated investigation. This approach helps to avoid duplication and ensures that all aspects of the concern are fully explored. The complainant is kept updated throughout the process.

In 2024/25, 28 complaints were investigated that had links to separate incidents recorded on Datix. Of these, 15 were associated with a Patient Safety Incident. One of these is summarised below.

Example of a Formal Complaint Related to a PSI

Complaint Summary: **Beech Ward, Rochford Hospital**

The complainant raised concerns about poor communication from staff and failures in following proper post-fall procedures after her husband sustained two falls while detained under Section 3 on Beech Ward. She was not kept informed about key developments, including ambulance arrangements, and felt agreed plans for contact were not followed.

Outcome and Learning Summary:

The complaint was partially upheld. Failures were identified in the post-falls procedure and communication with the complainant. Apologies were issued and corrective actions implemented:

- Staff reminded to complete post-falls risk assessments promptly.
- Named Nurse (or deputy) to complete follow-up assessments.
- Staff reminded to keep families updated, especially during key care events.
- Plans to improve staff communication across shifts were initiated.

Legal Claims related to Complaints

Seven new claims were opened that related to complaints during the year—six alleging clinical negligence and one concerning personal injury. Separately, 12 claims linked to formal complaints were closed during the year; these were all submitted prior to 2024/25 and do not include any of the seven newly opened cases.

Of the 12 closed claims, damages were awarded in seven cases, amounting to a combined total of £426,740.

PATIENT DEMOGRAPHICS

Patient demographic information, including ethnicity, age, and gender, is recorded on our complaints database where available. The charts below present a comparison between the demographic profile of patients who made a formal complaint in 2024/25 and the overall demographic profile of our total patient population.

Ethnicity

Figure 4: Formal Complaints by ethnicity of patient

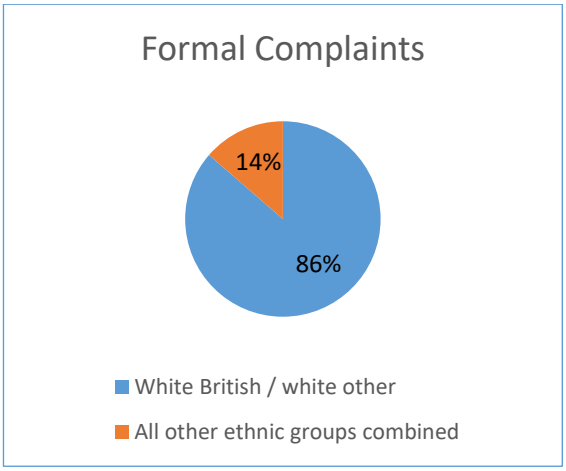
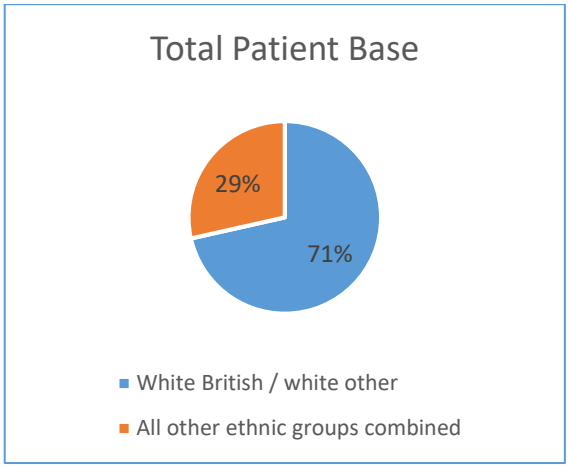


Figure 5: Total patient base by ethnicity



The ethnicity breakdown shows that:

- 71% of the total patient base identify as White British or White Other, while 86% of patients who made a formal complaint were from this group.
- Patients from all other ethnic groups combined make up 29% of the patient base but accounted for only 14% of formal complaints.

What This Tells Us

- White British/White Other patients are proportionately more likely to raise formal complaints compared to their representation in the overall patient population.
- Patients from minority ethnic groups are under-represented among those raising complaints.

This suggests that people from ethnic minority backgrounds may face barriers to using the complaints process — potentially including language barriers, cultural perceptions about complaining, lack of awareness, or trust issues with health institutions.

Age

Figure 6: Formal Complaints by patient age group

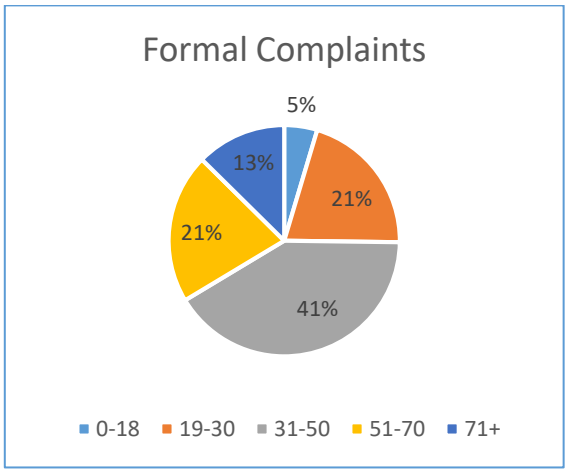
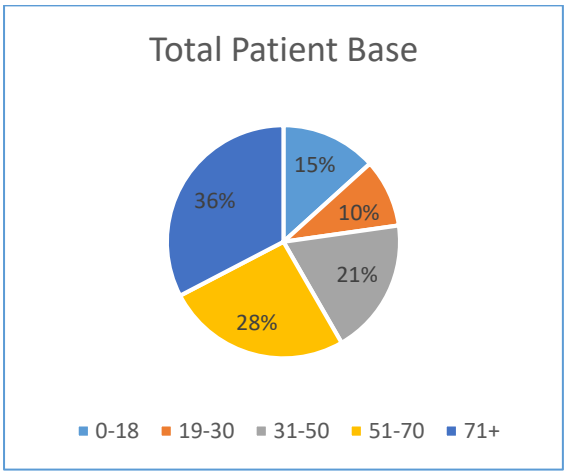


Figure 7:Total patient base by age group



The age breakdown shows that:

- 0–18 years make up 15% of the patient base but account for only 5% of formal complaints.
- 19–30 years represent 10% of the patient base but make up a disproportionately higher 21% of complaints.
- 31–50 years also show a significant over-representation, comprising 21% of the patient base but 41% of formal complaints.

In contrast, older age groups are under-represented:

- 51–70 years make up 28% of patients but only 21% of complaints.
- 71 years and over represent the largest portion of the patient base (36%) but only 13% of complaints.

What This Tells Us

- Younger and middle-aged adults (19–50 years) are significantly more likely to raise formal complaints compared to their proportion in the patient population.
- Children, young people (0–18) and older adults (71+) are much less likely to formally complain, despite being substantial user groups for our services.

This pattern suggests that younger and middle-aged adults may be more confident or willing to use formal complaints processes, while older people and families of children may face more barriers — such as unfamiliarity with the process, feeling uncomfortable complaining, or being unsure how to escalate concerns.

Gender

Figure 8:Formal Complaints by patient gender

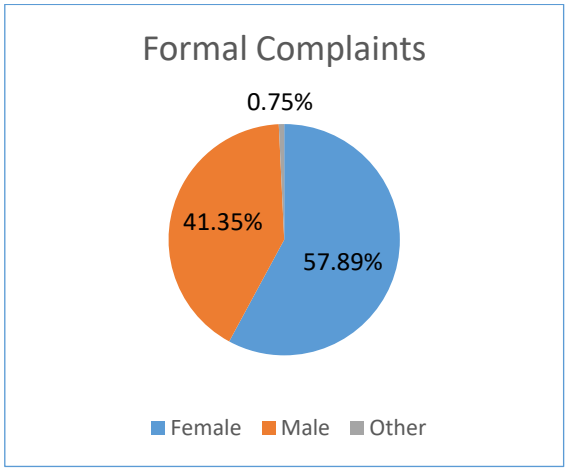
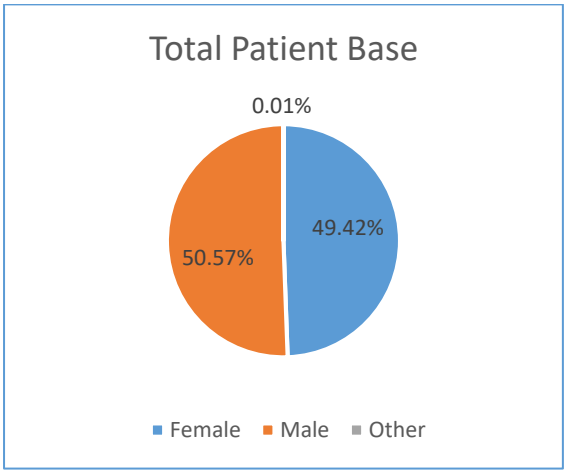


Figure 9: Total patient base by gender



The gender breakdown shows that:

- Females account for 49% of the patient base but make up 58% of formal complaints.
- Males represent 51% of the patient base but only 41% of formal complaints.
- Patients recorded as Other gender make up a very small proportion of both the patient base (0.01%) and formal complaints (0.75%).

What This Tells Us

- Women are more likely to raise a formal complaint than men, relative to their share of the patient population than men.
- Although the proportion of patients identifying as "Other" is very small, it is positive that complaints have been received from this group, highlighting that the process is accessible across genders.

This suggests that women may feel more empowered or comfortable raising concerns, whereas men may face barriers such as perceptions about complaining or reluctance to report issues.

Summary

These findings indicate that while our complaints process is accessible to some groups, there are others who may be less likely or less able to formally raise concerns. We must continue efforts to:

- Make the complaints process visible, welcoming and culturally sensitive.
- Use alternative routes (such as advocacy, family feedback, informal resolution mechanisms) to capture concerns from under-represented groups.
- Regularly review and adapt our approaches to ensure they meet the needs of all our patients and carers.

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 are regularly used 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.

Patient story 1: "This Should Never Have Happened"

Anna's husband, Mark, was admitted to an inpatient mental health ward in 2024. He was struggling with severe anxiety and depression, and it was no longer safe for him to remain at home. Anna hoped that his admission would provide the care and support he needed to begin recovering.

Mark remained on the ward for six weeks, but Anna felt he wasn't making much progress. He was granted some periods of leave, yet still didn't seem well. On one occasion when he was returning to the ward, Anna recalled how he sat in the car pulling at his clothes — clearly in distress. Not long afterwards, she received a call — not from staff, but from Mark himself — letting her know he had been discharged.

Anna was completely unprepared. No one had contacted her ahead of time to let her know this was happening. In fact, she and their two children weren't even at home when Mark returned — they were attending her father's funeral. When she called the ward to find out what had happened, she was told that Mark was considered well enough to go home, and that staff had been too busy to notify her. Although Anna remained calm and polite on the call, she was deeply upset. She hadn't been involved in any discharge planning at all — even though Mark had given consent for staff to share information with her.

The next morning, at around 5am, Anna woke up to find Mark sitting at the end of their bed. He had harmed himself. When she called the ward for help, she was told he couldn't return. Left with no other option, Anna took him to A&E, where he was assessed by the Mental Health Liaison Team. He wasn't supervised while waiting and left the department. Thankfully, the Police later found him safe and brought him home — but Mark admitted to Anna that he had tried to end his life.

The events of that night have left lasting effects. Mark has not yet returned to work. Anna remains shaken by how close her family came to tragedy. Their two young children were in the house when Mark came home that evening and she dreads to think what could have

happened, or what they might have seen. Reflecting on this, Anna said simply: “This should never have happened.”

What We Learned

In response to Anna’s complaint, a full review was carried out. It was clear from the records that Mark had consented for Anna to be involved in his care. Yet she was not included in any discharge planning, and no explanation was documented. Unfortunately, several of the staff involved were no longer working in the service by the time of the investigation, meaning we could not directly ask why this had happened. However, we fully acknowledged that this was a failure to follow best practice.

On behalf of the Trust, a sincere and unreserved apology was given to Anna. Her concerns were shared with senior management and an internal review was requested to understand what went wrong and how we can make sure it doesn’t happen again. The Complaints Team is monitoring this action to ensure it is followed through.

Anna’s story is a powerful reminder of the importance of including families in discharge planning — not just because it is good practice, but because it can make a critical difference to safety and recovery. We are grateful to Anna for coming forward and helping us learn.

Patient story 2: Learning from a Missed Opportunity in Community Care

Jean, aged 90, lives at home with her daughter Sarah, who cares for her full-time. Jean’s complex cardiac condition had been stable for months under the care of the community cardiac team, with regular blood monitoring overseen by a trusted specialist nurse.

In late September, Sarah noticed worrying changes: Jean became confused and her physical health deteriorated. Sarah raised concerns, left messages, and chased updates to check if blood tests had been done, but despite her efforts, they were not carried out.

Eventually, Jean was admitted to A&E as an emergency. Critically ill, she was found to have dangerously low sodium levels, low blood pressure and oxygen, and was experiencing delirium and seizures. Diagnosed with acute and chronic hyponatraemia, Jean spent over two weeks in hospital, suffering confusion and distress throughout.

When discharged, Jean’s condition had changed dramatically. She had lost mobility, needed continence support, and required input from physiotherapy and occupational health teams. Sarah, already struggling with her own health, faced a much greater caring burden.

The day after returning home, Jean's condition worsened again with painful blisters. Despite calls for help, no district nurse arrived until the following day, and even then, blood tests were only taken through the persistence of staff on the ground.

While Sarah praised the compassion shown by individual community nurses, she was left with serious concerns: why hadn't the critical blood tests been done, and why were urgent notes missing from Jean's record? In Sarah's words: *"I'm a huge advocate for the NHS... But someone made a wrong decision with serious consequences. Everything that followed could have been avoided. I just want to make sure this never happens again."*

Sarah raised a formal complaint not to blame individuals, but to understand how the system failed — and to help ensure others are better protected. Her experience is a powerful reminder that clinical safety depends not just on protocols, but on listening, acting promptly, and supporting staff to do the right thing at the right time.

What We Learned

Sarah's complaint prompted a full internal investigation. It was found that Jean's blood tests had been repeatedly deferred without clear clinical justification, and that urgent flags raised by the cardiac team were not properly actioned or documented within the system. The investigation identified communication failures between community services and administrative teams as a significant contributing factor.

Key learning points included:

- **Clearer escalation protocols**: All urgent clinical concerns must be formally documented and flagged for senior clinical review.
- **Training on clinical prioritisation**: Staff were reminded of the importance of prioritising patient safety over routine scheduling concerns.
- **Improved handover processes**: Changes were made to ensure urgent notes are clearly visible and actioned in patient records across all services.
- **Strengthened follow-up systems**: A tracking mechanism was introduced to alert staff when scheduled clinical tasks, such as blood tests, have not been completed within agreed timescales.

An apology was given to Sarah and Jean, acknowledging that had the blood tests been carried out in a timely manner, Jean's emergency admission could likely have been avoided. Sarah's experience directly contributed to changes in practice, with the aim of preventing similar failings for other vulnerable patients in the community.

FEEDBACK ON OUR COMPLAINTS SERVICE

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.

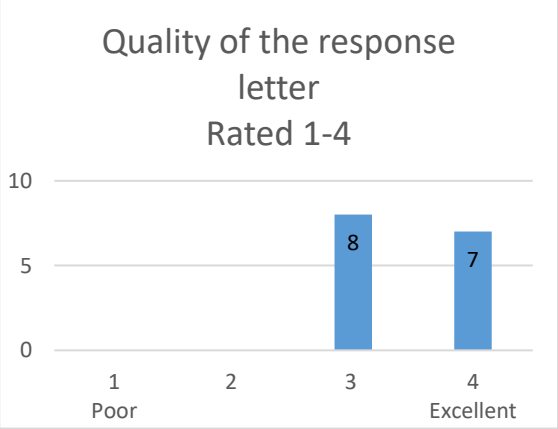
A total of 15 reviews have so far been completed for Q1-Q3 2024/25, which represents 7% of the total formal complaint responses that were sent in the whole year (218). A further 7 reviews will be completed, to ensure that a total of 10% are reviewed.

Of the 15 reviews that have been completed:

- 93% were rated positively for 'how the investigation was handled'
- 100% were rated positively for the 'quality of the response letter'

Figure 10: NED reviews - how the investigation was handled

Figure 11: NED reviews - 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.

Really great communication with the patient throughout the process - well handled

There are words consistent of NHS jargon intermittently. We should always aim to be replying sooner, but it was a reasonable turnaround. Clear and concise investigation

Really good to see the comprehensive set of actions arising from this complaint

Complaints Survey Results

Our complaint response letters include a QR code at the end of every response letter that provides a digital link to our Complaints Response survey, which asks for feedback on people's satisfaction with their experience of the complaints process.

In 2024 we saw a poor response rate to the Complaints Feedback Survey, with only 12 responses received (representing only 5.5% of the total responses sent).

Summary of results 2024/25:

- 37.5% were satisfied that all aspects of their complaint were addressed (v. 28% in 2023/24)
- 27% % believed the complaints process was fair (v. 21% in 2023/24)
- 27% were satisfied with the timescale of the response (v.28% in 2023/24)
- 26% were satisfied with the overall handling of their complaint (v.22% in 2023/24)

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

> Absolutely waste of time they are only there to protect their useless colleagues hopefully the ombudsman will take action. A very disappointed person.

> All conversations between staff, patient and relatives should be recorded. Daily emails to ward and reply within a week.

> There should be more effort to verbally discuss the complaint with the complainant. There should be involvement from everyone involved, including handlers of previous complaints on the same matter and any witnesses. The investigation should not be based solely on the recollection/reports of the person the complaint was about (this is not a balanced, fair approach).

Although satisfaction scores improved compared to the previous year, feedback indicates that we must continue to strengthen trust with those who use our services. Despite the Complaints and PALS teams operating with a degree of independence from clinical services, some individuals expressed concerns that complaint investigations were biased or unfair.

In response, we took several steps in 2024/25 to enhance the fairness and transparency of our processes:

- All members of the Complaints Team completed training provided by the Parliamentary and Health Service Ombudsman (PHSO), aimed at developing skills and confidence in conducting impartial, evidence-based investigations.
- We introduced a new process of sharing the investigation plan with the complainant at the outset, to promote greater transparency and clarity around how we intend to explore their concerns.

Looking ahead to 2025/26, we are committed to building on this progress. Our priorities will include:

- Ensuring all investigations and responses are consistently fair, balanced, and clearly evidence-based.
- Enhancing transparency throughout the process to build greater trust with service users.
- Improving response rates to the Complaints Survey to better capture feedback and guide further improvements.

Direct feedback to Complaints Team

We received lots of positive feedback directly to the team from people that had used the complaints service in 2024/25. Some examples are given below:

"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."

"Thank you for your response to my complaint. It was endearing to hear that lessons could be learnt from the issues that I raised, at least something good will come of it. The apologies were welcomed for both the lack of support/communication issues and the ongoing situation which never seemed to get resolved and for the personal issues relating to myself which were raised. Thank you once again for all your help in responding to my concerns and for the detailed/outlining of the comments raised.

"Can you please pass my thanks to Jon [Complaints Liaison Officer] for the time and attention this response has taken. It's a really thorough response for a complex complaint and I hope this helps the family understand the process and improvement we've made."

(Comment received from Clinical Advisor from the Service)

"Just wanted to say thank you for the thorough investigation and honesty shown. The empathy in the complaints response. It is very reassuring."

COMPLIMENTS

1,545 compliments were received by services in 2023/24, compared with 1,344 the previous year (+15%). A selection is published throughout the year in our internal newsletters and uploaded to the website on individual service pages. Compliments are also shared with teams to discuss in meetings and display in work areas.

Received by Care Unit

Care Unit	Compliments
Community Delivery Mid and South Essex	718
Community Delivery North Essex	68
Community Delivery West Essex	189
Inpatient and Urgent Care	233
Specialist Services	263
Psychological Services	40
Corporate	34
Total	**1545**

Table 12: Compliments logged by Care Unit

Learning from Compliments

Along with complaints, all compliments received by the Trust are analysed for potential learning, as they can provide an excellent opportunity to highlight good practice. Below are examples of lessons from compliments shared in internal reports and Trust-wide in the monthly Lessons Identified Newsletter in 2024/25.

You have a strength, kindness and empathy beyond the uniform. Mum and I couldn't have managed at home without you, Sally. We want you to know how much we both value your support, advice kindness and "road runner speedy actions". Without me even realising, you saved me breaking in half with your gentle persuasion and encouragement to access services I didn't think we needed. On the day mum said goodbye, you gave mum (and me) unfaltering dignity and respect I will never forget. You gave me the strength and support to prepare mum to leave which I could never have done alone. Thank you isn't enough.

Palliative Care, Thundersley Clinic

This heartfelt compliment highlights several key elements of good practice in delivering end-of-life care:

- **Compassionate, Person-Centred Care** – Emotional support and empathy were central to both patient and carer experience.
- **Timely, Proactive Support** – Swift actions helped ensure access to essential services when most needed.
- **Empowerment Through Gentle Guidance** – Sensitive encouragement helped the carer manage and access support they hadn't realised they needed.
- **Dignity at the End of Life** – The patient's final moments were handled with unwavering dignity and respect.

I wanted specifically to highlight the first voice of the first team. The shout out goes to Tom on Derwent reception and also Jan. These two people make me feel valued and heard. They give me time to speak to them without pushing me away despite the very busy day they have. They are incredibly kind and caring and deserve FIRST place award for their consideration towards people who need that little bit of kindness in amongst the murky sea of many things. I won't ever forget their kindness towards me.

Home First Team,
The Derwent Centre

This thank you letter identifies some key learning for delivering compassionate clinical care:

- **Warm and Welcoming First Contact –** Reception and admin staff played a crucial role in making the service feel accessible and supportive from the outset.
- **Active Listening and Time Given –** The individuals took time to listen without rushing, helping the patient feel heard and valued.
- **Kindness in Everyday Interactions –** Simple acts of compassion had a lasting positive impact on the person's experience.
- **Recognition of Non-Clinical Staff Contribution –** The compliment highlights the vital role of non-clinical team members in delivering compassionate care.

I would like to thank you for your sensitivity, kindness, professionalism, and support. During what could have been a difficult visit, you made my mum—who is generally suspicious and anxious about all new callers—feel safe and valued. I was also very impressed at the speed and clarity with which you arranged onward interventions and provided continued updates, giving us a clear path forward. Thanks to you, my father is now more open to receiving the support we have been discussing for many months. We hear a lot about the failings of the NHS, but little of the professional services working hard out there. Thank you for your assistance.

Dementia Intensive Support Team, The Crystal Centre

This thank you note reflects several important principles of high-quality dementia care:

- **Sensitive, Person-Centred Approach** – The team built trust with a vulnerable patient who is typically anxious about new people.
- **Clear and Efficient Coordination** – Onward referrals and support were arranged promptly and communicated clearly.
- **Effective Communication** – Regular updates provided reassurance and a clear plan for the family.
- **Positive Influence on Wider Family Engagement –** The support helped encourage a previously reluctant family member to accept help.

To the Doctors and all the ward staff,

When I arrived, I was at my mental and physical lowest ebb and I honestly believed there was no way back from it.

I give you my heartfelt thanks for nursing me back to where I am today. I realise I have a long way to go, but I'll get there! I have amazing support.

Have a wonderful Christmas and a happy new year.

Henneage Ward,
The King's Wood Centre

Here are the key lessons in good practice drawn from this thank you message:

- **Holistic, Recovery-Focused Care –** The patient experienced improvement in both mental and physical health, suggesting integrated, person-centred support.
- **Restoration of Hope –** The team helped the individual move from a place of despair to a renewed sense of optimism and motivation.
- **Supportive Therapeutic Environment** – The message reflects the impact of a compassionate ward culture that fosters recovery.
- **Continuity of Support Beyond Discharge –** The patient's reference to "amazing support" indicates that care extended beyond inpatient treatment, reinforcing the importance of ongoing encouragement and follow-up.

UPDATE ON PRIORITIES SET FOR 2024/2025

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

Priority	Status	Action Taken
Focus on maximising the integrity of our internal complaints service through the delivery of NHS Complaints Standards training.	Complete	PHSO training completed by the whole Complaints Team (NHS Complaints Standards accredited course), to increase skills and confidence in conducting evidence-based investigations that are balanced and fair.
Build trust with complainants and improve their faith in our service by sharing our investigation plan with them at the beginning of the process.	Complete	This was implemented into our process early last year, with the following benefits: ➢ (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.
Improve response times by providing more effective early dispute resolution, including resolving a greater proportion of concerns via the PALS service.	Complete	We achieved an uplift of 12% in concerns resolved via PALS, which helped reduce Formal Complaint investigations by 12%. This resulted in an improved average response time for Formal Complaints of 85 working days (down from 100 days the previous year).
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.	Complete	We have introduced a 'PALS Follow-up Form' which is emailed to the service with every concern logged by PALS, which asks for details of the outcome to the concern and any lessons learned. These are now captured on Datix with the PALS record.
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. .	Complete	We now log the Ethnicity, Age and Gender of the patient with the complaint record, where these details are known. An analysis of this data is included in this year's Annual Report.

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.
Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective.	Carry Forward	Work began this year on consolidating complaint categories on Datix, but due to operational pressures this has not been completed.

PRIORITIES FOR 2025/2026

- Reduce the average response time for formal complaint responses by a further 10% (currently 85 working days) through streamlining and improving process efficiency.
- Reduce re-opened complaints to below 8% (from 13%), focusing on quality improvements to address issues classed as 'Inadequate response/not fully addressed'.
- Improve patient confidence in the complaints process by increasing transparency, enhancing staff training on impartial decision-making, and publicly sharing anonymised examples of learning and action.
- Raise findings on under-representation of minority ethnic complainants with the Health Inequalities Steering Group to support action on equitable access to complaints.
- Consolidate complaint themes and align across PALS & Complaints so that theme analysis is more effective (Carried forward from 2024/25)

The Complaints Team has made excellent progress over the past year, delivering on the priorities we set for 2024/25 and embedding meaningful improvements across our processes. We have listened carefully to the feedback from people using our service and will use it to further strengthen the way we work — as reflected in the priorities set out for the year ahead. With this strong foundation in place, I am confident we are well equipped to meet the challenges of the coming year.

Report produced by:

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

On behalf of:
Ann Sheridan, Executive Nurse

May 2025