Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Annual Complaints Report

April 2020 to March 2021

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1. Introduction and executive Summary

This report contains the annual complaint information for Berkshire Healthcare NHS Foundation Trust (referred to in this document as The Trust), as mandated in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The Trust formally reports patient experience through our Quality Executive and Trust Board on a quarterly basis, alongside other measures including compliments, the Friends and Family Test, PALS and our internal patient survey programme.

This report looks at the application of the Complaints Process within the Trust from 1st April 2020 to 31st March 2021 and uses data captured from the Datix incident reporting system.

Factors (and best practice) which affect the numbers of formal complaints that Trusts receive include:

- Ensuring processes are in place to resolve potential and verbal complaints before they escalate to formal complaints. These include developing systems and training to support staff with local resolution;

- An awareness of other services such as the Patient Advice and Liaison Service (PALS – internal to the Trust) and external services including Healthwatch and advocacy organisations which ensure that the NHS listens to patients and those who care for them, offering both signposting and support;

- Highlighting the complaints process as well as alternative feedback mechanisms in a variety of ways including leaflets, poster adverts and through direct discussions with patients, such as PALS clinics in clinical sites.

When people contact the service, the complaints office will discuss the options for complaint management. This gives them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally.

The number of formal complaints received about the Trust has decreased slightly to 213 in 2020/21 compared to 231 in 2019/20, 230 in 2018/19 and 209 in 2017/18. The Trust actively promotes feedback as part of 'Learning from Experience', which within the complaints office includes activity such as enquiries, services resolving concerns informally, working with other Trusts on joint complaints, and responding to the office of Members of Parliament who raise concerns on behalf of their constituents.

In addition to complaints, there were 34 enquiries and concerns raised by MPs on behalf of their constituents in 2020/21.

Our complaint handling and response writing training which is available to staff has been adapted to be provided over Teams and continues to take place on a regular basis across the different localities,

in addition to bespoke, tailored training for specific teams which has taken place to staff groups and teams.

The past year, during the Covid pandemic, brought temporary changes to the complaints process for example the Complaints Office supporting Investigating Officers with compiling response to complaints, triaging complaints in a different way to escalate concerns about patient safety, and following a review, placing a small number of formal complaints on hold (or paused). All the complaints that were paused have since been responded to in full. The Parliamentary and Health Service Ombudsman (PHSO) has a backlog of 3000 cases to be reviewed and are responding to cases where they can have the most impact. Over the past year there have not been any cases taken forward for investigation by the PHSO (we have received 5 requests for further information and two requests to further attempt local resolution at a Trust Level).

The Trust had one breach in responding to a complaint within agreed timescale. The service carried out a review of the circumstances around the breach and have put actions in place locally to prevent this from happening again. The Trust continues to monitor the number of locally resolved and informal complaints through the quarterly Patient Experience Report. Complaint files are managed in real time and information is available on a dashboard that is accessible to the Divisional and Clinical Directors.

We have been unable to use the Model Hospital programme data as the data was not collated during 2020/21.

Care and treatment was the main subject of the most complaints received in 2020/21, with 47% (100) of all formal complaint received . Of these 47%:

- 66% (66) were about the clinical care received
- 11% (11) were about either delaying, or not making on onward specialist referral
- 7% (7) involved delays or not being visited
- 5% (5) were about mot been examined, or the examination not being thorough enough
- 3% (3) were about either not making a diagnosis, or making one that was incorrect

2. Complaints received – activity

2.1 Overview

During 2020/21, 213 formal complaints were received into the organisation**.** Table 1 evidences the number of formal complaints by service and compares them to the previous financial year.
The information in this report excludes complaints which are led by an alternative organisation, unless specified.

Table 1: Formal complaints received

	2019-20						2020-21						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Change (Annual)**
CMHT/Care Pathways	8	10	6	13	**37**	**16.02**	4	11	7	12	**34**	**15.96**	↓
CAMHS - Child and Adolescent Mental Health Services	10	8	8	4	**30**	**12.99**	2	3	3	6	**14**	**6.57**	↓
Crisis Resolution & Home Treatment Team (CRHTT)	2	2	4	6	**14**	**6.06**	4	2	3	4	**13**	**6.10**	↑
Acute Inpatient Admissions – Prospect Park Hospital	5	3	7	6	**21**	**9.09**	7	4	1	9	**21**	**9.86**	=
Community Nursing	4	3	6	2	**15**	**6.49**	2	1	5	2	**10**	**4.69**	↓
Community Hospital Inpatient	6	1	5	3	**15**	**6.49**	5	6	3	4	**18**	**8.45**	↑
Common Point of Entry	2	6	2	2	**12**	**5.19**	1	1	3	1	**6**	**2.82**	↓
Out of Hours GP Services	0	1	7	1	**9**	**3.9**	4	0	3	1	**8**	**3.76**	↓
PICU - Psychiatric Intensive Care Unit	0	0	1	0	**1**	**0.43**	2	0	0	2	**4**	**1.88**	↑
Urgent Treatment Centre	1	1	1	0	**3**	**1.3**	1	0	1	0	**2**	**0.94**	↓
Older Adults Community Mental Health Team	1	0	0	0	**1**	**0.43**	1	1	1	2	**5**	**2.35**	↑
13 other services in Q4	11	19	21	22	**73**	**31.6**	11	33	21	13	**78**	**36.62**	↑
Grand Total	**50**	**54**	**68**	**59**	**231**		**44**	**62**	**51**	**56**	**213**		

The table above demonstrates that the number of formal complaints for Crisis Resolution/Home Treatment Team (CRHTT), Acute adult inpatient wards, Out of Hours GP and Urgent treatment

Centre remained similar compared to last year whilst). Whilst recognising the numbers are small there was an increase in complaints received in relation to Community Hospital Inpatients, PICU - Psychiatric Intensive Care Unit and Older Adults Community Mental Health Team compared with the previous year.
Community Nursing, Common Point of Entry (CPE), CAMHS and CMHT experienced decreases in the number of formal complaints received, with the most significant decreae being seen in complaints received in relation to CAMHS.

Table 2 below details the main themes of complaints and the percentage breakdown of these.

Table 2: Themes of Complaints received

Main subject of complaints	Number of complaints	% of total complaints
Care and Treatment	100	46.95
Communication	48	22.54
Attitude of Staff	28	13.15
Confidentiality	7	3.29
Medical Records	6	2.82
Medication	5	2.35
Access to Services	5	2.35
Discharge Arrangements	4	1.88
Waiting Times for Treatment	3	1.41
Abuse, Bullying, Physical, Sexual, Verbal	3	1.41
Other	2	0.94
Support Needs (Including Equipment, Benefits, Social Care)	1	0.47
Admission	1	0.47

The main theme of complaints received during 2020/21 was care and treatment with 46.95%, and then communication with 22.54% and attitude of staff with 13.15%. This is compared to care and treatment accounting for 46.75% of formal complaints and 19.48% attitude of staff and 11.69% for communication received during 2019/20. In 2018/19 care and treatment was 51.74% and attitude of staff was 16.75%.

As detailed above care and treatment was the main subject of the most complaints received in 2020/21, with 47% of all formal complaint activity. Complaints received in relation to care and treatment are wide ranging and focus very much on individual circumstances and therefore it has not been possible to pick up themes or areas for specific action by services in relation to these. There were minimal complaints received in relation to Covid, which was helped by targeted communication from our inpatient wards (both in mental health and physical health) and communication around community based virtual appointments.

Of these 47%:

- 66% were about the clinical care received
- 11% were about either delaying, or not making on onward specialist referral
- 7% involved delays or not being visited
- 5% were about mot been examined, or the examination not being thorough enough

- 3% were about either not making a diagnosis, or making one that was incorrect

23% of formal complaints were about communication, of these:

- 29% was about communication with other organisations
- 10% was about verbal communication (these were split across Adult Acute Admissions, CMHT, Community Nursing and CAMHS)
- 17% was about written communication (the majority of these (63%) of these complaints were from the same person)

There had been a notable decrease in complaints received about access and waiting times for CAMHS compared with previous years.

The following tables show a breakdown for 2020/21 of the formal complaints that have been received and where the service is based.

2.2 Mental Health service complaints

Table 3 below details the mental health service complaints received, this shows that the main services where formal complaints are attributed to are CMHT and Adult acute Admissions wards. 43% of the complaints were about care and treatment (which is around the same as in 2019/20 and 2018/19 and an increase from 29.54% of mental health service complaints in 2017/18). Complaints about adult mental health services accounted for 52% of the total complaints received in 2020/21 compared to 64% in 2019/20.

Table 3: Mental Health Service complaints

Service	Number of complaints
A Place of Safety	2
Adult Acute Admissions - Bluebell Ward	10
Adult Acute Admissions - Daisy Ward	7
Adult Acute Admissions - Rose Ward	2
Adult Acute Admissions - Snowdrop Ward	2
CMHT/Care Pathways	34
CMHTOA/COAMHS - Older Adults Community Mental Health Team	5
Common Point of Entry	6
Complex Treatment for Veterans	1
Criminal Justice Liaison and Diversion Service - (CJLD)	2
Crisis Resolution and Home Treatment Team (CRHTT)	13
Eating Disorders Service	1
IMPACTT	3
Older Adults Inpatient Service - Rowan Ward	1
PICU - Psychiatric Intensive Care - Sorrel Ward	4
Psychological Medicine Service	2
Talking Therapies	1
Talking Therapies - Admin/Ops Team	4
Talking Therapies - PWP Team	1

Traumatic Stress Service	2
Veterans TILS Service	7
Grand Total	110

2.2.1 Mental Health Complaints by service

The adult mental health services receiving higher numbers of formal complaints in 2020/21 are detailed further below.

Community Mental Health teams (CMHT)

As detailed in table 4, within CMHT services most complaints were received regarding the services in West Berkshire (26%) and Slough (21%). In both service areas there were multiple complaints from the same patients.

Reading has seen an increase with 18% from 8% last year and compared to 27% in 2018/19.

Wokingham CMHT also saw a sustained reduction to 12%, from 14% last year and 22% in 2018/19.

Table 4: CMHT complaints

	Geographical Locality						
Main subject of complaint	Brackn ell	Readi ng	Slou gh	West Berks	Windsor, Ascot and Maidenhead	Wokingh am	Grand Total
Access to Services				1		1	2
Attitude of Staff	1	2		1			4
Care and Treatment	1	2	4	5	1	3	16
Communication	3		1		1		5
Confidentiality		2			1		3
Discharge Arrangements				2			2
Medication			2				2
Grand Total	5	6	7	9	3	4	34

Adult mental health inpatients

As detailed in table 5, 36% of complaints received by the acute adult admission wards were about clinical care/ care and treatment (compared to 57% last year); these were individual to specific patient circumstances.

This includes four complaints received in relation to Sorrel ward (compared to one in 2019/20).

There was one complaint received about our Older Adult Mental Health Wards, which was for Rowan Ward, there were no complaints about Orchid Ward.

Table 5: Adult mental health inpatient ward complaints

	Ward					
Main subject of complaint	Bluebell Ward	Daisy Ward	Rose Ward	Snowdrop Ward	PICU - Psychiatric Intensive Care - Sorrel Ward	Grand Total
Alleged Abuse, Bullying, Physical, Sexual, Verbal		1	1		1	3
Attitude of Staff	8					8
Care and Treatment	2	3	1	1	2	9
Communication		3		1	1	5
Grand Total	10	7	2	2	4	25

CRHTT

Table 6 below demonstrates that there were 13 complaints received about CRHTT in 2020/21; similar number to the 14 received in 2019/20.

As with previous years, a higher percentage were in relation to services received in the West of the county and predominantly Reading where the main hub for the west is located.

Table: 6 CRHTT complaints

	Geographical Locality					
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Wokingham	Grand Total
Attitude of Staff	2		2			4
Care and Treatment		5			2	7
Communication		1				1
Confidentiality				1		1
Grand Total	2	6	2	1	2	13

Table 7: Older Adults Community Mental Health Service Complaints

Older adult services

There were 5 formal complaints about the Older Adults Community Mental Health Team received in 2020/21. This is compared with 1 in 2019/20 and 3 in 2018/19 (all of the complaints received in the three previous years have been about the Wokingham based service).

	Geographic Locality			
Main subject of complaint	Slough	West Berks	Wokingham	Grand Total
Communication		2		2
Medical Records			2	2
Medication	1			1
Grand Total	1	2	2	5

2.3 Community Health Service Complaints

24% of formal complaints received into the organisation in 2020/21 a reduction from 29% in both 2019/20 and 2018/19.

Table 8 below details the community health service complaints received, this shows that the main services where formal complaints are attributed to are Community Inpatient services (35%, from 21%), WestCall out of hours services (15% from 13%) and Community Nursing (District Nursing 19% from 22%). 67% (compared to 56% last year) of the total community health service complaints were about care and treatment. There were no themes with complaints raised around specifics of care delivery and patient's individual circumstances.

Table 8: Community Health Service Complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Community Dental Services				1			1
Community Hospital Inpatient Service - Donnington Ward				1			1
Community Hospital Inpatient Service - Henry Tudor Ward					6		6
Community Hospital Inpatient Service - Jubilee Ward			3				3
Community Hospital Inpatient Service - Oakwood Ward		6					6
Community Hospital Inpatient Service - Windsor Ward						2	2
Community Physiotherapy		1					1
Community Respiratory Service		1					1
Continence				1			1
District Nursing	2	4	1	2		1	10
Integrated Pain and Spinal Service - IPASS						2	2
Out of Hours GP Services		7		1			8
Phlebotomy				1			1
Podiatry		2			1		3
Rapid Response				1		1	2
Sexual Health			1				1
Tissue Viability					1		1
Urgent Treatment Centre				2			2
Grand Total	2	21	5	10	8	6	52

2.3.1 Community Health Complaints by service

The top 3 community services receiving formal complaints in 2020/21 are detailed further below.

Community Nursing

As detailed in Table 9; 7 of the 10 complaints were regarding care and treatment, review of these has not identified any themes.

Table 9: Community Nursing Service complaints

	Geographical Locality					
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Wokingham	Grand Total
Attitude of Staff	2					2
Care and Treatment		3	1	2	1	7
Communication		1				1
Grand Total	2	4	1	2	1	10

Community Health Inpatient Wards

Table 10: Community Health Inpatient Ward Complaints

	Ward					
Main subject of complaint	Donnington Ward	Henry Tudor Ward	Jubilee Ward	Oakwood Ward	Windsor Ward	Grand Total
Attitude of Staff			1			1
Care and Treatment		4	2	4		10
Communication	1			2	2	5
Discharge Arrangements		1				1
Medication		1				1
Grand Total	1	6	3	6	2	18

The number of formal complaints for Community Inpatient Wards has increased from 15 last year, 17 in 2018/19 and 11 in 2017/18.
Care and treatment continue as the main subject for complaints received about Community Inpatient wards. Both Henry Tudor Ward and Oakwood Ward were attributable for 33% of the formal complaints received. There were no themes for the complaints about these wards.
There were no formal complaints received about Ascot Ward and Highclere Ward in 2020/21.

WestCall Out of Hours GP Service

As shown in Table 11 WestCall received 8 complaints in 2020/21, a reduction from 9 complaints in 2019/20 and 17 in 2018/19.
The complaints for the out of hours GP service were found to be about care and treatment, confidentiality, and medication.

Table 11: WestCall Out of Hours GP Service complaints

	Geographical Locality		
Main subject of complaint	Reading	West Berks	Grand Total
Care and Treatment	5	1	6
Confidentiality	1		1
Medication	1		1
Grand Total	7	1	8

2.4 Children, Young People and Families

Table 12 below details the children, young people and families' complaints received, with 21% of all complaints received attributable to these services. The main services where formal complaints are attributed to our Health Visiting service (it is worth noting that 14 complaints were from the same person).

Table 12: Children, Young People and Family Service Complaints

	Geographical Locality							
Service	Bracknell	Other	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Adolescent Mental Health Inpatients - Willow House							3	3
CAMHS - AAT			1		1	1		3
CAMHS - ADHD					2			2
CAMHS - Anxiety and Depression Pathway	1		1					2
CAMHS - Child and Adolescent Mental Health Services	1							1
CAMHS - Rapid Response						1		1
CAMHS - Specialist Community Teams			2		2			4
Children's Speech and Language Therapy - CYPIT			3					3
Common Point of Entry (Children)		1			1		1	3
Community Paediatrics				1				1
Health Visiting	3		5		11		2	21
Grand Total	5	1	12	1	17	2	6	44

CAMHS

Child and Adolescent Mental Health Services received 13 complaints in 2020/21 compared to 31 in 2019/20, 25 in 2018/19 and 26 received in 2017/18. This is reflective of the hard work that has taken place including the CAMHS Urgent Care Service which continues to bring positive clinical outcomes for young people. CAMHS have worked hard over the past three years to improve the support offered to 'waiters', with the aim of improving communication with the young people who are waiting to be seen and their cares. In addition to this, there is more signposting to services such as the Emotional Health Academy and parent support services.

Access to CAMHS services was the main subject of 1 complaint compared to 7 2019/20 and 3 formal complaints in 2018/19. There were no formal complaints about the attitude of staff in 2020/21 compared to 2 in each of the previous 2 years and there was a reduction in complaints about communication with 3 compared with 4 in the previous year.

The community CAMH Services have been separated out on the reporting system Datix (AAT, ADHD, Anxiety and Depression Pathway, Rapid Response and Specialist Community Teams), and the table below shows the activity for these services combined.

Table 13: Community CAMHS Complaints

	Geographical Locality				
Main subject of complaint	Bracknell	Reading	West Berks	Windsor, Ascot and Maidenhead	Grand Total
Access to Services				1	1
Care and Treatment	2	2	1	1	6
Communication		1	2		3
Discharge Arrangements		1			1
Waiting Times for Treatment			2		2
Grand Total	2	4	5	2	13

3 Complaints closed – activity

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). Table 13 shows the outcome of complaints.

Table 14: Outcome of closed formal complaints

	2019-20						2020-21						
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 19/20**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 20/21**	**Change (Annual)**
Case not pursued by complainant	0	0	0	0	0	0	1	1	0	0	2	1.83	↑
Consent not granted	1	0	0	0	1	0.45	0	0	2	0	2	0.45	-
Local Resolution	1	1	0	0	2	1.92	0	0	0	0	0	0	↓
Managed through SI process	0	0	0	0	0	0	0	1	1	0	2	0	-
Referred to another organisation	1	0	0	0	1	0.45	0	0	0	0	0	0	↓
Not Upheld	16	20	23	24	83	37.56	9	25	19	18	71	33.51	↓
Partially Upheld	17	22	28	23	90	40.72	13	34	20	28	95	46.33	↑
Upheld	11	13	10	9	43	19.46	12	6	0	7	25	17.88	↓
Disciplinary Action required	0	1	0	0	1	0.45	0	0	0	0	0	0	↓
Grand Total	**47**	**57**	**61**	**56**	**221**		**35**	**67**	**42**	**53**	**197**		

The national reporting statistics for 2020-21 have not yet been published (delayed due to the pandemic).

Complaints can cover several services and issues which are investigated as individual points which contributes towards higher partially upheld outcomes.

Weekly open complaints situation reports (SITREP) sent to Clinical Directors, as well as on-going communication with the Complaints Office throughout the span of open complaints to keep them on track as much as possible.

Table 15 – Response rate within timescale negotiated with complainant

2020-21				2019-20				2018-19				2017-18				2016-17			
Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
100	100	99	100	100	98	100	100	100	100	100	100	100	100	100	100	100	100	100	100

During quarter two the Trust had one instance of not responding to a complainant in the agreed timescale. The service has put actions in place locally to stop this from recurring.

4 Complaints as a mechanism for change – learning

An external audit took place during Quarter 4 which demonstrated that the Complaints function is responsive and offers a high-quality service. A management action has been taken forward to triangulate patient experience information with other quality and performance data to further improve the quality and safety of patient care.

The Divisions monitor the outcomes and learning from complaints within their Patient Safety and Quality Meetings. From Quarter one 2020/21 a Patient Safety, Experience and Learning Group will take place on a weekly basis, further learning will be shared and disseminated in a Trust wide learning newsletter.

5 Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process. The table below shows Trust activity with the PHSO.

Table 16: PHSO activity

Month open	Service	Month closed	Current Stage
Dec-18	Psychological Medicines Service	Open	Investigation Underway
Nov-19	CAMHS	Open	PHSO have requested information to aid their decision on whether they will investigate
Mar-20	CMHT/Care Pathways	Open	Underway
Sept 20	CPE	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate

Oct 20	Community Inpatient Services	Open	PHSO have requested we have a final meeting with family
Nov 20	CMHT/Care Pathways	Open	PHSO have requested we attempt to reach resolution with mother of patient who has not given consent to share
Jan 21	Community Inpatient Services	n/a	PHSO have requested information to aid their decision on whether they will investigate
Feb 21	Community Inpatient Services	n/a	PHSO have requested information to aid their decision on whether they will investigate

The PHSO advised that the COVID-19 pandemic has had a significant impact on their workforce, along with delays by Trusts in responding to enquiries. At the end of March 2021, there was a queue of over 3,000 complaints waiting to be reviewed so they have decided to focus on the more serious complaints about health services in which people may have faced a more significant impact and where they can make the biggest difference. For other complaints (where someone has faced less of an impact) they will consider whether there is anything they can do to help resolve things quickly, but if not, they will close the complaint.

6 Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they contribute to, but are not the lead organisation (such as NHS England and Acute Trusts). Table 17 below details this activity.

Table 17: Formal complaints led by other organisations

Organisation	Service	**Summary of element of complaint relating to Berkshire Healthcare services**
CCG - West	District Nursing	Carer wishes to know how a hospital referral for a routine pressure sore in September can be ignored for 3 months
CCG - West	CAMHS - Anxiety and Depression Pathway	Following suicide attempts family feel their child has been failed
CCG - East	CAMHS - Specialist Community Teams	Following a F2F video assessment, pt received a call to say there would be no package of care and no medication. Family believe this is because pt is soon to be 18
SCAS	Out of Hours GP Services	Patient spoke with 111 and OOH GP and asked that details of her call were not shared with her own GP. 111 said they'd put a note on the system but OOH GP said it automatically happens
CCG - West	Common Point of Entry	Family feel the pt has no support from services. Says CBT is felt to be inappropriate for the pt due to anger issues. Medication issues. Family wish to see a review of MH treatment for autistic adults so they have access to services
CCG - East	East Berkshire Wheelchair Service	Pt unhappy that CCG no longer allow electric and manually operated wheelchairs and that following a review he has been told to keep his electric wheel chair and send back the manual one
NHS England	Out of Hours GP Services	Diagnosis of UTI given by WestCall Dr operation to remove cyst on ovary performed requiring 2 surgeries within 4 days

Frimley Health	Community Hospital Inpatient Service - Henry Tudor Ward	Family unhappy pt did not receive Physio, nutritious food, help with eating when on the ward. Given drugs that had bad side effects and tablets that were not needed
Frimley Health	Physiotherapy Musculoskeletal	Saw a physio at Upton who exacerbated pain; saw 2nd physio the following day who made a referral to Orthopaedics but also previously ruled out a Syndrome - despite symptoms
Frimley Health	Community Hospital Inpatient Service - Henry Tudor Ward	Care and treatment received following discharge from Wexham Park Hospital
Frimley Health	Psychological Medicine Service	Family members believes PMS did not visit pt on the ward on separate occasions
NHS England	Common Point of Entry	NHSE wish BHFT to comment on areas where we have had dealing with the patient
CCG - East	CMHT/Care Pathways	Pt discharged from private hospital under Ealing Trust into BHFT having moved to Slough when they turned 18. Concerns over transition and accessing services which family filled with private care
SCAS	Out of Hours GP Services	Pt had to wait 10 hours for Dr to call following their initial call to 111 and 3 subsequent chases
Frimley Health	Psychological Medicine Service	Pt in A&E, service asked for a psych assessment and says it was refused
Frimley Health	Community Hospital Inpatient Service - Jubilee Ward	Concern about care and treatment, and dignity. Did not feel it was appropriate to be washed by a member of staff of a different gender, and that he was rough with the patient. Received a cut on her back which is unexplained and that staff did not support her when she was on the ward when using the commode, staff motioned to her to be quiet, and that she was naked longer than necessary when being washed

7 Complaints training

The Complaints Office has continued to offer a programme of complaint handling training, which is accessible through the Learning and Development Department. Over the last year, the Complaints Office has delivered the training virtually over MS Teams and has adapted the training to have smaller, interactive groups more frequently.

8 Mortality Review Group

The Trust Mortality Review Group (TMRG) meets monthly and the Complaints Office feeds information into this group. There were 18 formal complaints forwarded to the MRG during 2020/21, compared with 13 in 2019/20.

The Medical Director is also sent a copy of complaint responses involving a death before they are signed by the Chief Executive.

Table 18: Complaints forwarded to TMRG

Service	Number of cases
Community Hospital Inpatients	6
Community Nursing	5
Rapid Response	2
Crisis Resolution and Home Treatment Team (CRHTT)	2
Community Physiotherapy	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Community Respiratory Service	1
Grand Total	18