Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Annual Complaints Report

April 2019 to March 2020

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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 2019 to 31st March 2020 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.

During 2019/20 there were 231 formal complaints received, a slight increase from 230 received in 2018/19; a sustained increase on the 209 received in 2017/18. The number of formal complaints closed was 221, of these 60% were either fully or partially upheld and 38% were not upheld. The remaining complaints were either not progressed, locally resolved or investigated via a differing process. Against one million contacts, 231 complaints received equates to 0.02% resulting in a formal complaint.

Using the Model Hospital programme (and data from Dec 2019), the Trust has a value of 14.85 formal complaints per 1000 WTE staff – this is less than the peer median of 16.18 and national median of 15.56.

The Trust had one breach in responding to a complaint within agreed timescale; the first in four years. The service carried out a review of what happened 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 Locality and Clinical Directors.

The services with the high numbers of formal complaints received were:

- Adult Community Mental Health teams (CMHT), with 37 complaints against 52,460 contacts (0.07% contacts)

- Acute adult admission wards, with 21 complaints against 1,028 discharges (2.04%)

- CAMHS - Child and Adolescent Mental Health Services with 30 received against 28,307 contacts (0.11%)

- Out of Hours GP Services providing care in the West of Berkshire, with 9 complaints against 69,190 contacts (0.01%)

- Community Hospital inpatient wards received 15 complaints against 2,083 discharges (0.72%)

- Crisis Resolution/Home Treatment Team (CRHTT) received 14 complaints against 62,299 contacts (0.02%)

The main theme of complaints received during 2019/20 was care and treatment with 46.75%, followed by attitude of staff with 19.48% and communication with 11.69%. This is compared to care and treatment accounting for 51.74% of formal complaints and 14.78% for both attitude of staff and communication received during 2018/19. In 2017/18 care and treatment was 57.89% and attitude of staff was 16.75%.

There are no particularly specific themes that are able to be extracted from the complaints received within each of these categories; many complaints are very specific to individual circumstance and concern. Further detail with regard to the services with higher numbers of complaints is detailed within the report.

Nationally, complaint statistics are reported on a quarterly and annual basis, with 2019/20 annual reported data not available until September 2020.

From mid-March 2020, to align with national guidance and directives, the active collection of the FFT was suspended and the information shown for March is taking from responses received up to this point, both in hard copy and electronically.
A revised complaints process was also introduced, which saw 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). These complainants were all contacted and informed of this, advising them to contact the Complaints Office if they had any concerns. New complaints continued to be logged.

2. Complaints received – activity

2.1 Overview

During 2019/20 231 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						Change (annual)	2018/19					
Service	Q1	Q2	Q3	Q4	**Total**	% of Total		Q1	Q2	Q3	Q4	**Total**	% of Total
CMHT/Care Pathways	8	10	6	13	**37**	**16.02**	↓	16	11	10	9	**46**	20
CAMHS - Child and Adolescent Mental Health Services	10	8	8	4	**30**	**12.99**	↑	5	6	8	6	**25**	10.87
Crisis Resolution & Home Treatment Team (CRHTT)	2	2	4	6	**14**	**6.06**	No change	2	5	3	4	**14**	6.09
Acute Inpatient Admissions – Prospect Park Hospital	5	3	7	6	**21**	**9.09**	↓	9	12	8	3	**32**	13.91
Community Nursing	4	3	6	2	**15**	**6.49**	↑	1	1	3	3	**8**	3.48
Community Hospital Inpatient	6	1	5	3	**15**	**6.49**	↓	6	7	1	3	**17**	7.39
Common Point of Entry	2	6	2	2	**12**	**5.19**	No change	3	3	2	4	**12**	5.22
Out of Hours GP Services	0	1	7	1	**9**	**3.9**	↓	4	5	7	1	**17**	6.96
PICU - Psychiatric Intensive Care Unit	0	0	1	0	**1**	**0.43**	↑	0	0	0	0	**0**	0
Minor Injuries Unit (MIU)	1	1	1	0	**3**	**1.3**	↓	1	1	2	0	**4**	1.74
Older Adults Community Mental Health Team	1	0	0	0	**1**	**0.43**	↓	1	1	0	1	**3**	1.3
15 other services in Q4	11	19	21	22	**73**	**31.6**	↑	12	11	13	16	**52**	22.6
Grand Total	**50**	**54**	**68**	**59**	**231**			60	63	57	50	**230**	

The table above demonstrates that the number of formal complaints for Crisis Resolution/Home Treatment Team (CRHTT) remained consistent and Community Nursing, CAMHS, have increased compared with the previous year. Acute Inpatient Admissions (Prospect Park Hospital), Community Hospital Inpatients, Community Mental Health Teams (CMHT) and Out of Hours GP Services (Westcall) experienced decreases in the number of formal complaints received.

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

Table 2: Themes of Complaints received

Main subject of complaint	Number of complaints	Percentage of total complaints
Care and Treatment	108	46.75%
Attitude of Staff	45	19.48%
Communication	27	11.69%
Access to Services	25	10.82%
Confidentiality	6	2.60%
Environment, Hotel Services, Cleanliness	5	2.16%
Discharge Arrangements	5	2.16%
Waiting Times for Treatment	2	0.87%
Other	2	0.87%
Admission	2	0.87%
Medication	2	0.87%
Medical Records	1	0.43%
Support Needs (Including Equipment, Benefits, Social Care)	1	0.43%

The main theme of complaints received during 2019/20 was care and treatment with 46.75%, followed by attitude of staff with 19.48% and communication with 11.69%. This is compared to care and treatment accounting for 51.74% of formal complaints and 14.78% for both attitude of staff and communication received during 2018/19. In 2017/18 care and treatment was 57.89% and attitude of staff was 16.75%.

There have been no specific themes identified with regard to complaints received although it is worthy of note that 7 of the complaints relating to access to services and both of the complaints about waiting times for treatment were in relation to CAMHS services and 5 of the total 27 complaints related specifically to communication was about our CAMHS services.

The complaints raised in relation to attitude of staff are spread across a range of services those services with more than 3 were CMHT, CRHTT and Admin and office based staff (3 were around the complainant being unhappy with the response from the complaints office, and 1 was about being reportedly hung up on by reception staff at a CMHT). All of the complaints about CRHTT were about the service based in the West of the County.

The complaints in relation to communication again cover a broad range of services, CAMHS (5), Talking Therapies (3), Acute Inpatient Admissions – Prospect Park Hospital (3) and CMHT (3).

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 particular themes or areas for specific action by services in relation to these.

The Trust Business Group structure (also known as reporting locality) has previously been used as the main mechanism for reporting complaint information; however, as this may differ from the geographical locality of where the service is based, it brings more value to report the latter. The following tables show a breakdown for 2019/20 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. 43.24 % of the complaints were about care and treatment (which is around the same as in 2018/19 with 43.47% and a sustained increase from 29.54% of mental health service complaints in 2017/18). Complaints about adult mental health services accounted for 64% of the total complaints received in 2019/20.

Table 3: Mental Health Service complaints

Service	Number of complaints
A Place of Safety	2
Admin teams and office based staff	4
Adult Acute Admissions - Bluebell Ward	7
Adult Acute Admissions - Daisy Ward	5
Adult Acute Admissions - Rose Ward	3
Adult Acute Admissions - Snowdrop Ward	5
CMHT/Care Pathways	37
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Common Point of Entry	12
Community Team for People with Learning Disabilities (CTPLD)	1
Crisis Resolution & Home Treatment Team (CRHTT)	2
Crisis Resolution and Home Treatment Team (CRHTT)	12
Early Intervention in Psychosis	2
Eating Disorders Service	2
Learning Disability Service Inpatients	1
Learning Disability Service Inpatients - Campion Unit	2
Older Peoples Mental Health (Ward Based)	2
Other or unknown location	1
Perinatal	1
PICU - Psychiatric Intensive Care - Sorrel Ward	1
Psychological Medicine Service	5
Talking Therapies	6
Traumatic Stress Service	1
Grand Total	115

2.2.1 Mental Health Complaints by service

The adult mental health services receiving higher numbers of formal complaints in 2019/20 are detailed further below.

Community Mental Health teams (CMHT)

As detailed in table 4, Within CMHT services most complaints were received by Windsor, Ascot and Maidenhead (30%) and Bracknell (24%). In both of these service areas there were multiple complaints from the same patients.

Reading has continued to see a reduction, down to 8% of all CMHT complaints compared to 27% in 2018/19. Wokingham CMHT also saw a reduction from 22% last year to 14% in 2019/20.

Table 4: CMHT complaints

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services	2			1			3
Attitude of Staff		1		1	3	2	7
Care and Treatment	5	2		6	6	2	21
Communication	1		1			1	3
Discharge Arrangements					2		2
Medical Records	1						1
Grand Total	9	3	1	8	11	5	37

Adult mental health inpatients

As detailed in table 5, 57% of complaints received by the acute adult admission wards were about clinical care/ care and treatment; these were individual to specific patient circumstances.
In addition, there was one complaint received in relation to Sorrel ward in 2019/20. There were two complaints received about our Older Adult Mental Health Wards (one each for Rowan Ward and Orchid Ward) were around general care and communication.

Table 5: Adult mental health inpatient ward complaints

	Ward					
Main subject of complaint	Bluebell Ward	Snowdrop Ward	Daisy Ward	Rose Ward	Ward 10 (Historical)	Grand Total
Access to Services	1					1
Attitude of Staff	1	2	1			4
Care and Treatment	3	2	3	3	1	12
Communication	1	1	1			3
Confidentiality	1					1
Grand Total	7	5	5	3	1	21

CRHTT

Table 6 below demonstrates that there were 14 complaints received about CRHTT in 2019/20, the same number as in 2018/19; and a sustained reduction on the 20 received in 2017/18.
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	1	2	2	2		7
Care and Treatment	1	2			2	5
Confidentiality		2				2
Grand Total	2	6	2	2	2	14

Older adult services

There was one formal complaint about the Older Adults Community Mental Health Team received in 2019/20 which was about the attitude of staff in the Wokingham based service. This is compared with 3 received in 2018/19; all of which were also about the Wokingham based service.

2.3 Community Health Service Complaints

29% of formal complaints received into the organisation in 2019/20 were about community health services; this is the same as in 2018/19.

Table 7 below details the community health service complaints received, this shows that the main services where formal complaints are attributed to are Community Inpatient services (21%), Westcall out of hours services (13%) and Community Nursing (District Nursing 22%).

56% of the total complaints were about care and treatment. There were no particular themes with complaints raised around specifics of care delivery and patient's individual circumstances.

Table 7: Community Health Service Complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Admin teams & office based staff				1			1
Community Hospital Inpatient		2	3	1	6	3	15
Dental Services			1				1
District Nursing	4	5	6				15
GP General Practice (Historical)			1				1
Health Visiting						1	1
Hearing and Balance Services			1		2		3
Integrated Pain and Spinal Service - IPASS		1		1		1	3
Intermediate Care				1			1
MIU/Urgent Care Centre				3			3
Occupational therapy			1				1
Out of Hours GP Services		2		5		2	9
Physiotherapy (Adult)	2			1	2		5
Podiatry	1				1	2	4
Rapid Assessment Community Clinic					1		1
Sexual Health			3				3
Tissue Viability					1		1
Grand Total	7	10	16	13	13	9	68

2.3.1 Community Health Complaints by service

The top 3 community services receiving formal complaints in 2019/20 are detailed further below.

Community Nursing
As detailed in table 8, 9 of the 15 complaints were regarding care and treatment, review of these has not identified any themes within these.

Table 8: Community Nursing Service complaints

	Geographical Locality			
Main subject of complaint	Bracknell	Reading	Slough	Grand Total
Care and Treatment	2	2	5	9
Attitude of Staff	1	2		3
Communication	1	1		2
Other			1	1
Grand Total	4	5	6	15

Community Health Inpatient Wards

Table 9: Community Health Inpatient Ward Complaints

	Ward							
Main subject of complaint	Ascot Ward	Donnington Ward	Henry Tudor Ward	Highclere Ward	Jubilee Ward	Oakwood Unit	Windsor Ward	Grand Total
Care and Treatment			4	2	2		2	10
Attitude of Staff		1				1		2
Discharge Arrangements						1		1
Environment, Hotel Services, Cleanliness					1			1
Access to Services	1							1
Grand Total	1	1	4	2	3	2	2	15

The Community Inpatient wards saw a decrease in the number of complaints received in comparison with 2018/19, from 17 to 15; in 2017/18 there were 11 complaints.

Care and treatment continues as the main subject for complaints received about Community Inpatient wards. 40% of the complaints about care and treatment were about Henry Tudor Ward.

Westcall Out of Hours GP Service
As shown in table 10 Westcall received 9 complaints in 2019/20, a reduction from 17 in 2018/19.

The complaints for the out of hours GP service were found to be about the attitude and communication from Doctors, and access to the service

Table 10: Westcall Out of Hours GP Service complaints

Main subject of complaint	Westcall
Attitude of Staff	3

Access to Services	2
Care and Treatment	2
Medication	1
Confidentiality	1
Grand Total	9

2.4 Children, Young People and Families

Table 11 below details the children, young people and families' complaints received, with 17% of all complaints received attributable to these services. The main services where formal complaints are attributed to are our CAMHS services.

Table 11: Children, Young People and Family Service Complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Adolescent Mental Health Inpatients - Willow House						2	2
CAMHS - Child and Adolescent Mental Health Services	1	7	4	5	3	11	31
Children's Speech & Language Therapy - CYPIT	1	1		1			3
Community Paediatrics			2				2
Health Visiting						1	1
Grand Total	2	8	6	6	3	14	39

CAMHS

Child and Adolescent Mental Health Services received 31 complaints in 2019/20 compared to 25 in 2018/19 and 26 received in 2017/18.

Access to CAMHS services saw an increase in 2019/20 to 7 from 3 formal complaints in 2018/19. The number of formal complaints about the attitude of staff remained the same (2 each year) and there was an increase in complaints about communication (up to 4 from 2) and confidentiality (1 complaint this year and none last year).

The CAMHS Urgent Care Service continues to bring positive clinical outcomes for young people. CAMHS have worked hard over the past two 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.

Table 12: CAMHS Complaints

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services		3			1	3	7
Attitude of Staff			1			1	2

Care and Treatment		3	3	2		7	15
Communication				1	2	1	4
Confidentiality	1						1
Waiting Times for Treatment				2			2
Grand Total	1	6	4	5	3	12	31

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 13: Outcome of closed formal complaints

	2018-19						2019-20						
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 18/19**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of 19/20**	**Change (Annual)**
Case not pursued by complainant	0	0	2	2	4	1.67	0	0	0	0	0	0	↓
Consent not granted	2	2	3	2	9	3.75	1	0	0	0	1	0.45	↓
Local Resolution	0	5	10	3	18	7.5	1	1	0	0	2	1.92	↓
Managed through SI process	0	2	0	1	3	1.25	0	0	0	0	0	0	↓
Referred to another organisation	0	0	0	0	0	0	1	0	0	0	1	0.45	↑
No further action	1	0	0	0	1	0.42	0	0	0	0	0	0	↓
Not Upheld	13	11	16	15	55	22.92	16	20	23	24	83	37.56	↑
Partially Upheld	25	26	36	19	106	44.17	17	22	28	23	90	40.72	↓
Upheld	12	15	12	5	44	18.33	11	13	10	9	43	19.46	↓
Disciplinary Action required	0	0	0	0	0	0	0	1	0	0	1	0.45	↑
Grand Total	**53**	**61**	**79**	**47**	**240**		**47**	**57**	**61**	**56**	**221**		

The national reporting statistics (including GP and dental service complaints) for 2018-19 showed that:

Upheld	32.8%
Partially Upheld	30.9%
Not Upheld	36.3%

Complaints can cover a number of 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. During Quarter 3, the Trust had its first breach in responding outside the timescale agreed with the complainant. This was within the Mental Health Inpatients Division and that service have revised their local processes to prevent this from recurring.

Table 14 – Response rate within timescale negotiated with complainant

2019-20				2018-19				2017-18				2016-17			
Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

4 Complaints as a mechanism for change – learning

Where complaints are upheld or partially upheld learning is shared with individuals, teams and the wider organisation where applicable; some examples of learning from complaints include:

What we were told: Mental Health Inpatients Wards aren't keeping an accurate log for patient property on the wards, meaning that the Trust has to pay to replace items.
What we have done: Supported wards with refresher information on recording patient property.

What we were told: Staff in The Place of Safety were not clear on the difference between PALS and independent advocacy services.
What we have done: Staff education on the differences between PALS and Advocacy so to manage patient expectations and signpost them to the right support.

What we were told: Patients don't always understand that rationale that staff used for making decisions about care on Mental Health Inpatient Wards.
What we have done: Reminded clinicians that a timely and clear rationale/explanation should be provided to patients for discharge or when a treatment/service they have requested is not considered clinically appropriate. Patients' understanding of the rationale provided should be checked.

What we were told: There needs to be clarity about the use of text messaging between patients and staff.
What we have done: Reminder to clinicians that they should be mindful about the language and tone of text messages sent to patients and make it clear that they will only be able to respond to patients' texts during working hours. Patients should be advised not to use texts for urgent communications.

What we were told: A family were unclear on whose responsibility it was to manage the behaviour of a young person during an appointment.
What we have done: Where child/ren become undisciplined/disruptive during consultation, parents/guardians should be quickly reminded of the need for them to supervise their child/ren independently of staff. This ensures that where such an event occurs, (1) parents/guardians feel empowered to act and do not wait for staff to direct child/ren and (2) that this non-home environment does not imply to parents/guardians that child/ren cannot be controlled by parents/guardians like they would be at home. A reminder to staff that they should quickly and proactively remind parents/guardians to supervise child/ren independently, where child/ren become disruptive or unruly.

What we were told: There have been delays in referrals due to change in clinicians (within CYPIT):
What we have done: Staff will check that there are no previous actions outstanding when there is a change of clinician and will action where appropriate.

What we were told: Patients who are discharged from hospital to the care of the Continence Advice Service don't have everything that they need.
What we have done: For all referrals received to the Continence Service for new catheter patients, whether temporary or permanent, Triage will make contact with the patient concerned to ensure that the hospital discharged them with all equipment they need, and they were shown in hospital how to change leg bag. They will also make sure that the patient has the service contact details in case they need advice.

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 15: PHSO activity

Month open	Service	Month closed	Current Stage
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	CPE	n/a	PHSO not proceeding
Aug-18	Out of Hours GP Service	n/a	PHSO not proceeding
Sep-18	Psychological Medicines Service	Apr-19	Not Upheld
Nov-18	Psychological Medicines Service	Nov-18	PHSO not proceeding
Dec-18	Psychological Medicines Service	Open	Investigation Underway
Dec-18	Community Hospital inpatient	Jul-19	Not Upheld
Jun-19	CMHT/Care Pathways	n/a	PHSO not proceeding

Nov-19	Older Persons Mental Health Inpatients	n/a	PHSO not proceeding
Nov-19	CAMHS	Open	PHSO have requested information to aid their decision on whether they will investigate
Jan-20	CMHT/Care Pathways	n/a	PHSO not proceeding as Local Resolution had not been exhausted with the Trust
Mar-20	CMHT/Care Pathways	Open	Underway

In January 2020, Healthwatch England published a report looking at the improvements that have been made in the NHS Complaints handling, called Shifting the mindset – a closer look at NHS Complaints. This is based on the findings of the report produced by Sir Robert Francis QC, as part of the public inquiry into the serious failings at Mid Staffordshire Foundation Trust. The Head of Service Engagement and Experience was part of the review team in this inquiry, focussing on the complaint processes and learning; when joining the Trust 7 years ago, the existing complaints processes and reporting were completely revised.
The recommendations and actions from this report are monitored on a quarterly basis through the quarterly Patient Experience Report.

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 16 below details this activity.

Table 16: Formal complaints led by other organisations

Organisation	Summary of element of complaint relating to Berkshire Healthcare services
Berkshire East CCG	Complaint about the attitude of CMHT staff
CCG East Berkshire	Patient is unhappy with the way that the Hearing Aid service was transferred to another provider
East Berkshire CCG	Joint complaint with CCG MH Commissioning team regarding a request for funding
Frimley Park Hospital	Complainant wishes to know if staff are trained to deal with hypoxic brain jury on a community inpatient ward
NHSE	Following an injury in 2017, patient is unhappy with care provided by MSK physio in Church Hill House
NHSE	NHSE complaint with an element relating to effectiveness of Talking Therapies and CPE declining referrals
Royal Berkshire Hospital	Complaint made to RBH re care and treatment received. However, complainant wishes to know why a referral was not made for domiciliary physio before discharge from Wokingham Inpatients
Royal Berkshire Hospital	Family of patient complaining of poor discharge from ICU of patient who had involvement with the Psychological Medicines Service
SCAS	Family feel OOH GP took too long to call back
SCAS	Patient states they did not get a call from Westcall after speaking to 111
Royal Berkshire Hospital	Comments were made by the Dr likening a mistake to a pizza delivery
SCAS	Pt's mother feels she had to wait too long for a call back from the Dr having called 111 and being told they would call within 2 hours

Berkshire West CCG	Complaint about waiting time for CAMHS. The Young person has been seen by a private Psychiatrist and is currently 24/37 on the waiting list for local CAMHS care
SCAS	Father of patient unhappy with the way the WestCall person spoke to his partner
Berkshire West CCG	Father complained to CCG about lack of commissioned services around CAMHS
NHS East Berkshire CCG	CCG require more content to our letter covering why concerns with Community Nursing occurred
Royal Berkshire Hospital	Deceased pt: Pt transferred from RBH - family extremely unhappy with the care and treatment the pt received
NHS East Berkshire CSCSU	Pt was unaware that they were no longer under BHFT
Royal Berkshire Hospital	Family feel pt was transferred to Oakwood from RBH too early and do not want the patient to go to a care home as a result from our ward
NHS East Berkshire CCG	DECEASED PT: - prolonged delays in medication sourcing, DN's unable to attend due to capacity, emergency cover also struggling to attend.

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 training to 56 delegates. Bespoke training, on a one to one basis, has been given to support individuals who are new in post and who need to have training ahead of the scheduled dates. The final face to face training session planned for March 2020, with 20 confirmed delegates, has had to be postponed due to the Covid-19 pandemic. This session will be rescheduled, hopefully for autumn 2020.

8 Mortality Review Group

The Trust Mortality Review Group (TMRG) meets on a monthly basis and the Complaints Office feeds information into this group. There were 13 formal complaints forwarded to the MRG during 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 17: Complaints forwarded to TMRG

Service	Number of complaints
Community Hospital Inpatient	5
District Nursing	2
Corporate (Policy)	2
Psychological Medicine Service	1
GP Practice	1
Out of Hours GP Services	1
Adult Acute Admissions	1
Grand Total	13

The two complaints under 'Corporate' were both complaints around the Serious Incident process. In one case the family felt their letter was not looked at as part of the SI process, and in the second case the family felt there were inaccuracies in the SI report. The original services these patients were under are Acute Adult Admissions and Talking Therapies respectively.