

Briefing paper summary

Service User and Carer Sub-committee Meeting

Meeting date:	11 th January 2015
Title of paper:	Trust-wide Patient Experience Report
To be presented by:	Sara Kerry, Patient Experience Co-ordinator
Paper summary:	<p>This report provides an overview of patient experience feedback collected across the Trust during the reporting period of 1st October to 31st December 2015. The Trust received a total of 124 complaints, 12 compliments, 342 PALS enquires, 120 Friends and Family postcards excluding the December returns and 11 patient stories from Patient Opinion.</p> <p>Compared with the previous quarter; complaints increased by 10%, compliments increased by 70% and PALS enquires decreased 22%.</p> <p>During the reporting period we received eleven completed stories on Patient Opinion, we are confident that this will continue to increase as the Trust continues promoting the use of this new system.</p> <p>Looking at the feedback overall, staff attitude is raised as a negative in all patient experience feedback. Further investigative work within each of the comments received will be undertaken and any trend patterns will be identified and included as part of this report for identifying actions that can be taken.</p>
Action required:	For approval, discussion and advice on the format and content of the report
Previously been discussed at:	N/A
Next steps:	To continue to improve patient experience feedback reporting and enhance the triangulation of data to provide assurance.
Relevance to service users	Yes
Relevant to carers	Yes

Trust-wide Patient Experience Report 1st October to 31st December 2015

1 PURPOSE

1.1 The purpose of this report is to provide the committee with the quarterly results from the various patient experience feedback tools in use across the trust including, complaints, PALs, compliments, Family and Friends Test and Patient Opinion.

2 RECOMMENDATION

2.1 The committee is asked to note the results and support the development of using patient experience feedback to make improvements to the services provided by the Trust.

3 INTRODUCTION

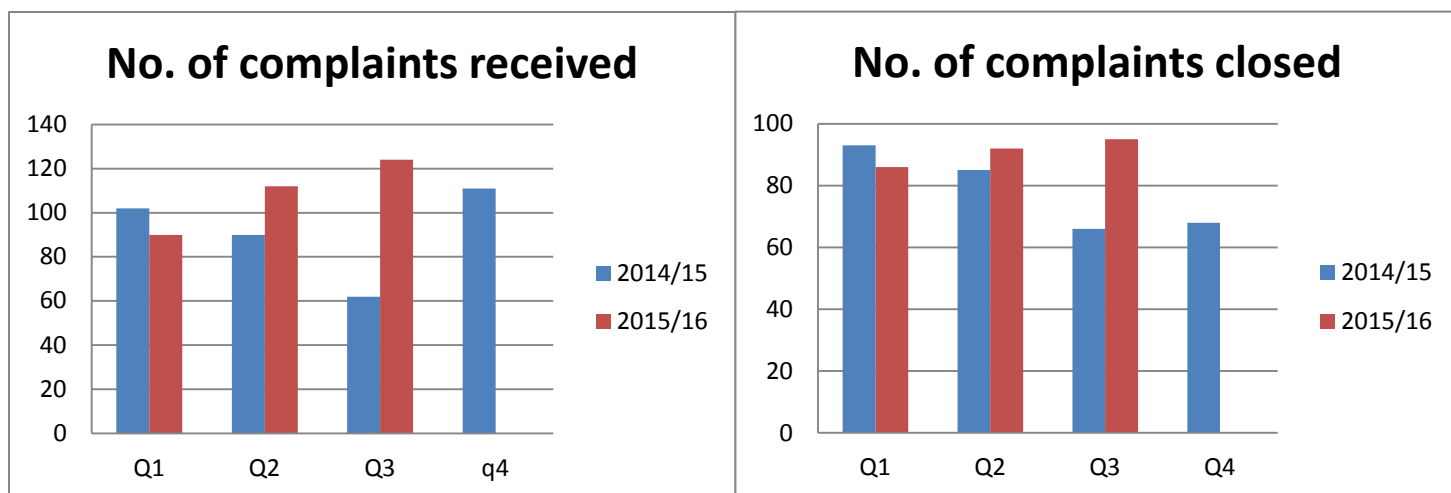
3.1 Previously numerous reports were produced to present the data captured by the tools used across the trust to collect patient experience feedback. Moving forward this report will provide a cumulative overview of the patient experience during the reporting period.

4 COMPLAINTS

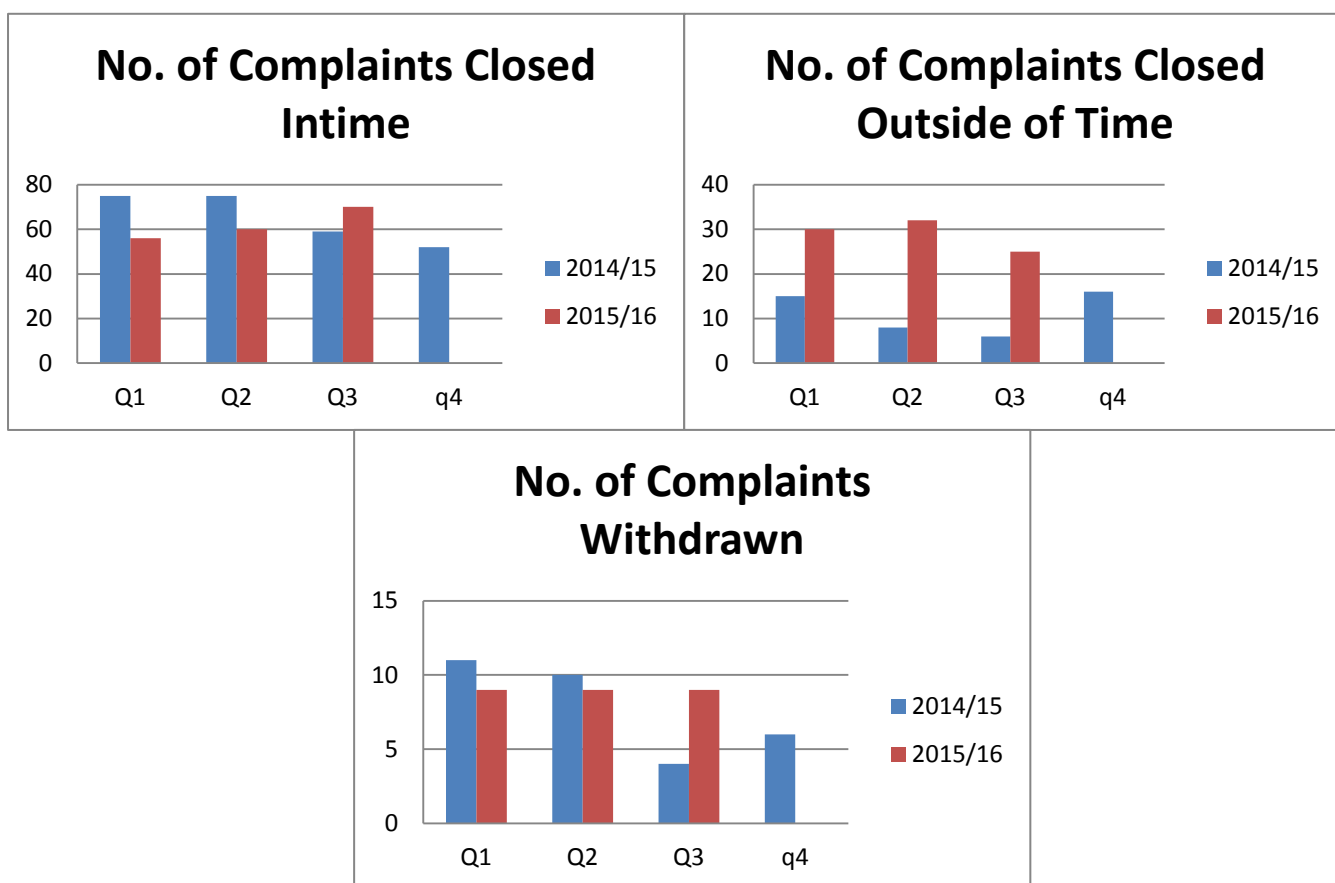
4.1 Of the total 124 complaints received during the reporting period:

4.1.1 37 were received in October, 42 in November and 45 in December.

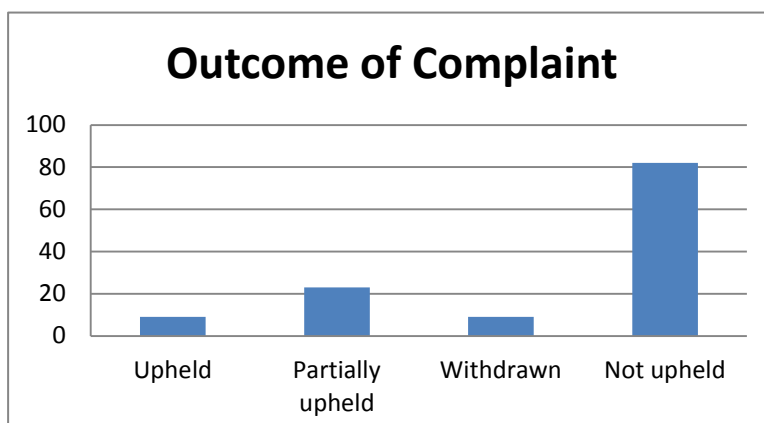
4.2 The following table shows the number of complaints received and closed for each quarter from quarter 1 2014/15 through to quarter 3 2015/16. The lowest number of complaints received in the time period was during quarter 3 2014/15, where 62 complaints were received. The highest number of complaints received was this quarter with 124.



- The tables below show the number of complaints closed in time, outside of time or withdrawn. The highest number of complaints closed in time was during quarters 1 and 2 2014/15. The highest number of complaints closed outside of time was in quarter 2 2015/16 and the highest number of withdrawn complaints was during quarter 1 2014/15.



4.3 During the current reporting period 1st October to 31st December 2015, the Trust received a total of 124 complaints. This is an increase of 10% (n=12) compared with the previous quarter. The highest numbers of complaints, 44% (n=54), were received in Local Services. This would be expected as Local Services has a larger number of service users in comparison to the Forensic Services.



- 4.4 The table above shows that, of the total 124 complaints received, 7% (9) were upheld and 19% (23) were partially upheld, nine withdrawn and 66% (82) were not upheld. There is currently no systematic process available to categorise the reasons for non-upheld complaints but discussions are to be held to look into this.
- 4.5 The Trust-wide distribution of complaints broken down by Clinical Service Unit is shown in the table below:

Complaints activity with each CSU	Quarter 3 October – December 2015				
	HSS	LS	WLFS	Estates & corporate	Total
No. of complaints raised	46	54	22	2	124
No. of complaints closed	30	51	12	0	95
No. of complaints closed in time	23	33	12	0	70
No. of complaints closed outside of time	7	18	0	0	25
No. of complaints withdrawn	7	0	2	0	9

- During this period there were 95 complaints closed in total across the Trust
- 70 of the complaints were closed within the timeframe agreed with the complainant
- 25 complaints were closed outside the agreed timeframe, High Secure Services provided the following reason for the months of October and November, West London Forensic services and Local services have not given reason but this will be requested for future reporting:
 - Investigator handed in late, the complaint response was rejected and further work was required prior to sign off.
 - The report was submitted late from the investigator; this was chased several times and then escalated up.
 - Delay in sign off and then more work requested (extension requested but not received).
 - Delay in sign off due to signatory absence and confusion over cover
 - The complaint report and draft response was submitted late by investigator and there were then further queries prior to sign off.
 - In High Secure Services the number of overdue complaints has been raised as a concern at senior management meetings. The complaints team have been proactively ensuring where possible that reports are submitted in a timely fashion to minimise the impact of overdue complaints and further work is being commissioned on the Exchange to assist Heads of Service in being kept up to date when complaints are not being submitted in time to the complaints handlers.
- In total nine complaints were withdrawn, Seven in High Secure Services and two in West London Forensic Services, the complaints were withdrawn for the following reasons:
 - Five of the complainants were interviewed and asked for the complaint to be withdrawn

- The concerns raised and the findings were the same as a previous complaint. Due to this, the complaint was withdrawn
- One complaint had no reason documented

4.6 The categories used in this report are those reported to the Department of Health however, these categories are further analysed to inform improvements required. Therefore in order to gain a greater knowledge of the complaints raised within our organisation and of those which were upheld and partially upheld, we have developed sub categories which enable us to see a more accurate picture.

HSS Subject of Complaint	Total Number of complaints			No. of complaints upheld			No. of complaints partially upheld		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Aids and appliance, equipment, premises	1	0	4	0	0	0	1	0	0
All aspects of clinical treatment	4	10	0	0	0	0	0	2	0
Appointments, delay/cancellation (inpatient)	0	1	0	0	0	0	0	1	0
Attitude of staff	10	13	10	1	0	0	4	2	0
Communication/information to patients	1	3	0	0	0	0	0	1	0
Failure to follow agreed procedures	3	0	1	1	0	0	0	0	0
Hotel services (including food)	2	2	0	0	1	0	2	0	0
Other	2	0	0	1	0	0	0	0	0
Patients privacy and dignity	0	0	1	0	0	0	0	0	0
Patients property and expenses	4	1	2	1	1	0	2	0	0
Personal records	1	2	0	0	0	0	0	1	0
Total Queries :	28	32	18	4	2	0	9	7	0

WLFS Subject of Complaint	Total Number of complaints			No. of complaints upheld			No. of complaints partially upheld		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
No Subject Selected	0	2	0	0	0	0	0	0	0
All aspects of clinical treatment	7	7	3	0	0	0	2	0	0
Attitude of staff	10	11	5	0	0	0	2	0	0
Communication/information to patients	2	1	0	0	0	0	2	0	0
Patients privacy and dignity	1	2	0	0	0	0	1	0	0
Patients property and expenses	2	1	0	1	1	0	0	0	0
Total Queries :	22	24	0	1	1	0	7	0	0

LS Subject of Complaint	Total Number of complaints			No. of complaints upheld			No. of complaints partially upheld		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Admissions, discharge and transfer arrangements	2	1	0	0	0	0	0	0	0
All aspects of clinical treatment	20	24	8	2	1	0	8	9	0
Appointments, delay/cancellation	2	10	7	1	3	0	0	2	0
Attitude of staff	5	12	1	0	0	0	0	3	0
Communication/information to patients	2	4	1	1	0	0	1	2	0
Complaints handling	1	0	0	0	0	0	0	0	0
Other	5	2	1	2	0	0	1	1	0
Patients privacy and dignity	1	1	0	0	0	0	1	0	0
Patients property and expenses	0	0	1	0	0	0	0	0	0
Total Queries :	38	54	19	6	4	0	11	17	0

E&F Subject of Complaint	Total Number of complaints			No. of complaints upheld			No. of complaints partially upheld		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Hotel services	2	0	0	2	0	0	0	0	0
Personal records	0	2	0	0	0	0	0	0	0
Total Queries :	2	2	0	2	0	0	0	0	0

4.7 Of the total complaints, 30% (37) were regarding 'Attitude of staff' which was the top category this quarter. Previously 'all aspects of care and treatment' was continuously the top category.

4.8 The following are examples of the complaints within the 'Attitude of staff' category:

- Service user is unhappy with the manner in which member of staff acted towards him. He feels she was very unprofessional and had an aggressive manner towards him particularly in her body language.
- A member of staff is treating him differently to other patients on the ward due to a previous incident.
- Treatment of patient and his family at a recent visit
- Doctor's attitude and care and treatment
- Staff are not treating her fairly

4.9 Examples of complaints within the 'all aspects of care and treatment' included:

- Patient unhappy that the social worker he had been seeing on a weekly basis, as part of his care plan, is leaving the trust and wasn't given enough warning of this and the fact that nothing has been put in place
- Family unhappy with the on-going treatment and diagnosis of their mother

- Attitude of a doctor and the fact that they want to begin hormone treatment.

4.10 During quarter 3, the Exchange system shows that 29 recommendations have been closed in the reporting period.

4.11 Below is a selection of vignettes taken directly from the clinical service unit's monthly reports:

West London Forensic Services
Complaint raised concerns about the attitude of staff - We have looked into this and have implemented the following: <ul style="list-style-type: none"> ○ Ward staff should make sure communication with service users and relatives is open and honest. In times of crises sometimes both patients and relatives require assurance and this can be achieved through effective communication. ○ Staff should be aware of their personal circumstances and this should not affect their interaction with staff – Service Users or carers.
Complainant raises concern about attitude of staff - We have looked into this and have implemented the following: <ul style="list-style-type: none"> ○ That if the assigned staff member is unable to inform visitors of the change to the visiting plans before the booked visit, another member of staff should be delegated with this task before the scheduled visit. ○ That members of staff from another ward may present a more neutral facilitating role for visits.
Complainant raises concerns regarding attitude of staff - We have looked into this and have implemented the following: <ul style="list-style-type: none"> ○ To discuss in supervision with the staff member concerned about attitude and mutual respect.
Complainant raises concerns regarding patient's privacy & dignity - We have looked into this and have implemented the following: <ul style="list-style-type: none"> ○ To ensure that such incidents do not happen again, the ward manager will remind staff through meetings and supervision of the correct procedures and new starters will be made aware through their security and secondary inductions.
Complainant raises concern about aids and appliances, equipment premises (including access) - We looked into this and have agreed to implement the following: <ul style="list-style-type: none"> ○ Should further problems happen with the lift, service user to raise the matter promptly with ward staff, who will ensure appropriate steps are taken to contact Estates & Facilities to resolve any faults.
High Secure Services
The complainant said that the TV in the dayroom was kept on too loud following Night Time Confinement and this disturbed him from sleeping. He had raised this locally but the problem persisted <ul style="list-style-type: none"> • The investigator found that the complainant had raised this issue before but felt that it continued to be a problem on some NTC wards. Wards were asked to reiterate the need to ensure that the volume of the TV following NTC should be turned down from 21:00 hours to ensure patients are not disturbed by the noise while trying to rest through CTM and Staff meetings.
The complaint said that they had been allowed to purchase eggs from the patients shop and that they had then not been allowed to boil the eggs on the ward or return the eggs. At the same time he had purchased some cashew nuts which were out of date. <ul style="list-style-type: none"> • The investigator found that the ward did not have appropriate cooking facilities for the complainant to be able to boil his own eggs and recommended that patients were reminded that certain food items should not be purchased from the patients shop. The complainant was reimbursed for the items and the shop was asked to ensure that stock rotation is adhered to.
The complainant complained that he had not received a copy of his psychology report prior to his CPA meeting and then it was not discussed at the CPA meeting. <ul style="list-style-type: none"> • The investigator found that this did occur, and the reasons around why this occurred were because the complainant had moved between wards and teams. The receiving psychologist had wanted to discuss the complainants' psychology work with the previous team psychologist prior to submitting the report but was unable to, an apology has been given. To ensure that this sort of issue does not

<p>arise again the following has been put in place; if a full hand-over from a professional predecessor on a team cannot be obtained before a CPA Review, this should be noted and disclosed in a legible report before the CPA meeting so the service-user is aware of any omissions.</p>
<p>The complainant stated that he was not happy with the temperature of not drinks being served on the ward.</p> <ul style="list-style-type: none"> • The investigator found that there was an operational policy on the ward with regards to the temperature of hot drinks being served, this has been clarified again and shared with all patients via the community meeting
<p>Local Services</p>
<p>Complaint Category:</p> <ul style="list-style-type: none"> ○ All aspects of clinical treatment <p>Details of Complaint:</p> <ul style="list-style-type: none"> ○ Complainant's daughter had a poor assessment from the Hounslow Liaison Psychiatry Service (HLPS) at WMUH and was discharged prematurely. Complainant and her daughter were kept waiting for hours in A&E on 30th June 2015 and the attitude of staff from Lakeside was "appalling", and the attitude of a doctor was "very disappointing" <p>What did the investigation find:</p> <ul style="list-style-type: none"> ○ There was a delay in referring the patient to HLPS. The assessment was not complete. It was very difficult to carry out as patient did not wish to engage with the nurse carrying it out and did not give consent to talk to her mother. There was no evidence to show that the nurse discussed the assessment with the consultant before discharging the patient. ○ The complainant was kept waiting in A&E. It was difficult to draw any conclusion about staff attitude as the staff could not remember the incident. ○ It is difficult to draw any conclusion about the doctor's attitude as there were no witnesses. The doctor did not feel that he was being dismissive and apologises if it appeared that way. <p>Recommendations/actions taken:</p> <ul style="list-style-type: none"> ○ Patients who present after self-harm should be referred to HLPS as soon as they arrive in the emergency department ○ An assessment of capacity should be carried out and documented in cases where consent to speak to relatives is refused ○ All HLPS cases seen in the emergency department should be discussed with appropriate senior clinicians. Decisions to discharge should not be made before this discussion has taken place. These discussions and decisions should be clearly documented in the notes. An incident form will be raised for this. ○ The HCRHT review their process for ensuring adequate cover if staff are away on study leave. <p>What can we learn from this complaint:</p> <ul style="list-style-type: none"> ○ The importance of communication about difficult cases ○ The importance of adequate staff cover
<p>Complaint Category:</p> <ul style="list-style-type: none"> ○ Communication/information to patients <p>Details of Complaint:</p> <ul style="list-style-type: none"> ○ The complainant was out of pocket by £29.80 for their carer's travel costs as they did not receive any notification of a cancelled appointment ○ They did not receive the text message sent to advise them of the cancellation of their appointment ○ The complainant felt that the staff should have checked to confirm that they had received the text message ○ The complainant felt that the staff should have taken additional steps to contact them <p>What did the investigation find:</p> <ul style="list-style-type: none"> ○ The complainant was out of pocket so a refund of the £29.80 was made ○ The GIC does not text patients so they should not have been advised that a text message was sent to them. The GIC always tries to call patients to advise them if an appointment is cancelled and, where this fails, they send a letter to confirm. If this is at short notice due to sickness they will endeavour, where possible, to reallocate the appointment on the day to another clinician, which is not always possible. In these cases they unfortunately have to wait for the patient to attend the clinic to be able to advise them of the cancellation ○ As explained above the GIC will always attempt to call patients directly. It is not the policy of the clinic to text cancellations of appointments. Any advice given to suggest that this is the process is erroneous for which we apologise

<ul style="list-style-type: none"> ○ As explained above the GIC would have attempted to call the complainant directly to advise of the cancellation of the appointment <p>Recommendations/actions taken:</p> <ul style="list-style-type: none"> ○ The Service Manager will ensure that the Administrative Team Leader reiterates the correct processes for contacting patients <p>What can we learn from this complaint:</p> <ul style="list-style-type: none"> ○ The importance of good communication and following correct procedures
<p>Complaint Category:</p> <ul style="list-style-type: none"> ○ All aspects of clinical treatment <p>Details of Complaint:</p> <ul style="list-style-type: none"> ○ Why was our sister released from hospital after 72 hours' treatment? ○ Why has our sister still received no mental health evaluation ○ Why did the hospital fail to give consideration to the safeguarding alert ○ Why was our sister sent home in a mini cab without contacting the family ○ Why was our sister deemed suitable for HTT ○ Why did the ward fail to provide basic standards of care and hygiene ○ Why did no-one speak to the family ○ The doctor's attitude was inappropriate <p>What did the investigation find:</p> <ul style="list-style-type: none"> ○ From the patient's presentation at the time the decision to discharge did not seem unreasonable ○ The patient did receive mental health evaluations ○ The ward were aware of the safeguarding alert but documentation was poor ○ There was no contact with the family. The use of a mini cab is in line with Trust procedures ○ There was a good assessment for suitability for HTT ○ The ward could have offered more support to the patient ○ The family should have been spoken to. ○ There is no evidence for inappropriate attitude but an apology was offered <p>Recommendations/actions taken:</p> <ul style="list-style-type: none"> ○ The ward will meet with the unit manager to review the care provided and an action plan will be written <p>What can we learn from this complaint:</p> <ul style="list-style-type: none"> ○ The importance of good communication with families and good documentation

5 COMPLAINTS/CONCERNS RAISED BY INDIVIDUALS VIA THE CARE QUALITY COMMISSION

- 5.1 The Trust has received eight complaints/concerns raised by patients, carers or staff via the Care Quality Commission (CQC) during quarter 3.
- 5.2 On receipt of these concerns the trust completes an initial investigation to ensure that if there are any immediate quality and safety concerns that these are immediately addressed and people are safeguarded. A summary of the outcome of this investigation is then sent to the CQC by the Director of Nursing. The person who raised the concern is then contacted by the Trust to ask if they would like their concern fully investigated under the trust complaint process.

No	Summary of CQC concern received	Summary of WLMHT response (including next steps)
October 2015		
1	A service user from High Secure Services made an initial complaint which has been investigated responded to and closed. The service user later contacted the CQC reporting that he was unhappy with the response he had received as he felt it did not deal with the issues he had raised.	<p>A copy of the initial response was sent to the CQC. The complaint was re-opened and re-investigated with the following outcome:-</p> <p>Access to food when the patient sleeps through mealtimes= this was not upheld, as a snack box is made available and reserved for him if he does not attend for meals. Staff continue to prompt him to complete a menu and attend meals at the appropriate times.</p> <p>Religion practice and access to religious services and festivities was partially upheld. It was found that this was affected due to the incompatible relationship with another patient. The Imam reported that the patient does not fully participate in the religious services, therefore priority is given to the other patient who is a practising Muslim.</p> <p>The multi-disciplinary team has subsequently challenged the Imam's decision and the patient will be given priority at the next event'.</p>
2	An agency nurse contacted the CQC regarding another nurse alleging that they were falsifying training certificates	Following investigation, it was confirmed that the staff member had not been employed in any capacity by West London Mental Health NHS Trust.
November 2015		
1	<p>A relative of a service user in Local Services sent in to the CQC a copy of a complaint that was sent to the Department of Health. The complaint asked the following;</p> <ul style="list-style-type: none"> • Why was our relative released from hospital after 72 hours' treatment? • Why has our relative still received no mental health evaluation • Why did the hospital fail to give consideration to the safeguarding alert • Why was our relative sent home in a 	<p>The complaint investigation showed that there are highlighted areas where trust policy and procedures were not followed in full. The ward is to meet with the unit manager to review the care provided and the areas where this did not meet our usual standards. They will be required to provide an action plan to ensure that these areas are improved as well as a process for monitoring this.</p> <p>Enquiries have been made on how the care and treatment of the patient was addressed and a copy of the action plan has been requested which will identify the standards that were not met, ensure the patient has received adequate input now and look at how the</p>

No	Summary of CQC concern received	Summary of WLMHT response (including next steps)
	mini cab without contacting the family <ul style="list-style-type: none"> • Why was our relative deemed suitable for HTT • Why did the ward fail to provide basic standards of care and hygiene • Why did no-one speak to the family • The doctor's attitude was inappropriate 	standards are to be monitored in the future.
2	During a CQC monitoring visit to a High Secure Services ward a patient stated that he has waited for over a month to see an Independent Mental Health Advocate.	The ward advocate has looked at the advocacy records but is not aware of a problem regarding access to an IMHA. He said that he is currently working with this patient with CPA matters. The advocate said that he introduces himself to new patients within 3 days of admission. He attends the ward community meeting every week and is available for any patient to contact him directly or by phone.
December 2015		
1	A service user from High Secure Services raised a complaint regarding a member of staff not allowing him to attend a forum for which he is the ward rep as he did not take his medication the previous evening.	During the interview with the complaint investigator, the patient stated that he no longer wanted to continue with the complaint any. At the time he made the complaint he thought he was being unfairly dealt with by staff not allowing him to attend a forum. He acknowledged that he was incorrect to say that the staff member disliked him and never treated him properly. Therefore, the complaint was withdrawn.
2	A Local Services inpatient complained that money was taken from their account. The service user stated that they have given the PIN number to the account to another service user but the complainant believes a member of staff is responsible. Clothes, vitamins, alcohol and non-alcoholic drinks have also been taken.	The service manager met with the patient and checked all the bank slips and accounted for all the money that had been withdrawn. The patient said that she had become confused with all the withdrawals and had thought that staff were taking money from her account. It was confirmed that staff did not have her pin number and the one patient that she had trusted to withdraw money on her behalf had been discharged and returned to France. A Safeguarding Adult concern was raised and closed.
3	The CQC have raised a concern regarding a frequent caller to the CQC from High Secure Services. He raised concerns about his care and treatment and some of his calls have been raised as safeguarding alerts. The CQC have asked that an action plan or his care plan reflects the way that these allegations are managed and checked against. The CQC are to send fortnightly summaries of the calls that have been made not for a direct response but for the team who provide clinical care to him to be aware of the calls he is making.	The team discussed the proposal from the CQC and welcomed the opportunity to work collaboratively with the following plan now in place:- <ul style="list-style-type: none"> • CQC to make contact with clinical nurse manager on the ward. • Clinical nurse manager to develop conduits of communication with the team. • Clinical nurse manager will support initial contact with primary nurse to support inclusion of thematic information into team and nursing plans. There is currently no safeguarding plan in place as the current risk is to others with no indication of the patient being at risk.
4	The CQC received a safeguarding alert	A statement was made by the Clinical Director outlining

No	Summary of CQC concern received	Summary of WLMHT response (including next steps)
	<p>regarding a serious assault from another patient and required follow up information.</p>	<p>the following occurrence:- The patient was punched twice without provocation. He lay on the floor for 10-15 minutes and was reported to be unresponsive as well as unconscious. Urgent care was given on site then he was transferred to A&E for an X-ray and CT scan. The patient was placed on enhanced observations when he returned to the ward the following day. The team initiated a safeguarding alert, the next of kin was informed and the assailant was moved to another ward. The assault was reported to and being investigated by the police. The incident is also subject to the full serious incident review process.</p>

6 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

- 6.1 We had one complaint referred to the Ombudsman this quarter on 29.12.2015. The Ombudsman said they are going to investigate a complaint about lack of care from the Hounslow Recovery Team East and the Home Treatment Team. The complaint was referred to stage 2 of the complaints process (medication); however the complainant didn't want to meet but be provided with a written response to her concerns. A copy of the complaints file has been requested and is due to be sent to the ombudsman.

7 COMPLAINTS SATISFACTION SURVEY

- 7.1 No complainant's satisfaction surveys were returned this quarter.

8 PALS

- 8.1 There were a total of 342 PALS contacts logged from service users, carers and the wider public during this reporting period. This is a decrease of 22% (85) compared with the previous quarter. The total amount of time dealing with the contacts was 153.67 hours compared with 178.1 hours in the previous quarter.

Distribution of PALS contacts			
	Q1	Q2	Q3
HSS	8% (26)	6% (26)	9% (32)
LS	78% (268)	75% (320)	75% (256)
WLFS	4% (14)	8% (35)	4% (13)
Other	11% (37)	11% (46)	12% (41)

	Quarter 1			Quarter 2			Quarter 3		
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Number of PALS received in month	108	111	126	158	159	110	129	122	91
Number of PALS closed	108	111	125	135	119	78	110	92	61
Number of PALS still open	0	0	1	23	40	32	19	30	30
Total time spent on calls (hours)	50.75	55.08	55.17	62.75	64.02	45.08	58.83	55.58	39.25
How many concerns were raised on behalf of another	15	7	9	16	25	8	5	5	8
Number of PALS concerns progressed to complaints	0	0	1	4	0	0	1	1	1

8.2 Due to the fact that PALS concerns are varied and often come from members of the public who seek general advice it is difficult to identify trends. The following table highlights the majority of themes identified.

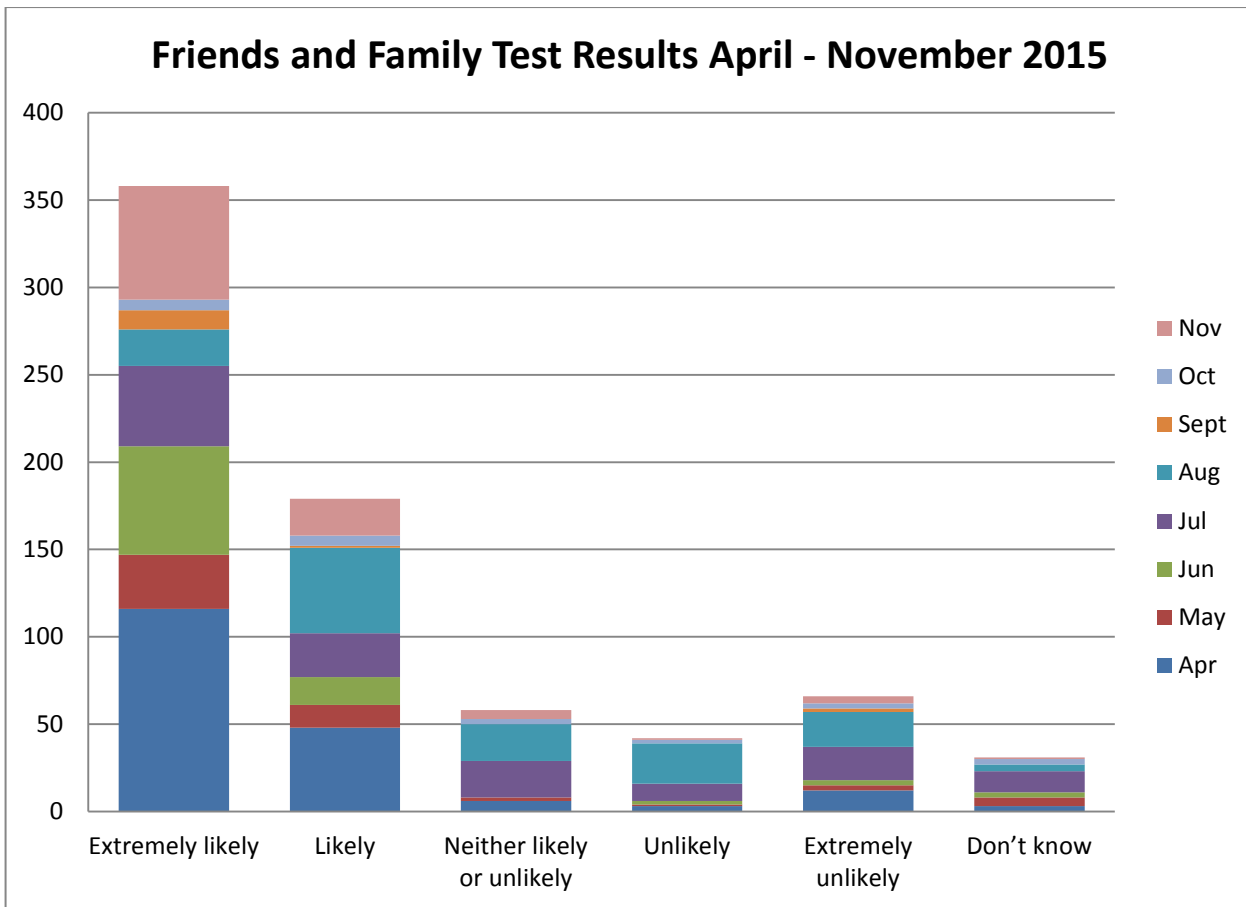
PALS THEMES	HSS	LS	WLFS	Total
Any aspect of care & treatment	3	25	5	33
Any other issue	10	73	5	88
Aids, appliances, equipment	0	1	0	1
Issues surrounding discharge	0	1	0	1
Waiting times – appointments	0	29	0	29
Communication	1	30	1	32
Confidentiality	0	1	0	1
Access to Services	0	45	0	45
Staff Attitude	13	7	0	20
Alleged discrimination	1	1	0	2
Hotel services	2	0	0	2
Medical and other records	1	17	0	18
Patient transport	0	1	0	1
Property/valuables	1	1	1	3
Relationships with staff	0	0	1	1
Support needs	0	25	0	25

- The most common theme within High Secure Services is 'staff attitude', West London Forensic Services is 'any aspects of clinical treatment/care received' and 'any other issues' and Local Services is 'any other issues'. The following are examples of the queries received:
 - Enquiring if they are still on the waiting list
 - Email regarding change of name and new appointments
 - Email to chase up a referral
 - Email received from brother concerned for his sister's current mental health and behaviour.
Email sent to CPN asking them to contact the family directly to discuss their concerns
 - Email with blood results attached to be sent forward to clinic
 - telephone call about accommodation
 - Call regarding communication between GIC and patient / patient's GP
- Other issues include:
 - Email about documentation to get a passport
 - Email to chase up a letter from the GIC
 - Letter requesting for compensation
 - Enquiry about generating an NHS number
 - Email about receiving the wrong letter
 - Telephone call about bringing in some food

8.3 Going forward

8.3.1 A work plan for the substantive PALS officer is to be developed and will include the plan to hold clinics, workshops, road shows etc. across the Trust. The PALS officer will work closely with patient experience leads within each of the service areas to ensure the proposed plans are developed in line with the service user's requirements and needs. As part of this work the themes of the PALS enquires received for each of the areas will be looked at with a view to improve practices.

9 FRIENDS AND FAMILY TEST



	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov
Extremely likely	62% 116	56% 31	72% 62	63%	35% 46	15% 21	79% 11	↓43%	26% 6	67% 65
Likely	26% 48	24% 13	19% 16	23%	19% 25	36% 49	7% 1	↓22%	26% 6	22% 21
Neither likely or unlikely	3% 6	4% 2	0% 0	4%	16% 21	15% 21	0% 0	↑16%	13% 3	5% 5
Unlikely	2% 3	2% 1	2% 2	2%	8% 10	17% 23	0% 0	↑13%	9% 2	1% 1
Extremely unlikely	6% 12	5% 3	3% 3	5%	14% 19	14% 20	14% 2	↑14%	13% 3	4% 4
Don't know	2% 3	9% 5	3% 3	5%	9% 12	3% 4	0% 0	↑6%	13% 3	1% 1

9.1 The above tables show the results for the Friends and Family test for quarters 1, 2 and partially for quarter 3. Overall the responses inform us that the patients would recommend our services to their friends and family but this has decreased from 86% in quarter 1 to 65% in quarter 2. Due to the timescale of this report the December data has not yet been received.

- 9.2 Patients who would not recommend our services to their friends and family have increased from 7% in quarter 1 to 27% in quarter 2. December data has not yet been received therefore quarter 3 analysis has not been undertaken.
- 9.3 Going forward
- 9.3.1 The organisation has recently implemented a new patient feedback system, Patient Opinion, to ensure all users of our services have an open way to share their experience and ensures that the Trust responds in a timely manner.
- 9.3.2 There is an option to include the friends and family test as part of this process which is being considered, it is hoped that this will streamline how we collect experience data and make analysis of the data more meaningful to inform our quality improvement plans.
- 9.3.3 Using the same system for both general feedback and the friends and family test would lessen the confusion of having numerous feedback cards and leaflets within the Trust.
- 9.3.4 To run the Friends and Family Test service using postcards via Quality Health, it costs approximately £500 per month; assuming that 20% of patients take up the opportunity to respond. This assumes that they only print postcards for a 20% proportion of your overall throughput and not everyone. Additional resources are chargeable.
- 9.3.5 To run the test in-house would be as follows; the printing and delivery costs for 5000 postcards every quarter will cost approximately £362. Staff within the Central Governance team would enter the results weekly onto a spreadsheet and the estimated timing for this will be approximately one hour per week. Entries made onto the website can be either via an email return link or directly onto a spreadsheet via survey monkey.
- 9.3.8 Looking at the two options, undertaking the in-house option would save the Trust £4552 per annum.

10 COMPLIMENTS

- 10.1 A total of 25 compliments were received during quarter 3 which shows an increase of 70% compared with quarter 2.
- 10.2 Five compliments were received in October, four in Local Services and one in High Secure Services. 11 were received in November, seven in High Secure services, three in Local Services and one in West London forensic Services. Nine in December, High Secures Services, Local Services and Estates and Corporate, all received three each.
- 10.3 The table below shows a breakdown of the compliments received within each service and some examples.
- 10.4 25 compliments were received for this quarter, which is an increase of 70% (13) compared with the previous quarter. The table below shows a breakdown of the

compliments within each of the CSU's and some examples of the compliments received.

CSU	No. of Compliments			Example
	Oct	Nov	Dec	
High Secure Services	1	7	3	<ul style="list-style-type: none"> • Visiting doctors from Frimley Park Hospital would like to acknowledge and thank the staff conducting the tour the Hospital. • Compliment to Cranfield ward for a visit they facilitated for a visiting Forensic Psychiatrist from Sydney • Compliment to Newbury Therapy from ex patient • Service user would like the Director of Nursing and Patient Experience to write a letter to Martin Clark to thank him for all the help and support he has given him and everyone else who has been in contact with him. • Patient would like to express his gratitude for support that staff have shown him
Local Services	4	3	3	<ul style="list-style-type: none"> • Patient grateful for the care they received from the team and in particular 2 members of the team. • Letter from patients wife thanking staff for the way they cared and treated her husband • Thanks to all the staff on Jubilee ward for their excellent care • Family complimentary about the service received from the red team especially P • Compliment received about home ward
West London Forensic Services	0	1	0	<ul style="list-style-type: none"> • Family member of deceased service user wished it to be passed on her genuine thanks to CTL M for his support and taking his time to meet with her through the families difficult time
Estates and Corporate	0	0	3	<ul style="list-style-type: none"> • M on the support line yesterday was very helpful • A thank you card for the coffee machine that was purchased for the ward

11 PATIENT OPINION

- 11.1 The Patient Opinion system now reflects all of the services, wards and areas within West London Mental Health NHS Trust. This process was undertaken to enable the story teller to relate their story to the location they are writing about.
- 11.2 Advertising, distribution of resources including postcards, business style cards, leaflets and posters and training for staff involved in Patient Opinion continues.
- 11.3 Vishal Jugessur, Crisis Resolution Home Treatment Manager, won the 'Patient Opinion Hero' award directly from Patient Opinion after his expert handling of a comment on the Patient Opinion website. A patient had commented on the independent feedback site that they'd had a poor experience with an Ealing Assessment Team. Vishal responded to them very promptly, offering his sincere apologies and promising to discuss the issue further with his team at their next clinical improvement group.

11.4 The following screen shots show the Trusts activity, what people have been saying about the services and how people have rated the service from when Patient Opinion was first initiated to date.

Activity

- 22 stories told
- 74 staff listening at this mental health trust
- 2 stories have led to changes

▶ Tell your story - make a difference

What are people saying about this service?

What's good?

- [staff](#)
- [service](#)
- [advice](#)
- [Care](#)
- [nurses](#)

What could be improved?

- [communication](#)
- [appointment](#)
- [punctuality](#)
- [service](#)
- [STAFF ATTITUDE](#)

How have people rated this service?

3 people *would recommend* this service
1 person *would not* recommend it

▶ Would you recommend this service?

accessibility	★★★★☆	2 ratings
environment	★★★★☆	5 ratings
information	★★★★☆	5 ratings
involved	★★★★☆	5 ratings
listening	★★★★☆	5 ratings
respect	★★★★☆	5 ratings
socialsupport	★★☆☆☆	1 rating
timeliness	★★★★☆	5 ratings

11.5 During the reporting period, 11 stories have been posted on the Patient Opinion website and viewed 1,493 times in all. A selection of reports is available from the Patient Opinion website and these are attached as appendices. It has been noted that seven of the 11 stories have not been responded to and this has been escalated to the patient opinion lead for the area. Of the four that have received responses three were responded to within the three day timescale.

12 CONCLUSION

12.1 During the reporting period we received a total of; 124 complaints, 12 compliments, 342 PALS enquires, 120 Friends and Family postcards excluding the December returns and 11 patient stories from Patient Opinion.

12.2 Compared with the previous quarter; complaints increased by 10%, compliments increased by 70% and PALS enquires decreased 22%.

12.3 Of the complaints received 7% were upheld, 19% partially upheld, 7% were withdrawn and 66% not upheld. Further work is to be undertaken to look into the number of complaints not upheld and the reasons for this.

- 12.4 The top category receiving 30% of the total number of complaints was regarding 'staff attitude' all aspects of care and treatment' was the top category from the previous three quarters.
- 12.5 Of the total 25 compliments, High Secure Services received 44% of them, Local Services received 40%, Estates and Corporate services received 12% and West London Forensic Services received 4%.
- 12.6 During the reporting period no complaint satisfaction surveys were returned.
- 12.7 342 PALS enquires were received in the reporting period and the most common theme was regarding 'any other issue', this made up 26% of the enquires. It was also noted that a substantial amount of concerns are raised regarding the Gender Identity Clinic. 43% of enquires were linked to this service.
- 12.8 The analysis for quarter 3 of the Family and Friends test is to be completed on receipt of the December data from Quality Health.
- 12.9 During the reporting period we received eleven completed stories on Patient Opinion, we are confident that this will continue to increase as the Trust is continues promoting the use of this new system.
- 12.10 Looking at the feedback overall, staff attitude is raised as a negative in all patient experience feedback. Further investigative work within each of the comments received will be undertaken and any trend patterns will be identified and included as part of this report for identifying actions that can be taken.

Sara Kerry
Patient Experience Co-ordinator
January 2016

STORY AND RESPONSE LISTING



Stories and responses

About this report

This report lists a selection of stories and responses published on Patient Opinion.

It was created on **06 January 2016**.

Which postings are included?

This report shows stories in the **West London Mental Health NHS Trust** subscription, which includes stories.

The report is also filtered to show only stories submitted between 01/10/2015 and 31/12/2015

Frequently asked questions

How do I find the original story online?

If you are viewing the report on a computer, you may be able to click the reference number to the right of the story. This will take you to the story online. If you are viewing the report on paper, you can find story number X online at: <https://www.patientopinion.org.uk/opinions/X>

Why might a story appear more than once in the list?

Some stories are about more than one service. If so, the story will be listed under each service it is about.

What do the story counts mean?

To the right of an organisation/service you will see a count. This tells you the number of stories listed in the report about that organisation or service (including any services run by that organisation/service).

What do the view counts mean?

The view count to the right of a story tells you the number of times the story has been viewed on Patient Opinion by public users (excluding subscribers and the PO team).

Why might unexpected services appear in my report?

The services listed in the report depend on the stories that are included, and that depends on how you have filtered the report. So, for example, if you have filtered only according to where authors live, you may find they have used services some distance away.

Sharing and reuse

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About Patient Opinion

Patient Opinion is a not-for-profit social enterprise which enables people to share the story of their care, and perhaps help care services make changes.

For more information, contact us via: <https://www.patientopinion.org.uk>

Show/hide responses

This report lists **11** stories

West London Mental Health NHS Trust

11 stories

I suffer from OCD

259775

Julius the patient 06/11/2015

I thought the therapist was patronising, rude and condescending and seemed to have an attitude problem. I ended up feeling very upset as a result. It was however good to have the opportunity to talk.

111 views

Would recommend? (Friends and family test): Likely

Janet Bell *Head of Governance* West London Mental Health NHS Trust 10/11/2015

Dear Julius, thank you for taking the time to leave a comment about your experience of our services. We are sorry that you felt patronised by the therapist, which left you feeling upset. This is not how we would have wanted you to feel following an appointment with any of our staff. We are pleased that you found the opportunity to talk helpful. We will share your comment across the Trust so that we can learn from your experience and improve the services we provide.
Regards
Janet

Extremely helpful

266470

Quality797 the patient 14/12/2015

Extremely helpful was avoiding it as no one else was capable to look after my autistic child (18 yrs old) who was very much dependent on own lifestyle and food. Having very acute hearing and learning difficulties needed 24/7 365 day/night care but even through it was against my will knowing how much my ASD child needed this important gap. Has made us realise how much he can achieve without being constantly with middle age parents. He is growing and learning every day. Although 6ft he is a gentle giant and is loved by all and very hard working child.

42 views

Ealing

2 stories

Assessment Team

2 stories

The entire experience has actually really upset me

264412

Upset and unimpressed the patient 02/12/2015

When I arrived the people didn't seem to be aware that I had an appointment, although they had confirmed it a few days prior, and were unable to locate the correct information and I had to call the Referral Team myself in order to confirm it. When I finally got to my appointment (45 mins after it was due to start) I was sat in someone's office with 3 people who stared at me like a zoo animal. 2 were psychiatrists (I was told that one was observing the other but they ended up taking over most of the appointment) and someone whose job title was a 3 letter acronym, which was never explained to me (who did not speak a single word during the hour I was there). The first psychiatrist asked me lots of very broad questions and I had to ask to clarify a lot. There was no easing in to the conversation and one of the first things I was asked, was 'why are you here?' My mental health is something I have discussed with about 4 people ever so perhaps asking me really bluntly in a roomful of strangers was not the best way of getting me to open up. My answers to a lot of the banal, but probably mandatory questions, were probably a bit snappy because I wasn't particularly impressed with the entire process.

462 views

If any of the people in the room had read any of the referral notes from either my GP or the initial assessment team I would be very surprised as they gave no indication of it at any point. After the first psychiatrist has finished asking me about what my parents do for a living the second psychiatrist indicated they wanted to take over and actually ask some questions about my mental health problems, however during the appointment I was asked several times about the voices I was hearing or if I heard voices or saw visions. I made it pretty clear that I had never heard any voices or seen any visions, but they seemed determined to trick me into admitting it or getting me to say I had. I was genuinely concerned that they had decided on a diagnosis and was just trying to shoe-horn me into fitting into it. Part of my mental health problems included going into disassociative states where I can't recall what has happened during them, I was told that my descriptions of these were vague and pressed me to answer questions about them. I found it rather distressing as the reason I was there was due to the fact that I am experiencing these 'blank-outs' and to be told that I am vague while describing them was not exactly helpful for my state of mind. I had no problems with anxiety before I went to this appointment but the entire experience has actually really upset me. I am concerned about my mental health, but I think I will have to be asked to be referred to another team as I found the entire experience to be distressing and I don't think I could work with this team. Whilst discussing if I could return to work, I stated that I wanted to do so soon. They questioned whether I was up to it, but gave no suggestions or recommendations and were fairly unhelpful on the subject. It has led to me questioning whether I am ready to go back, with no doctor's opinion and just my own self doubt (which I did not go into the meeting with).

Vishal Jugessur CRHT Manager West London Mental Health NHS Trust 02/12/2015

Dear Sir/Madam,

I would like to apologise for the service you have received from my team and I agree with you that this must not have been a very good experience at all. It is unacceptable that you had to wait for 45 minutes for your appointment, when we encouraged our service users to be on time for their appointments.

I would also like to apologise that you were not asked for your permission for other professionals to be present in your assessment. From your description, I can only think that they would have been medical, nursing or social work students. Whilst it is important for our students to learn and have hands on experience, this has to be done with our service users' expressed consent. You should have been asked for your permission for them to be present.

I have informed my team of your concerns and I plan to discuss this further with the whole team at our next clinical improvement group. Without knowing more information or knowing who the clinicians are, I am unable to discuss the situation with them. We absolutely want to learn from instances where we could have been better and hence I would invite you to contact our PALS to give more information for me to look into this further.

Thank you for taking time to providing your feedback and once again, I do apologise your experience was not positive.

Thank you,
Vishal Jugessur

We are preparing to make a change

Vishal Jugessur CRHT Manager West London Mental Health NHS Trust 07/12/2015

Dear upset and unimpressed,

As stated, I discussed your case with my team today and looking at the information you have given, we believe that the appointment in question took place with another team within the service. The professional who did your initial assessment in the team here was able to confirm this, looking at the information you have given.

We carried out your initial assessment and made a referral for you to be seen. This said, the principles discussed in my initial response still stand. I will contact the team concerned and inform them of your concerns.

Thank you,
Vishal Jugessur

when I was eventually seen, my experience was good

Constructive Feedback the patient 02/12/2015

Areas for improvement: I needed to wait for an hour before I was seen due to an error regarding the previous appointment. This was not a positive start, as it left me feeling very annoyed. Appointments should be carried out on time. If there is a delay, then patients should at the very least be telephoned

264511

243 views

before their appointment to make them aware. This definitely needs to be improved. It is a matter of respect. I made a concerted effort to get to my appointment on time, and it would help me to feel respected if I was seen at the agreed appointment time, or notified via telephone if there was a delay so that I would not have to wait for a whole hour to be seen. The waiting room is too hot, and the chairs are very uncomfortable so it felt like I was waiting for a lot longer than an hour. On a positive note, when I was eventually seen, my experience was good. I felt as though I was listened to and given good advice so I am grateful for the service. I just hope that improvements can be made to ensure service users feel more valued and respected.

Would recommend? (Friends and family test): Likely

Vishal Jugessur CRHT Manager West London Mental Health NHS Trust 04/12/2015

Dear constructive feedback,
I am very thankful to you for taking time to give your feedback and I am really sorry that you had to wait an hour to be seen. I have recently replied to another service user who equally had an unacceptable waiting time. We ask our service users not to come more than 15 minutes late and then, unfortunately, did not run on time ourselves.
I am of course unaware of what caused the delay at this stage. I note your comments about the waiting room and I promise to look into these. We will be meeting as a team on the 07.12.2015 and I will be bringing your story as well as another one published before to the meeting.
On a positive note, I am very pleased that you had a good experience when you were seen. It is always nice to hear positive feedback and I will pass this on to the team. Please do not hesitate to contact the team and ask to speak to me if you would like to discuss further.
Thank you,
Vishal Jugessur

We are preparing to make a change

Lakeside Mental Health Unit

5 stories

Was hard to understand

267594

Heaped814 the patient 21/12/2015

37 views

I began shaking when I came back to hospital, including my speech - was hard to hear and understand.

Grosvenor Ward

1 story

Better experience

266474

Nature486 the patient 14/12/2015

Much much better than the 3 hospitals I have been in

49 views

Kingfisher Ward

4 stories

Want to say a huge thank you!

266472

Moon678 the patient 14/12/2015

I have found it a very interesting experience etc. I just basically wanted to say a huge "thank you" to the nurses and all the staff at the nurses' station. My favorite was a very experienced, helpful and beautiful lady called Margaret – thank you Margret

183 views

Better experience

266474

Nature486 the patient 14/12/2015

Much much better than the 3 hospitals I have been in

49 views

The service is ok but could be improved

266475

Blank157 the patient 14/12/2015

Hello, the service can be good at lakeside, but I think that it depends upon how much effort you make, so that others (staff and other service users) can reciprocate. If you are rude and uncommunicative you cant expect much in return. If you care about others and approach them with care it can make for a happier healthier time. If you give input for yourself and others showing constructive criticism, they will endeavour to be open minded. Sometimes a change of ward helps! A change of options can lift moods, health diet, exercise, just like outside the ward. If not given the time of day and unkindness shown, then a patient is bound to deteriorate. If given attention and care is given, recovery is possible

131 views

Staff are very helpful

266476

Reader263 the patient 14/12/2015

I have been here for a few months now and I find the staff very helpful. When I feel down or experience difficulties I know I can speak to an of them that are on duty. I did not have good experience on another ward.

163 views

Kingfisher ward staff from ward manager to HCA to domestic staff are all helpful and they are willing to listen to us and they are very supportive. I would like to thank all the staff on Kingfisher ward for helping and supporting me even though I am not the easiest or willing at times to accept support.

St Bernard's Hospital	2 stories
Forensic Services	2 stories
Tagore Ward	2 stories

Care was wonderful

267593

Vale677 the patient 21/12/2015

I recently was taken to A and E from the 3 bridges unit, tagore ward and although the doctor took a while to come and see me, the care and help I received from the staff from my ward was more than helpful, thank you tagore ward staff.

26 views

Would recommend? (Friends and family test): Likely

Staff are caring

267644

Noble838 the patient 21/12/2015

the views and care and concerns with the staff are very appreciative with our care and welfare.

46 views

I think overall that is very caring and well.

Tanaka Mapfumo *Ward Manager* West London Mental Health NHS Trust 30/12/2015

Thank you very much for your positive feedback after your stay at Tagore Ward. This positive feedback is highly motivating and we feel challenged to continue achieving our objectives of being an excellent care provider.

STORIES IN SUMMARY



Stories in summary

About this report

This report shows summary information about a selection of stories published on Patient Opinion.

It was created on **06 January 2016**.

Which postings are included?

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Frequently asked questions

How is story criticality rated?

Story criticality is rated by our moderations at the time each story is moderated. It is a measure of how critical the most critical part of a story is, according to a criterion-based system. Criticality is rated in order to support our filtered email alerting system for staff, and is not intended for publication.

What do the story counts mean?

To the right of an organisation/service you will see a count. This tells you the number of stories listed in the report about that organisation or service (including any services run by that organisation/service).

What does "most popular" mean?

The most popular stories are those which have been read most often per day, since publication. This measure does produce a small bias towards more recent stories, but at least it is simple to understand.

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For more information, contact us via: <https://www.patientopinion.org.uk>

This report summarises **11** stories

To date, the stories in this report have been viewed on Patient Opinion **1,493** times in all

These are the three most popular stories, out of all the stories included in this report

You can click the story title to see the story online

The entire experience has actually really upset me

Posted by **Upset and unimpressed** as the patient Last month

When I arrived the people didn't seem to be aware that I had an appointment, although they had confirmed it a few days prior, and were unable to locate the correct information and I had to call the Referral Team myself in order to confirm it.

When I finally got to my appointment (45 mins after it was due to start) I was sat in someone's office with 3 people who stared at me like a zoo animal. 2 were psychiatrists (I was told that one was...

Want to say a huge thank you!

Posted by **Moon678** as the patient 3 weeks ago

I have found it a very interesting experience etc.

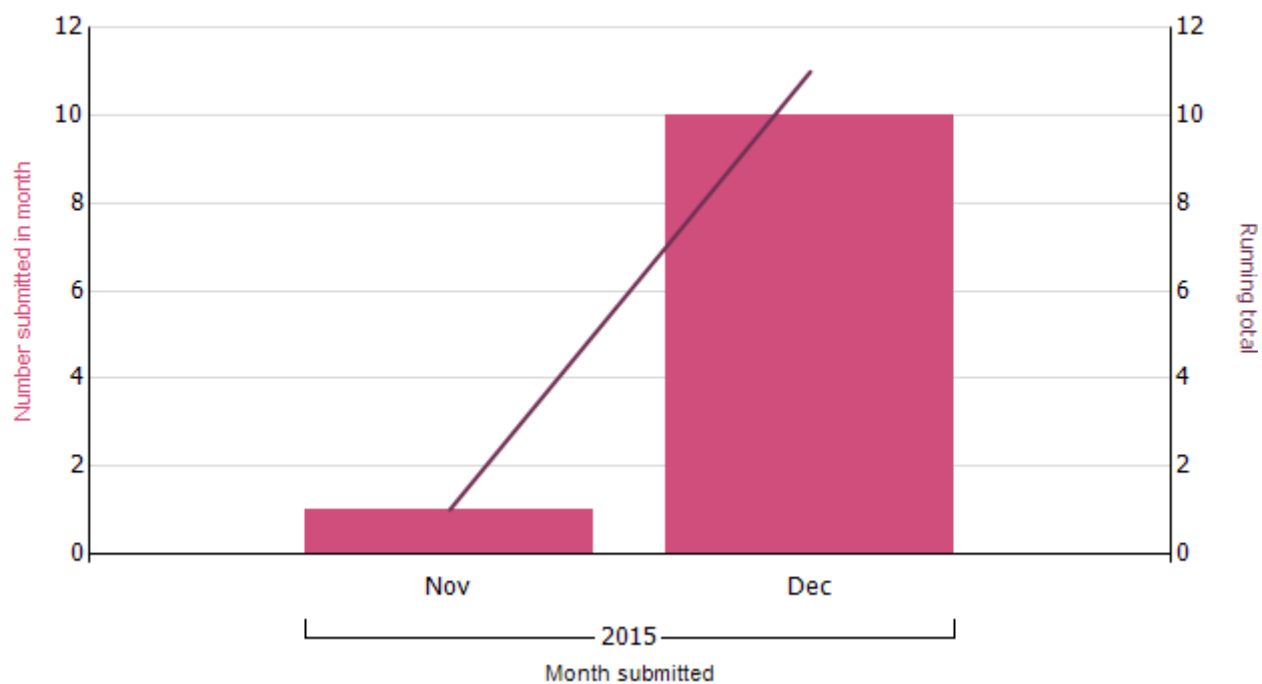
I just basically wanted to say a huge "thank you" to the nurses and all the staff at the nurses' station. My favorite was a very experienced, helpful and beautiful lady called Margaret – thank you Margret

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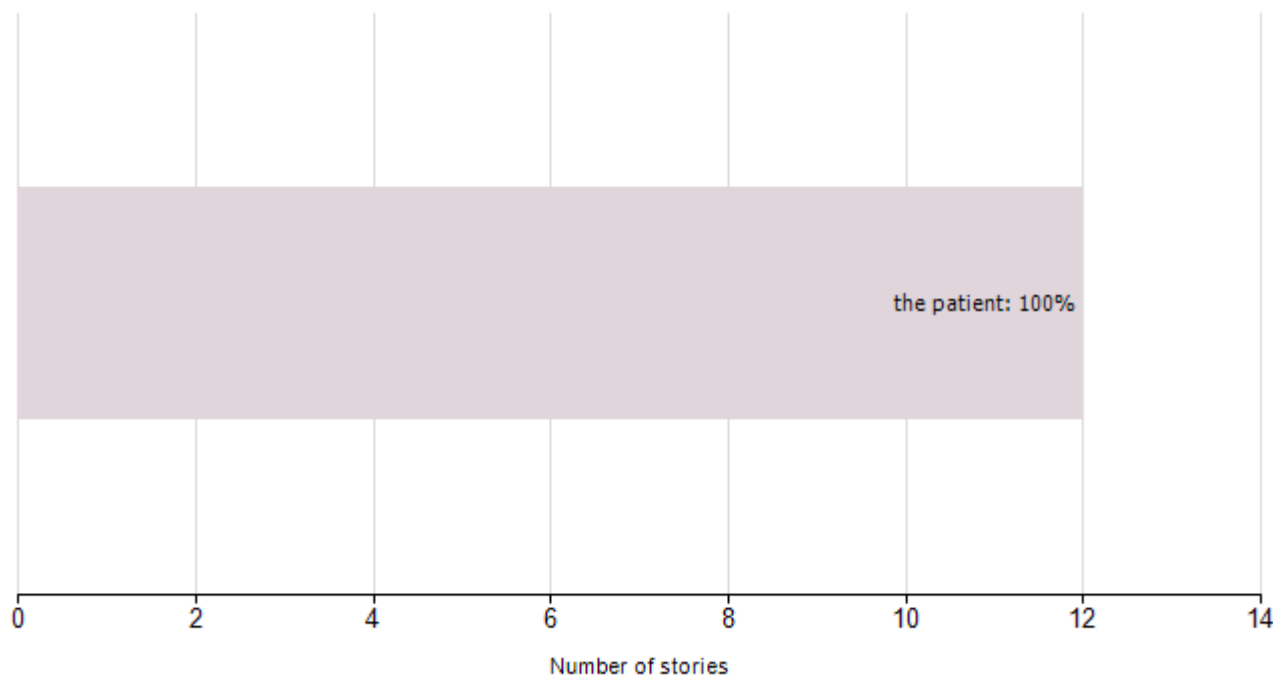
Posted by **Constructive Feedback** as the patient Last month

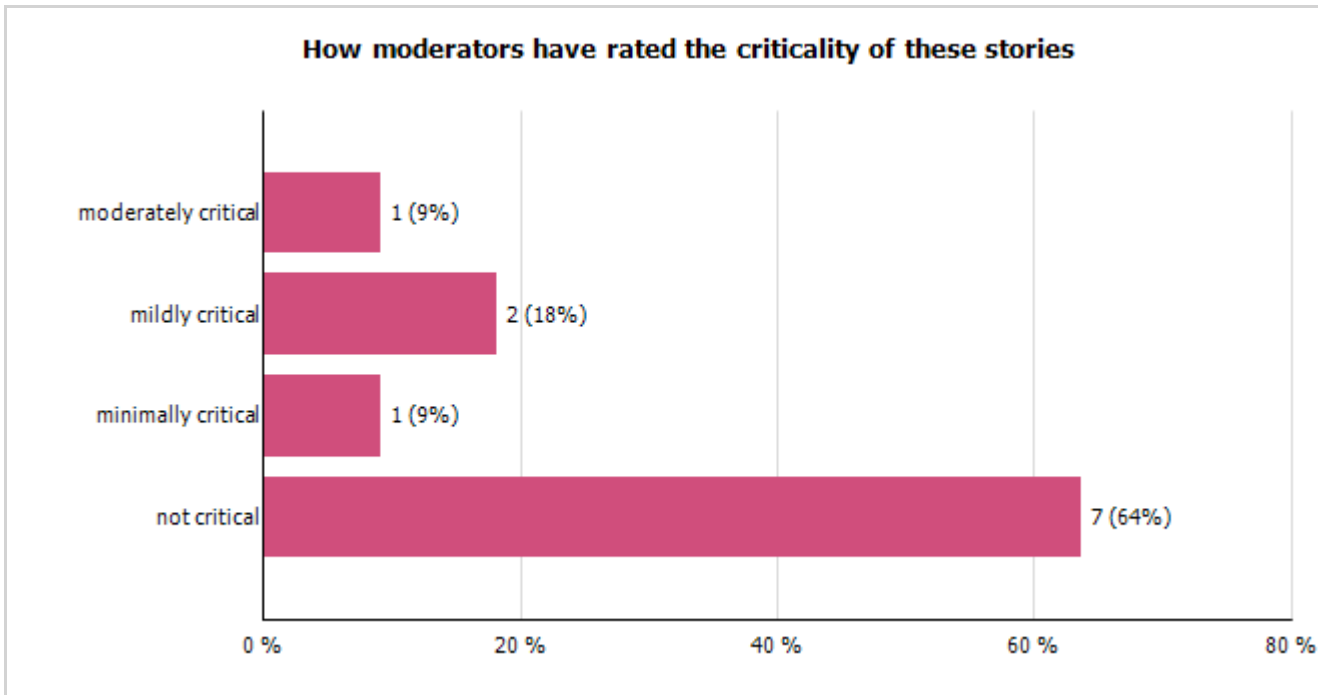
Areas for improvement: I needed to wait for an hour before I was seen due to an error regarding the previous appointment. This was not a positive start, as it left me feeling very annoyed. Appointments should be carried out on time. If there is a delay, then patients should at the very least be telephoned before their appointment to make them aware. This definitely needs to be improved. It is a matter of respect. I made a concerted effort to...

When these stories were told



How the authors of these stories identify themselves





NB: criticality scores are assigned by moderators (not the public) to stories to support our alerting service. They are assigned *per story* not *per service*, so may reflect criticism of services other than your own. We provide them here purely for information, with these caveats in mind.

Where these stories have come from

NHS Ealing CCG	5	<div style="width: 80%;"></div>
NHS Hounslow CCG	4	<div style="width: 64%;"></div>
NHS Harrow CCG	1	<div style="width: 16%;"></div>
Unknown	1	<div style="width: 16%;"></div>

What's good?

staff	3
service	2
advice	1
Care	1
nurses	1

Initial feelings

anxiety	2
upset	2
annoyed	1
distressing	1
thank you	1

Most common tags added by authors to these stories

What could be improved?

mental health	6
communication	2
anxiety	2
upset	2

appointment	1
process	1
punctuality	1
service	1
STAFF ATTITUDE	1
therapist	1
annoyed	1
autistic	1
breathing difficulties	1
depression	1
diagnosis	1
distressing	1
hearing voices	1
learning difficulties	1
mental illness	1
OCD	1
psychiatrists	1
schizophrenia	1
thank you	1
therapy	1

Services the stories are about	Number of stories	Latest story
West London Mental Health NHS Trust	11	21/12/2015
Ealing	2	02/12/2015
Assessment Team	2	02/12/2015
Lakeside Mental Health Unit	5	21/12/2015
Grosvenor Ward	1	14/12/2015
Kingfisher Ward	4	14/12/2015
St Bernard's Hospital	2	21/12/2015
Forensic Services	2	21/12/2015
Tagore Ward	2	21/12/2015

RESPONSES AND STORY PROGRESS



Responding in summary

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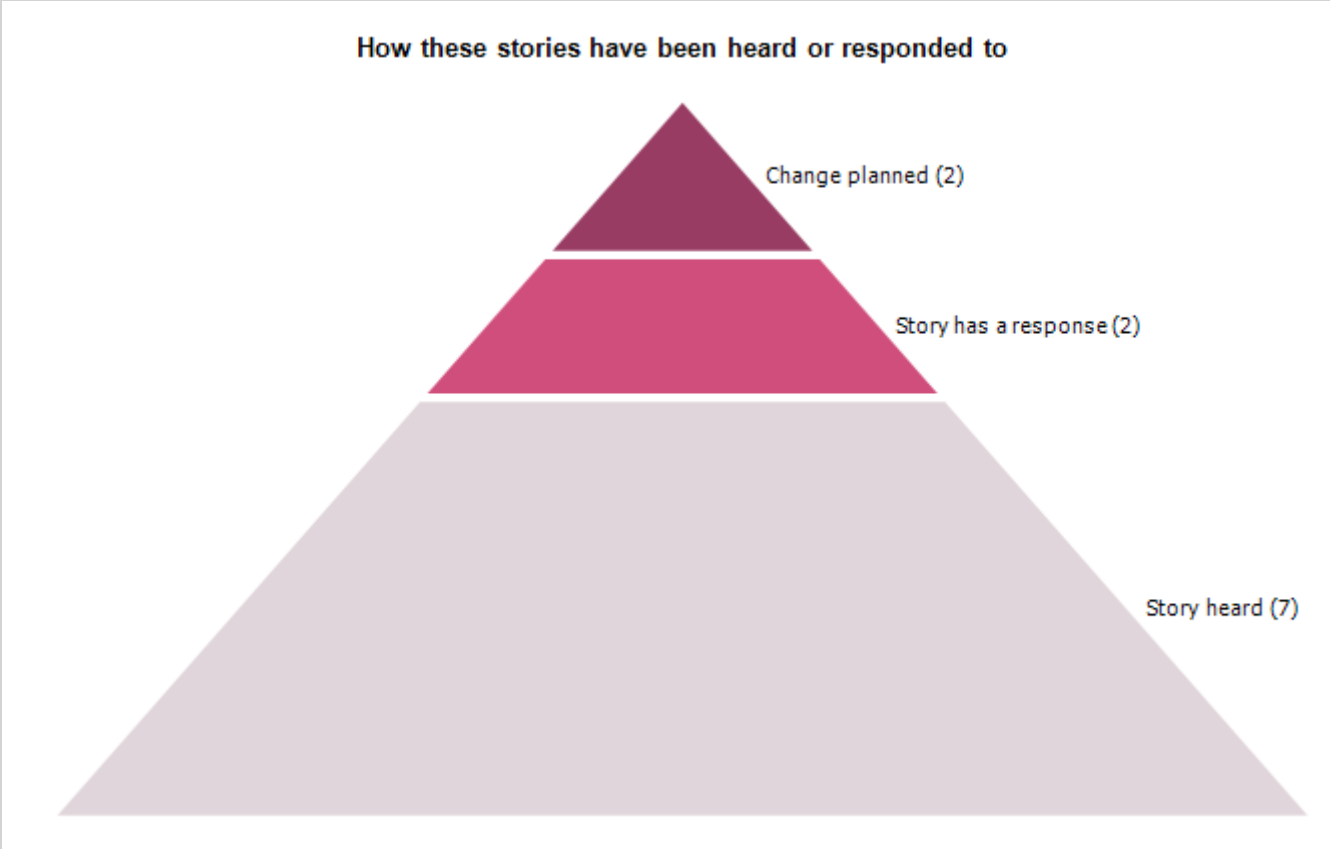
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About Patient Opinion

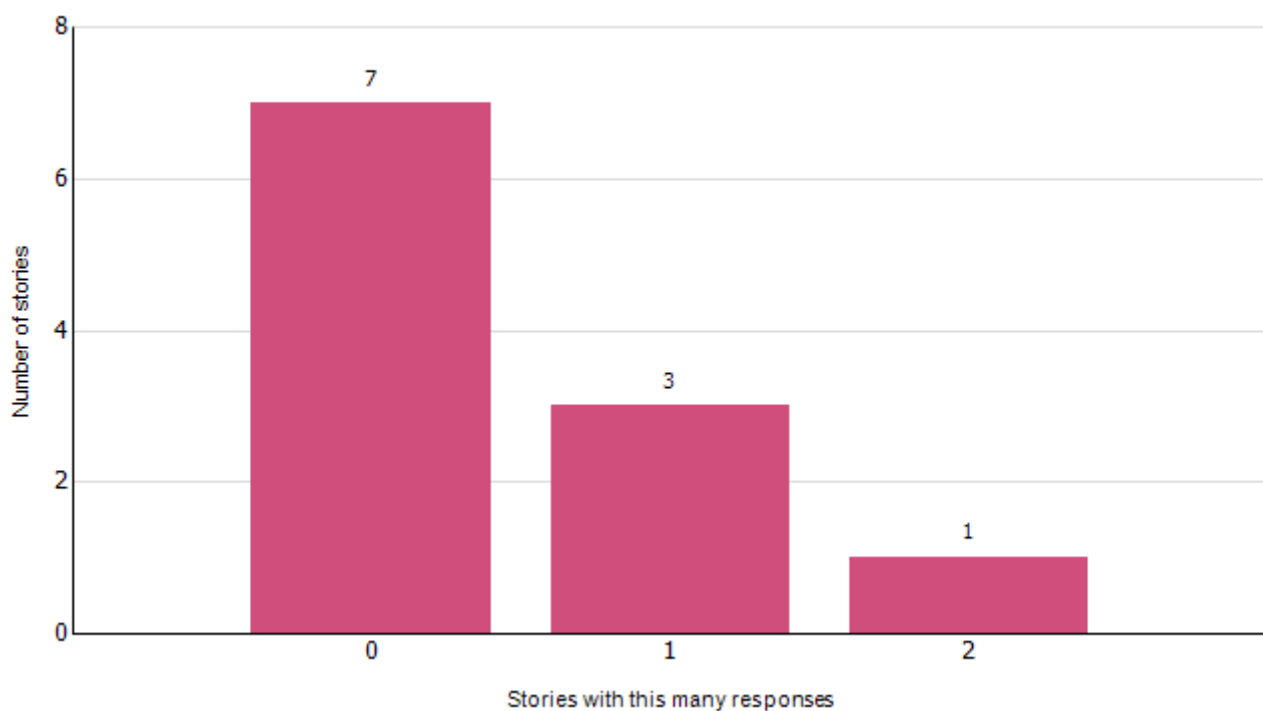
Patient Opinion is a not-for-profit social enterprise which enables people to share the story of their care, and perhaps help care services make changes.

For more information, contact us via: <https://www.patientopinion.org.uk>

This report summarises **11** stories and **5** responses



The number of responses these stories have received



The number of days from publication until the first response to these stories

