University Hospitals Plymouth NHS Trust

Complaints Annual Report

2019-2020

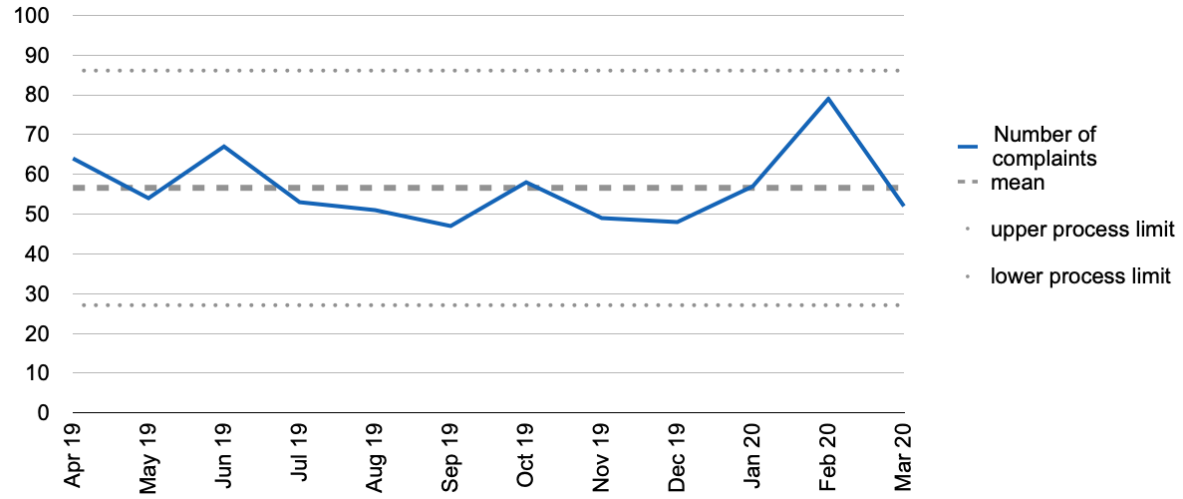
1. Introduction

Listening to feedback from patients, relatives and carers, both positive and negative, is an important element of organisational learning. This Complaints Annual Report provides a detailed overview of activity relating to complaints between April 2019 and March 2020. It has been produced in line with the statutory complaints legislation (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009), under regulation 18. It will provide a detailed view of performance in respect of meeting target times, alongside qualitative complaints information.

Particular focus has been given to identification of areas for improvement, learning that has taken place, progress made in meeting the associated performance targets and standards within the new Complaints policy, ratified in November 2019.

2. Complaints Activity 2019-20

Between 01 April 2019 and 31 March 2020, The Trust received 679 formal complaints, detailed by month in the table below. This represents a 4.2% decrease compared to the same period last year. The Trust received 4,102 PALS enquiries during 2019/20 which has decreased by 7.4% (4,432) in the previous year.

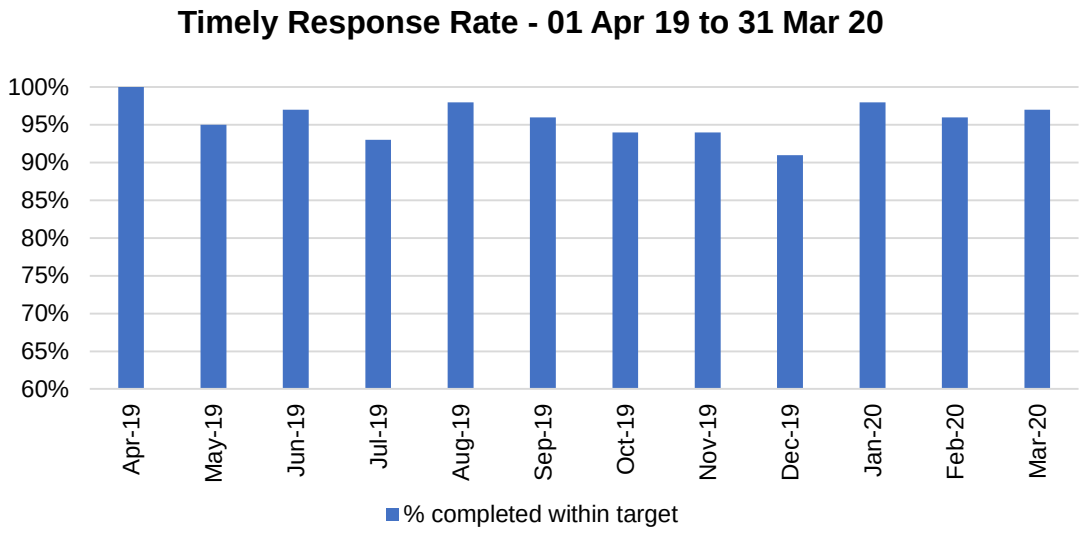


3. Performance

The Trust's performance target for responding to complaints within 25 working days, or by the agreed extension with the complainant or family, was 96% for 2019/2020. The response rate accurately reflects the number of complaints responded to within appropriately agreed timescales. Performance for each service line is reported internally every month.

Of importance, despite permission from NHS England to suspend our complaints procedure during March 2020 at the start of the Covid-19 pandemic, we continued the service.

The following chart illustrates the performance against our agreed target.



4. Re-opened Complaints

The number of re-opened complaints is an essential quality metric. For the year 19-20, the Trust re-opened 22 complaints (3.2% of total complaints received), a drop from 15.5% the previous year. In part, this significant drop is due to a change in the definition of a re-opened complaint; those for which we have failed to answer the issues and questions fully in the original complaint. If a complainant returns to the Trust for any other reason, for example, where the complainant disagrees with the outcome, the Trust provides further responses but does not classify these as re-opened.

Service Lines are encouraged to make early contact with the complainant to clarify the points for investigation and to guide their investigation. Our goal is that through contact with a complainant at the beginning of the process, services are better able to listen to and understand the person's concerns. This allows staff to respond to immediate concerns or issues with care, and helps to clarify the scope of investigation by understanding the person's expectations and the outcomes they are seeking.

We enhanced the quality checking process with the introduction of the Associate Chief Nursing Office role to oversee all responses for each Care Group. This results in better complaints responses, and will further reduce the number of re-opened complaints.

Some teams value the learning that comes from proactively contacting complainants early in the process and highlight the benefits of this approach. For example, the Oncology team met with a bereaved family to discuss their questions. They said:

> *"Meeting the family today was certainly the right approach in this case as it provided a dual benefit. As a team, there are evidently areas whereby some learning has come of out this, which Dr X is going to feedback and review. We are going to offer to meet with the family again in the next 6-8 weeks to reassure them that we have listened, and have used this case as a learning opportunity."*

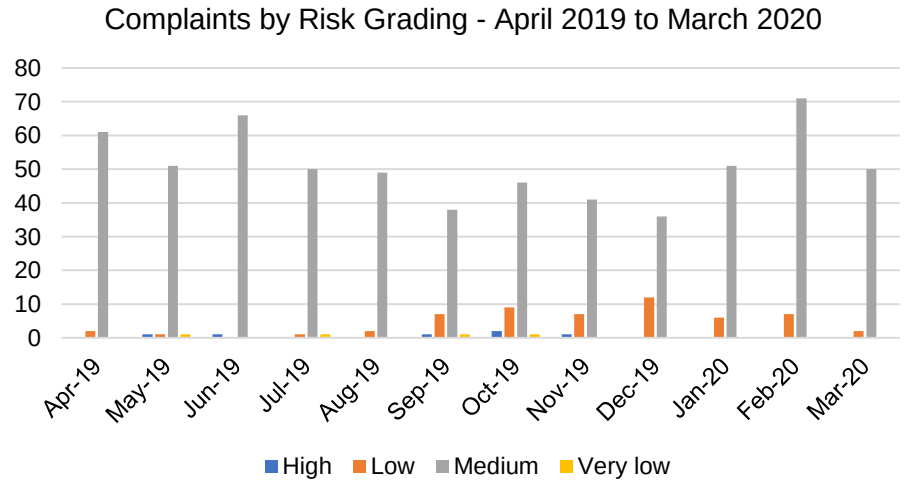
5. Outcomes of Complaint Investigations

On completion of the investigation of each complaint, the Trust classifies each complaint as 'upheld', 'partially upheld' or 'not upheld'. Definitions of the classifications are outlined below, along with the numbers cases for each outcome.

Outcome	Definition	Number	Percentage
Upheld	Complaints in which the concerns were found to be correct on investigation	141	21.5%
Partially Upheld	Complaints in which some of the concerns were found to be correct on investigation	211	32.1%
Not Upheld	Complaints in which the concerns were not found to be correct on investigation	290	44.2%
Ongoing	Complaint investigation ongoing, therefore, outcome has not yet been confirmed	0	N/A
Withdrawn	Complaint withdrawn	14	2.1%

6. Levels of Risk

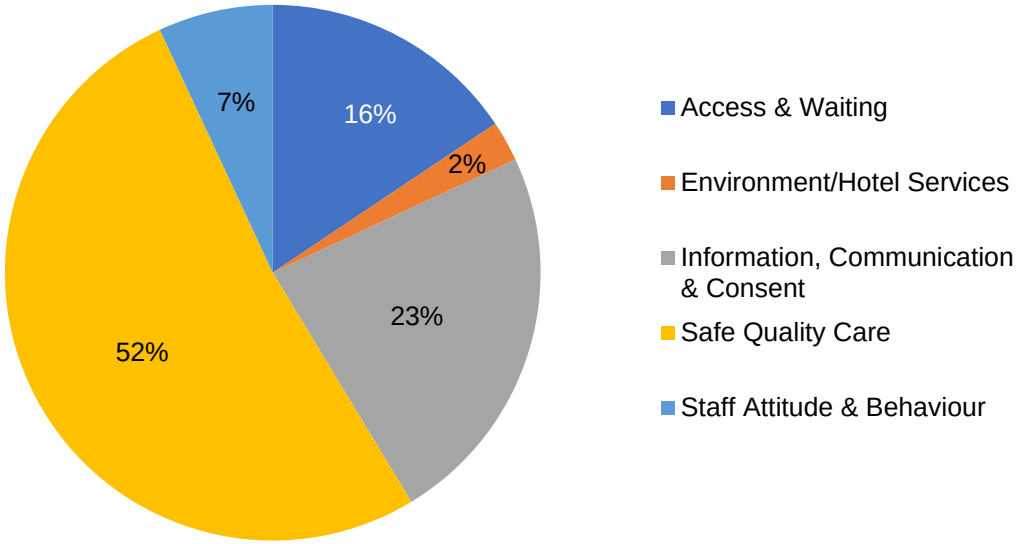
All complaints are categorised for levels of risk based on the Trust Risk Management Policy. The chart below illustrates the risk score for complaints received in 2019/2020.



7. What concerns our patients and relatives?

Trend analysis of both complaints and PALS is now possible using the same categories to identify key areas of concern more easily. The graph below provides an overview of key themes for complaints received in 2019/2020.

Proportion of complaints by subject



8. Feedback and Learning

Based on the learning from complaints and concerns, some examples of changes made or planned at Care Group level are detailed below.

Safe Quality Care

- An audit into the lack of options provided to a patient prior to their baby's delivery – audit to take place.
- MRI could not be performed as the patient's Vagus Nerve Stimulator could only be switched off by one person who was on leave. The neurology epilepsy team arranged for the company to provide staff training.
- Lack of awareness of premature babies weak immune system – University of Plymouth lecturers were informed of the incident and so shared the learning with nursing students. The anonymised complaint was shared at the Clinical Governance meeting.
- Following an error where a sample was not sent externally for sampling, the Service Line rectified this by aligning the two electronic systems, which means that the alert sign cannot be missed in future.
- Following a poorly worded Discharge Summary, consultants reviewed a large selection of discharge summaries to ensure content is up to date and accurate.
- A review of the provision of joint uro-gynae and colorectal clinics to ensure there are more frequent and regular clinics reflective of the demand for appointments.
- There has been a review of breastfeeding training for Maternity HCAs and Nursery Nurses.
- A review of Transitional Care Ward lodger status helped to ensure mothers requiring care or pain relief can still receive this.

- A life-threatening blood disorder was not picked up by the surgical team whilst the patient was having orthopaedic surgery. As a result, consultants now request bloods at the point of outpatient review only if they are urgently required; otherwise, they request these during the preoperative assessment appointment and follow up appropriately. If bloods are requested prior to this, consultants ensure dictated clinical letters alert the secretary of the requirement to track and relay the results to the consultant for review. In addition, the orthopaedic preoperative nursing team have been re-educated on the importance of reviewing blood results at the preoperative assessment appointment at all times and escalating as necessary.
- Following a missed diagnosis of a cleft palate and after concerns about treatment provided to the mother following her C-section:
    - The midwife involved with the mother's delivery and also with the midwife involved with the discharge received additional one-to-one support.
    - There was an audit and review of the compliance with the full completion of the new-born wellbeing in accordance with the daily checklist.
    - Staff have been reminded of the importance of completing regular assessments of pain scores for patients who have undergone surgery and offering appropriate pain relief before mobilising a patient.
    - Infant Feeding Lead was made aware that conflicting advice is being given to mothers and as a result, to provide evidence that regular support for all staff within the inpatient area is being given.
- A patient suffered facial skin damage following the use of tapes for the breathing tube for anaesthesia for surgery. As a result, the department is trialling a new tape to prevent tape damage and offer patients lip balm to promote their skin integrity. Theatre staff have been reminded of the importance of ensuring the tape is not too tight.
- A member of staff noted head bobbing, nasal flaring and chest recessing on the baby, but then arranged for a GP appointment for 3 hours later in the day, rather than consulting immediately with a medic or calling an ambulance. In response, as well as 1:1 training with the midwife involved, there is now a lecture on "Management of the sick neonate" introduced onto mandatory training week.
- Following delays in molecular cases being tested for patients with cancer, the Pathology Manager now reviews whether on-site testing would be more efficient. Pathology now has a member of the administration team who actively monitors timescales associated with molecular cases, highlighting any time-sensitive cases and breach of agreed timeframes.

Access and waiting

- Delayed clinic appointment - regular announcements to be made during clinic times to update patients. Records to be kept for future clinic profile planning.

Information, Communication and Consent

- An ambiguous admission letter led to a review of letters and the admission process to bring about greater clarity for patients coming into hospital.

Staff attitude

- Following concerns regarding the involvement and attitude of the psychologist, all patients are offered a chaperone for these appointments. Staff to be offered conflict resolution training.
- Following poor customer care provided by a member of a Unit's Reception staff, the staff have been reminded how every visitor needs to be treated with care and respect. The specific member of staff has been made aware of the effect of their non-verbal communications.
- Complainant advises the telephone was not answered on the ward and when it was, he and his wife were spoken to inappropriately. As a result, the Ward Sister has used the patient's feedback for reflection and training within the team to ensure her staff are aware of the standards she expects and to highlight how upsetting this experience was for family members.

Environmental

- Following a lengthy wait at Lloyd's pharmacy, and following recognition of patient waiting times and other feedback, the service has introduced a 'buzzer' device that allows the patients to leave the pharmacy to wait in a more comfortable area. In the long term, the Trust has identified a new and much larger location to relocate the service, which should result in reduced waiting times and a larger waiting area.

Miscellaneous

- A family complained about the delay in receiving the patient's Medical Cause of Death Certificate. Awareness training was provided to doctors and ward clerks regarding the importance of the timely completion of medical certificates. The team has introduced identification sheets which clearly highlight priority checking the order of certificates to the team and made improvements to the administration process to speed up the completion of all the documentation and paperwork. The team also now has a daily huddle whiteboard meeting which takes place to identify the number of certificates received and being processed through the Bereavement office so that the team can access additional support when demand is high.
- Following a baby's death, the paperwork was sent to the mortuary in error, and the presence of a consent form for a post mortem was not checked, resulting in the baby being sent to Oxford. The mother had to ask for bereavement help repeatedly before she received this. Since this complaint staff have been reminded of the criteria for raised blood pressure assessments and not to use labels when referring to mothers. Two members of staff now check the documents before arranging a transfer to the mortuary, and the department has designed business cards which will be ready to use shortly, to ensure all women receive the contact details for bereavement support.

Summary

Following the review of actions taken following complaint investigations and the learning opportunities over the last year, this has increased from the previous year's 12 actions to a total of 41 separate actions or learning.

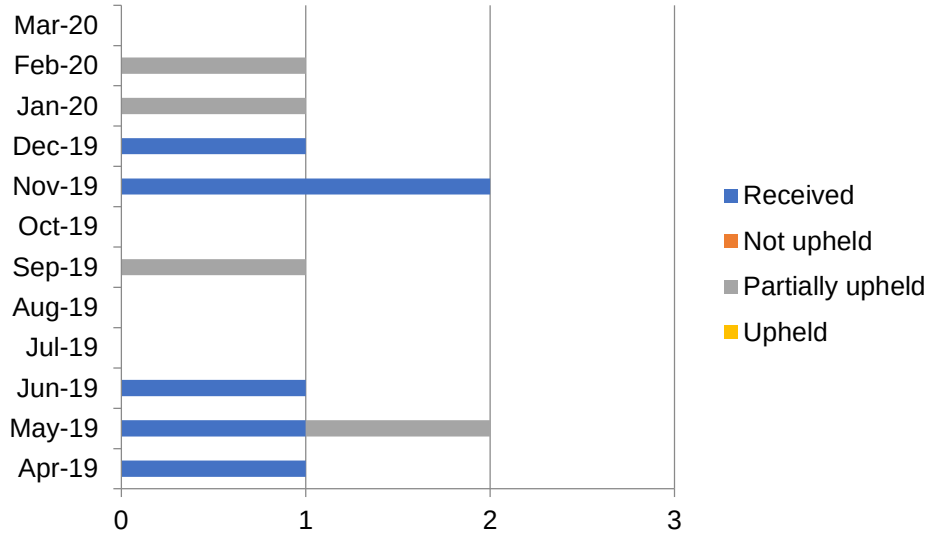
The majority of our learning falls within Safe Quality Care, and involves the training of an individual or a team, and improvements in the process involved in the complaint.

9. Parliamentary & Health Service Ombudsman (PHSO)

Complainants have the right to refer their case to Parliamentary and Health Service Ombudsman (PHSO) for review following resolution with the Trust.

For 2019-2020, the PHSO made 15 requests for information to establish whether or not they will proceed to investigate a complaint. The PHSO initiated six investigations during that time. As at the end of March 2020, two of those cases had been closed, and four remain ongoing.

During this period, four PHSO investigations were closed (four cases were old cases from previous years), where each case was partially upheld.



Partially Upheld Reports

1. There was a failing in April 2018 as the Trust did not carry out a pain assessment and did not consult a doctor before giving the patient a controlled drug. The PHSO also concluded that there was a failing as we gave the patient the medication in a manner contrary to our controlled drugs policy, and delayed our response to the patient's wife's concerns.

2. The PHSO found no failings in all areas complained about, except one. They concluded that we did not act in line with relevant guidance, and should have monitored the patient's bowel movements daily. However, due to the location of the patient's fistula, the PHSO said there is little evidence to suggest that this failing had a significant impact on the patient.

3. There were the failures in:

    a. Lack of investigation/intervention between 2013 and 2015;
    b. Delay in providing the patient with pain relief; and
    c. DNAR notice was not discussed with family but signed off.

    The PHSO went on to say "We have identified failings in the Trust's management of *****'s care. However, we are unable to link these failings to her sad death and, therefore, we cannot say her death was avoidable. We do find though that the failings have caused uncertainty, upset and distress for [the family]. The Trust has not identified all the failings, nor has it acknowledged the impact or put things right. For this reason, our decision is we partly uphold the complaint about the Trust. We have made recommendations to address the remaining impact of these failings."

4. PHOS identified failings in:

    a. Misdiagnosed the patient on 14 October 2016;
    b. Failed to fully explain the diagnosis to the patient; and
    c. Did not handle her follow up appointment correctly.

    They go on to say… "The evidence we have seen shows the patient was assessed correctly in line with GMC guidance. However, based on results of examinations, the possible diagnosis of optic nerve damage was not correct. It is clear the Trust wrongly suggested optic nerve damage to the patient, misleading her to believe she had been diagnosed with this condition."

As of 31 March 2020, four cases remained open, awaiting the PHSO's findings.

10. Complaints training

The format of Complaints training changed in 2019. The usual two day training took place on 25 June and 4 July, but the sessions changed to one single day and took place in:

- October
- November
- January, and
- March

Members of the CCG Patient Experience team asked to attend the training last year, so they came along for one of the days. The CQC gave positive feedback about the attendance of patients or their family members at the training.

Feedback has been requested over the last 12 months and used to adapt and improve the training. Feedback has been largely positive. Examples of feedback are detailed below:

In response to suggestions for improvement:

- The training has been shortened from 2 days to 1 day.
- More regular breaks are offered during the day.
- Patients or relatives attend each training day.
- Complaint letter writing session has been developed and expanded.

During the complaints training last year, various speakers have continued to attend to speak to the staff, such as:

- Patients and families – to share their experience of the complaints process
- Consultant – to share his approach to response writing
- Members of staff who have investigated complaints – to share their experience
- Staff member – to share best practice when arranging meetings for patients, families and their carers

11. Plans for 2020/21

1. Continue to improve the quality of response letters through training and 1:1 support.
2. Continued work to provide, when acceptable to the complainant, early telephone contact. This can provide greater clarity for the investigator and, in some cases, speedy resolution for the person raising the complaint.
3. Complaints team to review response letters to identify actions already taken to avoid the need for the completion of a stand-alone action plan.
4. Closely monitor those complaints that require re-opening – to identify learning and improvements that we can make to the process for complainants.
5. Continue to deliver complaints management training package for staff, and to embed learning from complaints into Trust-wide training and development programmes.
6. Enhance staff training by dedicating more time to drafting response letters by using techniques that promote empathy and compassionate writing.
7. Work with the People First team to further improve/streamline the internal complaints processes.