**Oxleas NHS Foundation Trust**
**Complaints Annual Report 2015/2016**

## Complaints received

In 2015/16 there were approximately 959,000 patient contacts with our services; in the same period of April 2015 to March 2016 we received a total of 175 formal complaints (0.02% of overall patient contacts) and 109 informal complaints (0.01% of overall patient contacts).

The Trust is now reporting on all complaints received in writing both formally and informally. We are required to evidence what has happened with formal and informal complaints alike to show robust and open complaints management. This is in line with submissions to KO41 Data Collection and the outcome of the Savile enquiry, which highlighted informal and weak processes around the management of verbal complaints, poor documentation and complaints made at service level not being brought to the attention of management. We are asked to record any complaint that is made in writing to any member of Trust or CCG staff, or is originally made orally and subsequently recorded in writing. Once it is so recorded, it should be treated as though it was made in writing from the outset. Complaints and comments/suggestions that do not require investigation are not included in complaints reporting.

Of the 284 complaints received:-

- 145 (51%) relate to Adult Mental Health and Learning Disabilities (31 Bexley, 60 Bromley, 54 Greenwich)
- 64 (23%) relate to Adult Community Health (29 Bexley, 35 Greenwich)
- 37 (13%) relate to Children and Young Persons (10 Bexley, 8 Bromley, 19 Greenwich)
- 16 (6%) relate to Older Persons (4 Bexley, 7 Bromley, 5 Greenwich)
- 18 (6%) relate to Forensic Services
- 4 (1%) relate to Corporate Services

## Complaints investigated

Of the 284 complaints have been investigated for this period, 761 concerns were raised. Of the 761 concerns, 194 (25%) were upheld, 160 (21%) partly upheld, 371 (49%) not upheld, and 36 (5%) were indeterminate.

Our review of the concerns raised has identified 3 prevalent themes:

| | Investigated | Upheld/partly upheld | % upheld |
|---|---|---|---|
| Clinical Care | 207 | 95 | 46% |
| Attitude of staff | 147 | 56 | 38% |
| Communication | 107 | 73 | 68% |

Clinical care covers issues like care and treatment, late or missed visits, lack of support.
Attitude of staff covers issues like inappropriate comments, rudeness, lack of compassion
Communication covers issues like unable to make contact, failure to share information, delay in writing/providing reports.

Other subjects investigated were;

| | Investigated | Upheld/partly upheld | % upheld |
|---|---|---|---|
| **Medication** | 54 | 13 | 24% |
| **Access & Waiting Times** | 49 | 23 | 47% |
| Records | 45 | 25 | 56% |
| **Admission & Discharge** | 38 | 13 | 34% |
| Environment | 28 | 11 | 39% |
| Service issues | 19 | 7 | 37% |
| Carers | 18 | 11 | 61% |
| Care Planning | 15 | 9 | 60% |
| Safety | 13 | 3 | 23% |
| Discrimination | 6 | 0 | 0% |
| Social Care | 6 | 2 | 33% |
| Mental Health Act | 5 | 0 | 0% |
| Accident | 4 | 3 | 75% |

**Complaints handling**

In line with the Trust's Complaints Policy the aim is to respond to complaints received within 30 working days and agree extensions with the complainant when it is not possible to complete the investigation within this time frame. Of the 284 complaints, 261 complaints have concluded their investigations and 141 (54%) were completed within the agreed timescales. Following the complaints investigation training the expectation is that complaints management within directorates will improve and lead to more timely responses.

**Parliamentary and Health Service Ombudsman (PHSO)**
Complainants who are dissatisfied with the Trust response have the right to ask that the PHSO reconsider their complaint. Since April 2015, three complainants asked for their case to be reviewed by the Ombudsman's Office. All three investigations are currently on-going.

**Learning from complaints**
Work continues to embed and disseminate lessons from complaints across all our services. This year a programme of complaints investigation training has been completed for all Band 8a and above. The next element of complaints training will be on general complaints handling with a focus on staff attitude and behaviour.

The Trust Patient Experience Group reviews action plans from each directorate and receives reports about progress with regard to implementation. This process is also reflected in each of the directorate Patient Experience Groups. A library of case studies has been developed by the Complaints and PALs team for services to use in embedded learning events and to share at team meetings to encourage discussion and promote good practice, a selection of the examples are below.

We will continue our focus in these areas in 2016/17 to improve the quality of the services we provide.

# Learning examples

## Adult Community Health Services

### Summary of complaint

A patient was admitted to an Intermediate Care Unit following an un-witnessed fall at home. The patient had a history of falls, mixed vascular dementia and had previously suffered a hip fracture.

After admission, the patient was found on the floor of the bathroom on the unit and informed staff that he had attempted to get up from the toilet to wash his hands when he fell. The patient sustained lacerations to his elbow and head and complained of pain in his knee. Whilst on the floor, the patient was reviewed by the ward doctor and although the patient could not extend his right knee the doctor advised staff that the patient could be moved from the floor.

During shift handover, the patient was observed to still be in pain, when staff were re-positioning him. The patient complained of pain in his back, right knee and hip (his right knee was visibly red and swollen). Staff dialled 999 and the patient was transferred and subsequently admitted to the Queen Elizabeth Hospital (QEH), where it was confirmed that the patient had sustained a fracture of his right hip.

### Investigation findings

1. The patient was assisted to the toilet and was checked on several times but insisted that he was not ready to come out. He had been given a call bell and he was advised to call when he had finished and the staff then left him on his own as requested. The investigation found that patients should not be left unattended in bathrooms for long periods without regular checking.

2. Patient's family felt that there was a lack of attention to detail in fundamental care needs when caring for their relative. This was upheld and actions have been put in place to ensure that care will be delivered to patients as their individual needs require.

### Learning outcomes

1. Staff were reminded that patients at risk of falls should not be left for longer than five minutes in bathroom without checking on them. Patients' preferences for using bathroom facilities, whether they are accompanied or not, must be documented in patients' care plans.

2. All Health Care Assistants will complete the Health Care Support Workers (HCSW) care certificate within one year of starting work for Oxleas.

## Adult Mental Health and Learning Disabilities Services

### Summary of complaint

The complaint related to confidential information being displayed prominently in the staff office opposite a window looking on to the general visiting area. Whilst the board could be closed it repeatedly wasn't and this information is displayed to other patients.

### Investigation findings

The investigation found that patient information was accidently displayed within the staff room where patients and visitors sitting in dining room could view the information through the window.

### Learning outcomes

Staff have been reminded of the need to protect patient confidentiality. Staff now use smaller font and initials rather than full names when recording information on the board and ensure it is closed over after each use. This has been shared with all other AMH inpatient wardswho now also follow this practice.

## Children and Young Peoples Services

### Summary of complaint

The complaint related to the length of time it had taken for a patient to be seen by a doctor to begin a trial of medication, and the fact that the family had not received any updates about this. The patient was also not informed that his care co-ordinator was going on Maternity Leave, and that he wasn't told who he could contact in her absence, and wasn't provided with alternative support.

### Investigation findings

1. The patient had waited over four months to begin a medication trial which is unacceptable.

2. There were delays in allocating a new care co-ordinator, and we did not keep the patient informed of the delays, or communicate regarding who to contact with any issues that might arise whilst they were waiting to begin their trial of medication.

### Learning outcomes

1. We now have a replacement clinician in post, and the patient commenced their trial of medication.

2. Service to look more widely at the expectations around what, when and how we communicate with clients and their families. There are broader issues with communication across the service, and these will be addressed at service level.

# Forensic Services

## Summary of complaint/concerns

In response to complaints received from two residents about the care they had received on Burgess Clinic, an investigation was undertaken. The complaints raised the following concerns:

- The attitude and behaviour of Burgess nursing staff – in particular, two named members of staff making derogatory remarks towards the resident
- The culture on the Clinic being one of intimidation, with a perception that residents were not listened to with concerns that a complaint would have an adverse effect on care and treatment.
- Instances of patients making complaints and subsequently withdrawing them.

The complaints were made shortly after an incident had occurred on the ward where a patient alleged a serious physical and verbal assault had been perpetrated by a qualified member of the nursing team in the presence of a number of colleagues.

In addition concerns were raised by the Independent Mental Health Advocates that they had had difficulty in getting into meetings on Burgess to represent their patients.

The combination of these events led the Directorate and the wider Trust to have concerns that a 'closed culture' had developed on Burgess clinic with the service not open to external scrutiny and where patients concerns were not listened to and acted on.

## Investigation findings

- During the investigation 5 clients and 30 members of staff were interviewed. The investigation concluded:
- On interview staff had not witnessed or were aware of any incidents occurring on the ward discussed in the complaint. Staff appeared to be guarded in their answers, inconsistent in their statements, and fairly uncooperative with the investigation process.
- The clients interviewed did not display any form of collusion in what they were saying, and appeared to be open and honest and consistent in their statements.
- What was apparent during the interviews was a split within the team with a majority of staff complaining of an "inner and outer circle of staff on the ward". Some staff felt that junior nurses on the ward were invested with more power and authority than more senior staff because they were within the 'inner circle' of staff and that staff in the 'outer circle' were not allowed to act with autonomy. This had an impact on how the ward was functioning.
- In relation to the alleged assault, the complaint was upheld; the member of staff was dismissed and the case was referred to the Nursing & Midwifery Council.

## Learning points

There are three inter-related learning points:

1. Management of complex wards, particularly in secure settings, relies on effective structures, strong leadership and full multi-disciplinary involvement in creating a culture of reflection and shared responsibility, which welcomes external scrutiny. On Burgess, an attempt to maintain safety appeared to have led to the development of a closed culture in which nursing became isolated from its multi-disciplinary colleagues and external support mechanisms. The MDT lost its reflective capacity, and became ineffective in upholding the duty of care to both patients and staff.
2. Minor lapses in professional behaviour and self-control can evoke sympathy, concern and support, and are helpful as early warning signs of stress leading to learning for the whole team. However, once the situation has escalated to a clear boundary violation – in this instance a serious physical assault on a patient – this behaviour is unacceptable.

3. Colleagues – in this instance nurses – understandably wish to support each other in the face of adversity. However, evasion and lying should never be mistaken for peer support. All staff must cooperate with the investigative and disciplinary processes, no matter how uncomfortable it is.

This was a difficult period for the Burgess team, although positive efforts were made to re-build multi-disciplinary team working and ensure that robust measures are in place to support staff when working in this challenging environment.

## Older Peoples Mental Health

### Summary of complaint

A complaint was received from a relative about the possessions that were due to be collected following the death of the patient. There were discrepancies regarding the possessions the relative was expecting to collect, after the patient's funeral, and what was actually handed over.

### Investigation findings

The investigation found that bags containing the patient's possessions were removed to the storage shed outside the ward. Another patient's belongings were also in the storage shed and this patient's clothes were to be taken to a local charity shop for sale. It is possible that some of the possessions belonging to the patient named in the complaint might have been collected in error and hence taken to a charity shop without permission.

### Learning outcomes

1. A store cupboard was purchased to store patients' property on the ward.
2. All staff have been reminded that all stored patient bags/boxes/suitcases and valuables must be clearly marked. In addition, an inventory of patient possessions must be kept until all items are collected, or a decision has been made on how to dispose of the items.