Agenda Item 15.1

Report to:	2gether NHS Foundation Trust Board – 6 June 2019
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SUBJECT: **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS QUARTERS 3 and 4 2018/19**

This Report is provided for:

Decision Endorsement **Assurance** **Information**

EXECUTIVE SUMMARY

A Non-Executive Director Audit of Complaints was conducted covering three complaints that have been closed between 1 October 2018 and 31 December 2018 and a further three complaints that were closed covering the period from 1 January to 31 March 2019.

RECOMMENDATIONS

The Board is asked to note the content of this report and the assurances provided.

1. INTRODUCTION

1.1 The agreed aim of the audit is to provide assurance that standards are being met in relation to the following aspects:

1. The timeliness of the complaint response process
2. The quality of the investigation, and whether it addresses the issues raised by the complainant
3. The accessibility, style and tone of the response letter
4. The learning and actions identified as a result

2. PREPARATION

2.1 In accordance with standard procedure, three cases for each quarter were chosen at random for review.

2.2 The documentation was properly prepared and easy to follow. .

2.3 It should be noted that two of the Investigators' reports were difficult to follow mainly because they did not follow the required format i.e. clarity of view and decision. As such, full assurance cannot be given on these reports.

3. SUMMARY OF FINDINGS

3.1 Case 1

3.1.1 Summary of complaint.

This complaint was made by a mother whose daughter had assaulted her badly. The daughter was assessed by our team after being brought in by the police. She was found to be anxious and upset but did not fit the criteria for admission. The act of aggression was not caused by mental health issues. The daughter, whose parents are divorced, was collected by her father. This gave rise to numerous questions from the mother:

- given her aggression and mental state why was she not admitted and why was the assessment negative
- information sharing concerns in that the father was given details but not the mother
- why was she released given the possible aggression risk towards mother
- why there was not a treatment plan
- various communication related issues.

3.1.2 Audit findings

The various elements of the complaint were investigated in detail. The investigation concluded that the assessment process was carried out properly and that confidentiality had been correctly protected. The daughter had requested information be given to the father. The investigator did however raise one issue in that non-consent regarding information sharing can be overridden where there is a risk to another individual e.g. the mother.

The Chief Executive Officer's response letter was very sympathetic and sensitive in terms of the complainant's experience whilst making the strong points that this was not a mental health issue. The daughter had refused help on various occasions which had been offered. Apologies were made in that the mother should have been informed that the daughter was not being admitted and that her father was collecting her.

Organisational learning was in the form of feedback to the team regarding maintaining confidentiality but taking a common sense approach particularly where family were concerned or at risk.

3.1.3 Conclusion of auditor

I would offer full assurance on three of the standards that require to be met. In respect of learning, I feel that this should be learned through the organisation, not just the team therefore significant assurance on this aspect.

3.2 Case 2

3.2.1 Summary of complaint

This is a complaint from a mother who accompanied her daughter to a CYPS appointment. She felt that she and her daughter had been dealt with unprofessionally by staff. Issues cited were inappropriate comments, lack of

confidentiality, unhelpful, distressing for both mother and daughter, staff were opinionated and protocol was not adhered to.

3.2.2 Audit findings

The complaints were fully investigated including interviews with the complainant and staff involved. The investigator challenged staff on the comments made who agreed that although they were trying to 'lighten' the situation, comments made may have distressed the patient. The language and overall communications were not up to standard. The investigators report did not follow the standard template and therefore it was difficult to understand the recommendations.

The CEO's response letter was far more comprehensive both in tone and in the apology for getting this wrong. He also clarified the learning process that was being instigated in this case.

Organisational learning was clearly outlined although this was perhaps more staff learning in this case.

3.2.3 Conclusion of Auditor

I offer full assurance in terms of the four standards with the caveat that investigators should follow the report template in clearly laying out their views on each of the issues.

3.3 Case 3

3.3.1 Summary of complaint

This complaint was concerned with an adult's assessment with the Autism Diagnostic Team. The complainant was not impressed with the assessment and felt that she could not contest the diagnosis. In addition she felt like she was treated like a naughty child. In terms of confidentiality she felt that information not given to her was shared with a friend who accompanied her. Also the letter from the team gave no detailed explanation of the diagnosis and asked her to read particular books on the subject which given her dyslexia was not appropriate.

3.3.2 Audit findings

The investigation was thorough and covered all of the complainants points adequately although there was no recommendation whether these various complaints were upheld or not. All staff and the complainant were interviewed and the investigator explained the issue on information to the friend as trying to look in depth at the complainant's history. In terms of the diagnosis the outcome was that this was correct given all of the information. The only issue was related to the books, as the complainant had mentioned in interview that she read a lot.

The CEO's response letter was sensitive and addressed all the key points. An appropriate apology was given with regard to the complainant receiving the recommendation to read books.

Organisational learning from the complaint is unclear within the report both in terms of what it identifies (if any) and who was accountable.

3.3.3 Auditor conclusion

I can offer full assurance in respect of the timeliness and response letter standards and significant assurance on the other two standards.

3.4 Case 4

3.4.1 Summary of complaint

This involved a complaint from a mother with regard to how her daughter was treated by the Lets Talk Team. The complaint revolves around how various small incidents conspired to become a larger situation compounding an already distressed young woman. The key areas of complaint surrounded appointments with the Lets Talk Team and included the therapist being unusually late for the appointment, a previous appointment where self help information was promised but did not arrive, and the way in which the interview was handled. This was further compounded when the mother called in to cancel the next appointment on the basis of wanting a new therapist. This was not communicated to the therapist who, when the patient failed to turn up, discharged her from the service.

3.4.2 Audit findings

The various elements of the complaint were investigated fully. The result of this was the exposure of small issues in handling and communication which together resulted in a poor and distressing experience for the patient and her mother. Examples of this include the therapist not being told that the patient was in the waiting area; an administrative glitch which records showed that the self help information had been sent but was not; and lack of recording/communication that the appointment had been cancelled, leading to the patient being unwittingly discharged. The investigator upheld all aspects of the complaint.

The CEO's response letter followed the reasoning in the investigators report and was sensitive in its response and apologetic for the mistakes made whilst trying to give more information as to why this all happened. The letter also hoped that this would not put the patient off remaining with 2gether for her ongoing treatment.

Organisational and team learning including individual training was brought out as a key part of the investigators report and within the CEO's response letter.

3.4.3 Auditor conclusion

I offer full assurance on all aspects of the handling of this complaint. I would commend this investigation as a way in which to handle and record future investigations.

3.5 Case 5

3.5.1 Summary of complaint

This complaint concerned a lady who was trying to contact and discuss her issues with the Crisis Resolution Team. Her complaint was made through a third party volunteer organisation and she did not want to be contacted by the

investigator. The lady herself at this time was in an extremely depressed and distressed state. The basis of her complaint was that she was very badly treated in trying to reach out to the Crisis Team. The basis of this was the poor response to her initial call which had been a difficult one. She was promised a call back which did not happen. She wished to understand why she was treated this way when she was in such a vulnerable position. In conclusion she wanted to understand how staff were trained and reviewed and asked for a full apology.

3.5.2 Audit findings

A full investigation including interviews with all staff involved (but not the complainant) was undertaken and was fairly comprehensive. It found that the staff receiving the initial call were using a mobile phone in a poor signal area and was a difficult call. The recording of the call however showed that staff had acted appropriately and dealt with the situation as best they could. In the call back that was promised staff tried to contact the complainant when they returned to the office but received no answer. This was not then followed up on later. The investigator found that the complaint of bad response was not upheld but that lack of contacting the complainant subsequently, was upheld. The investigator also partially upheld the complaint regarding the initial call as the phone could have been handed to a colleague who was beside the member of staff at the time.

The CEO's response letter to the complainant via the voluntary organisation outline this in a detailed explanation and appropriate apologies for what occurred are given in the letter. The tone of the letter is appropriately sensitive to the way in which the complainant was feeling at the time of the incident.

Full learning is detailed both in the investigators report and in the CEO's response letter. This included organisational learning, team learning and the individual members of staff involved.

3.5.3 Auditor conclusion

I give full assurance on all aspects of this investigation.

3.6 <u>Case 6</u>

3.6.1 Summary of complaint

This complaint surrounded the issue of a diagnosis letter in connection with the GRIP Team. In the complainant's letter there was a substantial list of complaints which when brought together could be summed up under three main headings: unprofessional conduct, inaccurate diagnosis report, and confidentiality. The confidential aspect involved the accusation that someone the complainant knew, and who worked for 2gether, had unduly influenced the report by discussing his personal circumstances.

3.6.2 Audit findings

The investigators report was comprehensive and involved interviews both with staff concerned and the complainant. In terms of the confidentiality issue the

investigator established that the member of staff who knew the complainant and the staff member carrying out the diagnosis were not known to each other. The investigator did not uphold any of the complaints in this case.

The CEO's response letter was sensitive in the way this information was imparted back to the complainant and although I doubt it was well received was appropriate in the situation.

There was no learning from this case.

3.6.3 Auditor conclusion

I give full assurance on all the standard aspects in this case.

4. SUMMARY

4.1 There is a definite improvement in the way investigations and reports are being carried out. As with the last NED report I see a great improvement in learning from these complaints being taken seriously and in the way in which we respond to complainants in the CEO's response letter.

4.2 My only slight caveat is that in a couple of the cases outlined there was still lack of clarity in the learning actions and lack of clear decisions in regard to whether complaints were upheld or not. We should encourage investigators to follow the report template if possible.