

ANNUAL COMPLAINTS REPORT 2020/21

1. Introduction

The National Health Service Complaints (England) Regulations 2009 requires all NHS organisations to have in place a policy and procedure for the management of complaints that are received about the services they provide or commission. The Regulations state that the NHS organisations should prepare an Annual Complaints report which specifies:

- The number of complaints received;
- The number of complaints which the organisation decided was well-founded;
- The numbers of complaints which the organisation has been informed have been referred to the Health Service Commissioner (Parliamentary & Health Service Ombudsman [PHSO]);
- A summary of the subject matter of the complaints received;
- Any matters of general importance arising out of those complaints, or the way in which the complaints were handled; and
- Any matters where action has been, or is being, taken to improve services as a consequence of those complaints.

This report sets out the information gained from the formal complaints received by NHS Derby and Derbyshire Clinical Commissioning Group (CCG) for the period 1st April 2020 to 31st March 2021.

2. Breakdown of all Complaints Received

On 29th March 2020, NHS England issued guidance to all NHS organisations promoting the suspension of the complaints process for 3 months, to enable resources to be diverted to assist with the emerging COVID-19 pandemic. The CCG adopted the suspension, in line with our escalation to Level 4 of our Business Continuity plan. All new complaints received from 1st April 2020 were acknowledged and assessed for patient safety or safeguarding issues, before being placed on hold until 1st July 2020, when the complaints process resumed.

During the year 2020/21, the CCG received a total of 97 formal complaints from its resident population, of which 33 related to the CCG's statutory functions. This is a 24% reduction on the total number of complaints received by the CCG in 2019/20 (127).

Breakdown of all Complaints Received 2020-21	Total	%
CCG Complaints	33	34%
Commissioned services	45	46%
Other NHS Organisations (e.g Primary Care or NHS England)	19	20%
Total	97	

Where a complaint related to a commissioned service or other NHS provider, the CCG ensured that the complaint was re-directed to the appropriate organisation, with the patients consent. The suspension of the complaints process did not impede the provider complaints being passed onto the appropriate organisation to take forward. Trends, themes, and outcomes from these types of complaints are reported via in-year quarterly Patient Experience reports, to aid quality and contract monitoring processes.

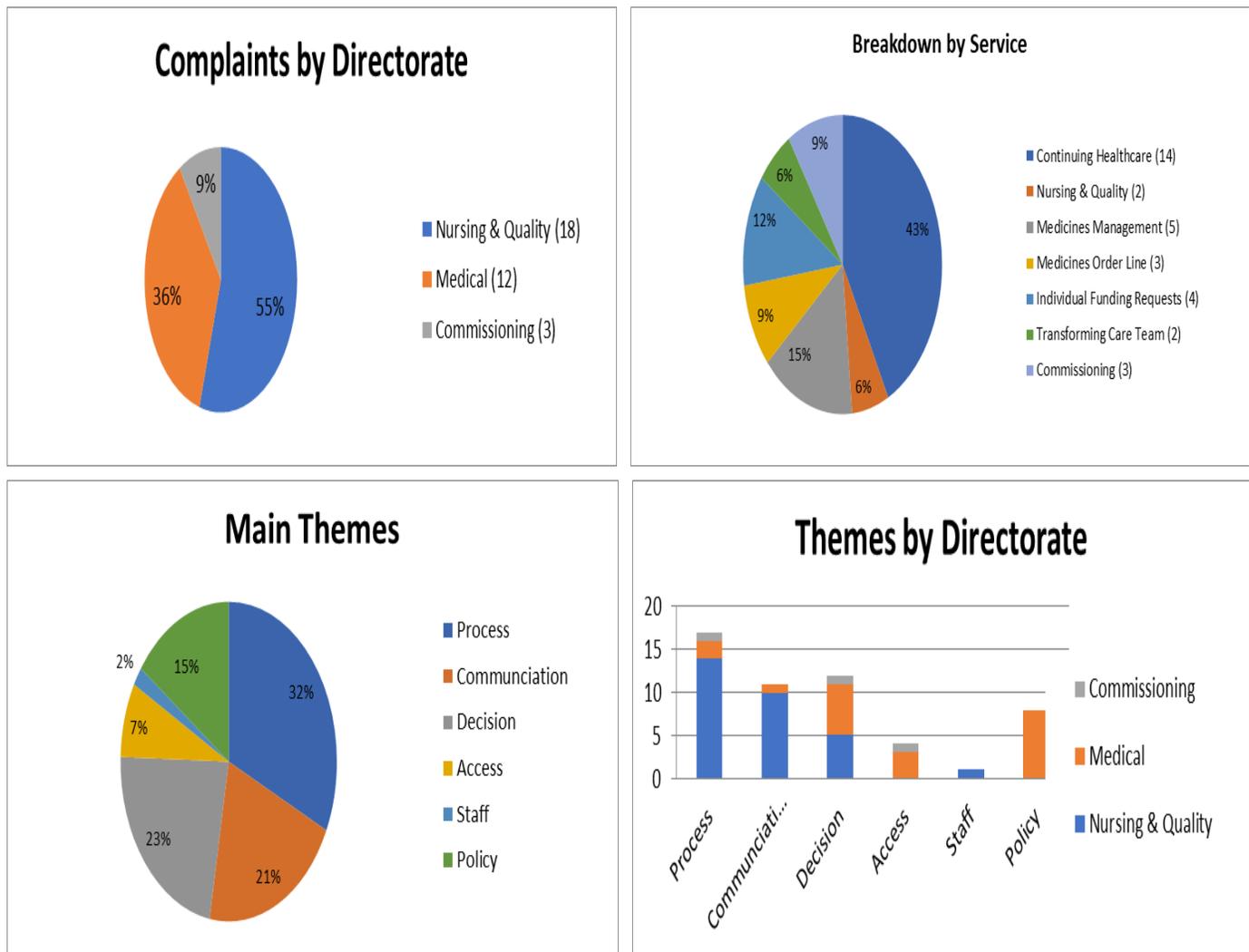
3. CCG Complaints

CCG Complaints Data	Total	%
CCG Complaints	33	
Complaints acknowledged within 3 working days	33	100%
Complaints resolved within initial agreed timescale (usually 35 working days)	26	79%
Complaints resolved within agreed extension period* (+ 35 working days)	7	21%
Complaints fully or partially upheld	17	51%
Complaints not upheld	16	49%
Complaints referred to the PHSO	1	

*Due to the complex nature of some cases, the average time taken to investigate and resolve this type of complaint exceeded the CCG's target of 35 working days. However, the extended timescales were all with the agreement of the complainant; these ranged from 40 to 74 working days, all within the 6-month timeframe stipulated in the NHS complaints regulations.

4. CCG Complaints Breakdown and Analysis

The charts below show a breakdown of the complaints received by Directorate, Service and Theme:



The majority of complaints relate to services which fall under the Nursing and Quality and the Medical directorates. Activities of the Continuing Healthcare (CHC) Service account for 42% of the total complaints received. Complaints attributed to Medicines Management, Medicines Order Line and the Individual Funding Request process collectively account for 33% of all complaints received.

Complaints relating to Process and Decisions feature across all directorates.

Process: 76% of process related complaints were about the CHC assessment and review processes. The remainder related to the processes of the MOL, IFR team and Transforming Care Team (TCT).

Decisions: 41% of the complaints about decisions relate to the IFR process, whereby the decision to decline a funding request was called into question. Decisions taken by the CHC service, Medicines Management team, Nursing and Quality Team, TCT and Commissioning, collectively account for 59% of the other decision related complaints.

Communication: 73% of complaints regarding communication relate to the CHC service. Lack of communication with next of kin regarding review and assessments meeting arrangements, delays in receiving outcomes letters, poor communication around the Personal Health Budget (PHB) application process, inaccurate letters and incorrect updates were the main issues raised.

Policy: 63% of the policy related complaints were associated to our Clinical and Prescribing Policies. Body Mass Index (BMI) criteria for Breast Reduction Surgery, the number of IVF cycles offered, policy on Inter Uterine Insemination (IUI) as a fertility treatment option and policies for the prescribing of Liothyronine (T3) thyroid hormone treatment and BD Auto-shield safety needles were all called into question.

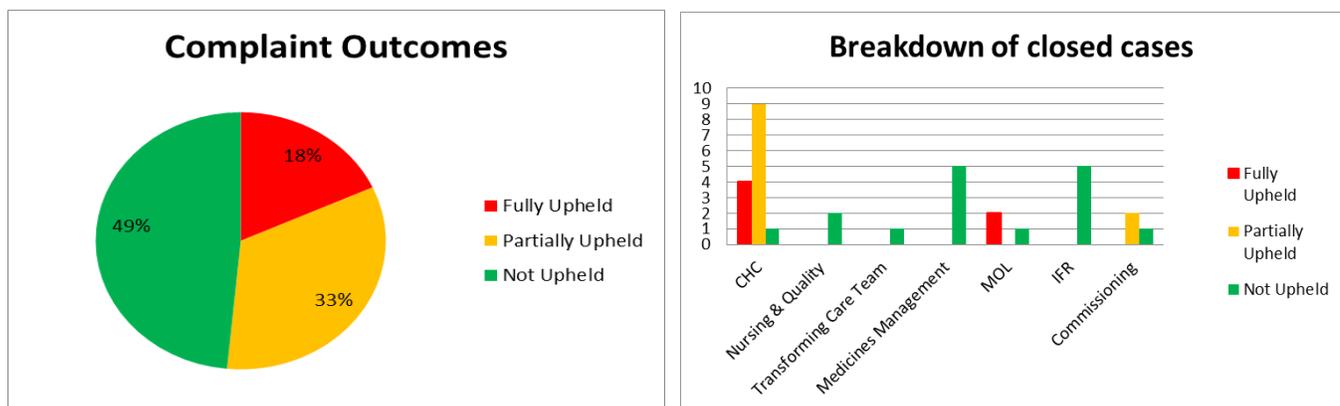
Access: 75% of access related complaint were about timely access to the MOL. Access to Adult ADHD assessments from private providers was also subject of complaint.

5. Ombudsman Referrals

There was one referral made to the Ombudsman in quarter 4. This related to a CHC complaint received in November 2019, about delays experienced with a care placement due to a disagreement with the Local Authority over the level of funding towards a joint package of care. The case is currently under investigation by the Local Government Ombudsman.

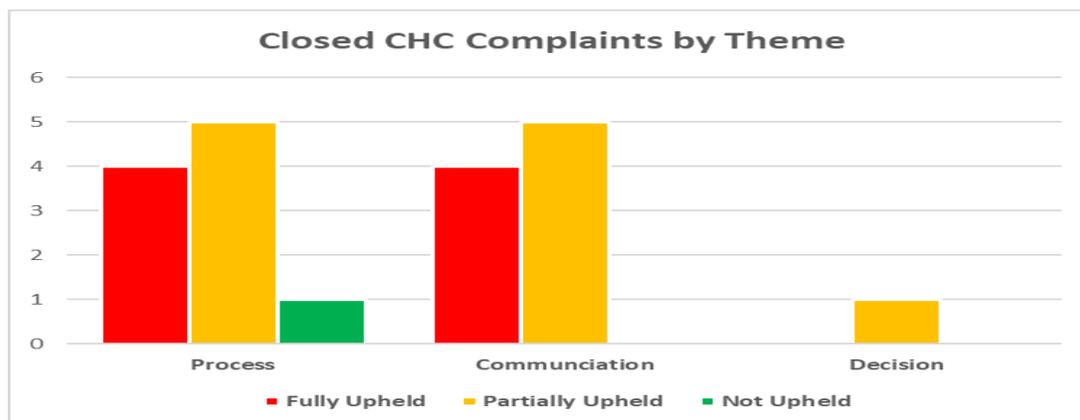
6. Outcomes and Learning

The following graphs show the proportion of complaints that were well founded and a breakdown by service area.



Of note is that 13 out of the 14 complaints received about the CHC service were either fully or partially upheld. Two out of three complaints about access to the MOL were fully upheld.

The following graph shows a breakdown of the CHC closed complaint cases by theme.



Process and communication are the two main areas of CHC complaints fully for partially upheld. These complaints identified issues with CHC assessments and reviews not being processed in line with the National CHC Framework requirements, issues with the setting up of Personal Health Budgets (PHB's) and internal processes not being correctly followed. The issues relating to communications were predominantly around outcome letters, whether they be inaccurate, not sent in a timely manner or not sent at all. These are all recurring themes seen in previous reporting periods, requiring ongoing improvements by the CHC service.

The following learning and changes have been identified from the complaints received:

Learning and Action Taken

CHC Service

Process:

Proof of Lasting Power of Attorney to be requested when undertaking a review or full CHC assessment and documented in the CHC records.

CHC service to review the process for communicating the outcome from the interagency dispute process with patients and their representatives

CHC service to request information about care agency from PHB holder, not directly without PHB holder's permission

CHC Quality Assurance (QA) process /ratification paperwork to be updated to ensure Multi-Disciplinary Team reconsider additional evidence before a case is sent to the CCG for a final decision

A review of eligibility outcome letters process to be undertaken and consideration given to the routine inclusion of the completed Decision Support Tool (DST) for not eligible outcomes

All CHC staff to be reminded of the Subject Access Request (SAR) process

CHC clinical staff to be reminded that all available evidence should be sought when QA process identifies a lack of evidence

The retrospective review administration team to ensure that all appropriate documents are received when a case is transferred over from another department

CHC administration staff will ensure that all patient records are correctly stored and appropriately logged

CHC nurses to receive additional training on how to correctly reference evidence on the Care Needs Portrayal documents, thus reducing the risk of confusion regarding the records considered

The Scheduling Team to be reminded to offer a copy of the CHC Public Information leaflets to Next of Kin/representatives when arranging a DST meeting.

All CHC Assessors to be reminded to add their signature to the DST when completing a non-quorate eligibility recommendation.

The CHC QA clinicians to be reminded to check that all completed DSTs contain the appropriate signatures.

Communication:

Local Authority to be asked not to communicate the outcome from an interagency dispute. CHC service to confirm once the outcome has been ratified by the CCG.

CHC staff to be reminded to ensure that eligibility outcome letters include full explanation for the decision

Regular updates to be provided to ensure NOK or their representatives are kept up to date on progress at each stage of the retrospective review process

All staff to be reminded to ensure that review outcome letters are sent to the patient and their representative.

CHC staff to be reminded to send a negative Checklist letter before closing a case file.

CHC staff to check that the correct letters are being sent to individuals regarding reviews, assessments and funding decisions.

Staff to ensure that letters are acknowledged and actioned in a timely manner.

Staff to improve approach to managing patient expectations on the CCG approval process timescales.

Staff:

CHC Nurse Assessor to change approach when handling Safeguarding review meetings in future.

Medicines Management

Communication:

Joint Area Prescribing Committee (JAPC) to reinforce the need for changes to local prescribing guidelines to be disseminated to all departments within provider organisations.

GP practices to be informed to contact CCG Cosmetic Assessment Service with queries rather than signposting patients to the team.

Access:

Work to be undertaken with GP practices, patient groups and local pharmacies to promote alternative methods for ordering prescriptions, which should reduce call numbers and enable the MOL call handlers to focus on the patients who need to use the service or cannot order by other means.

Commissioning

Process:

Discharge teams at Kingsmill Hospital to be reminded that prior approval for Non-Emergency Patient Transport is not required for Derbyshire patients

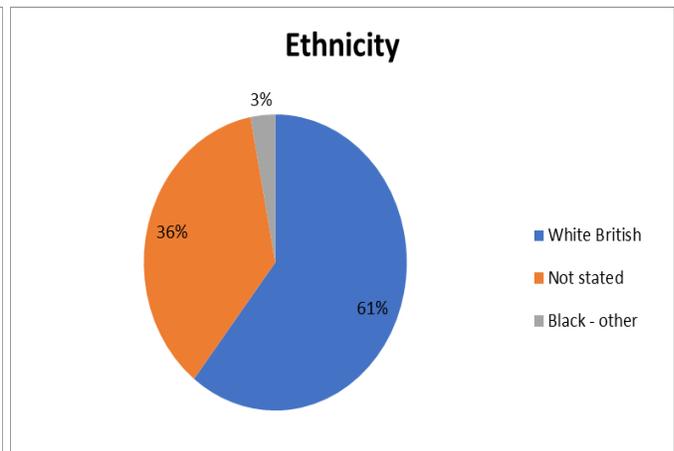
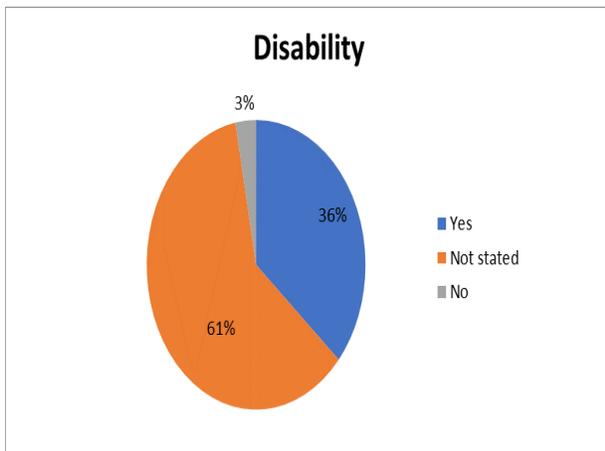
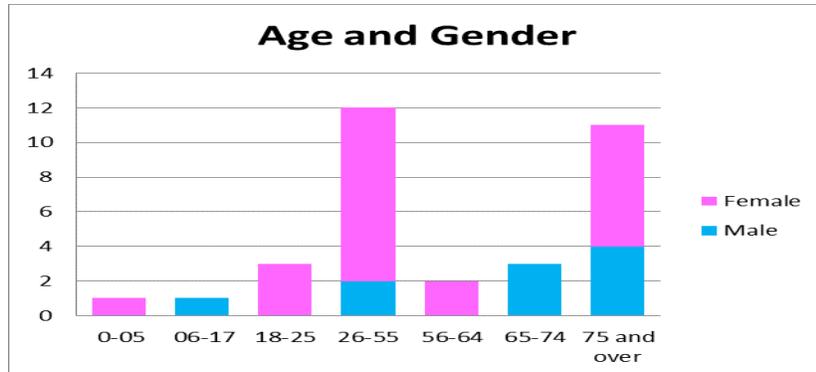
CCG Contract Manager to continue monitoring issues around the transfer of patient records from previous providers of the Orthotics Service.

Access:

Clarity to be provided to GP Practices regarding the referral process for Adult ADHD assessments from other providers who hold a NHS contract.

7. Equality and Diversity data

The following patient demographic information has been gained from the CCG complaints received. This information relates to the person affected rather than the complainant, as the complaint may have been made by a representative.



8. Reporting

The Annual Complaints Report for ratification by the Governance Committee.

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