Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Annual Complaints Report

April 2018 to March 2019

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1. Introduction and executive Summary

This report contains the annual complaint information for Berkshire Healthcare NHS Foundation Trust (referred to in this document as The Trust), as mandated in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The Trust formally reports patient experience through our Quality Executive and Trust Board on a quarterly basis, alongside other measures including compliments, the Friends and Family Test, PALS and our internal patient survey programme.

This report looks at the application of the Complaints Process within the Trust from 1st April 2018 to 31st March 2019 and uses data captured from the Datix incident reporting system.

Factors (and best practice) which affect the numbers of formal complaints that Trusts receive include:

- Ensuring processes are in place to resolve potential and verbal complaints before they escalate to formal complaints. These include developing systems and training to support staff with local resolution;

- An awareness of other services such as the Patient Advice and Liaison Service (PALS – internal to the Trust) and external services including Healthwatch and advocacy organisations which ensure that the NHS listens to patients and those who care for them, offering both signposting and support;

- Highlighting the complaints process as well as alternative feedback mechanisms in a variety of ways including leaflets, poster adverts and through direct discussions with patients, such as PALS clinics in clinical sites.

When people contact the service, the complaints office will discuss the options for complaint management. This gives them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally.

During 2018/19 there were a total of 230 formal complaints received which is an increase on the 209 received in 2017/18. The number of formal complaints closed was 240, of these 62% were either fully or partially upheld and 23% were not upheld. The remaining 15% were not progressed, locally resolved or investigated via a differing process. Against the approximate one million contacts the 230 complaints received equate to a 0.02% contacts resulting in a formal complaint.

For the third consecutive year 100% of complaints being responded to within the agreed timescale was maintained throughout 2018/19.

The number of local resolution complaints that the Patient Experience team have been notified about has reduced to 126 in 2018/19, from 205 received in 2017/18. Information on local resolution complaints is captured in real time on a dashboard that is accessible to the Locality and Clinical Directors. There have been 20 informal complaints logged, which is the same as last year.

The five services with the highest number of formal complaints received were:

- Community mental teams (adult and older adult), with 48 complaints against 99,587 contacts (0.05% contacts)

- Acute adult admission wards (Rose, Snowdrop, Daisy and Bluebell) received 32 complaints against 850 admissions (3.8% admissions)

- CAMHS - Child and Adolescent Mental Health Services with 25 received this is against 7438 referrals received and approximately 32,000 contacts (0.08% contacts/ 0.3% referrals)

- Out of Hours GP Services providing care in the West of Berkshire, with 17 complaints this is against 70,921 contacts (0.024% contacts resulting in formal complaint)

- Community Hospital inpatient ward received a total of 17 complaints against 1804 admissions (0.9% admissions)

There were no formal complaints for Rowan Ward, Ascot Ward, Willow House and Sorrel ward.

The main category of reason for complaints received during 2018/19 was care and treatment with 51.74%, followed by communication and attitude of staff both with 14.78%. This is a small reduction in care and treatment as well as staff attitude complaints compared to 2017/18 where the care and treatment was 57.89% and attitude of staff was 16.75%. There has been a slight increase in complaints associated with communication at 14.78% this year compared with 11.48% in 2017/18.

A total of 16 (7%) formal complaints received across our services were in relation to an aspect of end of life care.

There are no particularly specific themes that are able to be extracted from the complaints received within each of these categories; many complaints are very specific to individual circumstance and concern. Although for CAMHS a number of the complaints are in relation to wait time, referrals and follow-up in part but not exclusively in relation to ADHD and ASD pathways. Further detail with regard to the services with higher numbers of complaints is detailed within the report.

Nationally, complaint statistics are reported on a quarterly and annual basis, with 2018/19 annual reported data not available until September 2019. Nationally formal complaints relating to care and treatment accounted for 26.2% of the complaints received in 2017/18 whilst within Berkshire Healthcare the percentage was 51.74%. Data available on Model hospital for 2017/18 demonstrated that the Trust was below the national and peer median in terms of complaints received when compared to number of complaints per 1000wte staff and per 100M turnover.

2. Complaints received – activity

2.1 Overview

During 2018/19 a total of 230 formal complaints were received into the organisation**.** Table 1 evidences the number of formal complaints by service and compares them to the previous financial year.

The information in this report excludes complaints which are led by an alternative organisation, unless specified.

Table 1: Formal complaints received

	2018/19							2017/18					
Service	Q1	Q2	Q3	Q4	**Total**	% of Total	Change	Q1	Q2	Q3	Q4	Total	% of Total
CMHT/Care Pathways	16	11	10	9	**46**	20	↑	11	11	12	10	44	22.08
CAMHS - Child and Adolescent Mental Health Services	5	6	8	6	**25**	10.87	↓	7	9	6	4	26	14.29
Crisis Resolution & Home Treatment Team (CRHTT)	2	5	3	4	**14**	6.09	↓	4	6	4	6	20	9.09
Acute Inpatient Admissions – Prospect Park Hospital	9	12	8	3	**32**	13.91	↑	4	9	4	6	23	11.04
Community Nursing	1	1	3	3	**8**	3.48	↓	4	4	1	3	12	5.84
Community Hospital Inpatient	6	7	1	3	**17**	7.39	↑	3	1	1	6	11	3.25
Common Point of Entry	3	3	2	4	**12**	5.22	↑	2	0	1	2	5	1.95
Out of Hours GP Services	4	5	7	1	**17**	6.96	↑	2	2	3	2	9	4.55
PICU - Psychiatric Intensive Care Unit	0	0	0	0	**0**	0	No change	0	0	0	0	0	0
Minor Injuries Unit (MIU)	1	1	2	0	**4**	1.74	↓	0	2	1	2	5	1.95
Older Adults Community Mental Health Team	1	1	0	1	**3**	1.3	↓	0	1	1	3	5	2.39
13 other services in Q4	12	11	13	16	**52**	22.6		5	14	19	11	49	23.44
Grand Total	60	63	57	50	**230**			42	59	53	55	209	

The table above demonstrates that the number of formal complaints for Crisis Resolution/Home Treatment Team (CRHTT) and Community Nursing have decreased compared with the previous year. Acute Inpatient Admissions (Prospect Park Hospital), Community Hospital Inpatients, Out of Hours GP Services and the Common Point of Entry experienced increases in the number of formal complaints received. Whilst Community Mental Health Teams, CAMHS, Minor Injury Unit and the total number received by other services across the organisation have remained comparable with 2017/18

Table 2 below details the main themes of complaints and the percentage breakdown of these.

Table 2: Themes of Complaints received

Category of Complaint received	Number of complaints	Percentage of total complaints
Abuse, Bullying, Physical, Sexual, Verbal	4	1.74%
Access to Services	11	4.78%
Attitude of Staff	34	14.78%
Care and Treatment	119	51.74%
Communication	34	14.78%
Confidentiality	7	3.04%
Discharge Arrangements	2	0.87%
Discrimination, Cultural Issues	1	0.43%
Financial Issues/Policy	1	0.43%
Management and Administration	1	0.43%
Medical Records	4	1.74%
Medication	5	2.17%
Other	1	0.43%
Patients Property and Valuables	2	0.87%
Support needs	2	0.87%
Waiting Times for Treatment	2	0.87%

The main theme of complaints received during 2018/19 was care and treatment with 51.74%, followed by communication and attitude of staff both with 14.78%. This is a small reduction in care and treatment as well as staff attitude complaints compared to 2017-18 where the care and treatment was 57.89% and attitude of staff was 16.75%. There has been a slight increase in complaints associated with communication at 14.78% this year compared with 11.48% in 2017/18.

There have been no specific themes identified with regard to complaints received although it is worthy of note that both the complaints about wait time and 3 of the 11 complaints relating to access to services were in relation to CAMHS services although only 2 of the total 34 complaints related specifically to communication was about our CAMHS services; this would appear to demonstrate that work undertaken around support to 'waiters' and the communication to these services users and their carers is effective although a number of the complaints that are received across all categories are in relation to waiting times, referral and follow-up.

The complaints raised in relation to attitude of staff are spread across a range of services those services with 3 or more were mental health Inpatients, CMHT, CRHTT and sexual health services although none were specific to 1 ward/ location. CRHT West received the most (4). There is on-going work with CRHTT staff around communication/ telephone handling to support improvement.

The complaints in relation to communication again cover a broad range of services, Common point of Entry (6), CMHT (7) and Westcall (4) received the highest numbers although there were no specific themes.

Complaints received in relation to care and treatment are wide ranging and focus very much on individual circumstances and therefore it has not been possible to pick up particular themes or areas for specific action by services in relation to these.

The Trust Business Group structure (also known as reporting locality) has previously been used as the main mechanism for reporting complaint information; however, as this may differ from the geographical locality of where the service is based, it brings more value to report the latter. The following tables show a breakdown for 2018/19 of the formal complaints that have been received and where the service is based.

2.2 Mental Health service complaints

Table 3 below details the mental health service complaints received, this shows that the main services where formal complaints are attributed to are CMHT and Adult acute Admissions wards. 43.47% of the complaints were about care and treatment (an increase from 29.54% of complaints in 2017/18). Complaints about adult mental health services accounted for 55% total complaints received in 2018/19.

Table 3: Mental Health Service complaints

Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot & Maidenhead	Wokingham	Grand Total
Adult Acute Admissions		32					32
CMHT/Care Pathways	6	12	6	6	6	10	46
CMHTOA/COAMHS - Older Adults Community Mental Health Team						3	3
Common Point of Entry	2	3	1	1		5	12
Criminal Justice Liaison and Diversion Service	1						1
Crisis Resolution & Home Treatment Team (CRHTT)	1	8	1	1	1	2	14
IMPACTT		1				1	2
LDS Community Patients		1					1
Learning Disability Service Inpatients		1					1
Neuropsychology		2					2
Older Peoples Mental Health (Ward Based)		3					3
Psychological Medicine Service		1	3				4
Talking Therapies			1	1		1	3
Traumatic Stress Service		2					2
Grand Total	10	63	12	9	8	22	127

2.2.1 Mental Health Complaints by service

The top 3 adult mental health services receiving formal complaints in 2018/19 are detailed further below. Older adult services are also detailed separately as they have been in previous years.

Community Mental Health teams (CMHT)

As detailed in table 4, Within CMHT services most complaints were received by Reading (27%) and Wokingham (22%) teams. For Reading this is a reduction on last year whilst for Wokingham this is an increase although review of the complaints does not show any high level themes amongst these. To

provide some context the total working age and older adult's contacts during 2018/19 were 99,587 and around 4,951 patients were discharged. The percentage of complaints against contacts was therefore 0.05% and against number of discharges was 0.97%.

Table 4: CMHT complaints

	Locality of Service						
	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Care and Treatment	1	5	3	4	3	4	20
Clinical Care Received	3			2		1	6
Communication		2			1	3	6
Confidentiality		1	2		1		4
Attitude of Staff						2	2
Healthcare Professional		1					1
Medication		1					1
Inaccurate Records	1						1
Abuse, Bullying, Physical, Sexual, Verbal			1				1
Written to Patients	1						1
Other		1					1
Financial Issues/Policy					1		1
Failure/Delay in specialist Referral		1					1
Grand Total	6	12	6	6	6	10	46

Adult mental health inpatients

As detailed in table 5, 53% of complaints received by the acute adult admission wards were about clinical care/ care and treatment; these were individual to specific patient circumstances.
There were no complaints received in relation to Sorrel ward in 2018/19.

Table 5: Adult mental health inpatient ward complaints

	Location of complaint					
Main subject of complaint	**Bluebell Ward**	**Daisy Ward**	**Non ward specific**	**Rose Ward**	**Snowdrop Ward**	**Grand Total**
Care and Treatment	3	4	5	1		13
Attitude of Staff		2	1		2	5
Clinical Care Received	2		1		1	4
Communication	1		1			2
Support needs	2					2
Abuse, Bullying, Physical, Sexual, Verbal				1		1
Discharge Planning		1				1
Lost Property				1		1
Patients Property and Valuables				1		1
Verbal to Patients				1	1	2
Grand Total	8	7	8	5	4	32

CRHTT

Table 6 below demonstrates that there were 14 complaints received about CRHTT in 2018/19; this is a reduction on the 20 received in 2017/18. As with 2017/18 a higher percentage were in relation to services received in the West of the county (71%) and predominantly Reading where the main hub for the west is located. The complaints for Reading were all related in some way to advice / care and treatment. Actions are in train within CRHTT regarding support for staff with telephone communication and holding difficult conversations. There were 22,910 contacts into CRHTT in 2018/19 so the 14 complaints relate to 0.06% of all contacts resulting in a formal complaint.

Table: 6 CRHTT complaints

	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services		1					1
Attitude of Staff	1	2	1	1			5
Care and Treatment		5			1		6
Discrimination, Cultural Issues						1	1
Medical Records						1	1
Grand Total	1	8	1	1	1	2	14

Older adult services

As detailed in table 7, formal complaints about the Older Adults Community Mental Health Team were 3 in number and all related to the Wokingham based service. There were 255 discharges for the Wokingham team last year, making a complaint rate of 1.17%.

Table 7: Older Adults Community Mental Health Team complaints

	w okingham	Grand total
Attitude of staff	1	1
Communication	2	2
Grand Total		3

The complaints for the older adult mental health inpatient wards were around physical health monitoring and documentation (handover from other Trusts and information sharing with the ward).

Table 8: Older Adults mental health inpatient wards complaints

	Location of complaint	
	Orchid Ward	Grand Total
Care and Treatment	1	1
Clinical Care Received	2	2
Grand Total	3	3

2.3 Community Health Service Complaints

29% of all complaints received into the organisation in 2018/19 were about community health services.

Table 9 below details the community health service complaints received, this shows that the main services where formal complaints are attributed to are Community Inpatient services (17), Westcall out of hours services (17) and District Nursing (10 including 2 out of hours nursing). 59% of the total complaints were about care and treatment. There were no particular themes with complaints raised around specifics of care delivery and patient's individual circumstances although 11 of the 16 end of life complaints were in relation to community health services.

Table 9: Community Health Service Complaints

	Locality of Service						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Assessment and Rehabilitation Centre			1				1
Community Dental Services					1		1
Community Hospital Inpatient		6	1	9	1		17
Continence						1	1
District Nursing	1	3		2	1	1	8
District Nursing Out of Hours Service		1			1		2
Integrated Pain and Spinal Service		1		1			2
Minor Injuries Unit				4			4
Multiple Sclerosis			1		1		2
Out of Hours GP Services		12		5			17
Outpatients	1						1
Parkinson's - Specialist Nursing					1		1
Physiotherapy - Rehabilitation			1				1
Physiotherapy (Adult)	1			2			3
Physiotherapy Musculoskeletal	1						1
School Nursing					1		1
Sexual Health			4				4
Grand Total	4	23	8	23	7	2	67

2.3.1 Community Health Complaints by service

The top 3 community services receiving formal complaints in 2018/19 are detailed further below.

Community Nursing

As detailed in table 10, eight of the ten complaints were regarding care and treatment, review of these has not identified any themes within these.

Table 10: Community Nursing Service complaints

	Locality of Service					
Service and main subject of complaint	**Bracknell**	**Reading**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
District Nursing	**1**	**3**	**2**	**1**	**1**	**8**
Care and Treatment		3	2	1	1	7
Attitude of Staff	1					1
District Nursing Out of Hours Service		**1**		**1**		**2**
Care and Treatment				1		1
Attitude of Staff		1				1
Grand Total	1	4	2	2	1	10

There were no complaints received directly to the Trust about the Community Nursing Service in Slough (one complaint was received via the CCG who led the complaint).

A co-created and facilitated group with the aim of 'getting to know your local Community Nursing Service', primarily for carers in the East of Berkshire was established last year, this provided patient education sessions and although attendees were small in number positive feedback was received and catheter clinics were introduced on the back of feedback. This group is currently being re-evaluated.

Community Health Inpatient Wards

Table 11: Community Health Inpatient Ward Complaints

	Location of complaint						
Main subject of complaint	**Donnington Ward**	**Henry Tudor Ward**	**Highclere Ward**	**Oakwood Unit**	**Jubilee Ward**	**Windsor Ward**	**Grand Total**
Care and Treatment	6	1	1	4		1	13
Attitude of Staff			1		1		2
Medication				1			1
Communication	1						1
Grand Total	7	1	2	5	1	1	17

The Community Inpatient wards saw an increase in the number of complaints received in comparison with 2017/18, from 11 to 17, this was against 1804 admissions (0.9% admissions resulting in a complaint) . Care and treatment continues as the main subject for complaints received about Community Inpatient wards. West Berkshire Hospital wards (Donnington and Highclere) account for 41% of these. 4 of the complaints for Donnington and Highclere wards relate to end of life although the detail of these is different in each case.
For a number of the community ward complaints related to communication between differing services and organisations.

Ascot Ward did not receive any formal complaints during 2018/19.

Westcall Out of Hours GP Service

As detailed in table 11 Westcall received 17 complaints during 2018/19 this was against 70,921 contacts which were made during the year this accounts for 0.02% contacts. The complaints for the out of hours GP service were found to be about the attitude and communication from Doctors, particularly if there has been a difference in opinion between the patient/carer and clinician, and where further care was given by another healthcare provider. There were also complaints about the time of night that patients were given a call back by a Doctor, in that it was too late and the patient had gone to bed.

Table 12: Westcall Out of Hours GP Service complaints

	Reading	West Berks	Grand Total
Out of Hours GP Services	12	5	17
Access to Services		1	1
Attitude of Staff	2		2
Care and Treatment	3	4	7
Communication	5		5
Medication	2		2
Grand Total	12	5	17

2.4 Children, Young People and Families

Table 13 below details the children, young people and families' complaints received, with 13.5% of all complaints received attributable to these services. The main services where formal complaints are attributed to are our CAMHS services.

Table 13: Children, Young People and Family Service Complaints

	Locality of Service						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot & Maidenhead**	**Wokingham**	**Grand Total**
CAMHS - Child and Adolescent Mental Health Services	3	12	2	2	5	1	25
Children's Occupational Therapy - CYPIT					1		1
Children's Physiotherapy - CYPIT				1			1
Children's Speech & Language Therapy - CYPIT						1	1
Health Visiting				1		1	2
School Nursing		1					1
Grand Total	3	13	2	4	6	3	31

CAMHS

Child and Adolescent Mental Health Services received 25 complaints in 2018/19 this is comparable with 26 received in 2017/18 and is against 7438 referrals received and approximately 32,000 contacts (0.08% contacts/ 0.3% referrals)

The theme for CAMHS complaints has been around delays in specialist referrals and clinical care, specifically following diagnosis of ADHD. Historically, the majority of complaints have been about waiting times and access to treatment. CAMHS have seen a reduction in complaints about waiting times due to the introduction of an initial assessment through the Trust Common Point of Entry service and the introduction of a Care of Waiters process, though complaints have been raised regarding delays in meetings taking place and timely referrals to other services. The CAMHS Urgent Care Service continues to bring positive clinical outcomes for young people.

Table 11: CAMHS Complaints

	Locality of Service						
Main subject of complaint	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Choice and Flexibility of Access					1		1
Clinical Care Received	1	5			1		7
Communication with Other Organisations		1					1
Failure/Delay in specialist Referral	1	2	2		2		7
Attitude of staff; Healthcare Professional		1			1		2
Inaccurate Records		2					2
Long Wait for an appointment		1		1			2
Unable to Access				1		1	2
Information; written to Patients	1						1
Grand Total	3	12	2	2	5	1	25

Table 12: Complaints about other services

	Locality of Service		
Service	**Bracknell**	**Reading**	**Grand Total**
Admin teams & office based staff	1		1
Corporate/Policy	1	2	3
Medicines Management		1	1
Grand Total	**2**	**3**	**5**

3 Complaints closed – activity

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). Table 13 shows the outcome of complaints.

Table 13: Outcome of closed formal complaints

	2018-19						Change	2017-18					
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of Total**		**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of Total**
Case not pursued by complainant	0	0	2	2	4	1.67	No change	1	1	1	1	4	1.95
Consent not granted	2	2	3	2	9	3.75	↑	0	1	0	4	5	2.44
Local Resolution	0	5	10	3	18	7.5	↑	3	3	6	2	14	6.83
Managed through SI process	0	2	0	1	3	1.25	↓	0	Only report in Q4 -4			4	1.95
Referred to other organisation	0	0	0	0	0	0	↓	0	1	0	1	2	0.98
No further action	1	0	0	0	1	0.42	↓	0	0	2	1	3	1.46
Not Upheld	13	11	15	16	55	22.92	↑	6	20	7	7	40	19.51
Partially Upheld	25	26	36	19	106	44.17	↑	18	19	22	28	87	42.44
Upheld	12	15	12	5	44	18.33	↓	8	18	10	10	46	22.44
Grand Total	53	61	79	47	240			36	63	48	58	205	

The national reporting statistics (including GP and dental service complaints) for 2017-18 showed that:

Upheld	34.9%
Partially Upheld	22.7%
Not Upheld	42.4%

The Trust has a lower percentage of complaints that are upheld or not upheld, with a greater proportion found to be partially upheld when compared to the national statistics; complaints often cover a number of services and issues which are investigated as individual points which contributes to this. During 2018/19 the process of apportioning an outcome for an investigation was changed and the Investigating Officer now apportions the outcome to their investigation.

4 Complaints as a mechanism for change – learning

Where complaints are upheld or partially upheld learning is shared with individuals, teams and the wider organisation where applicable; some examples of learning from complaints include:

What we were told: A carer wasn't kept informed about care provided by the Parkinson's Service.
What we have done: Introduced peer reviews to observe practice, creating the opportunity to generate discussion and reflection, recognising where improvements can be made to individual practice and service delivery. The SBAR tool is looking to be implemented to standardise documentation. The staff are to contact GP's if struggling to understand content of letters.

What we were told: Wait times for ADHD are too long and families need support
What we have done: We are working closely with a service called Parenting Special Children who are providing re-assessment workshops for ADHD and are opening up their parenting courses for ADHD and sleep for children and young people on wait list. We are also recruiting a number of

emotional well-being practitioner trainees who will be able to provide some therapeutic interventions to children and young people whilst they are waiting ADHD and ASD assessments.

What we were told: Staff lacked compassion during telephone contact with CRHTT
What we have done: Telephone calls are used during clinical supervision to support learning with individuals and where appropriate the wider team. Staff are receiving training in handling of telephone calls where the caller is very distressed.

What we were told: The Daughter of a patient was concerned that staff on an inpatient ward did not appear to be concerned about a mother's pain. Whilst there was some evidence in the notes regarding pain, there was no written evidence of the patient being asked about her levels of pain through her stay.
What we have done: Pain charts are now used in conjunction with pain care plans to capture the patients experience and perspective of their pain is regularly documented to ensure that appropriate medication is always provided.

What we were told: There was no named contact for patient whilst their care coordinator was off sick resulting in a two week gap in care.
What we have done: To address this issue a new Standard Operating Procedure (SOP) for caseload management for CMHTs has been developed. The guidance contained within this SOP has been designed to ensure that all staff working within the Trust's Community Mental Health Teams (CMHTs) are fully informed about what is expected in relation to periods of planned and unplanned absence

What we were told: There was a lack of consistency around catheter care in the community.
What we have done: In addition to a review of the management for this specific patient:

- A continence and catheter pathway workshop was held as part of Community Nursing review.
- It has been acknowledged that catheters can have a huge impact on a patients' life and that Multi-Disciplinary working and improved communication could improve patient experience. A meeting is being arranged to include GP, Community Nursing and the Continence Team to explore this further.
- Introduction of a catheter passport across Trusts-to improve communication on transition of care, with clear plan for future care to be adopted by Frimley and Berkshire Health Care Trusts.
- Catheter clinic introduction-as an alternative option for patients who are not housebound.
- Review of the Trust policy flow chart, actions and responsibilities around catheter care to ensure consistency across the Trust in conjunction with the Continence Team.

5 Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process. The table below shows the 2018/19 Trust activity with the PHSO.

Table 16: PHSO activity

Month open	Service	Month closed	Current Stage
Aug-17	Talking Therapies	Apr-18	Not Upheld
Mar-18	Older Adults Community Mental Health Team	Oct-18	Not Upheld
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	Common Point of Entry (CPE)	Aug-18	PHSO not proceeding
Aug-18	Out of Hours GP Service	Oct-18	PHSO not proceeding
Sep-18	Psychological Medicines Service	n/a	Investigation Underway
Nov-18	Psychological Medicines Service	Nov-18	PHSO not proceeding
Dec-18	Psychological Medicines Service	n/a	Investigation Underway
Dec-18	Community Hospital inpatient	n/a	Investigation Underway

The PHSO published a report on complaints about the NHS in England from October to December 2018. This report shows that they assessed 1,661 cases, of which 399 progressed to investigation. In the same quarter, the Trust had three complaints against them referred to the PHSO, of which two progressed to investigation. The data would indicate nationally that 24% complaints referred to PHSO went on to be investigated. In the same period the Trust had 66% (2 of 3) of the complaints referred progressing to investigation, although in Q2 this figures was 33% (1 of 3) due to very small numbers it is not possible to draw any real conclusions from this data.

464 investigations were closed involving 533 health organisations.

Of the cases that were investigated:

- 190 (41%) of the total closed cases were either fully upheld (36, 8%) or partly upheld (154, 33%);
- 2 (0.4%) were resolved before the investigation was concluded;
- 236 (51%) of the complaints were not upheld;
- 36 (8%) of the investigations were ended for other reasons, for example at the complainant's request.0

Of the recommendations made as a result of the investigation there were:

- 115 formal apologies;
- 80 payments to make up for financial loss or to recognise the impact of what went wrong; this totalled £67,714.51;
- 102 service improvements, including changing procedures or training staff;
- 33 other actions to put things right. For example, asking a GP practice to correct errors in medical records.

6 Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they contribute to, but are not the lead organisation (such as NHS England and Acute Trusts). Table 17 below details this activity.

Table 17: Formal complaints led by other organisations

Organisation	Summary of element of complaint relating to Berkshire Healthcare services
Acute Trust	Information contained within a report from CPE
	Parents were not happy that clinicians did not recognise that their child wasn't putting on weight
	Concern about catheter care from the District Nursing Service
CCG	Care from the WestCall Primary Care Centre
East Berkshire CCG	CRHTT, call to patient not made
	District Nursing and provision of their service
	District Nursing complaint regarding the pressure of a mattress not being set properly and not being adequately managed
Frimley Health NHS Foundation Trust	Community hospital inpatient and transfer to acute trust
	Mental Health Liaison Service and waiting time for a young person to be seen
NHS England	CMHTOA/COAMHS - Older Adults Community Mental Health Team and explanation around appointments stopping
	Care on Henry Tudor Ward
Oxford Health	Criminal Justice Liaison and Diversion Service and repeated MHA assessments and the patient not being admitted to a psychiatric hospital
Royal Berkshire Hospital	Concerns about psychiatric medication being withdrawn during admission to the acute trust and lack of oversight/communication with mental health services
SCAS	Westcall potential misdiagnosis
	WestCall, call to patient not made
	WestCall, clarification on what service offered patient overnight
	NHS 111 advised a home visit however WestCall telephoned the patient
SCAS/111	Waiting time for a visit from Westcall Services
	Patient did not get a call back from WestCall following a call with 111
South, Central & West Commissioning Support Unit	Patient not happy about a change in the waiting time for Occupational Therapy

7 Complaints training

The Complaints Office offers a programme of complaint handling training which is accessible through the Learning and Development Department. In addition, bespoke sessions are available when requested to teams or service areas that are having specific challenges. As a result of a formal complaint, a session on complaint handling has been arranged for CAMHS East and West, and Podiatry with requests from further services for 2019/20.

The course content is adapted following feedback from staff and people who have used the complaints process with the training being well received.

8 Mortality Review Group

The Trust Mortality Review Group (TMRG) meets on a monthly basis and the Complaints Office feeds information into this group. There were 16 formal complaints forwarded to the MRG during 2018/19 (this equates to 7% total formal complaints received from across services being in relation to end of life care)

The Medical Director is also sent a copy of complaint responses involving a death before they are signed by the Chief Executive.

Table 18: Complaints forwarded to TMRG

Service	Number of complaints
Community Hospital Inpatient	5
District Nursing	3
Psychological Medicine Service	1
Older Peoples Mental Health (Ward Based)	1
District Nursing Out of Hours Service	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Out of Hours GP Services	1
Adult Acute Admissions	1
CMHT/Care Pathways	1
Assessment and Rehabilitation Centre	1
Grand Total	16