Royal Free London
NHS Foundation Trust

Report to	Date of meeting	Attachment number
Trust board	22 July 2020	Paper 6

Complaints annual report 2019/20

Executive summary

This report provides information on the complaints received in the trust between 1 April 2019 and 31 March 2020. It provides a summary of the complaints received, the areas concerned, the main issues raised and trends identified, as well as the actions taken in response or those planned for the future. It also looks at our performance against agreed response targets and the number of complainants who have come back dissatisfied following their initial response.

Action required/recommendation

For information and consideration.

Meetings where this report has been discussed previously

N/A

Meeting	Date	Decision

Board/GEC/LEC/committee goals

GOALS	BAF risks	
Quality		
Top 10% vs peers staff recommend as place to work (FFT> 90%)	G-024	☐
Directors developed and appointed to other trusts		☐
Top 10% for leadership	G-029 / G-043	☒
Promote equality and diversity	G-027	☒
Match leader on patient and staff engagement	G-030	☒

CQC standards impacted	Safe / effective / caring / responsive / well led
Financial/business implications	No
Equality analysis	No identified negative impact on equality and diversity
Compliance impact	The poor response performance (page 4) highlights that a number of deadlines have been missed and would indicate a lack of updates being provided to complainants during the course of prolonged

	investigations. This falls outside trust policy and complaints legislation and could be criticised by the Parliamentary & Health Service Ombudsman or the Care Quality Commission.

Report from: Deborah Sanders, Barnet hospital chief executive & group chief nurse

Author: Stephen Evans, head of patient experience & interpreting, RFH

Date: 15 July 2020

Annual Complaints Report – 2019/20

Introduction

Feedback from patients, relatives and carers provides the trust with a vital source of insight about people's experiences of healthcare at the Royal Free London NHS Foundation Trust, and how our services can be improved. The ultimate aim of the trust's complaints process is to listen and respond to the issues being raised and use the information received to improve our services and, in turn, the experience of our patients.

This report provides information on the complaints received in the trust between 1 April 2019 and 31 March 2020. It provides a summary of the complaints received, the areas concerned, the main issues raised and trends identified, and the actions taken in response or those planned for the future. It also looks at our performance against agreed response targets and the number of complainants who came back dissatisfied following receipt of their initial response.

Background

The statutory instrument for complaints in the NHS is contained in the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*. The legislation expects that each responsible body has arrangements for dealing with complaints to ensure that:

1. complaints are dealt with efficiently;
2. complaints are properly investigated;
3. complainants are treated with respect and courtesy;
4. complainants receive, so far as is reasonably practical -
    I. assistance to enable them to understand the procedure in relation to complaints; or
    II. advice on where they may obtain such assistance;
5. complainants receive a timely and appropriate response;
6. complainants are told the outcome of the investigation of their complaint; and
7. action is taken if necessary in light of the outcome of a complaint.

The Department of Health issued *Listening, Responding, Improving: A guide to better customer care* in February 2009 to support organisations in responding to and learning from complaints.

The Parliamentary Health Service Ombudsman (PHSO) *Principles of Good Complaint Handling* has six principles:

1. getting it right
2. being customer focused
3. being open and accountable
4. acting fairly and proportionately
5. putting things right
6. seeking continuous improvement.

Complaints received

There were 1,330 complaints received between 1 April 2019 and 31 March 2020. 748 of those were complaints regarding Royal Free Hospital services; 462 were regarding Barnet Hospital services; and 120 were regarding Chase Farm Hospital services. This is less than the 1,642 complaints received in 2018/19 – 937 of which were for the Royal Free Hospital services, 553 for Barnet Hospital services and 152 for Chase Farm Hospital services.

The 1,330 complaints received are from a total of 1,643,576 emergency department, inpatient and outpatient episodes. This equates to a complaint ratio of 0.1%, the same percentage as the last 6 years.

As of 9 July 2019, 1,192 of the complaints have been responded to. Of those, 229 have been fully upheld, 624 have been partially upheld and 339 have not been upheld. There have been 1,499 response targets in this time period and we met 1,077 of them, which equates to an overall response rate of 72%.

	Q1	Q2	Q3	Q4	Overall
Deadlines met	305 of 361	313 of 467	212 of 310	247 of 361	1,077 of 1,499
Percentage	84%	67%	68%	68%	72%

Weekly meetings between the complaints managers and the corporate complaint leads on the Royal Free Hospital site continue, and meetings between the complaints managers and the corporate complaints leads for the Barnet and Chase Farm Hospital sites take place regularly. The corporate complaints teams are also assisting with the extending and negotiating of deadlines where necessary.

However, the end of year position of 72% is disappointing and worse than previous years' performance. The average response rate for 2019/20 for the Barnet complaints team was 49%; Chase Farm complaints team was 80%; and the Royal Free complaints team was 89%.

Unfortunately, the complaints team on the Barnet site has been short-staffed for large periods of 2019/20 due to sickness and ongoing vacancies, which were only able to be filled sporadically with interim cover. As a result, the team's performance has dipped and a back-log of complaints built up which exacerbated the situation.

A new Barnet corporate complaints manager started in April 2019, a new Barnet Surgery and Associated Services (SAS) complaints manager started in October 2019 and a new Barnet Medicine & Urgent Care (MUC) complaints manager started in March 2020. The divisional nurse directors, with support from colleagues across the trust, have helped cover the complaints work and the director of nursing implemented an action plan to try to address the situation. The situation has been stabilised and the back-log is being cleared gradually, but staffing levels were unstable for a long time and performance has been hampered as a result.

We appreciate that any missed target reflects poorly on the trust and potentially exacerbates a complainant's feelings of upset and frustration, and we are working hard to improve the response rate in this regard. The trust's default position is still to respond to complaints in 35 working days and the average response time for those complaints closed in 2019/20 was 61 working days. This is unacceptable and has been significantly hampered by the issues

referred to above affecting the performance of the Barnet Hospital complaints team. Their average was to respond in 91 working days, compared to the Royal Free Hospital's 42 working days and Chase Farm Hospital's 26 working days.

Complaints re-opened following receipt of their first response

As demonstrated by the table below, the number of complainants who have re-opened their complaint regarding services provided by the Royal Free Hospital, following receipt of their first response letter, reduced significantly post 2011/12 but has since plateaued at 5%. Despite the increase in numbers registered since the acquisition in 2014, there has been a decrease in the number of re-opened complaints regarding services provided by Barnet & Chase Farm Hospitals. This figure too would appear to have now plateaued at approximately 6%.

NB: the numbers for 2019/20 are accurate as of 10 July 2019 and may continue to change over the next few months.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Royal Free Hospital	75 of 797 (9%)	57 of 709 (8%)	50 of 653 (8%)	60 of 698 (8%)	37 of 785 (5%)	42 of 853 (5%)	43 of 765 (7%)	53 of 937 (5%)	38 of 748 (5%)
Barnet & Chase Farm Hospitals	59 of 207 (29%)	53 of 295 (18%)	31 of 337 (9%)	26 of 461 (6%)	41 of 671 (6%)	45 of 713 (6%)	48 of 769 (6%)	-	-
Barnet Hospital	-	-	-	-	-	-	-	50 of 553 (9%)	28 of 462 (6%)
Chase Farm Hospital	-	-	-	-	-	-	-	2 of 152 (1%)	2 of 120 (2%)

Top 10 primary Subjects

The table below is a breakdown of the complaints by primary subject, along with a comparison of the primary subjects reported in last year's annual report. The top 10 subjects are the same as 2018/19 but the order has changed.

2018/19	
Clinical treatment	429
Communication	268
Transport	205
Values & behaviours (attitude)	204
Appointments	178
Facilities (including car parking)	77
Nursing or midwifery care	62
Admission / discharge	54
Waiting times	49
Access to treatment / drugs	34

2019/20	
Clinical treatment	376
Values and behaviours	188
Communication	166
Appointments	162
Transport	88
Admission/discharge	75
Waiting times	59
Nursing or midwifery care	56
Facilities (including car parking)	43
Access to treatment / drugs	24

Clinical treatment is again the most common primary subject of the complaints received and the top five subjects are the same, with communication, attitude, appointments and transport again featuring.

The most significant change is the decrease in transport complaints received, which possibly accounts for the overall decrease in complaints received for Royal Free Hospital services. Last year's increase was linked to the eligibility assessment criteria and the application of said criteria resulting in patients no longer being deemed eligible for patient transport. Following a prolonged period of contacts from patients and carers on this issue a new escalation process, overseen directly by DHL Transport, has resulted in a reduction in contacts with the complaints and PALS teams.

Further analysis of the top 3 subjects

A more detailed analysis of the top three subjects will follow below, along with examples of actions taken and changes implemented in response to those complaints. In addition, the same analysis will be undertaken for the nursing care complaints received, as has been the case since the Francis Report in 2013.

Clinical treatment

There were 474 complaints received where clinical treatment was recorded as a subject of the complaint – in 376 cases it was the primary or sole reason for the complaint. The 474 complaints were received from a total of 1,643,576 emergency department, inpatient and outpatient episodes, which equates to a complaint ratio of 0.02% (2014/15 was 0.02%, 2015/16 was 0.04%, 2016/17 was 0.04%, 2017/18 was 0.04% and 2018/19 was 0.04%).

Of the 474 complaints received, 44 have been fully upheld (74 are still under investigation). Detailed explanations have been provided to each complainant along with apologies and information regarding the action taken as a result. There has been escalation to the serious incident process whenever appropriate and/or the involvement of human resources for further investigation. There is no identifiable trend in terms of staff member(s) involved.

The table over the page breaks the clinical treatment complaints down by primary specialty and primary sub-subject for the 10 most complained about specialties.

	Awareness Under Anaesthetic	Delay or Failure to undertake Scan/X-ray	Delay or Failure in acting on Test Results	Delay or Failure in observations	Delay or Failure in Ordering Tests	Delay or Failure in Treatment for Infection	Delay in Induction of Labour	Delay or Failure to Monitor Observations	Delay or Failure in Treatment or Procedure	Delay or Failure to Diagnose (inc missed fracture)	Delay or Failure to Follow Up	Inadequate Pain Management	Inappropriate or incorrect Procedure	Inappropriate or incorrect Treatment	Injury Sustained during Treatment or Operation	Mismanagement of Labour	Missed or Incorrect Diagnosis	Post-Treatment Complications	Retained Needle/Swab/Instrument	Total
Obstetrics/Maternity	0	0	0	2	0	2	3	3	17	2	0	2	0	4	1	10	3	0	2	51
Emergency Dept - RFH	0	2	2	1	4	1	0	0	9	15	0	0	0	4	0	0	3	0	0	41
Orthopaedics & Trauma	0	2	1	0	0	0	0	0	9	8	0	1	0	8	3	0	1	1	0	34
Gynaecology	0	4	3	0	2	0	0	0	2	3	0	1	1	3	0	0	3	0	0	22
Emergency Dept - Barnet	0	1	1	3	1	1	0	0	0	2	1	0	0	2	0	0	9	0	0	21
Plastic Surgery	0	0	0	0	0	3	0	0	11	1	1	0	0	0	1	0	0	0	0	17
HPB Surgery	0	1	0	0	0	0	0	0	0	1	1	0	4	6	0	0	0	2	0	15
Urology	0	0	0	0	0	0	0	0	8	0	3	2	2	0	0	0	0	0	0	15
Paediatrics	0	0	0	0	1	2	0	0	2	0	0	0	0	6	0	0	3	0	1	15
Nephrology	1	0	0	0	0	1	0	0	4	0	0	0	0	0	0	0	1	0	0	7
Total	1	10	7	6	8	10	3	3	62	32	6	6	7	33	5	10	23	3	3	238

Delays with treatment taking place and allegations with regard to the failure of treatment are again the common underlying themes for the complaints received, and our emergency departments, along with obstetrics & maternity and orthopaedics & trauma, are once again the most common specialties to be referred to.

Example actions taken in response to the complaints are listed below:

- Urology is working hard to address the root cause of the delays patients are experiencing with the removal of their stent i.e. the fact that the demand on the urology service is currently outstripping capacity. Long-term strategies are in place to increase our workforce and physical space, to develop current staff and to better utilise existing theatre capacity. In the meantime, the service is running as many additional clinics and theatre lists as they are able to.

- Following an appointment a plastics doctor did not send the patient to medical illustration for photographs to be taken. The doctor was new in post as a clinical psychologist and forgot to complete this part of the pathway. The lack of photographs delayed the patient's treatment. The clinical pathway administrator has now implemented a tracking process to ensure that the relevant information is chased swiftly to allow for patients to be discussed without delay.

- The respiratory department has mandated that the medical handover process explicitly identifies patients who are expected to die within days so that, if there is a medical team who are unfamiliar with the patient, they have an opportunity to ensure that they have appropriately prioritised that patient's clinical review. This has also been discussed with the medicine and urgent care divisional medical director, with a plan for it to become the practice across all services.

Values and behaviours

There were 301 complaints received where communication was recorded as a subject of the complaint – in 188 cases it was the primary or sole reason for the complaint.

The complaints related to a wide range of departments and specialties and there is no obvious trend in terms of numbers received or the departments or staff member(s) involved. The table below breaks the complaints down by specialty and sub-subject for the 10 most complained about specialties.

	Attitude of Nursing staff/Midwives	Attitude of Medical staff	Attitude of Admin & Clerical staff	Attitude of other staff	Breach of confidentiality	Failure to act in a professional manner	Failure of staff to introduce themselves	Rudeness	Sexual Abuse/Assault (alleged)	Verbal Abuse (alleged)	Other	Total
Obstetrics/Maternity	15	1	0	0	1	1	0	1	0	0	1	20
Emergency Dept - RFH	5	9	1	0	0	0	0	0	0	1	0	16
Emergency Dept - Barnet	2	6	1	0	0	0	0	0	0	0	0	9
Rheumatology	1	5	1	0	0	0	0	0	0	0	0	7
Urgent Care Centre - Chase Farm	1	1	2	1	0	1	0	1	0	0	0	7
Radiology	0	2	1	1	0	1	0	1	0	0	0	6
Orthopaedics & Trauma	0	5	0	0	0	1	0	0	0	0	0	6
Dermatology	0	4	0	0	0	0	1	0	0	0	0	5
Gynaecology	1	1	0	0	0	1	0	0	1	0	0	4
Urology	3	0	0	0	0	0	0	0	0	0	0	3
Patient Transport	0	0	0	3	0	0	0	0	0	0	0	3
Total	28	34	6	5	1	5	1	3	1	1	1	86

Attitude of medical and nursing staff are the dominant sub-subjects of these complaints. Example actions taken in response to the complaints are listed below:

- A DHL (the trust's transport provider) call handler was found to have been rude and curt during an eligibility assessment call. They will be retrained and have been spoken to by their line manager regarding their behaviour.

- A member of urology administration staff will undergo two training courses to improve her communication skills and her behaviour will be monitored by her line management team.

- The domestic manager has arranged for the domestic to attend further training to ensure compliance with the standards expected from our domestics and has reallocated her duties to another area of the hospital.

- Matron had a reflective discussion with the member of staff concerned about divulging clinical information to a third party without consent. The member of staff has also repeated their information governance training.

Communication

There were 366 complaints received where communication was recorded as a subject of the complaint – in 166 cases it was the primary or sole reason for the complaint.

The complaints again related to a wide range of departments and specialties and there is no obvious trend in terms of numbers received or the departments or staff member(s) involved. The table below breaks the communication complaints down by specialty and sub-subject for the 10 most complained about specialties.

	Breaking Bad News	Breakdown in communication between staff	Breakdown in communication re appointments	Communication with patient	Communication with Relatives/Carers	Communication with GP	Conflicting information	Delay in giving information/results	Delay in reporting results	Inadequate record keeping	Incorrect Entry on Medical Records	Incorrect/inaccurate interpretation	Incorrect/No information given	Insufficient information provided	Patient Not Listened to	Total
Urology	0	3	0	7	0	0	0	2	0	0	2	0	1	8	1	24
Cardiology	0	0	1	2	0	1	0	2	2	0	1	1	1	1	0	12
Rheumatology	0	0	0	1	0	0	0	0	0	0	0	1	0	8	0	10
Emergency Dept - RFH	0	0	0	4	1	0	0	1	0	1	0	0	1	0	0	8
Radiology	1	0	0	2	0	0	0	1	2	0	1	0	1	0	0	8
General Medicine - Barnet	0	0	0	2	2	0	1	0	0	2	0	0	0	0	0	7
Obstetrics/Maternity	0	0	0	3	2	0	0	1	0	0	1	0	0	0	0	7
Dermatology	0	0	0	0	0	0	2	3	0	0	0	0	0	0	1	6
Orthopaedics & Trauma	0	0	0	3	0	0	0	0	1	0	0	0	1	0	0	5
Emergency Dept - Barnet	0	1	0	3	0	0	0	0	0	0	0	0	1	0	0	5
Total	1	4	1	27	5	1	3	10	5	3	5	2	6	17	2	92

Communication with the patient is once again the key underlying theme, followed by insufficient information provided, which in most cases would relate to information being provided to the patient during the course of their treatment.

Example actions taken in response to the complaints are listed below:

- A breast clinic doctor should have explained to a patient during their clinic appointment that the procedure she was being booked for (8G extraction) would be more invasive than a standard core biopsy. This expectation has been relayed to the doctor concerned and the wider team, and the clinical lead will ensure that the explanation of procedures is incorporated into training for all doctors in the department. He will also look into creating YouTube videos that will give patients a brief description of the department's procedures.

- Unfortunately, the DHL assessment centre was very busy towards the end of 2019 and was experiencing high volumes of calls; a situation exacerbated by staff shortages. Since this time DHL have been working hard to improve the time a patient waits before their call is answered and they are now regularly achieving a sub 3 minute wait time. During busier periods, they have also now introduced a same day call back service.

- An administrative member of staff for the Central and East London Breast Screening Service did not telephone a patient about the need for a cancellation and then sent another standard appointment letter as opposed to a cancellation and rebook letter. The patient was not informed of the cancellation, was not reassured by the further appointment letter and was left upset and inconvenienced. The member of staff has been remindid of the correct process to follow and provided with refresher training to avoid such instances occurring in future.

- A patient's procedure was cancelled without reasonable notice being given. The member of staff involved has been reminded that, due to the short notice, the patient should have been telephoned to ensure he was aware as well as a letter being sent. The member of staff should also have checked the HPB surgical diary to see if a hotel had been booked and cancelled that booking as well. Consequently, a weekly review meeting between nursing and admin staff has been reinstated to confirm that all scheduling and logistical arrangements have been finalised for patients being admitted the next week. The team are also in the process of improving the record keeping in the surgical planning diary to support this porocess, enabling maintenance of an audit trail of any changes.

- We are developing a clinical support worker role within the oncology team. This will be an administrative role to support the clinical nurse specialist, with the intention of making contact with the clinical nurse specialist easier, as well as freeing up more of their time for clinical matters, such as answering questions about care and treatment from patients and family members.

Nursing and midwifery care

There were 92 complaints received where nursing/midwifery care was recorded as a subject of the complaint – in 56 of those complaints it was the primary or sole reason for the complaint being lodged.

The directors of nursing review and sign off all complaint responses, ensuring that appropriate explanations and apologies have been provided in each case and action taken in response to the points raised. The directors of nursing are also informed of any issues raised regarding unsafe practice or potential serious incidents.

The table on pages 14 and 15 of this report breaks the nursing complaints down by the primary location and primary sub-subject for the complaints received. The data highlights that the concerns raised about nursing care are spread across a large number of wards and departments, with no area receiving more than 7 complaints and no identifiable trend in terms of staff members involved. Failure to provide adequate care, patients' care needs not being met and a lack of support for patients during their admission were again the common underlying themes.

Example actions taken in response to the complaints are listed below:

- 7 West ward are starting a quality improvement project with the community district nursing team in order to improve the length of stay and experience of those patients who need to be discharged with a VAC pump insitu.

- Matron for 7 West ward has undertaken work to improve the nursing staffs' knowledge in diabetic care through.
  - ✓ ward teaching sessions.
  - ✓ emphasising the need to involve pharmacy and doctors in assessments when required.
  - ✓ ensuring that patient's diabetic needs are specifically discussed during the ward's daily safety briefing.

- On review of a complaint, the endoscopy unit recognised that their standard protocols were not followed meaning that an opportunity to escalate the patient's care, whilst she was at the endoscopy unit, was missed. Had the medical and PARRT been contacted around 12:30pm, the patient may have been monitored and/or admitted for treatment before the scheduled transfer to her local hospital. In learning from this, we have:
  - ✓ Introduced a local escalation protocol, whereby patients with a NEWS2 score of 1-2 are escalated to the endoscopy senior matron, so that they can ensure that the patient is sufficiently reviewed with involvement of other staff if necessary.
  - ✓ Fed back at a meeting with junior sisters in endoscopy about the coordinator role and the need to satisfy themselves that a patient is safe for discharge.
  - ✓ Organised teaching sessions with endoscopy nursing staff regarding NEWS2.
  - ✓ Arranged to use the patient's experience as part of simulation training with the endoscopy nursing staff.
  - ✓ Planned to audit the utilisation of NEWS2 and escalation using the resulting scores following the completion of the above teaching and simulation training.

- The sister for 10 North ward has advised that there is now a volunteer who helps with hair care and shaving for patients, which helps free up the nurses and enables them to concerntrate on their other duties.

Examples of actions taken in response to other complaints received

In addition to apologies and explanations, the majority of our complaint responses will include details of specific action(s) taken as a result of the complaint that has been received. Some general examples of actions taken/changes implemented are listed below:

- It was clearly documented in the notes on admission that a patient had a penicillin allergy and this was not noticed or considered when prescribing medication. This medication error was raised as an incident and the principal pharmacist for surgery discussed the error with the pharmacist for 7 North ward and reiterated the importance of thoroughly checking medical notes before administering prescribed drugs. She has also used this incident as a learning tool and went through it with all pharmacists during recent team briefings.

- The patients in the transport lounge have mobility issues and often experience difficulties making their way to vending machines. The volunteers have made arrangements for a trolley selling coffee and sandwiches to visit the transport lounge twice a day during their daily trolley round between 9:30am and 12:30pm and 1:30pm and 3:30pm.

- A patient was paid £50 for the loss of clothing whilst an inpatient on 5 East B ward.

- The failure to be able to get through to the urology administrative team meant that there was a delay in a patient being able to reschedule her procedure. All of our services should have robust systems in place that do not fail if someone is on leave. This has been discussed with the urology team and the service have put in place a new system to ensure there is detailed handover and that the phone is diverted to colleagues in times of absence. In addition, the service manager has discussed with the team the importance of answering phone calls and responding to messages in a timely manner. The service will now obtain a weekly report of how many calls are received, answered and missed.

- Due to noise from a bin lid affecting the rest and recovery of a patient, soft closing bins have been ordered for the recovery area in theatres.

- A patient raised concerns about timely access to podiatry services for urgent attention, which has prompted detailed discussion and review from the podiatry and ED leads in an effort to streamline the pathway for patients through the ED. This has to be for all podiatry patients who have risks of long term complications including, among others, diabetics, renal and peripheral vascular disease patients. The current discussions have developed to the stage of assessing where the podiatry services can be located within the ED, how patients can be streamlined through to them and how referrals can be made by various sources. This complaint case will also be used (anonymously) as an opportunity to highlight services and ulcer management to the junior doctors who work within the department, emphasising the need to obtain podiatry reviews early and always consider an acute referral from the ED.

- DHL have recruited four additional two-man stretcher crews to their fleet to give them greater resilience and flexibility and prevent delays for patients requiring these specialist crews.

- The trust is working with DHL to review the transport assessment process. To this end we are currently reviewing how information about patients' long term conditions is currently used to streamline the assessment process.

- The rheumatology service is implementing a series of service initiatives that over time should see a return to the balance of demand versus available appointment slots. The immediate steps being taken include the recruitment of a new general rheumatology consultant and two new clinical nurse specialists working across the rheumatology service. We intend to implement a new nurse-led clinic, which is solely for short-notice booking of patients experiencing a flare of their known medical condition. We will also be able to reinstate telephone clinics that were previously put on hold because of insufficient nursing capacity.

- The breast service has implemented pre-surgery counselling clinics at Barnet Hospital (a service that can be formally booked on Cerner) to address patients' concerns prior to any surgery taking place. The aim of these clinics is to ensure that patients feel fully briefed on the surgery they are about to undergo.

Complaints referred to the Parliamentary & Health Service Ombudsman (PHSO)

The PHSO continue to record any preliminary reviews of complaint files as investigations in their annual figures, as opposed to only those cases that went on to be formally investigated.

Of the 1,330 complaints opened in this financial year, 5 have so far been escalated to the PHSO by the complainant. 1 of those was a complaint regarding a service provided by Barnet Hospital and 4 are complaints regarding services provided by the Royal Free Hospital. To date, all 5 cases are under review.

Summary

The primary subjects remain largely the same as the last financial year, with the most common subjects being clinical treatment, values and behaviours, communication and appointment issues.

The actions outlined in this report demonstrate that trends are acted upon and the complaints received in the trust are taken seriously and used to inform pieces of work aimed at improving the patient experience. The responses provided invariably outline actions that have been taken in response to the concerns raised or explain what is planned as a result of issues identified during the investigation.

Policy and procedure and the way in which complaints are recorded and dealt with is harmonised across trust sites. We have systems in place to systematically review the complaints received and ensure that investigations are undertaken appropriately, in line with legislation, and escalated within the trust as necessary. The data collected is used to inform reports, is disseminated amongst divisional teams and taken to various committees to inform ongoing work within the trust.

Disappointingly, the trust's response rate for the year was only 72% and is not where we aim to be. As explained, the complaints team on the Barnet site has been short-staffed for large periods of 2019/20 and the team's performance has dipped as a result, which had a significant knock-on effect for the overall trust performance.

Whilst our response rate is disappointing, the number of complainants coming back unhappy following receipt of their response letter (5% to date) and the number of cases that are upheld by the PHSO (0 to date) would continue to suggest that our quality of investigation and response is good. This was highlighted in the Care Quality Commission's report, following their 2019 inspection, where they made reference to *'complaints investigations being completed to a good standard but frequently being completed beyond their timeframes'*. Hopefully, with the Barnet complaints team now established, our response rate performance will be significantly better in 2020/21.

	Acquired infection	Acquired pressure ulcer	Call Bell - failure to respond	Care needs not adequately met	Catheter care	Cannula management	Cannula left in situ on discharge	Did not get help to mobilise	Failure to provide adequate care	Failure to adopt infection control measures	Failure to monitor pressure ulcer	Failure to provide assistance with eating/drinking	Failure to provide food appropriate to clinical condition	Failure to provide adequate fluids	Inadequate discharge planning	Inappropriate care setting	Inadequate support provided	Insufficient staff	Moving and handling issues	Personal hygiene - not helped to wash	Slips trips and falls - unwitnessed	Total
Barnet Hospital																						
Acute Admissions Unit				1																		**1**
Beech				2					5													**7**
Coronary Care Unit									1													**1**
Cedar						2																**2**
Damson									1													**1**
Emergency Dept				2			1		2							1						**6**
Medical Short Stay				1																		**1**
Galaxy						1																**1**
Larch									1													**1**
Mulberry										1												**1**
Palm				1					1													**2**
Rowan				1							1											**2**
Spruce				1					1													**2**
Surgical Assessment				1	1	1			1													**4**
Victoria									1				1									**2**
Walnut				1					1													**2**
Willow									4													**4**

Chase Farm Hospital																						
Surgical ward																	1	1				**2**
Royal Free Hospital																						
Acute Admissions Unit			2	1																		**3**
Endoscopy								1														**1**
Emergency Dept															1					1		**2**
ICU																	1					**1**
Mary Rankin										1									1			**2**
Recovery															1							**1**
3 North A									1													**1**
5 East B				1	1												1					**3**
5 North A																	1					**1**
5 South				1																		**1**
6 East				1															1			**2**
6 South					1																	**1**
7 East A									1													**1**
7 West				1									1				2					**4**
7 North									1								1					**2**
8 North													2		1							**3**
9 North														1							1	**2**
9 West				1	1								1									**3**
10 East		1															3				1	**5**
10 North															2		3					**5**
10 South A	1							1									2					**4**
11 West																	1					**1**
11 East												1										**1**
Total	**1**	**1**	**2**	**17**	**4**	**4**	**1**	**2**	**22**	**2**	**1**	**1**	**5**	**1**	**5**	**1**	**16**	**1**	**2**	**1**	**2**	**92**