Northern Health and Social Care Trust

Annual Complaints Report

1 April 2021- 31 March 2022

Introduction

The Report gives an overview of complaints and feedback received from service users, patients, their carers and family members by Northern Health and Social Care Trust (NHSCT) from 1 April 2021 to 31 March 2022.

The NHSCT provides health and social care services to a population of approximately 470,000, which is the largest resident population in Northern Ireland. The Trust provided treatment and care for a significant number of people during this year including;

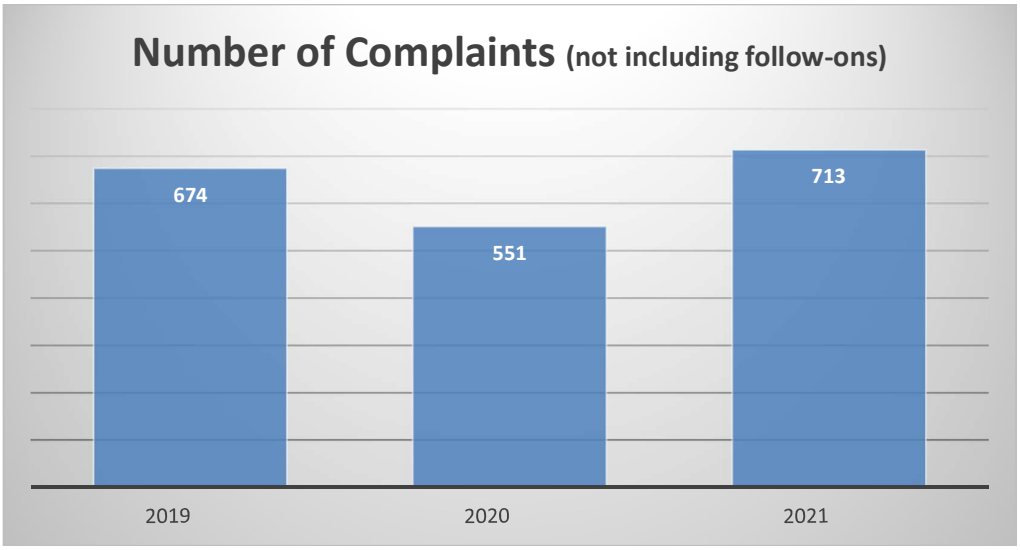
- 95,306 inpatients, inclusive of elective inpatients (compared to 87,488* in 2020/21)
  *(*The figures for Mental Health inpatients were not available for 2020/21 due to changeover to a new information system)*
- 327,538 acute outpatients across all specialties (increase from 189,654)
- The figures for Mental Health outpatients are not available due to changeover to a new information system
- 143,954 attendances at Emergency Department and Minor Injury Units (increase from 119,997)
- 20,287 day case patients across all specialties (increase from 11,334)
- 3,857 births (increase from 3,785)
- 750 children looked after by Trust (increase from 737)
- 522 children on child protection register (increase from 492)
- 6,983 domiciliary care packages for older people provided in the community (increase from 4,964)

The report provides details of the number and nature of complaints received by the Trust. The overall number of complaints received increased from 635 to 823 this year (this includes follow on complaints where complainants return to the Trust to request further information). We are committed to listening to and learning from all of our patients and service users, so that we can continually improve the quality of our services; particularly when the care provided may not have been of the standard that we ourselves would expect. Compliments and suggestions/comments made by patients and service users are acknowledged and shared with the relevant staff/teams.

We aim to respond to complaints within 20 working days, where possible, and strive to ensure that there is a full, fair and objective review of the issues and concerns raised and that an effective response/outcome is provided. The Trust must offer every opportunity to exhaust local resolution and therefore encourages complainants

to contact the Trust again should they remain dissatisfied. We will continue to do our utmost to resolve complaints.

Number of Complaints by Year



Method of complaints received during 2021/22

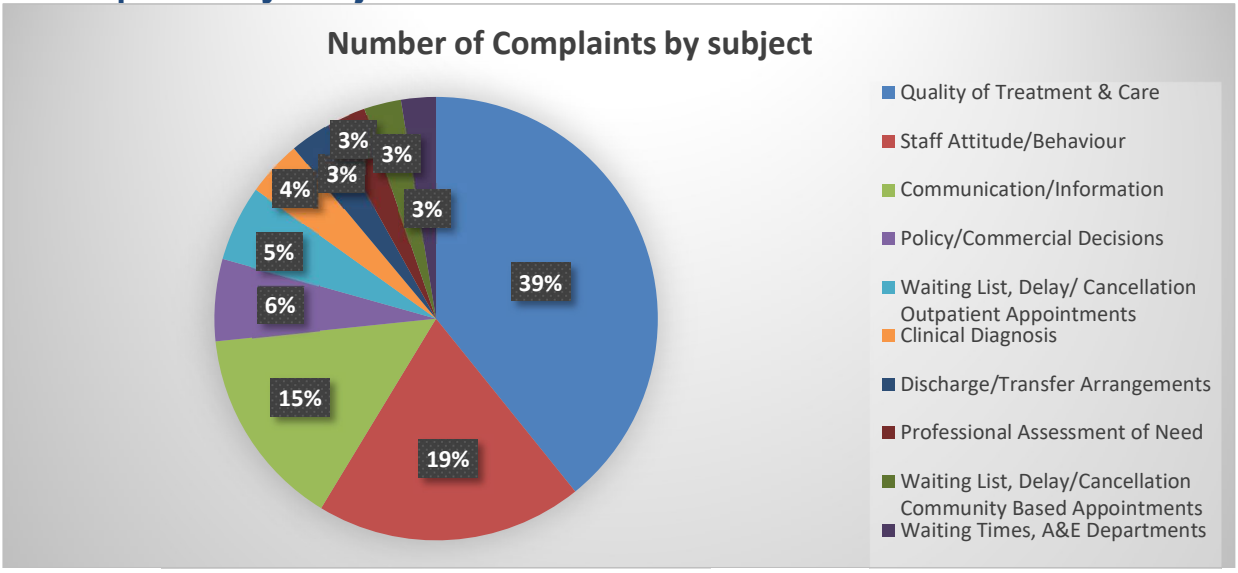
Email 73%

Letter 11.5%

Trust feedback form 12%

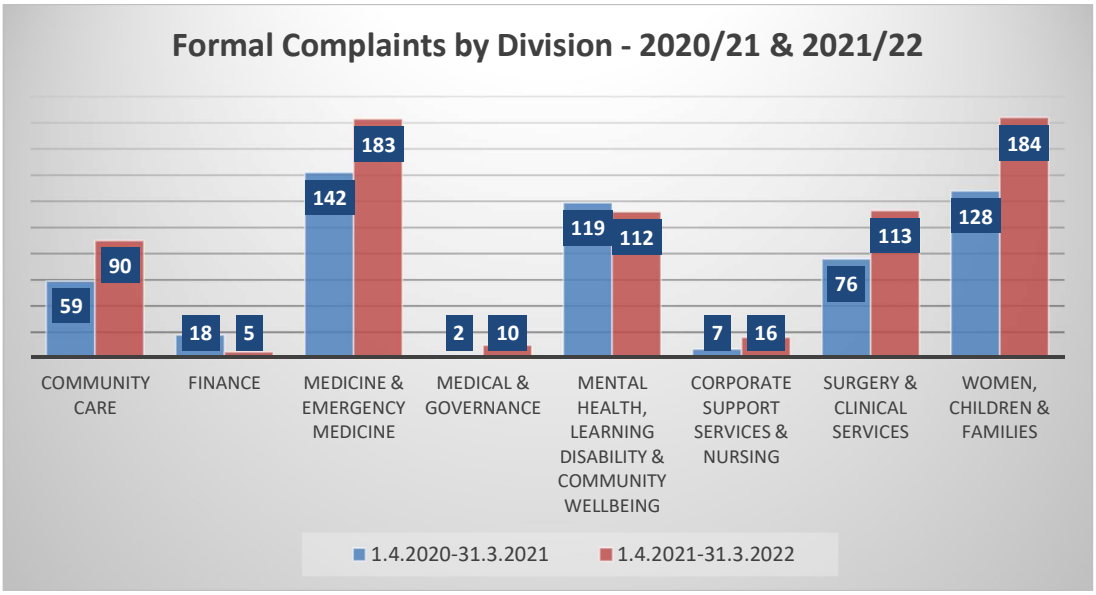
Phone/ Person 3.5%

Complaints by Subject



Complaints Received by Division

The services provided by the NHSCT are organised into 10 Divisions. The graph below shows the distribution of complaints across these Divisions over the past year 2 years.

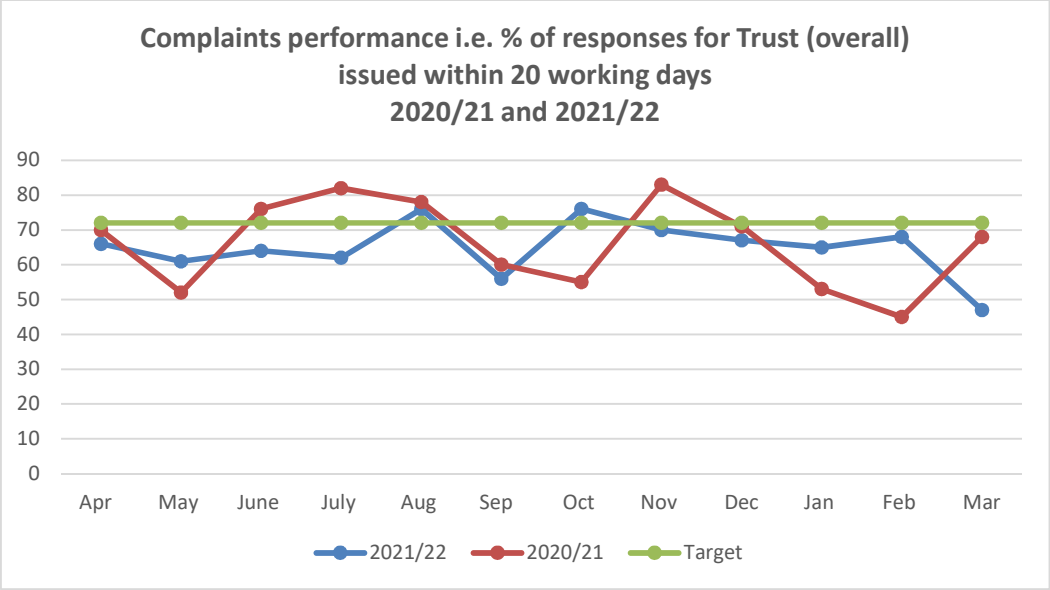


Response Times

The HSC Complaints Procedure outlines that complaints should be acknowledged within 2 working days and that complaints should be responded to within 20 working days, if at all possible.

Various factors can impact on the time taken to review a complaint, such as information may be awaited from other agencies or due to the complexity of the complaint review.

During 2020/2021, 67% of complaints were responded to within 20 working days, which is the same as the previous years' response time. **(The target response time is 72% within 20 working days).**



	Number of complaints	Percentage
Acknowledged ≤ 2 days	823	100%
Response ≤ 20 days	548	67%

(The figures in this report are subject to change based on the reporting process)

Monitoring, Reporting, Learning

The Trust values all feedback received from patients and service users, including complaints. When there is an identified need to improve our services we take all the necessary actions to ensure these improvements happen.

In order to record and monitor complaints activity, the complaints department is required to maintain a database of complaints and provide regular reports to senior management, directorates and various Committees within the Assurance Framework including the Equality, Engagement, Experience & Employment (Quadruple E) Group. These reports highlight themes and trends across the Trust to ensure learning takes place. The Trust continues to provide monthly monitoring returns to the Strategic Planning and Performance Group (SPPG) regarding lessons learned from all complaints closed each month.

An action/learning pro forma is completed, where appropriate, for complaints. We use this information to provide feedback to patients, service users and staff on the changes and improvements made. Complaints are discussed with relevant staff and issues brought to staff meetings where service improvements are agreed.

A number of improvements have been introduced during 2020/2021 following complaints. Below are some examples of learning:

A) Summary of Event

A Service User was referred for an ultrasound scan of neck but the appointment letter stated ultrasound scan of thyroid. On attendance she felt the Radiologist was rude, did not introduce himself and did not appear to know what area was to be scanned.
Outcome: Unfortunately, the accompanying “Information and Preparation” sheet that was sent out with ultrasound neck appointment letters has an inaccurate title that states “Thyroid”. Essentially, thyroid and neck ultrasound scans are performed in the same manner, so the content within the preparation sheet is accurate but may be misleading to Service Users.
Learning Points/Action :

- A new leaflet has been prepared to be issued with the appointment letters
- The Consultant Radiologist has offered his unreserved apology for any hurt or upset he has caused.

B) Summary of Event

Mother of young child advises her daughter received a first vaccination twice in error and the nurse who administered the vaccination did not check her child's record.
Outcome: The initial date of the vaccination was the 15/7/21 but as the child was unwell she didn't attend and the Child Health Department was notified. Subsequently another appointment was made with the GP practice to get her vaccination on 29/7/21, which was administered. When the child received her vaccination on the rescheduled date 29/7/21, further documentation was sent to the Child Health Department to update.

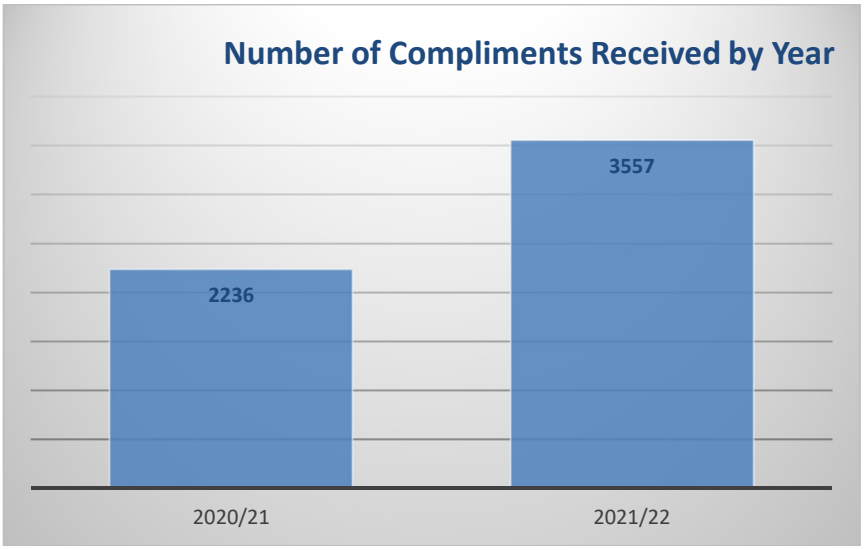
Unfortunately, this documentation overlapped with their letter, inviting to attend on the 19/8/21. On 19/8/21 the nurse did not check the vaccination history on the system. She advised that the vaccination prescription was signed by the GP. It is very clear that the nurse did not follow the correct checking procedure on the electronic system, which would have alerted her that the vaccination had already been administered. The nurse expressed her sincere apologies and upset that this incident and advised that she always seeks to act with care and compassion and acknowledges that a check of the vaccination history should have been completed. The Treatment Room Manager contacted the mother to discuss the incident. She sought to reassure that she had contacted the Public Health Agency who advised her that there should be no adverse consequences for the child and the normal monitoring procedure for any vaccination should be followed over the next month in relation to what to look out for and to seek medical advice if worried or concerned. The GP has also sought to reassure the mother and she has not needed to seek any further medical advice.

Learning Points/Action :

- The checklist not followed therefore this was reissued to all staff.
- Staff are not just to take what child health has on their form, but should always double check history with the parent and computer records.
- The practice will now forward a vaccination prescription sheet, which has all vaccinations listed from 8 weeks to 3 years and 4 months to reduce risk of potential errors.
- A timely return of unscheduled sheets and the green child health sheet to reduce potential for parents to be recalled.
- Computers moved into individual treatment rooms.

Compliments received

Services across the Trust receive many compliments on a frequent basis, in the form of written thank you letters, emails, cards, verbal feedback and via Care Opinion. During 2021/2022, over 3557 compliments were received, relating to a wide range of different service areas. Divisions/services also monitor the compliments they receive locally. Compliments are always appreciated as they allow patients and service users' positive experiences to be shared with our staff, as well as identifying good working practices that can be shared with other service areas. Below are some examples of compliments received during 2021/2022.



The treatment and care I received from the staff throughout my pregnancy was excellent and the staff went above and beyond their duties

My experience of A&E was a very positive one. Everyone I met through observation, x-ray and resuscitation was very helpful. The doctors and nurses were reassuring at all times. At every stage I knew exactly what was happening and my family was also kept informed.

I am really pleased with the care I receive in Antrim Day Centre. The staff are very caring and consistent in the work they do and truly earn their pay in looking after us auld folk! Cleanliness is their priority at all times and I enjoy communicating with the carers and other senior users. Long may it continue

Children Order Complaints

Complaints by, or on behalf of children about services provided to them under Part IV of the Children (NI) Order 1995, are dealt with under a separate procedure – the Children Order Representations & Complaints Procedure.

Over the year, there were no complaints dealt with under this procedure. The timescale for responding to Children Order complaints is 28 days.

Additional Information

There were 97 formal enquiries and 301 informal enquiries received during 2021/2022 with most being received from MLAs, MPs or local Councillors. A number of these were received from service users, carers or other third parties.

During 2021/2022, over 718 staff received face to face, E Learning Complaints Training Level 1 and Complaint Reviewer Training Level 2. Complaints Training was also included in a number of other courses delivered during the year including Corporate Induction, Managers' Induction and NVQ training.

If complainants are dissatisfied:

Sometimes people are not always happy with the outcome of the investigation into their complaint. The Trust encourages people to let us know if they are unhappy, and we will consider other options to attempt to resolve their concerns. The Trust routinely offers to meet complainants, as this allows the opportunity for more detailed discussions, on a face-to-face basis.

Ombudsman

Sometimes people are not always happy with the outcome of the investigation into their complaint. For those who remain dissatisfied, they may approach the NIPSO Office directly. The Advice, Support Service and Initial Screening Team (ASSIST) is the public's first point of contact with the office. Where the ASSIST team decide that they cannot resolve the complaint, the case is forwarded to the Ombudsman's Investigations Team.

In 2021/2022, there were 18 requests for information from the NIPSO Office:

- 6 cases were closed and not upheld,
- 4 cases were issued with apologies,
- 8 are on-going.

Our Vision

To deliver excellent integrated services in partnership with our community

If you would like to give feedback on
any of our services please contact:
Email: user.feedback@northerntrust.hscni.net
Telephone: 028 9442 4655

Northern Health and Social Care Trust

@NHSCTrust

www.northerntrust.hscni.net