

**To: Gloucestershire Partnership NHS Trust Board**  
**From: Jennifer Berry Mental Health Development Manager**  
**Date: 25<sup>th</sup> June 2007**  
**SUBJECT: SERVICE EXPERIENCE REPORT**

**1. PURPOSE OF REPORT**

This Report provides the Trust Board with an Executive Summary of Patient and Public Involvement (PPI) activities within the Trust between April 2006 and March 2007

**2. RECOMMENDATIONS**

It is recommended that:

- a) The content of the Executive Summary and Appendices be noted .

**3. LINKS TO TRUST OBJECTIVES**

The Trust's Patient and Public Involvement Strategy requires that there are regular reports of involvement activity.

**4. FINANCIAL IMPLICATIONS**

There are no financial implications arising directly from the report.

**5. RISK MANAGEMENT**

There is strong evidence that listening to and, where appropriate, responding to issues raised by Service Users, Carers and the Public will enable risks to be identified and controlled at an earlier stage.

**6. EQUALITY ISSUES**

The Trust's Patient and Public Involvement work is more developed within some Care groups than others and it is likely that certain groups will be under represented in any feedback received.

**7. CONSULTATION**

The purpose of this report is to provide the Board with information about issues raised by Service Users, Carers and others.

**8. AUDIT/REVIEW**

The Strategic Health Authority and PPI Forum are required to monitor and review the Trust's performance in relation to Complaints, PALS and other involvement activity.

## 9. BACKGROUND

The Service Experience Report provides an Executive Summary of Patient and Public Involvement activity between April 2006 and March 2007

The Report is in 3 sections:

**APPENDIX A** - An Executive Summary of Patient and Public Involvement activities for the year

**APPENDIX B** - This report records the number, nature and disposal of the complaints received by the Trust during the year

**APPENDIX C** - An update of the action plan to address themes arising from feedback received in the third quarter

**APPENDIX D** –An action plan to address themes arising from feedback received in the final quarter .

### EXECUTIVE SUMMARY OF PATIENT AND PUBLIC INVOLVEMENT ACTIVITIES April 2006-March 2007

#### 1. Directorate feedback

Service Users and Carers have continued to be involved in varying degrees in day to day, operational and strategic planning meetings across all care groups. See full report for details.

#### 2. Service User and Carer Groups

The Partnership Trust Service User and Carer Group has now joined with Speakout Gloucestershire which will avoid duplication of topics discussed and strengthen and consolidate membership.

#### 3. Chatterbox

The main themes arising related to the quality and variety of food on the inpatient wards at Wotton Lawn and boredom on the wards (see table p3 for actions taken).

#### 4. Star Wards

The wards at Wotton Lawn Hospital are participating in a nationwide project to improve mental health admission wards. 'Star Wards' has seventy five practical suggestions on how to improve a ward. As a result of adopting the scheme many new ideas have already been implemented at Wotton Lawn Hospital in the past six months. Occupational Therapists along with other therapists are now working seven days a week and providing evening sessions which enables service users to participate in a wide range of activities including walking groups, cooking, art, leisure, work, 'recovery' and substance misuse groups.

#### 5. Discharge questionnaires

92% of respondents found ward staff welcoming, 71% reported having found group activities helpful while 79 % found their one to one sessions helpful. The overall stay was rated as poor or very poor by 8% of respondents and as good by 50% of respondents with 24% rating it as excellent.

#### 6. Service Users and Carers Involved in training

Service Users and Carers have delivered training to medical students and 1<sup>st</sup> and 3<sup>rd</sup> year mental health nursing students. An additional sixteen Service Users and Carers have made a video of their experiences to be used in training mental health nurses and doctors.

Carers have also delivered training to Health Care Assistants, Thorn Course students, social care staff and inpatient nurses.

#### 7. Recruitment

Service Users and Carers have been involved in recruitment to a number of key positions across the Trust including the Director of Nursing, Social Care and Therapies and the Chief Executive. The Service User and Carer Best Practice Committee are working on an Involving Service Users and Carers in Recruitment Policy which will be considered by the

Joint negotiating Consultative Committee in July. Recruitment and selection training for Service Users and Carers is planned

#### **8. Getting Involved Newsletter**

A regular newsletter is now being produced by the Service User and Carer Participation Workers which updates Service Users and Carers on opportunities for involvement, forthcoming events and reports on past events and projects. It is available in both hard copy and electronically

#### **9. Carer feedback**

Footprints, a group for Carers of people with problematic substance use raised some concerns with the Substance Misuse Clinical Board re information, attitude and confidentiality .As a result a working group including Trust staff , third sector colleagues and Carers will be devising training for staff ,developing a Carers Education Group and an information pack for Carers.

#### **10. Improving the Carer Experience**

Concerns were expressed by Carers that they are not made to feel welcome on wards and often feel disregarded in the care planning process. A pilot designed to improve the Carer experience has started on Abbey Ward Wotton Lawn .Ward staff have been identified to work with Carer Participation Worker ,a new information leaflet for Carers has been produced , training will be to be set up for staff and links have been established with Carers Gloucestershire .

#### **11. GUIDe & PALS**

The two services merged in November 2006 and in January 2007 moved to be employed by the Primary Care Trust. The current location is less visible and accessible and led to a drop in activity levels due to increased home visits. Since the merge GUIDe & PALS have commenced a large publicity drive in the form of literature, displays presentations, newsletters and local papers

PALS has a close working relationship with the Complaints department. There is now joint training with input from Rethink and ICAS. PALS also liaises closely with the Trust's Service User and Carer Participation Workers and Carers Gloucestershire Mental Health workers and continues to attend the PPI Forum and has good communication with the Forum members .

The provision of PALS in Prison will be piloted in July.

#### **12. Freedom of Information requests.**

There were 37 requests in 2006/7 compared with 34 in 2005/6.The number of "hits "on the site has increased with a total of 152,469 in 2006/7.

#### **13. Themes arising from Service User and Carer feedback**

The purpose of listening to the views of Service Users and Carers is to learn from their experience of our services and to enable the Trust to respond to their views of how needs could be more effectively met. The following identifies some of the themes arising from consultation, and contact with PALS and the complaints procedure. The actions taken by the Trust may not have fully addressed or eliminated the concern completely.

THEMES ARISING FROM SERVICE USER AND CARER INVOLVEMENT	TRUST ACTIONS
Poor quality and lack of variety of food on inpatient units	New menu introduced in August 2006 which offers greater variety including a choice of 3 / 4 hot options at lunchtime with a Vegetarian option as standard as well as salad or a sandwich. There is a choice of two puddings in addition to fruit and yoghurt. Supper offers a choice of soup, salad or sandwich plus pudding and special dietary and cultural requirements can be met.
Complaints of boredom and lack of therapeutic activity on inpatient wards.	A review of recreation and therapeutic activity has been under taken at Wotton Lawn resulting in an increase of opportunities with planned activities 7 days a week and during evening time.
Concerns expressed by Carers that they are not made to feel welcome on wards and often feel disregarded in the care planning process	Pilot with Abbey Ward to improve the Carer experience .Ward staff identified to work with Carer Participation Worker ;new information leaflet for Carers produced including ten standards Training to be set up for staff and links established with Carers Gloucestershire Carers Support Workers
Concerns raised about potential impact on Carers of Service Redesign changes e.g. fewer beds, Crisis Home Treatment Teams	Carers Support Workers to identify both issues for Carers and operational issues for their team. Aim is to improve communication between the Trust workers and the Carer support Workers. The Joint Working Protocol is being reviewed and will be taken to the Adults of Working Age Clinical Board
Staff attitude is recurrent theme in Complaints	Service Directors have met with Complaints Manager and Assistant Director of Clinical Governance to identify /analyse trends in relation to particular clinical areas and individual personnel
Complaints about lack of information about medication and possible side effects	Information about what Service Users need to know has been incorporated in to the new Policy for the Prescribing and Administration of Medicines which is now ratified. Posters are due to be costed, printed and circulated in May 2007.
Survey results indicated very few service users have an out of hours telephone contact number	Partnership Accelerating Change Project addressing issue of access to out of hours numbers working closely with Crisis Services Steering Group

#### 14. Patient and Public Involvement Strategy

The Service User and Carer Best Practice Committee is currently working on a Service User and Carer Involvement Approach which will form part of a new Patient and Public Involvement Strategy.



**ANNUAL COMPLAINTS REPORT  
2006 – 2007**

73 formal complaints were made to the Trust during 2006/07, 8 fewer than in the previous year. In addition, 46 recorded contacts were resolved informally or referred to another agency.

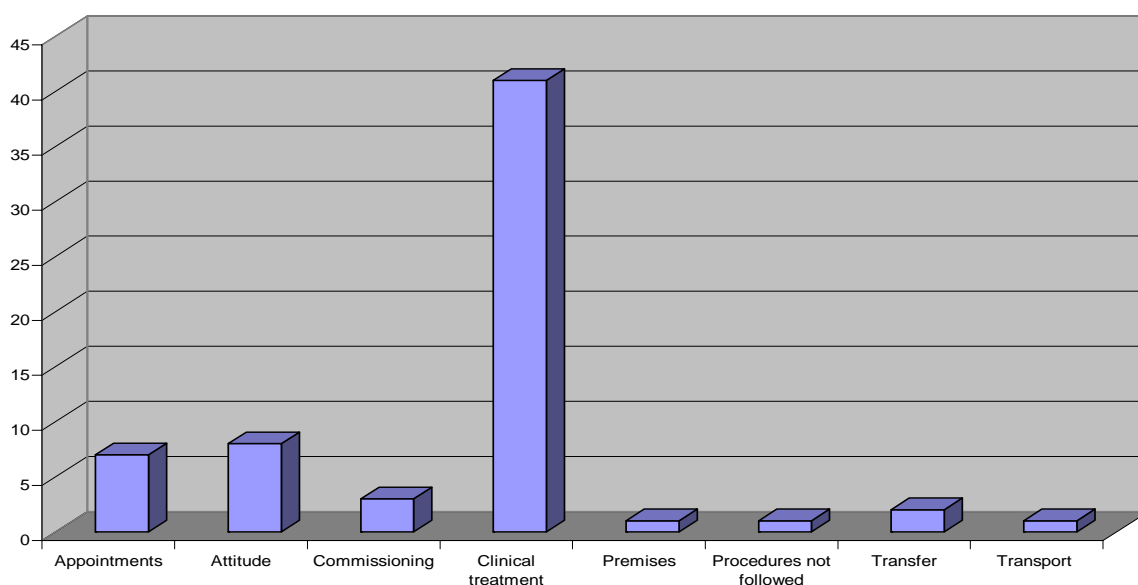
In August 2006 the Department of Health introduced new legislation increasing the timescales for responding to complaints at local level from 20 to 25 working days but also providing Trusts with more flexibility to extend local resolution deadlines, in agreement with the complainant, in order to provide a more robust response. 59% of complaints in 2006/07 were responded to within 25 working days (compared with 59% within 20 working days last year). The Complaints Department is working with clinicians and managers to improve this response rate. However in its publication, 'Spotlight on Complaints' (January 2007), the Healthcare Commission stated that it would not take issue with a provider which agreed additional time to respond to a complaint, where this had been done to provide a more meaningful response. The Healthcare Commission has identified this Trust as a better performing one at resolving complaints and has visited to look for examples of good practice which can be shared more widely.

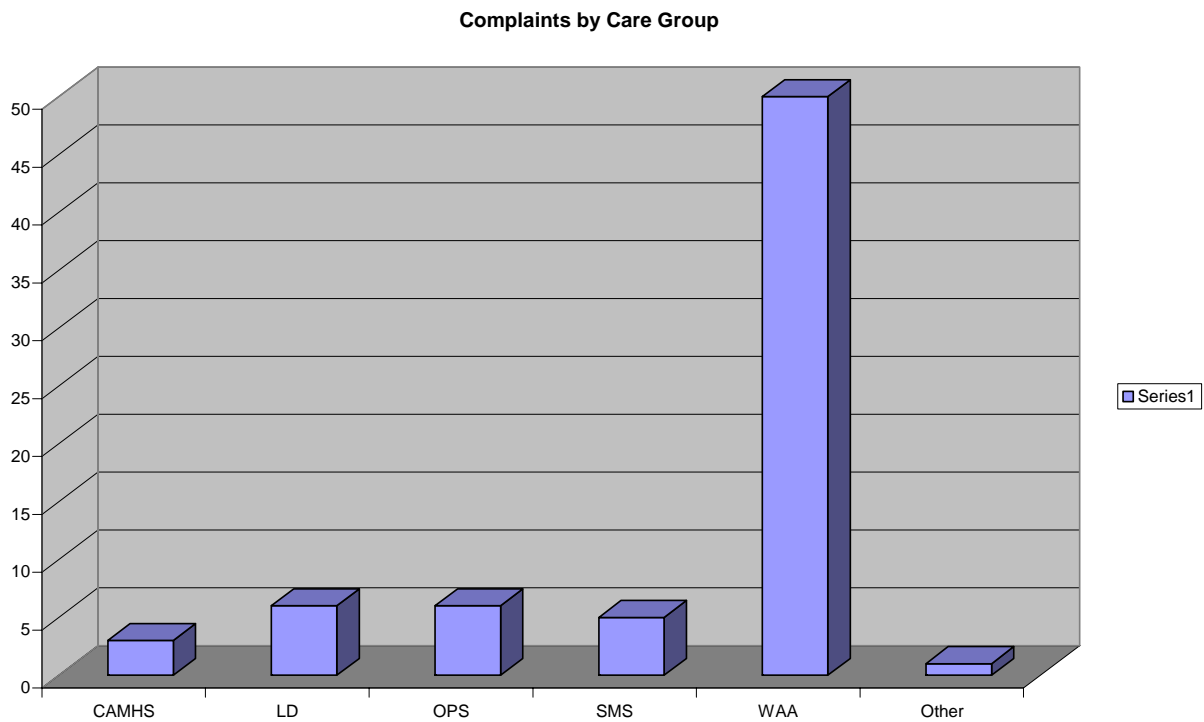
During 2006/07 the Healthcare Commission reviewed eight unresolved complaints. It made specific recommendations on three, to which the Trust has responded.

The Trust's Complaints Policy and Procedure have been revised following Department of Health legislation on NHS complaints and new arrangements on Social Services complaints.

The Complaints Manager has continued to contribute to the corporate induction programme and, in association with the Patient Advice and Liaison Service and the Independent Complaints Advocacy Service, has delivered several one-off training sessions to staff.

**Complaints by Subject (KO41)**





## SUMMARY OF COMPLAINTS

### CAMHS

19. A head teacher complained about the way in which a clinician had spoken to a member of staff.

*The clinician felt that the issue could not be resolved through a discussion with the member of staff from the school but only through a meeting with all relevant people. He had not intended to appear disparaging.*

39. A mother complained that the promised assessment of her child and meeting with her and her husband had not taken place.

*An apology was offered for the delay due to the length of the waiting list. However, the complainant appeared to have misunderstood what the Trust's assessment would provide, and the role of the Education Service was clarified.*

58. The mother of a service user complained about difficulties in arranging a convenient appointment.

*The parents met the Programme Manager. Action was taken to prevent a recurrence of the difficulties they had encountered.*

## LEARNING DISABILITIES

8. The father of a service user complained about the process, communication and consultation relating to the identification of suitable equipment and adaptations. He wished a different OT to be allocated.

*The process of identifying an appropriate solution for complex needs was outlined. It was not felt appropriate to change the OT. The complainant was unhappy with the response and met a NED and the complaints manager to clarify issues. He sought an apology from a consultant for the advice given to the team and an admission from the OT that she had made mistakes. The consultant's role was explained and a meeting with the OT and professional head was offered. The complainant remained dissatisfied and made a Freedom of Information Act application for specific information.*

20. A former service user had been referred to a WAA doctor, who had asked an LD colleague to carry out a further assessment. He complained that:

- he had communication difficulties with the WAA doctor, whose letter to his GP contained factual inaccuracies;
  - the appointment letter for the LD doctor did not make the location clear;
  - the LD doctor was late for an appointment;
  - the LD doctor did not give a clear answer to questions about his qualifications;
  - Trust doctors did not know that the PCT's contact with another Trust included access to a specific doctor whom the complainant saw privately.
- 
- *The WAA doctor's clinical findings were not affected by perceived communication difficulties or by minor factual errors for which he had already apologised.*
  - *An apology was offered for an unclear appointment letter.*
  - *The LD doctor was delayed by an emergency.*
  - *The LD doctor shared his conclusions at the end of the assessment and explained that the diagnosis letter would be delayed by the need for further research.*
  - *The LD doctor understood that the question of his experience in the use of diagnostic tools had already been resolved.*
  - *Trust doctors would not necessarily know about agreements between the PCT and other Trusts.*

*The complainant expressed dissatisfaction with the response. He asked for reimbursement of the cost of a private assessment he had arranged. The Trust could not offer this, but the complainant was invited to contact the complaints manager to identify specific issues requiring a further response.*

32. The mother of a service user complained about the way in which a doctor had described her son in a letter.

*The description was not intended to help the manager of the care home to understand the medical background. The doctor felt that this description had then been used out of context in subsequent correspondence.*

*A further letter from the service user's parents expressed disappointment with the investigation, as no witnesses had been questioned, and with the response. It was*

*clarified that a witness would not have been able to comment on the doctor's intention in using the description. The parents were assured of the doctor's commitment to treat their son with dignity and respect and were offered the opportunity to meet the doctor.*

54. The mother of a service user complained that transport had not been provided for a meeting.

*An apology was offered for confusion about the responsibility of coordinating future professionals' meetings. They had now been arranged to take place in a location which the complainant could attend independently.*

64. The parents of a service user complained about the actions of a clinician and demanded that a different one visit her son.

*The complainants met the Programme Manager and Professional Head. A way forward is being put together.*

## **OLDER PEOPLE SERVICES**

27. A service user complained about difficulties with appointments with his community nurse and a lack of contact from her at his next day hospital visit.

*A scheduled home visit did not take place due to an emergency elsewhere. The nurse asked a receptionist to contact the complainant, who telephoned while the receptionist was looking for his number. Due to a misunderstanding between the nurse and the receptionist, the complainant was expecting another home visit, but the nurse telephoned when he was not at home. She felt it inappropriate to interrupt his conversations and activities at the day hospital.*

41. The daughter of a former inpatient expressed concern to her MP about the suitability of the Charlton Lane Centre for older people.

*An explanation was provided of the service redesign and the adaptations already carried out and planned.*

45. The daughter of a deceased inpatient complained that she had not been informed of her mother's falls and that her injuries had not been investigated appropriately.

*Staff decided not to contact the family until after the doctor has seen the patient in order to be able to provide as much information as possible. This practice has been changed. Several different doctors saw the patient. Neither they nor nursing staff saw any indication of an injury subsequently diagnosed at another hospital. A meeting with senior staff was offered.*

*The complainant asked the Healthcare Commission to review the complaint. The Commission suggested that the complainant go ahead with the proposed meeting.*

48. The daughter of a service user expressed concern about the closure of Stonebury.

*The service redesign was explained. The complainant was assured that current patients would continue to receive the same level of service in relation to their assessed needs during the transition to new teams and that they and carers would be engaged in planning what affected them personally. She was encouraged to contact the local team manager to discuss any concerns about the impact on her mother.*

49. The daughter of a service user expressed concern about the closure of Stonebury and inpatient facilities at Colliers Court.

*The Service redesign was explained. The complainant was assured that current patients would continue to receive the same level of service in relation to their assessed needs during the transition to new teams and that they and carers would be engaged in planning what affected them personally. She was encouraged to contact the local team manager to discuss any concerns about the impact on her mother.*

65. The daughter of an inpatient expressed dissatisfaction with her transfer to another hospital, which she believed would result in a deterioration in her mother's condition. She was also unhappy with the response of a nurse to her questions about the move.

*The patient could not initially be admitted to her local unit because there was no bed available. The nurse felt unable to reassure the daughter about the normal procedure of moving patients to their local units. Staff did not notice a deterioration related to the transfer.*

## **SUBSTANCE MISUSE SERVICE**

14. The friend of a service user complained about the delay in transfer to a service in a neighbouring county.

*The service user had been asked to contact the new pharmacy to enquire about their capacity and the new drug service in order to commence transfer. When he did not do so, the Trust contact and arranged the transfer.*

21. A service user and her father complained about a number of issues, including the following.

- The service required a daily methadone collection and would not provide the father with a supply, although a general hospital had done so in the past.
- Clinic staff had removed the service user's car keys to prevent her from driving.
- There had been a lack of clarity about mental health assessments.
- There was general dissatisfaction with the keyworker.
- It had not been possible to meet the Chief Executive to discuss an earlier complaint (C009/06).
- The father felt unsupported.
- The service user had not been referred to a CMHT.
  
- *Prescribing decisions in a general hospital are made there and not by GPT.*
- *In view of the service user's condition, staff believed that they had a duty to intervene in order to protect public safety.*
- *The nature of assessments was explained.*

- *As the father had already met the complaints manager and a senior manager, the Chief Executive could not provide any additional information.*
- *Carers support was available.*
- *The service user could discuss the issue of CMHT input with the SMS or GP.*

37. A service user and her boyfriend complained about her keyworker's comments about them.

*The investigation is continuing.*

50. The service user expressed concern about a delayed appointment and a camera in a waiting room.

*The appointment had been delayed due to the previous client, but the complainant had not informed staff of his arrival. The camera is not functional.*

71. A former inpatient reported the way in which a member of staff had spoken to her.

*The investigation is continuing.*

## **WORKING AGE ADULTS**

2. The mother of a service user complained about confusion and communication problems surrounding her daughter's admission.

*The service user had been admitted to an out of county Eating Disorders Unit. There was uncertainty about which CMHT would support her on her discharge, but the Eating Disorders Team held her case during the transition and liaised with all parties. The complainant raised further ongoing communication problems and concerns that Trust clinicians had made a different diagnosis from those in the unit. After readmission to the unit the complainant requested written details of planned discharge arrangements and expressed uncertainty about service redesign. She declined the offer of a meeting with the complaints manager to identify her outstanding concerns and expressed further frustration with a perceived lack of continuity.*

3. A detained inpatient complained that staff had not passed on telephone messages.

*No evidence of a failure to pass on messages could be found.*

4. A detained inpatient who wished to stop smoking complained that nicotine therapy was not available to inpatients.

*The aim of the Trust's Smoke Free Policy was explained, as were the ability of detained patients to go outside in order to smoke and the need to provide suitable external areas for those detained under the MHA. Although Trust doctors can prescribe nicotine replacement therapy when it is an essential part of a person's mental health treatment, the Trust is not resourced to provide it to all inpatients. A way of doing so was being addressed.*

5. The mother of a service user complained about the waiting time for cognitive behavioural therapy.

*The waiting time to start therapy with the Eating Disorders Team is 7-10 months. The service user declined the offer of a further meeting with the Team Leader, who suggested she contact Connexions and offered a review appointment if things got worse. He would also discuss with colleagues what interim support could be offered.*

6. A service user complained that an appointment with two clinicians had been cancelled at short notice due to the sickness of one of them. He queried why it could not have gone ahead with one clinician and why the rearranged appointment was one month later.

*It was not known until the morning of the appointment that one of the clinicians was unwell. It is normal practice for two clinicians to participate in the assessment process of clients whose history is complex. The clinicians offered the next date when they were both available.*

*ICAS wrote on behalf of the complainant to clarify concerns about the secretary to whom the complainant had spoken on the day of the cancellation.*

7. The mother of a service user complained that staff were encouraging him to stay away from her, were ignoring her phone calls and spending insufficient time with him.

*The team had not encouraged the service user's decision not to have contact with his mother but they had suggested a 'cooling off' period, during which the mother would not contact her son and they would encourage him to re-establish contact. The complainant was in contact with the Carers Support Group and was welcome to talk to the Team Leader.*

9. The mother of an inpatient complained about an earlier admission, when she felt that staff had been reluctant to admit her daughter and had then discharged her prematurely.

*The admitting GP had not followed new protocols to contact the Crisis and Home Treatment Team. The patient could not be detained under the Mental Health Act and, although staff listened to the family's views, they had to follow the patient's wishes about discharge. The family was given contact numbers for the Crisis Team but appeared not to have used them.*

*The complaints manager met the complainant, who reiterated the communication problem and mentioned the loss of items on the ward. It was hoped that the creation of new teams would alleviate communication difficulties. Staff did not feel that they could have taken further steps to prevent the loss of items belonging to the patient.*

10. A service user complained that a Rethink service was not continuing.

*As resources are to be concentrated on people with complex needs, the contract would not be reviewed. Care Coordinators would assess and discuss how needs could be met in different ways.*

11. The family of a service user complained that her medication had not been monitored closely enough and that there had been a delay in admitting her. They also felt that staff had not heeded the family's concerns and that communication between staff had been poor.

*Medication had been monitored but an apology was offered that some had not been prescribed during a brief admission. Communication could have been better. The current redesign of community teams was likely to improve communication between staff.*

12. A detained inpatient complained about:
- her consultant, whom she wished to change;
  - her named nurse, who had discussed her care with colleagues;
  - the decision to detain her under a section of the MHA;
  - the cleanliness of her room;
  - a delay in a review of her leave;
  - the removal of her belongings to another room.
- 
- *The Consultant was not clear about the reasons for her dissatisfaction and would discuss this with her.*
  - *The named nurse had discussed the complainant's case with colleagues during handover to the next shift.*
  - *The complainant was already exercising her rights of appeal.*
  - *No particular problem with cleanliness had been noted; domestic staff enter patients' rooms only with their agreement.*
  - *The complainant approached the consultant in a public area and was told that leave would be discussed in the confidentiality of the forthcoming ward round.*
  - *It was necessary to allocate the complainant a different room when she was on leave.. Her belongings were kept safe until her return.*
15. The sister of a former service user complained about the response of a community nurse to her sister's request for support.

*After being contacted by the former service user, the nurse spoke to the GP, who did not consider CMHT input necessary. The complainant declined the offer for the nurse to discuss concerns with her sister and reiterated her dissatisfaction. It was clear that it would be difficult to resolve differing memories of the conversation between the former service user and the nurse.*

16. The husband of a former inpatient complained that the diagnosis of a previous psychiatrist had not been agreed with and that medication would not be prescribed. He sought reimbursement of the cost of private treatment which she had subsequently received.

*Trust staff did not agree with the diagnosis of depression made in the past by a private consultant elsewhere in the country. The Trust consultant recommended psychological therapy rather than medication but agreed to prescribe medication for the service user's anxiety until it started. There was no indication that the wife had discussed with her GP the possibility of a referral to another NHS consultant for a*

*second opinion. The Trust could not consider reimbursing the cost of private treatment.*

17. The mother of a service user complained about the response to her daughter's refusal to enter the building to attend an appointment, as she felt that they could have.

*Staff tried to persuade the daughter to go in but could not prevent her from leaving the site. The mother telephoned the Complaints Department to say that she would put in writing her dissatisfaction with the perceived lack of effort to intervene but did not do so.*

18. The wife of a detained inpatient complained that:

- her husband's initial admission had been voluntary and he had discharged himself;
- on his readmission on a section of the MHA he had been allowed to go out unsupervised;
- his mobile phone had not been taken away;
- the requirement to maintain confidentiality restricted the information given to her;
- she felt dismissed by staff.

*Compulsory admission is used as a last resort. The patient agreed to admission and, when he discharged himself against medical advice, was not considered detainable.*

*Leave can be a therapeutic tool but was suspended when the patient breached his conditions.*

*Staff initially had insufficient grounds to remove the phone.*

*The rules on confidentiality were explained. New paperwork provides additional guidance to clinicians and an amended consent to information sharing form.*

*An apology was offered that the complainant felt her views were not listened to. However, the patient's records indicated that staff took her anxieties into account.*

22. The husband of a service user complained about the CMHT's delay in responding to letters from him and the GP.

*The GP was unaware that, as the service user had recently discharged himself, the team felt that a time of reflection outside the service would be appropriate. The Team Leader's letter to the husband crossed in the post with his.*

23. A solicitor wrote on behalf of a service user to complain that two different consultants had made different diagnoses and to request a second opinion.

*The difference in opinion was minor. The service user had been discharged to her GP, with whom she should discuss a second opinion.*

24. The mother of a service user was concerned about a deterioration in her condition and a reluctance on the part of the CMHT to engage with her.

*The service user was increasingly reluctant to engage with staff, but her CPN remained in regular contact with her.*

25. A detained inpatient wrote many letters relating to his treatment.

*The complainant was encouraged to challenge his detention by asking for a review by the MHA Managers and/on Mental Health Review Tribunal and to work with an advocacy service to identify issues to be addressed through the complaints procedure.*

26. A service user was disappointed by the lack of continuity in the doctors he was seeing in clinic.

*Since the complainant's transfer from another team, he had had the same care coordinator, but changes to his medication had led to more frequent medical appointments. The nature of the issues being addressed was considered suitable for doctors at SHO grade, who are normally in post for a limited period. Although the complainant had not seen the consultant recently, the SHOs had discussed medication options with him.*

28. A service user complained about statements made to him by members of a CMHT.

*Staff had different recollections of some conversations. The complainant declined offer of a meeting with the complaints manager to try to find a way forward.*

29. The mother of a service user complained that:

- an interpreter had not been present during assessments;
  - she had been diagnosed incorrectly;
  - a second opinion had not been provided;
  - the complaints manager had not returned telephone calls;
  - a Community Care Assessment had been delayed.
- 
- *An apology was offered for a misinterpretation of the service user's ability to communicate in English.*
  - *Three psychiatrists did not consider that the service user had the diagnosis identified by her mother.*
  - *The complaints manager understood that the complainant's partner would be making contact. When a subsequent message was left with both the Complaints Department and PALS, it was agreed that PALS would make contact in order to avoid duplication.*
  - *An apology was offered for the delay in a Community Care Assessment. The Trust would clarify with the County Council responsibility for the assessment of vulnerable people without an identified mental illness.*

30. A service user complained about the difficulty in seeing a psychiatrist and the lack of diagnosis.

*The Consultant's view was that the complainant was not suffering from a complex mental health problem but from emotional difficulties, for which talking therapies could be helpful. The complainant was already working with a CPN and was seeking counselling.*

31. The husband of a service user complained to his MP about a lack of input from her CMHT.

*A limited reply was provided, as the Trust did not have the service user's consent to share information. A reassurance was given that the team was in regular contact and was aware of the husband's concerns. The husband was encouraged to seek a carer's assessment.*

33. A service user complained that he had been discharged from a CMHT after his refusal to see a doctor whose first language was not English. He felt that the explanation given to his GP suggested racism on his part.

*The Complainant and Team Leader had different understandings of their conversation about the unwillingness to see the doctor. Whatever the basis of the wish not to see the doctor, there was no other available whose first language was English.*

*The complainant remained concerned about the impression given to the GP, who received a further letter of clarification from the Team Leader.*

34. The husband of a service user complained about the uncoordinated approach towards his wife's care and the threat of a loss of service.

*The service user also had physical needs being treated by another Trust and she was advised to discuss the coordination of these and her mental health care with her GP. The service redesign was also explained.*

*The husband replied seeking confirmation that his wife would not be discharged from the Trust's services. It was confirmed that she was transferring to a recovery team.*

35. A service user expressed unhappiness with a change in his clinical team.

*The service redesign was explained. The complainant's keyworker would not be transferring to his new team. He met the complaints manager to reiterate his concerns. A further letter was sent to him assuring him that his new team would get to know him as soon as possible. The complainant contacted the Healthcare Commission, which took no further action.*

36. A service user's son, who was also her Nearest Relative under the MHA, complained about the lack of information about her care.

*As the service user had not been detained under the MHA for several years, the Nearest Relative status did not currently apply. An apology was offered for any misunderstandings of the service user's wishes about the sharing of her confidential information. The CMHT had confirmed with her that she was happy for information to be shared with her son.*

*The complainant contacted the Healthcare Commission, which is carrying out an initial review of the complaint.*

38. The mother of a service user complained about the service redesign and his wait for psychological therapy.

*The service redesign was explained. The complainant initially declined a meeting to discuss her concerns but then did so. She expressed frustration with the wait for therapy, especially as her son's former keyworker had reportedly stated several months earlier that he was at the top of the waiting list. She was also frustrated that her son had seen different doctors, who appeared to offer contradictory opinions. The situation with psychological therapy was explained. The other issues remain under investigation.*

40. The husband of a service user raised concerns to his MP about the impact on his wife of service redesign.

*The service redesign was explained. The service user would continue to receive a service from the Trust.*

42. The mother of a deceased service user expressed general dissatisfaction about her late son's treatment and complained about the Trust's response to her attempts to contact a member of staff.

*The son's treatment was several years ago and the complaints manager provided an overview of the last year's input. The complainant's ongoing attempts to contact a member of staff who had had no involvement in her son's care were finally reported to the police. The complainant queried whether the individual member of staff had contacted the police or whether the Trust had done this. It was confirmed that the Trust had done so, which the complainant continued not to believe.*

43. A detained inpatient complained about:

- his detention under the MHA;
  - his consultant's and ward staff's refusal to give medication;
  - the side effects of his medication;
  - an alleged assault by a member of staff;
  - refusal to allow walks outside;
  - lack of blood tests;
  - finding a table on the floor.
- 
- *The Mental Health Review Tribunal had decided not to discharge the complainant.*
  - *At a clinic attendance the complainant had requested medication but had then changed his mind. Whilst an inpatient he had asked for something to help his anxiety and staff had explored whether there was an alternative.*
  - *Information was provided on the side effects, which did not include the specific problem about which the complainant was concerned.*
  - *A member of staff had directed the complainant back to the ward with minimal force.*
  - *One request to go outside had initially been declined due to the weather and the complainant's mental state.*
  - *There was no indication in the complainant's records of blood tests not having been carried out.*
  - *There may be rare occasions when patients manage to conceal their tablets.*

46. A service user expressed concern about the possibility of discharge due to service redesign.

*The service redesign and basis on which people could be discharged to their GPs were explained. The new recovery team would be asked to see the complainant.*

47. A service user complained that she was no longer seeing her psychiatrist and would lose her CPN.

*The service redesign was explained. The complainant would continue to see a psychiatrist and to have a CPN, whose identity was not yet known.*

51. A service user complained about the closure of a woodwork group.

*The service redesign was explained. The woodwork group had run for a short time twice a week but would continue to meet weekly.*

52. A service user complained that appointments with a therapist had not been helpful. She stated that the therapist had:

- said therapy would not work;
  - refused her request to be accompanied by her mother;
  - attributed her problems to her relationships;
  - had not sent her a copy of the letter to her GP.
- 
- *The therapist shared her view that CBT might not be the most helpful starting point.*
  - *The therapist had suggested that the complainant's mother join them during their meeting, but the complainant had felt this was unnecessary.*
  - *The therapist commented that the complainant's condition might have developed as a coping strategy to help manage difficult experiences and feelings, including those in relationships.*
  - *A letter had not yet been sent to the GP, as the assessment process had not been completed.*
  - *The complainant's GP requested a second opinion and a meeting with a different therapist was offered.*

*The complainant disagreed with some of points. A trial of therapy was about to start with another therapist.*

53. A service user complained about plans to discharge her during service redesign.

*The service redesign was explained. The complainant was continuing to receive a service from the Trust.*

55. A service user expressed concern about service redesign.

*The redesign was explained. The complainant would continue to see the same psychiatrist and nurse.*

*The complainant wrote again with concerns about the new recovery teams, timescales for working people and the waiting times for psychological therapy. Recovery teams would be expected to apply the timescale in a sensitive and clinically appropriate way. An explanation was given of how the Trust is tackling long waiting times for psychological therapy.*

56. The mother of a service user felt that the level of support given to her son was inadequate and described her own stress.

*The service user had been discharged from a rehabilitation unit due to his behaviour. After a day in bed and breakfast accommodation he was asked to leave due to his behaviour. He went to his mother's home, where an incident led to his arrest and conviction. On his release from prison a care plan was agreed, which involved daily and crisis support. A review of the events of the day when the service user returned to his mother's house had identified some organisational issues.*

*The mother expressed thanks for the reply and raised comments which it was felt would be best addressed by meeting to discuss them.*

57. The mother of a service user complained that her son had lost his keyworker and other support.

*Service redesign had resulted in a change of keyworker. The service user had been part of a group which was currently being led by other service users and he continued to have access to an advocacy service. The mother was provided with the details of carers' support.*

60. A member of a support group contacted her MP to raise concerns about support for people with eating disorders.

*The complainant had already received a letter from the team setting out its challenges. The team had reviewed the most effective use of its resources.. The Eating Disorders Strategy Group had been reconvened.*

61. The mother of a service user complained about the lack of support provided to her daughter and in particular that:

- she was looked after by inexperienced staff;
  - she had not had a promised visit;
  - a general hospital admission had not been risk assessed;
  - there had been insufficient support in hospital;
  - there had been no plans for administering medication in hospital.
- 
- *The carers providing the care package are appropriately trained.*
  - *The lack of one visit was an oversight, although a member of staff had phoned.*
  - *A copy of the risk assessment had been provided to the complainant.*
  - *There were no incidents in hospital.*
  - *Hospital staff took on responsibility for the dispensing of mental health medication.*
  - *The Team Leader had offered to meet with the complainant.*

62. A service user complained about administrative difficulties with appointments and a lack of psychological therapy input.

*An apology was offered that appointments had been sent to a previous address. Steps were being taken to prevent a recurrence. An explanation was provided of action being taken to address the long waiting times for psychological therapy.*

63. A service user complained about the actions of his care coordinator, including the failure to provide a coping strategy.

*Some of the complainant's allegations were unclear. His contact with his care coordinator had been paused due to his verbal aggression. However, he remained in touch with a sports therapist and had an open invitation to contact his care coordinator again.*

66. A service user complained about the waiting time for an appointment for psychological therapy and about a letter asking if she wished to remain on the waiting list.

*The difficulty of the waiting list was acknowledged and an explanation was given of the action being taken to address it. This included writing to everybody waiting for treatment in order to confirm whether they still wished to be treated or if their circumstances had changed.*

67. An inpatient described the way in which he had been restrained as brutal and unnecessary.

*The complainant recognised that he had responded to a request not to use his phone in a communal area in a way which could have been perceived as aggressive. The investigation indicated that, although the decision to restrain the complainant had been justified,, the incident could have been avoided if the complainant had understood the policy on the use of mobile phones.*

68. The mother of a service user complained about:
- a lack of information about her section;
  - her confinement to the ward;
  - leave taking place without the community team being informed;
  - no follow up on discharge;
  - no problems obtaining a repeat prescription.

*The investigation is continuing.*

69. A service user complained about the closure of a day centre.

*Although the location was changing, the service would continue.*

70. A service user complained about a lack of support from his social worker.

*The social worker had already apologised for a misunderstanding that had led to a failure to meet on one occasion. The complainant was encouraged to continue to work with the social worker, who remained willing to work with him.*

72. A former inpatient complained that a delay in receiving treatment for a medical problem had been deliberate in order to make him accept mental health treatment.

*The complainant did not initially consent to a physical examination. When he did so, a physical problem was identified and an appropriate referral made.*

73. A service user complained that she could not be referred for psychological therapy.

*The difficulty of the waiting list was acknowledged and an explanation given of action being taken.*

74. A former service user complained about his psychiatrist's attitude prior to his discharge.

*The psychiatrist denied the allegations of an inappropriate action, which were not supported by what had been documented in the health records. The complainant had been discharged because no further input could currently be offered.*

## **OTHER**

44. A member of the public asked how and why it had been agreed to publish the consultation document on proposed changes to mental health services only in the Trust's website and to produce a hard copy only on request. She complained that her own request had not been responded to.

*An apology was offered that her emailed request had not been responded to. The distribution of the consultation document formed part of the overall communication strategy agreed between the Trust and the HOSC. There appeared to have been extensive coverage of the consultation in the local media.*

*The complainant remained concerned about the availability of the document and could not accept NHS Trusts' reliance on the editorial decisions of local media. She also reported her request for a list of consultation meetings. A list was provided. The complainant's comments would be taken into account during the Trust's review of its communication strategy.*

*The complainant requested details of advertisements placed in the local media. No advertisements were published, but the complainant was sent copies of a number of articles specifically mentioning the consultation meetings.*

## COMPLAINTS CONSIDERED BY THE HEALTHCARE COMMISSION

59/04

The Commission made a number of recommendations having reviewed a complaint from parents of a deceased service user.

- Ensure that all staff on the unit receive training in the completion of incident forms.  
**All staff on the unit have received training. A completed template of a form is on display. All senior managers have been trained in root cause analysis.**
- The Trust to offer an unreserved apology for the way in which the investigation of an injury was handled and for the additional distress caused.  
**This was done.**
- The Trust reflect on the nursing advisor's comments about the unit's environment.  
**An internal review was carried out. The unit will close in the near future.**

53/05

The Commission made a number of recommendations having reviewed a complaint about the decision to discharge a service user after inappropriate behaviour.

- Ensure that the complainant receive an independent assessment as soon as possible.  
**This was arranged.**
- Explain why the complainant's assessment could not be conducted until resolution of the complaint.  
**This was done.**
- Review complaints policy and practice.  
**This took place during 2006-07.**
- Consider reminding staff of the importance of ensuring care plan information is communicated to patients.  
**CPA paperwork has been revised. The complainant was provided with copies of two relevant forms.**
- Consider reminding staff of the importance of maintaining support for patients at all times, even if the person they ask for is not available.  
**The relevant CPA form was shared. This will be included in future training.**
- Consider ensuring that one individual clinician's supervision and case management decisions are maintained at all times.  
**The clinician takes part in regular clinical supervision.**

- Consider documenting minutes of meetings.  
***A statement to this effect has been added to the revised Health and Social Care Records Policy and Procedures.***
- Consider carefully who should attend any future meetings with patients or complainants, decide each person's role and explain in advance.  
***There is guidance in the new Care Coordination Policy and in the revised Complaints Policy and Procedure.***

80/05 The Commission made a number of recommendations having reviewed a complaint from the husband of an inpatient.

- A named doctor should discuss the case with a senior medical colleague.  
***This has happened.***
- A named doctor should discuss the case with a senior medical colleague.  
***This has happened.***
- The Trust should review its record keeping policy.  
***This is currently taking place.***
- The Trust should review its policy on Section 17 leave.  
***This is currently taking place.***

51/06 The Commission is carrying out a further review of a complaint about an inpatient who sustained a serious injury after leaving the ward.

62/06 The Commission is carrying out a further review of a complaint from a service user unhappy with the support provided.

65/06 The Commission reviewed a complaint that a mental health diagnosis had been reached without consideration of a physical diagnosis. It considered the Trust's actions appropriate and made no recommendations.

35/07 The Commission reviewed a complaint about changes to a service user's clinical team and location of appointments but made no recommendations.

45/07 The Commission received a complaint about a delay in informing a family of their mother's fall and inadequate investigations of an injury. It advised the complainant to take up the Trust's offer of a meeting to discuss the concerns.

## Appendix C

### UPDATED ACTION PLAN TO ADDRESS THEMES ARISING FROM SERVICE USER AND CARER FEEDBACK

Issues arising from feedback	Actions	Update
<b>Poor quality and lack of variety of food on inpatient units</b>	Raise issues with Anne Hannaford Hotel Services Manager	New menu introduced in August 2006 which offers greater variety including a choice of 3 / 4 hot options at lunchtime with a vegetarian option as standard as well as salad or a sandwich. There is a choice of two puddings in addition to fruit and yoghurt . Supper offers a choice of soup, salad or sandwich plus pudding and special dietary and cultural requirements can be met.
<b>No provision of water machines in inpatient units</b>	Approach Modern Matrons with view to applying to Charitable Trust funds	Raised with Matron Managers – Peag meeting in June to discuss.
<b>No warning of lights going out in bathroom in inpatient units unless there is movement</b>	Offer of production of poster advising that movement activates light for display in bathrooms	Raised with Matron Manager
<b>Anxieties of Service Users and Carers re implications of Service Redesign reinforced by anxiety of staff</b>	Trust Board to be aware that a more robust system of support for staff put in place at an earlier stage might have been helpful in managing the process. Similarly guidance on a consistent message to be given by staff to Service Users and Carers might have minimised anxiety .	Brought to Board's attention

<p><b>Concerns expressed by Carers that they are not made to feel welcome on wards and often feel disregarded in the care planning process</b></p>	<p>Training input to Mental Health Nurse training</p> <p>Input to mandatory risk assessment training</p> <p>Input to induction training</p> <p>Pilot with Abbey Ward to improve the Carer experience</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ward staff identified to work with Carer Participation Worker ;new information leaflet for Carers produced including ten standards Training to be set up for staff and links established with Carers Gloucestershire Carers Support Workers .</p>
<p><b>Concerns raised about potential impact on Carers of Service Redesign changes eg fewer beds, Crisis Home Treatment Teams</b></p>	<p>Carers Gloucestershire and GPT Carer Participation Worker to discuss Carer Support issues</p>	<p>Carers Support Workers to identify both issues for carers and operational issues for their team . Aim is to improve communication between the Trust workers and the Carer support Workers .The Joint Working Protocol is being reviewed and will be taken to the Adults of Working Age Clinical Board .</p>
<p><b>Staff attitude is recurrent theme in Complaints</b></p>	<p>Service Directors to meet with Complaints Manager and Assistant Director of Clinical Governance to identify /analyse trends in relation to particular clinical areas and individual personnel</p>	<p>Meeting took place 7/3/07</p>

## Appendix D

### ACTION PLAN TO ADDRESS THEMES ARISING FROM SERVICE USER AND CARER FEEDBACK JAN-MAR 2007

Issues arising from feedback	Actions	Accountability	Timescale for completion
<p><b>Carers Gloucestershire have reported increased anxiety amongst Carers re the impact of Crisis Resolution / Home Treatment Teams eg fewer admissions and earlier discharges</b></p>	<p>Information /training to be offered to Carers Gloucestershire by Team manager and Consultant Psychiatrist re both the evidence base for crisis resolution /home treatment and the local experience to date</p>	<p>Service Director AWA /Substance Misuse</p>	<p>August 2007</p>
<p><b>Concern expressed that extended sick leave of frontline practitioners impacts on service user care when no cover is offered</b></p>	<p>As reallocation of cases and cover during sick leave is not covered within CPA documentation Mental Health Development Manager to attend Team Managers Forum to discuss current practice.</p>	<p>Mental Health Development Manager</p>	<p>August 2007</p>
<p><b>Working service user told unable to have depot injection outside 9 - 5 hours</b></p>	<p>Suggested by Service Director that administration of depot by Practice Nurse is less stigmatising although there is more scope for negotiation with Teams working more flexible hours</p>	<p>Service Director AWA /Substance Misuse</p>	<p>May 2007</p>
<p><b>Concern expressed to Pals that long waiting list for Psychological Therapies impacting on Service User's mental state</b></p>	<p>Currently no new referrals being accepted to enable current waiting list to be addressed. Primary Care Assessment and Psychological Therapies Teams to be reviewed and additional Cognitive Behavioural Therapy training to be available for PCAT workers .</p>	<p>Service Director AWA /Substance Misuse</p>	<p>Ongoing</p>

<p><b>Concerns expressed to Pals by Carers in the Forest of Dean that bed closures at Colliers Court will result in admissions elsewhere and ultimately impact on the Secretary of State's decision</b></p>	<p>Confirmation by Service Director for Older Age Services that there have been no transfers from Colliers Court due to shortage of beds. 50 of an available 65 beds are occupied and there is a reduction in the length of stays.</p> <p>Ward staff happy to talk to service users about current situation.</p> <p>Pals/Guide manager can access monthly control reports written for Trust Board in relation to bed occupancy</p>	<p>Service Director for Older Age Adults</p>	
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