| **Report of:** | Deputy Director of Corporate Affairs and Governance  
| **Responsible Officer:** | Director of Corporate Affairs and Governance  
| **Accountable Officer:** |  
| **Authors of Report:** | Customer Care Manager  
| **Subject/Title** | Appendix 2b Annual Complaints Report 2018/2019  
| **Background papers (if relevant)** | Complaints Policy 2018  
| **Purpose of Paper** | To provide committee members with a report on the complaints/PALS activity, identifying trends and lessons learned for 2018/2019  
| **Action/Decision required** | To note the contents of the report, assurance provided and improvement action proposed.  
| **Mitigates Risk Number: (identify)**  
| **On Corporate Risk Register** | CRR 341 Score 9: If we do not comply with Health & Social Care 2008 (Outcome 16, Assessing and monitoring the quality of service provision) then this could lead to restrictions on service provision and financial penalty.  
| **Mitigates Risk Number: (identify)**  
| **On Assurance Framework** | AF 2 Score 12: If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population.  
| **Link to Care Quality Commission Domain** | All domains  
| **Link to:**  
| ➢ Trust's Strategic Direction  
| ➢ Corporate Objectives | Patients - Provide the best services to our population through improvements to safety, productivity and patient experience.  
| | People – Empower, develop and value staff in providing innovative patient focused care.  
| **Legal implications - (identify)** | None  
| **Impact on quality** | This report provides assurance in relation to lessons learned and improvements to practice as a result of complaints.  
| **Resource impact** | None  
| **Impact of equality/diversity** | None  
| **Avoid acronyms or abbreviations - if necessary list:** | A&E – Accident and Emergency  
| | PALS – Patient Advise and Liaison Service  
| | FFT – Friends and Family Test  
| | MAU – Medical Admissions Unit  
| | CAG – Corporate Affairs and Governance  
| | PHSO - Parliamentary Health Service Ombudsman  

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Customer Care Annual Report 2018/2019

The purpose of this paper is to present the annual overview for Complaints and Patient Advice and Liaison Service (PALS) for the period 2018/2019.

This report includes information on the following:
- Introduction
- Governance Arrangements
- Complaints Performance
- Key Performance Indicators for Complaints
- Learning and Improvement from Complaints
- Parliamentary and Health Service Complaints
- Patient Advice and Liaison (PALS) Performance
- Improvement Actions for 2019/2020

The trust is committed to a continuous improvement approach which is achieved within customer care through listening and responding to feedback from patients and their relatives. The lessons learned through complaints, PALS and compliments received influence the processes and polices staff follow, as well as their practice on an individual and team level.

1 GOVERNANCE ARRANGEMENTS

1.1 The trust has a Complaints Policy which was approved by the Board in July 2018. This policy is accessible to patients, their relatives, the wider public and staff via the trust website. To support the operational implementation of this policy, a complaints procedure is in place, which outlines responsibilities for complaints handling, investigation and review with expected timescales.

1.2 Trust responses to complaints and the learning identified are reported each month to the Safety Quality and Standards (SQS) Committee, the Quality Forum and within directorate SQS Sub-committees via the Governance Data Packs. In addition, a quarterly Complaints, Incident, Claims, and Patient Experience Report is presented to the SQS Committee and Risk Management Sub-committee. Patient stories arising from complaints are presented and discussed at Trust Board and the SQS Committee.

1.3 The trust has a responsibility to ensure that complaints are handled in line with statutory requirements and that patients and their relatives/carers are advocated for and supported to achieve a satisfactory and timely resolution to their concerns.
Complaints and any associated action plans are monitored within the directorates to ensure that learning translates into practice to reduce the likelihood of re-occurrence in the future. The Customer Care Manager is responsible for monitoring evidence provided by directorates to provide assurance on actions taken.

The trust is required to complete and submit a KO41 report to the Department of Health on a quarterly basis. The KO41 monitors written Hospital & Community Health Services complaints (by service area, profession and type) received by the NHS each year.

Complaints data is also a contributing indicator within the monthly Risk Assessed Data Report (RDaR), which retrospectively identifies service hot spots where quality may have been impacted. This report highlights associated Learning from all areas.

In March 2019, the annual assessment of the trust against the standards in the Equality and Delivery System took place. The stakeholder group received a presentation from the Customer Care Team on how embedded trust systems and processes support individuals from seldom heard from groups (or their relatives) to raise concerns or complaints about their care. This includes those with autism and learning difficulties. The outcome was a rating of ‘outstanding’.

There have been a total of 134 complaints received which is a decrease of 4% (6 complaints) compared to 2017/2018 where 140 complaints were received.

The top complaints categories identified are:
- Clinical treatment 56% (75)
- Staff attitude/behaviour 11% (15)
- Date for appointment 8% (11)
- Ineffective verbal communication 8% (11)
- Ineffective written communication 4% (6)
These categories are in line with national mandatory complaints reporting requirements.

2.3 Within the category of clinical treatment the top four trends identified were co-ordination of medical treatment (31), nursing care unsatisfactory (15), unclear diagnosis (9), treatment didn’t have expected outcome (4) and patient required further information (3).

2.4 The service areas which received the most complaints about clinical treatment were the Emergency Department (ED) (13), Surgical Specialities (12) and MAU (5).

Further breakdown about ED, clinical treatment complaint themes shows that there were six concerns raised about the co-ordination of medical treatment, two concerns about the nursing care not being satisfactory and five concerns about various other issues. Key learning and associated actions are highlighted in section 4.

2.6 The breakdown from Surgical Specialities on clinical treatment highlights that there were seven concerns about the co-ordination of medical treatment, three concerns with an unclear diagnosis and two concerns didn’t have the expected outcome. Key learning and associated actions are highlighted in section 4.

3 KEY PERFORMANCE INDICATORS FOR COMPLAINTS

3.1 The trust has met its target of 100% for all complaints to be responded to within timescale agreed with the complainant.

There were 135 complaints responded to of which 95% (128) were responded to in the initial timescale agreed with complainants.

Sixteen (100%) of complaints were responded to within the locally agreed timescales of 25 days. 119 complaints were initially agreed for response in 45 days. An extension was subsequently agreed for seven of these. 112 (94%) were responded to within the initial 45 days but 100% were responded to in the agreed extended timescales.
3.2 As part of the complaints resolution process, complainants are offered face to face meetings. Six facilitated meetings took place between clinicians and complainants. These meetings were either held before the investigation to assist in clarifying issues and facts from the complainants’ perspective or to feedback the outcome of the investigation.

3.3 During the year, 99% of new formal complaints were acknowledged within three working days. The target was 100%. This refers to one complaint. The complainant already had a complaint (A) with the trust and the second complaint (B) was mistakenly registered as part of complaint A as opposed to a new complaint being opened.

4 LEARNING AND IMPROVEMENT FROM COMPLAINTS

Safety measures have been improved in ED to ensure strengthen sepsis screening and clinical observations for paediatric patients

4.1 • The Clinical Lead for ED has communicated directly with a locum doctor agency for them to share a complaint and its outcomes with the identified doctors involved.
• The Operational Manager in ED has completed an audit of the documentation made by the clinical and nursing staff to ensure that documentation and the co-ordination of care is being undertaken to the standard required.
• Complaints have been shared as part of the training sessions with the ED junior doctors.
• Refresher training on sepsis and on paediatric early warning scores has been undertaken in ED. Ongoing training is also taking place on sepsis screening for all clinical staff.
• Children triaged as ‘orange’ will not be asked to wait in the paediatric waiting area.
• The Ward Sister and Matron from ward 2 have reviewed the local induction that all new staff, including agency staff have to undertake, making it more specific to individual areas.
• Specialist Palliative Care Nurses to visit patients and carers regularly/daily, where appropriate when a patient is in hospital on the end of life care plan or nearing the end of their life.
• The care pathway in terms of nutrition has been updated with a planned rollout to staff which includes education and training with regard to the completion of food charts.
Improved communication and information for patients continues to be a priority

4.2 The appointment letter which is sent to patients who are attending for an enema will have its wording amended to include, 'digital rectal examination may take place at the beginning of the test' to inform patients of this possibility prior to attending the hospital.

The day case patient pathway is under review by the matron, senior sister and pre-operative team. The aim being to improve the patient experience by streamlining processes and improving the information offered to patients.

Appropriate management action has been taken in incidences of poor staff performance

4.3 Management action has been taken in line with trust policies and procedures to address individual staff performance or conduct issues identified through complaints investigations, including:

- One to one formally documented meetings with supervisors or managers
- File notes placed in personal files
- Audits of practice to ensure that standards have improved
- Documented reflection on learning, this also supports revalidation for nurses and doctors
- Discussion in annual appraisal
- Additional training provided or the need for staff to refresh familiarity with trust policy.

5 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

Positive external assurance on complaints handling

5.1 There were two reports issued to the trust from the Parliamentary and Health Service Ombudsman during 2018/19 following investigation of unresolved complaints.

One complaint was not upheld and one complaint was partially upheld with recommendations. There were no findings in relation to the way the trust had handled either of the complaints.

5.2 Recommendations:

The trust was asked to write to the complainant within a month of receiving the report from the Parliamentary Health Service Ombudsman apologising for the failings. It was also asked to provide the complainant with an action plan within
The recommendations were completed and reported back to the PHSO who were satisfied with the trust’s actions and closed the case.

6 PATIENT ADVICE AND LIAISON (PALS)

6.1 The role of PALS is to offer confidential advice, support and information on health-related matters. PALS staff provided a point of contact for patients, their families and carers.

There have been a total of 1121 PALS received this year which is an increase of 26% (229) compared to 2017/2018 where 892 were received.

Twenty meetings took place with clinicians and users of our service as a result of a PALS concern raised. These meetings were either held before the concerns were looked into to assist in clarifying issues and facts from the person’s perspective or to feedback the outcome of the investigation.

The areas that received the highest volume of PALS were Surgical Specialities 22% (243), Accident and Emergency 7% (78), Radiology 6% (64) and Corporate Affairs and Governance (general enquires) 4% (44), Obstetrics and Gynaecology 4% (40).

6.2 PALS enquiries often feature more than one area of concern. The information below is based on the main area of concern.

- date for appointment 27% (307)
- clinical treatment 17% (192)
- ineffective verbal communication 12% (135)
- ineffective written communication 9% (77).

Within the category of date for appointment the themes identified were in terms of:

- An unacceptable time to wait for an appointment 14% (158)
- Cancellation of appointment 6% (65)
- General enquiry about appointments 5% (60)
- Appointment date continues to be rescheduled 2% (19).

7.0 LEARNING AND IMPROVEMENT FROM PALS
Learning from PALS cases has contributed to improvements in patient care

7.1 The patient experience of the ED streaming process needs to improve, as there is a lack of privacy at the streaming desk which causes concern for both patients and staff.

- Initiatives are in place to improve the streaming process particularly with reference to privacy and dignity, for example moving patients through to other areas for nurse assessment and the use of individual rooms to use for private assessments.
- New signage is now evident in the waiting room and at each reception desk offering a private place to speak to staff if required.
- Communications have gone to all staff through team meetings to ensure consistency in the use of the numbering system in relation to the streaming process.

7.2 Patients attending the breast clinic are waiting too long for an appointment to be seen.

- Additional breast clinics have been arranged, as well as extra patients being seen in the pre-arranged clinics.

7.3 Some patients attending the Endoscopy and Treatment Unit do not understand what the term sedation means.

- The Endoscopy and Treatment Unit leaflets are being updated to explain that under sedation does not mean that the patient is fully asleep.

8.0 PALS OUTREACH

Proactive PALS Outreach provides positive feedback

8.1 The PALS outreach service continues to provide successful patient outcomes, with the team liaising with 1464 patients and relatives during the year. This involves a member of the Customer Care Team visiting the hospital wards and departments on a daily basis, Monday to Friday, to talk to patients and visitors about their experience of the hospital. Any issues or concerns are dealt with immediately by the senior nurse on the ward at the time.

986 positive comments were verbally received for example: ‘I give the hospital five stars, it’s marvellous here’. ‘Staff are wonderful and go the extra mile’.

78 comments were made relating to improving services for
example: ‘car parking needs to improve’, ‘patient requested pain relief, which was obtained.

115 general comments were recorded for example: different patients requested various items a toothbrush, comb, blanket and a comfy chair all of which were obtained.

9 PROPOSED ACTION FOR 2019/2020

9.1 • PALS outreach support will continue in order to improve the experience of service users specifically during periods of operational pressure and to promote timely and local resolution of concerns.
• The trust is undertaking deeper scrutiny of reopened complaints and alongside the Complaints Scrutiny Group will explore opportunities to reduce these numbers.
• The department will increase the number and diversity of patient representatives on the Complaints Scrutiny Group to further improve the complaints process and improve patient outcomes.
• Directorate SQS data packs will be strengthen to promote accurate and timely complaints responses.

10 RECOMMENDATION

Committee members are asked to note the report.

Sign off
Julie Green - Director of Corporate Affairs and Governance

Role title