CUSTOMER CARE ANNUAL REPORT 2016/2017

1.0 PURPOSE

The purpose of this report is to present the annual overview for Complaints and Patient Advice and Liaison Service (PALS) for the period 2016/2017.

1.1 A key objective of the organisation is the willingness to change, improve and evolve in response to complaints and the need for improvement. The lessons learned and trends identified through capturing and monitoring data through complaints and PALS plays a key role in improving the quality of care received by patients and is a priority for the trust.

2.0 GOVERNANCE ARRANGEMENTS

2.1 The Trust has a Complaints Policy which was approved by the Board in July 2016. 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.

2.2 Trust responses to complaints and the learning identified are reported each month to the Safety Quality and Standards (SQS) Committee, the Quality Forum and with directorates via the Governance Data Pack. 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.

2.3 The Trust has a Customer Care Manager and team, whose responsibility it is 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.

2.4 Complaints and any associated action plans are monitored within the directorates of the trust to ensure that learning translates in to 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.

2.5 The trust is required to submit the KO41 return to the national Health and Social Care Information Centre on a quarterly basis and has complied with this requirement.

3.0 COMPLAINTS PERFORMANCE

3.1 This year there have been a total of 125 complaints received which is a decrease of 29% (52) compared to 2015/2016 where 177 complaints were received.

The highest volume of complaints relate to clinical treatment and the following service areas: Accident and Emergency (28), Surgical Specialities (18 -not specific to a ward
and encompassing Orthopaedic and General Surgery), Ward 8 - MAU (10), Ward 4 - Respiratory (6) and Obstetrics and Gynaecology (4).

Complaints are also an indicator within the monthly Risk Assessed Data Report (RADaR), which retrospectively identifies service hot spots where quality may have been impacted.

4.0 KEY PERFORMANCE INDICATORS

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| 100% complaints acknowledged within 3 working days | Achieved (100%). |
| 95% of complaints resolved first time | 134 complaints were sent in 2016/2017 the annual performance is 87% (117). |

| 100% of complaints responded to within initial timescales agreed with complainant | 95% (127) of complaints were responded to within the initial timescale. This is an improvement from 2015/2016 where 80% (132) were responded to within the initial timescale. Customer Care team make regular contact with staff in the Directorates to ensure responses to complaints are on track. If delays are encountered the complaint escalation process is followed. |
| 0% of total responses for which extensions were requested | Annual performance is 5% (7), which includes 3 cases where the trust was not able to seek extensions prior to the response date passing. This is a significant improvement on 2015/2016 during which the performance was 20% (32). |
| No more than 15 complaints where the over-riding concern related to communication regarding clinical care. | Achieved - there have been 13 clinical care communication complaints |

| Facilitated Meetings | 9 meetings took place with clinicians and complainants as a result of a complaint. These meetings were either held before the investigation to assist in clarifying issues and facts from complainants’ perspective or to feedback the outcome of the investigation. |
5.0 LEARNING AND IMPROVEMENT FROM COMPLAINTS

5.1 During 2016/17 the following top complaints categories identified are:

- Clinical treatment 51% (64)
- Staff attitude/behaviour 15% (19)
- Ineffective verbal communication 10% (12)
- Date for appointment 6% (8). The majority of these complaints relate to unacceptable time to wait for appointment or appointment cancellations.

These categories are in line with national mandatory complaints reporting requirements. Within the category of clinical treatment the top four trends were identified in terms of co-ordination of medical treatment (31), nursing care unsatisfactory (14), unclear diagnosis (4) and error in performing a procedure on patient (2).

5.2 Examples of outcomes of learning from complaints:

**Practice or Service Improvement**

- Where appropriate, patients’ regular medication prescribed by their GP must be prescribed and given when admitted to hospital.

- The importance of ensuring patients and their families understand the reasons for different practices and the dressings which are used.

- The need to ensure that all patients have received adequate pain relief, irrespective of their presentation or whether or not they have been referred to a specialist clinical team. This will be reiterated to all Emergency Department clinical staff by the Clinical Lead for Urgent Care.

- The Paediatric Clinical Team needs to improve communication at the point of prescribing medication and the reasons for a change in treatment needs to be explained to ensure parents have a full understanding. Written information should also be provided for further clarification. This will be reinforced at the paediatric staff meetings and during the junior doctors’ induction.

- District Nurses’ awareness has been raised of the need to increase syringe driver doses as per the individual patient's prescription.

- Medical Admissions Unit staff have been reminded that they must make sure that all patients are familiar with the discharge process and that any medication given to the patient is explained to them.

- More capacity is required for new patient appointments in the fracture clinics. The Service Manager for surgery is reviewing the capacity available in the fracture clinic and the requirement for additional clinics.

- The standard operating procedure for patients undergoing surgical management of miscarriage will be reviewed and strengthened.
• Emergency Department staff have been informed of the escalation process for women with a pregnancy of 20 weeks or more as per the care of the pregnant/postnatal women seen in the Emergency Department guidelines.

• Consultant has confirmed that the induction for all new Obstetrics and Gynaecology trainees will include further training regarding the management of early pregnancy.

• Post-operative instructions to be made clear to all patients in terms of wound management and staff must ensure they advise patients to return to the ward if they are experiencing post-operative complications.

• Within physiotherapy action has been taken to ensure staff check equipment/aids prior to undertaking therapy. All frames on the medical and surgical wards have been assessed by physiotherapist for safety and corrective action taken where required.

• Specialist Registrar in Cardiology to review the Trust's endocarditis guidelines and make recommendations relating to patients taking Gentamicin.

Communication Improvement

• Staff members must have a professional attitude and demeanour at all times when dealing with patients and their families.

• Within the ED department a member of staff is allocated on each shift to liaise with families of deceased patients. This will ensure their individual needs and preferences are responded in terms of communication, care, compassion and dignity.

• Parents and children in the children’s waiting area of the Emergency Department (ED) will be kept more informed of waiting times and activity during peaks of activity in the ED to improve patient communication.

• Medical staff member in out of hours service has reflected and acknowledges that, on the occasion concerned, the communication with patients and family members could have been more effective.

• Within Obstetrics and Gynaecology, a doctor has improved the quality of their communication with patients going forward through enhancing their clinical knowledge of hormonal level readings during pregnancy.

• In line with the trust’s Duty of Candour – Being Open Policy, nursing staff need to contact family when their relative has a fall. The senior sister in the ward area concerned has discussed the learning from the complaint at a staff meeting for awareness and to reiterate the importance of good communication with relatives.

• Families and carers must be updated if there are unexpected delays in theatre. It has been reiterated to staff the importance of keeping families and carers updated if delays are experienced in theatre.
Documentation Improvement

- Emergency Department (ED) medical staff have been reminded to ensure discharge documentation is accurate.

Management Action

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 formal 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 at appraisal
- Additional training provided or the need for staff to read trust policy.

6.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (HSO)

6.1 8 complaints were referred by complainants to the HSO during 2016/17. There were 7 final reports issued by the HSO following investigation of which 5 were not upheld, 1 complaint was partially upheld and 1 complaint was upheld with recommendations made.

6.2 Actions highlighted as a result of recommendations from the HSO include:

- The trust is to acknowledge and apologise for the failings that led to the missed opportunity to reduce the patient’s risk of a fall.
  - Provide complainant with evidence of all the actions that have been taken to prevent falls in the future and how these actions will be audited.
  - Compensation of £1000.
- The trust is to acknowledge and apologise to the patient that we may never know if the application of ice to the patient’s shoulder exacerbated their condition.

The recommendations were completed and reported back to the HSO who were satisfied with the trust’s actions and closed this complaint.

7.0 PATIENT ADVICE AND LIAISON SERVICE (PALS)

7.1 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.

7.2 There have been a total of 968 PALS received this year which is an increase of 9% (82) compared to 2015/2016 where 886 were received.
7.3 A standard target ratio of PALS: Complaints was set at 7.5:1 and the ratio we achieved is 7.7:1 in terms of combined PALS enquiries received by the team and the outreach activity where local action was required.

7.4 21 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.

7.5 Learning and Improvement

It should be noted that PALS may feature more than one area of concern.

- During 2016/17 the following top themes have been identified: Date for appointment 20% (193), Clinical treatment 18% (178), Ineffective verbal communication 15% (141), and Ineffective written communication 8% (78).

- Within the category of Date for appointment themes identified were in terms of Unacceptable time to wait for appointment 56% (109), Cancellation of appointment 22% (42), General Enquiry about appointments 14% (27).

- The areas that received the highest volume of PALS relating to Date for appointment were Surgical Specialities (44), Audiology (24), Podiatry (17) and Ophthalmology (17).

- PALS outreach service continues to be a success. This involves a member of the Customer Care Team visiting the hospital wards 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 with the senior nurse on the ward at the time.

- In 2016/2017 the PALS outreach spoke with 2748 patients and/or relatives. 1557 positive comments were made and there were 168 comments relating to improving the service. There were also 266 general comments received.

7.6 Similarly to complaints, learning and action that has been taken as a result of PALS indicate changes to practice, policy and communication.

7.7 Examples of outcomes of learning from PALS:

**Practice or Service Improvement**

- A service review is underway within Audiology to address the staffing issues that adversely impact on the timeliness of patients being offered an appointment.

- Within maternity staff awareness has been increased regarding identification of tongue tie in new babies.

- The Orthopaedic Consultant has fed back to the orthopaedic doctors team the importance of offering patients the correct post-operative exercises. Physiotherapy staff will check that correct exercises are given to patients.

- Tissue Viability Team has been made aware that that elderly/vulnerable patients living alone may not appreciate unannounced visits. Measures have been put in
place to ensure patients are contacted prior to collection of equipment wherever possible.

**Communication Improvement**

- Within respiratory specialty awareness has been raised with medical staff in relation to communication with patients and families with regard to the Do Not Attempt Cardiopulmonary Resuscitation decisions.

- Ward 4 Sister has communicated to her team and a particular member of the staff the importance of clear communication and documentation. Staff members have been made aware of the importance of informing the next of kin if the patient has deteriorated and the urgency of them attending.

- ETU Manager will feedback and discuss the experience of the complainant with the team and remind staff to ensure they discuss the patients’ requirements for either sedation or Entonox.

**9.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (HSO) PALS**

9.1 There were no PALS cases referred to the HSO during 2016/2017 and there was one final report issued following investigation that was not upheld and there were no recommendations for the trust.

**10.0 IMPROVEMENT ACTION FOR 2017/2018**

- Strengthen diversity of patient engagement via expanded membership of Complaints Scrutiny Group
- Continue to expand PALS outreach activity across non-inpatient and community services
- Implement learning from where complaints were not responded to within initial timescales and/or were not resolved first time.
- To develop a programme of screen savers from the compliments received

**11.0 RECOMMENDATIONS**

11.1 Committee members are asked to:

- Note for assurance the achievements in terms of trust complaints handling and actions taken to ensure quality of service provision and patient experience is improved as a result of organisational learning.
- Note the proposed actions for improvement for 2017/18.