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PATIENT EXPERIENCE QUARTER 4 AND ANNUAL REPORT

Presented by	Karen Dawber, Chief Nurse	
Author	Karen Bentley, Assistant Chief Nurse Patient Experience Sally Scales, Deputy Chief nurse	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	Patient Experience 4 (Including complaints)	
Key control	This paper is a key control for the strategic objective to provide outstanding Care for patients.	
Action required	To note	
Previously discussed at/ informed by	Patients First (in part)	
Previously approved at:	**Committee/Group**	**Date**
	Quality Committee	29.05.19

Key Options, Issues and Risks

This report provides an update on the work of the Patients First Sub-committee, which includes work undertaken by the central patient experience team, divisional teams as well as corporate work streams. The report also includes a report of Quarter 4 (Q4) complaints and PALS. It should be noted by the committee, that the complaints data referred to in this report is discussed in terms of *Divisions*, as the data runs up until the 31 March 2019. Future reports will reflect the relevant Care Group.

During Q4 work has continued to embed the Patient Experience Strategy, ensuring that this is a key strand through all patient experience work.

Analysis

Promotion of the Patient Experience Strategy remains a key priority to the Chief Nurse Team.

The Patient Experience Collaborative (PEC) work has now begun with the Transformation Team.

AccessAble is now “Live” and a formal launch will take place on 23 May 2019 in the Listening for Life Centre.

National inpatient survey Trust level results are still awaited and as a result in significant differences in the year’s sample, mean that comparison with last year’s results is not possible. Results of the national CQC comparative results are still awaited.

Friends and Family Test results remain stable, with the 96% of patients overall recommending the Trust.

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Below are the headlines from the analysis of complaints:

- Q4 has seen 138 complaints; this is significantly lower than complaints received during the same quarter during 2017/18.
- PALS contacts remain high at (335) during Q4.
- The theme of most complaints is in relation to appropriateness of treatment.
- There have been no complaints graded as extreme or high during Q4.
- Whilst AED remains the area with the highest number of complaints, this has reduced significantly by over 50% during Q4.

Recommendation

- Support is required from all areas to embrace the new PE Strategy.
- The terms of reference for the Patient First sub-committee should be changed to reflect the current Patient Experience Strategy to the Patient Experience sub-committee.
- The reporting arrangements to the sub-committee need to be amended to reflect the revised management structure.
- Future work required to ensure SOPs produced, reflecting collective approach to data submission for all annual National Surveys.
- Area leads for inpatient and other relevant surveys to arrange workshops with the Trusts contracted provider.
- Use of QI methodology for tests of change.
- Benchmark against other Trusts that are doing well or significantly better in key PE areas.
- Consider current resource within the PE team to fill vacancy and manage absence.
- There is the requirement for a *tight grip* to remain on the handling and processing of complaints to enable the trajectory to continue.
- Support from all the CBU Complaints Leads and Heads of Nursing is essential for the effective ongoing management complaints.
- The monthly meetings with Heads of Nursing and Chief Nurse Office and the complaints team to continue to ensure complaints remain on track.

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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☐	☒
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☒	☐
Diversity and Inclusion implications	☐	☒
Performance implications	☒	☐

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant)
☐Risk Assessment Framework ☒Quality Governance Framework

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☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Caring	
Care Quality Commission Fundamental Standard: Person Centred Care	
NHS Improvement Effective Use of Resources: Clinical Services	
Other (please state):	

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☐	☐	☐	☐	☐

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1 PURPOSE/ AIM

This report provides an overview to the Board of Directors on the work that is being undertaken within Bradford Teaching Hospitals NHS Foundation Trust to improve patient experience. The report includes the complaints report for Quarter 4, 2018/19 (Q4). The Patient Experience Team and the work streams that sit within this portfolio of work are focussed on supporting the delivery of the Foundation Trust's mission; to provide the highest quality healthcare at all times.

From a governance point of view, work carried out within the Trust in relation to patient experience has continued to be over seen by the Patients First Sub-Committee. This sub-committee meets on a monthly basis and reviews the strategic patient experience work plan to provide on-going assurance that the objectives are being met and that any work required to support and improve Patient Experience is progressing. In addition to providing this assurance to the Board of Directors, it is recognised that there is a need for effective dissemination down throughout the organisation to all areas within the Trust to ensure patients, friends and family are at the forefront of all that we do. Currently, there are two Patient and Public Voice Representatives appointed as members of the Patient First Sub-Committee, increasing our accountability and transparency and furthering our ethos of co-working.

This report provides an update on some of the key pieces of work being undertaken in relation to patient experience, by either the corporate patient experience team, the divisional teams or as part of identified work streams that report to the sub-committee. This includes:

- National CQC Survey updates.
- Friends and Family Test Results for Q4
- Accessible Information Standard.
- AccessAble.
- Patient Experience collaboration

The work streams which provided their scheduled report to the Patients First Sub-committee during Q4 included:

- Cancer Board
- Dementia Steering Group
- Complaints Steering Group
- Learning Disability Forum

Furthermore, each month, one of the divisions presents their quarterly patient experience report to the sub-committee. This report will highlight key themes from each of the divisional reports presented during Q4.

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This report also provides an update on Complaints and Patient Advice and Liaison Service (PALS) for quarter 4.

2 CURRENT POSITION

2.1 National Survey updates

2.1.1 In-Patient Survey

During the sample checking process for the 2018 Adult Inpatient Survey, the Survey Coordination Centre conducted checks on all participating Trust's samples and looked for any differences between their 2017 and 2018 sample. This is to ensure that historical comparisons are appropriate to make between the two years. For any major differences identified, it is investigated and the reasons why discussed with the Care Quality Commission (CQC).

Bradford Teaching Hospitals NHS Foundation has undergone multiple service changes since the previous sample, including;

- An increase in virtual ward and other services such as ACU and CDU.
- A general reduction in geriatric medicine and elderly services.
- The introduction of EPR, bringing significant changes to working practices, capture, recording and reporting of activity.
- Current known system issue with Accident and Emergency disposal method (Data).

Differences between the 2017 and 2018 samples were noticed, such as a large decrease in patients age 66 and older by 10 percentage points, as well as differences seen in length of stay, some of which may be as a result of the changes identified above. This means that the Trust's 2018 sample is made up of different types of patients in comparison to the 2017 sample, thus making direct comparison of any changes in the results unreliable.

This matter has been flagged to the Trust by the survey provider (Patient Perspective) and has meant that the Trust has not yet received any analysis from them, as the result provided by them entail a comparison with the previous year. The results are also provided to the CQC as part of the mandatory national inpatient survey, who then analyse the result in a different way to give a comparison with all Trusts nationally. The Trust has been assured that we will be included in the National In-Patient survey, but we may not be able to compare our performance to our own previous year's data because of this. These results are expected to be available in late May or June 2019.

2.1.2 National Urgent and Emergency Care Survey

The preliminary results for the Urgent and Emergency Care Survey 2018 have been received by the Trust. Discussions have taken place with the Unplanned Care Clinical Business Unit Leads and the Trust is currently waiting for finalise data from CQC. Patient

Perspective will be presenting the findings and working with staff to compile an Action plan in the very near future. Included within this work will be the evidence of developments that may have already taken place since the survey data was collected in September 2018.

2.2 Friends and Family Test

Figure 9 shows the friends and family test results for Q4 and the total for 2018-19. Results have been relatively stable across the year, with a small improvement in the response rate for Q4 (13% compared to 10% for Q2 and 3, and 11% for Q1).

	Q4			2018-19		
Area	Recommend %	Not Recommend %	Response rate %*	Recommend %	Not Recommend %	Response rate %*
Wards	96%	1%	37%	95%	1%	37%
A&E	83%	17%	0%	87%	2%	0%
Maternity	97%	1%	24%	97%	1%	21%
Day Case	98%	1%	19%	98%	1%	13%
Outpatients	96%	2%	-	96%	2%	-
Trust Total	96%	1%	13%	96%	1%	12%

Figure 9

2.3 Accessible Information Standard

A Task and Finish group is being established to review the current position of the Trust in relation to the accessible information standard. The introduction of the Electronic Patient Record has provided new opportunities to address the requirements of the standard and work is being progressed in conjunction with Calderdale and Huddersfield NHS Foundation Trust to progress this.

2.4 AccessAble

In 2017, the Trust was approached by a charity called Disabled Go, a charity set up to provide free information to the public (via a website) about the accessibility of a range of public venues, such as restaurants, shops, cinemas, universities and more recently hospitals. The website provides information describing the accessibility features of these venues including parking, ramps, toilet/changing facilities etc. and includes dimensions/pictures/maps as appropriate. During 2018, the Trust has been working with this organisation to develop the information for all Trust sites, developing guide pages. It was originally due to be completed in 2018, but the company itself has been through a rebranding process which meant the original planned launch was deferred.

The company is now called AccessAble, and the information relating to the Trust's facilities is now live, and can be accessed via www.AccessAble.co.uk a link for which sits on the front face of our Trust website. This site is useful to any patient and visitor to the Trust as this

provides a comprehensive up-to-date guide of all areas. The official launch of AccessAble is due to take place on 23 May 2019 at 12.45 pm in the Listening for Life Centre.

2.5 Patient Experience Collaboration

A new Patient Experience Collaborative (PEC) has been established, which is a quality improvement project designed to enhance the experience of care across the Trust. This work is intended to support the implementation of the Patient Experience Strategy by enabling patients, families and carers to share their experiences and to facilitate staff to understand and use feedback to improve care.

Using the principles of co-design the PEC will use the Institute for Healthcare (IHI) Always Events Toolkit and the Yorkshire Patient Experience Toolkit as frameworks for making improvements. It is anticipated that improvements will include work that assists with the delivery of the Trust's Dementia Strategy. Providing a supportive environment for individuals with dementia and their carer's whilst in the acute hospital setting is a key domain within the NHS Dementia Well Pathway. The PEC is currently in the early planning stages being led by the Assistant Chief Nurse for Patient Experience and the Quality Improvement team. This has involved scoping out specific issues, identifying key people to support the Collaborative and developing an aims statement.

2.6 Patients First Committee Work Stream Updates

2.6.1 Cancer Board

The Patients First Committee received a report from the Trusts Cancer Board in February, which included an update on the launch of the communication standards, which have formed part of the launch of the Patient Experience Strategy. To support the introduction of these standards, the Lead Cancer Nurse reported on the establishment of "Sage and Thyme" training, which has been rolled out to a wide range of staff responsible for communicating with cancer patients, including admin and other non-clinical as well as clinical staff. The uptake on this training has been excellent and evaluation has been very positive. A video has also been produced as part of the work to promote the communication standards.

The group also reported that in response to feedback from patients undergoing chemotherapy, changes have been made to introduce free car parking for patients on a chemotherapy pathway.

2.6.2 Dementia Steering Group

The Dementia Steering Group, chaired by the Associate Director of Nursing for Unplanned Care, reported that since the appointment of the new Lead Nurse for Dementia in January 2019, the group have revised their work plan for 2019. They are focussing on several areas

of work to raise the profile of dementia and improve the care that we provide to these patients and their families. Key areas of focus include:

- Launching the Trusts Dementia Strategy
- Undertaking a review of education and training for dementia to ensure it is in line with national requirements. This includes a review of Dementia Champion training.
- Promoting the awareness of the John's Campaign which was launched in 2017.
- Review of the tool used for assessing the needs of patients with Dementia, which involves replacing the "See Who I Am" document with "This is Me", which is more user friendly.

2.6.3 Complaints Steering Group

The update included a briefing on the current position, which has been covered section 2.8 of this report. The complaints steering group recognises that whilst there has been progress in delivering the improvement in response times, this still requires considerable focus to achieve the targets set. The group has also been working with the divisional teams to ensure that there is a real focus on learning lessons from complaints. Some examples of these are identified in the divisional reports.

2.6.4 Learning Disability Forum

The Learning Disability Forum is chaired by the Named Nurse for Safeguarding Adults, who reported that the Trust has participated in the National Learning Disability Audit, although has yet to receive any results from this. The new Learning Disability Standards have been reviewed, and for the basis of the work plan for the group. A particular are of focus has been the flagging of patients with a Learning Disability on EPR, to ensure that all patients are flagged appropriately.

Members of the Adult Safeguarding team have also been working with Mencap, as part of the Treat Me Well campaign, to improve the care of patients with a learning disability accessing NHS services. Plans are in place to participate in the Learning Disability Awareness week on 19 June 2019.

2.7 Divisional Reports

During Q4, the Patients First Committee has received an update from each of the Divisional Heads of Nursing on the activity being undertaken to improve the patient experience within the Division.

Each of the reports follows a similar format, with an overview of Feedback from patients and relatives/carers has been collated from the following sources:

- Friends & Family Test
- Complaints and PALS
- Compliments
- NHS Choices comments
- Healthwatch (where appropriate)
- Ward and Department initiatives
- Patient Stories

This information has been used by the divisions to

- Share feedback and identify opportunities to improve the service they provide.
- Identify where changes have been made as a result of the feedback we have received.
- Share positive comments and compliments to highlight areas of good practice and patient satisfaction.

2.7.1 Examples of Learning from Division of Medicine and Integrated Care

Diabetes: Patient with Asperger's Syndrome not happy with Consultant's management

Action Taken: Instead of sending out a formal response; Diabetes Specialist Nurses met with patient to discuss the management and also agreed an action plan to ensure patient gets the best out of future appointments.

Cardiology: Systematic failing of how referral to another Trust was processed and tracked. This delayed treatment.

Action Taken: Electronic tracking and recording process implemented within the medical secretarial department.

Acute Medical Unit: Doctor ignored pain management plan in place for Sickle Cell patient.

Action Taken: Flag added to electronic record to advise pain management plan exists and to discuss any issue with Sickle Cell Nurse. Case discussed at CG meeting.

2.7.2 Examples of Learning from Division of Anaesthesia, Diagnostics and Surgery

Westwood Park Treatment Centre: Patient and relative complained about poor signage, notices and lack of use of volunteers.

Action Taken: Sister has worked with support from matron to address notices and use of volunteers. Division has addressed signage issues with estates.

Orthopaedic Wards: complaints from relatives / patients about poor communication

Action Taken: Introducing “Tea and Chat” sessions with Sister on wards 27 and 28 to give relatives and carers the opportunity to raise any issues, concerns or ideas with the ward sister.

2.7.3 Examples of Learning from Division of Women and Children

Maternity services: following feedback from women and their families / partners, a number of issues have been identified.

Action Taken: improvements are being made to provision for the birthing partner and the environment for meals and changes to visiting are being revised.

Paediatrics: The Pants and Tops initiative continues to be promoted as an innovative way of seeking feedback from children, and changes made as a result of issues identified. One example is changes to the meals.

2.8 Complaints

During quarter 4 (Q4), the Patient Experience team have continued to focus on measures to improve the quality and timeliness of responses to complaints. This work was initiated in April 2018, and at this time a trajectory for improvement was set. At this time, tight monitoring and control measures were put in place by the Deputy Chief Nurse, with robust tracking, and weekly review of performance in

Figure 1 demonstrates performance against the trajectory to reduce the total number of open complaints within the system at any one time from April 2018 to the latest position in March 2019.

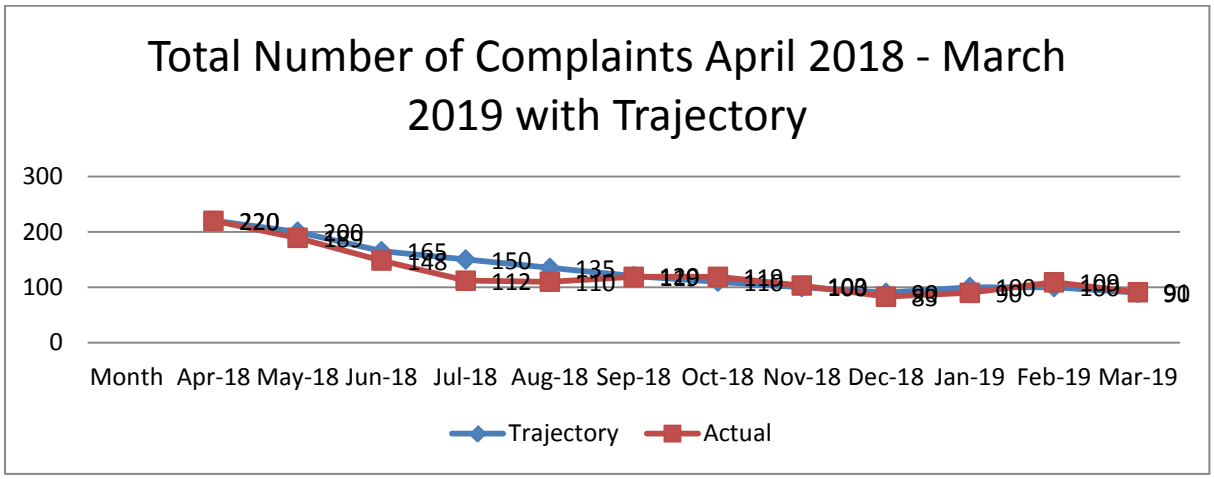

Figure 1

The number of complaints at the end of Q4 was in line with the trajectory set (N = 90). This is a fantastic achievement, as during Q4 the Trust received an additional 20 complaints

compared to the previous quarter and managed to maintain delivery of the trajectory, despite additional clinical winter pressures impacting of the workload of complaint investigators.

Table 1 (below) demonstrates the Q4 figure for the number of complaints received by division in comparison to the preceding quarterly figures. All Divisions (with the exception of Central Services) have seen an increase in the number of complaints received, with the Division of Anaesthesia, Diagnostics and Surgery showing the largest increase from N = 49 up to N = 60 in Q4.

	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Division of Anaesthesia, Diagnostics and Surgery	69	55	78	49	60
Division of Medicine and Integrated Care	61	53	59	55	59
Division of Services for Women and Children	15	19	20	8	13
Central Services	7	7	7	7	6
Total	152	134	164	119	138

Table 1

The table illustrates that the Q3 figure for the number of complaints received was 119, which was the lowest number experienced; whereas the figure of 138 complaints received during Q4, is the in line with the usual overall average. Since the former Complaints and PALS teams have merged to become one Patient Experience Team, an increasing number of contacts have been effectively dealt with at initial contact, thus preventing them becoming formal complaints. This is reflected in the increase in the number of contacts being recorded as PALS.

At the review undertaken in April 2018, it was identified that a large number of complaints were beyond their due date. Thus the remedial work plan has focussed on addressing this backlog as well as improving the overall quality of responses. The Patient Experience Team has been providing additional support to Investigating Officers during this time and this has been effective in strengthening the quality as well as improving the timeliness of responses.

Figure 2 shows the current position in relation to the number of complaints beyond their due date. During Q4 the number of complaints beyond due date has risen, this has been due to the capacity of complaint investigators. To address this, the divisions have increased the number and roles of staff that are investigating and responding to complaints, for example to include directorate and departmental managers in addition to the matrons. This is beginning to have an impact. Divisional teams, and going forward Clinical Business Units, are also being encouraged to ensure that where there is a genuine reason for extending the standard timescale, this is being appropriately recorded in the Datix system.

Figure 2 (below)

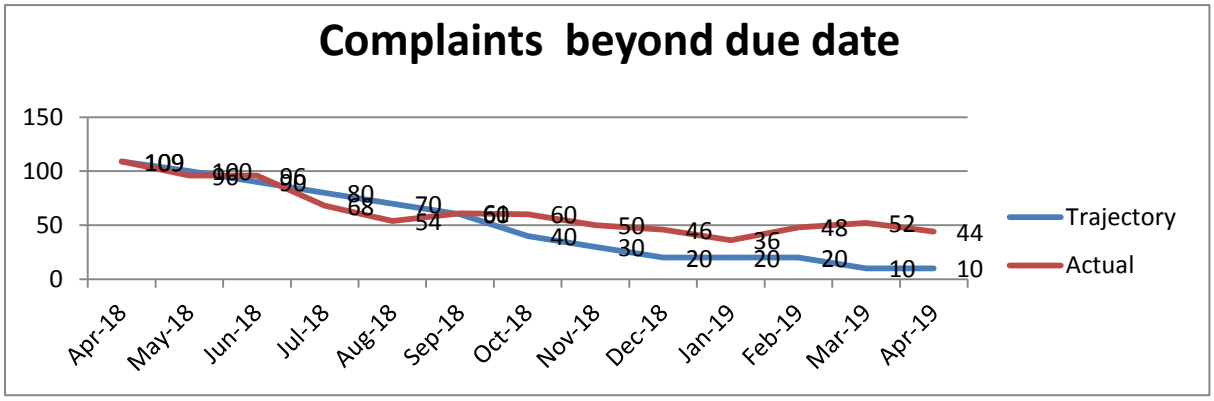

Figure 3 shows the number of complaints that are 6 months in excess of their due date, and here again the trajectory has not been achieved, with small number still exceeding this timeframe. In the majority of cases these have been complex complaints involving either multiple specialities or multiple issues which have taken time to investigate and respond to, and in some cases have been dependent on information being provided on other agencies. Never-the-less, it is recognised that there needs to be a sustained focus to reduces this number so that all complaints are responded to within the maximum six month timescale.

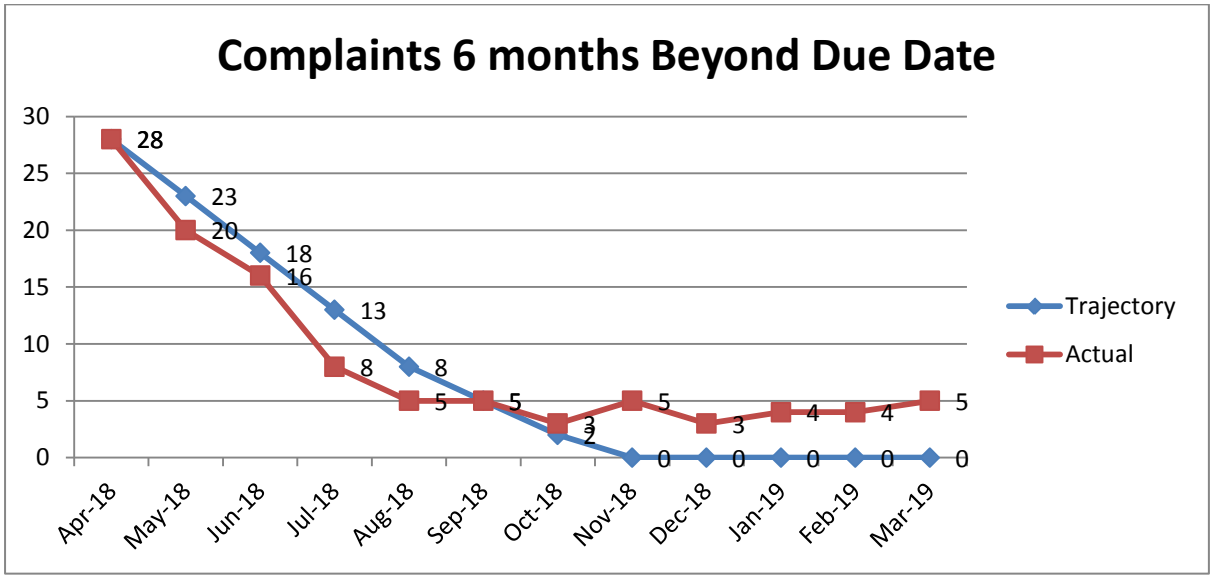

Figure 3

As a result of the sustained work over the last year, there has been a significant improvement in the overall number of complaints and going forward, each Care Group and CBU, have a more manageable total number of complaints from which to achieve an improved position during 2019-20.

When further analysing the breakdown of complaints by speciality, Figure 4 clearly highlights that the largest number received are about the Accident and Emergency Department. This was the position for Q3; however the total number for AED has fallen, as has the overall percentage. In Q3, AED complaints accounted for 21% of the overall complaints; this figure has significantly reduced to 9% for Q4. Changes in nursing leadership and management in this area are starting to have an impact on the number of complaints, and in addition to focussing on addressing the quality and responsiveness of formal complaints; they have been working on addressing issues informally at the time of attendance.

Elderly Medicine has seen a rise from 4 to 11 complaints during Q4; the Head of Nursing (now Associate Director of Nursing) is undertaking some further analysis on this trend.

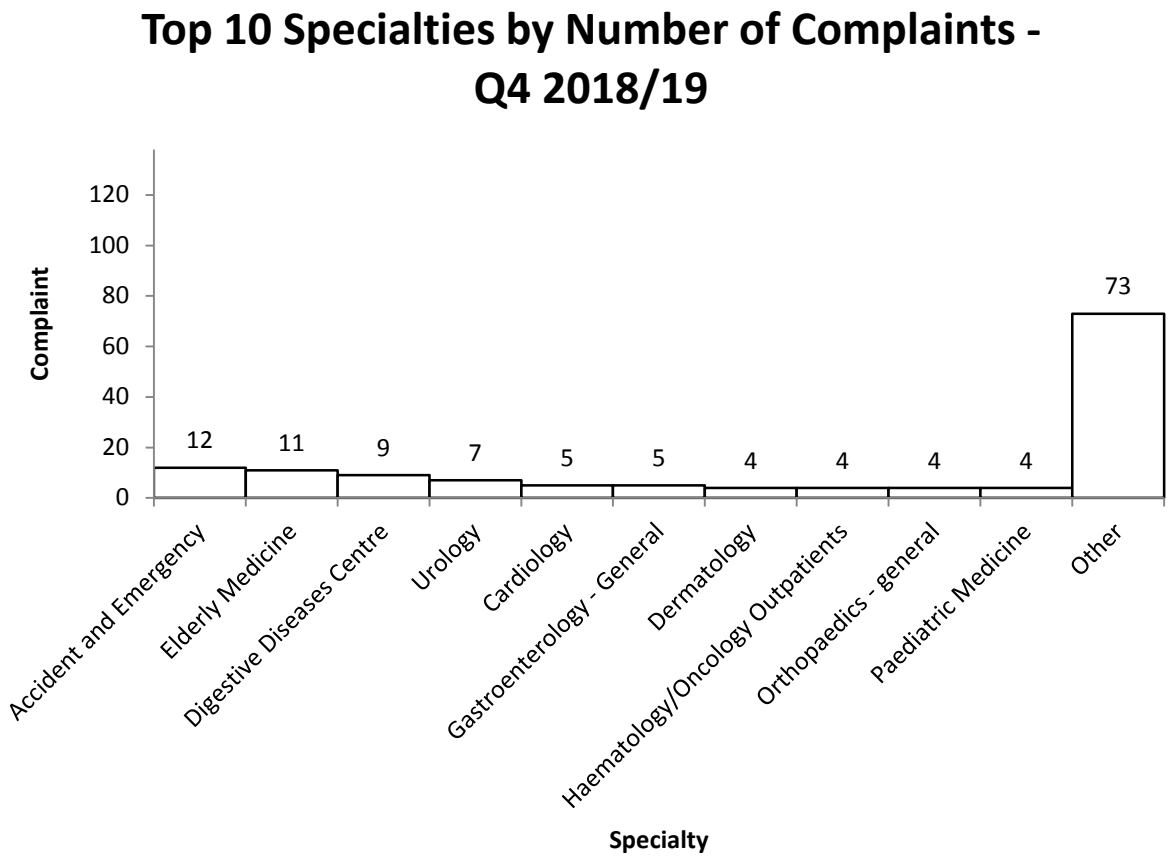

Figure 4

Figure 5 reports the top themes of complaints. It should be noted that complaints usually contain more than one theme. Triangulation against other sources of data i.e. patient feedback surveys and risk incidents are monitored within the divisions and at performance meetings.

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Reporting of themes is monitored at the Patients First meeting, along with actions being taken to address issues identified. Reports on complaint themes have also been supplied for departmental quality improvement initiatives, such as 'deep dives' and 'time-out' sessions to review services. Appropriateness of treatment continues to be the highest category of complaints

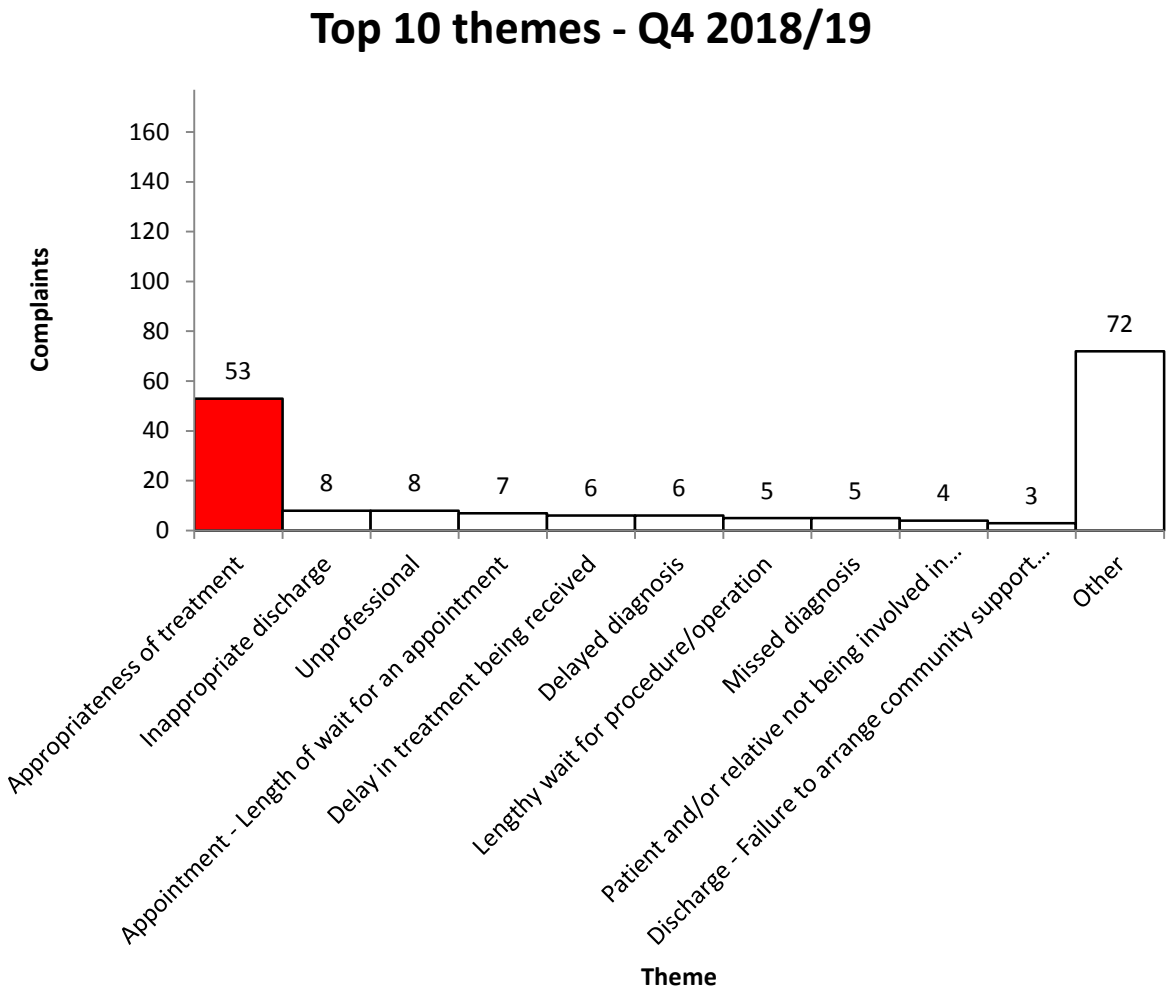

Figure 5

When complaints are received and reviewed, they are recorded and graded on the Trust Datix system. There were no complaints received during Quarter 4 graded as extreme or high, which is excellent. There continues to be on-going collaborative work and scrutiny between the risk and complaints team and the daily "Huddle" provides a robust mechanism for testing these results. The remaining grading for Q4 is 56 Moderate/Medium and 82 low.

Figure 6 illustrates the grading of all complaints received during Q4 by division.

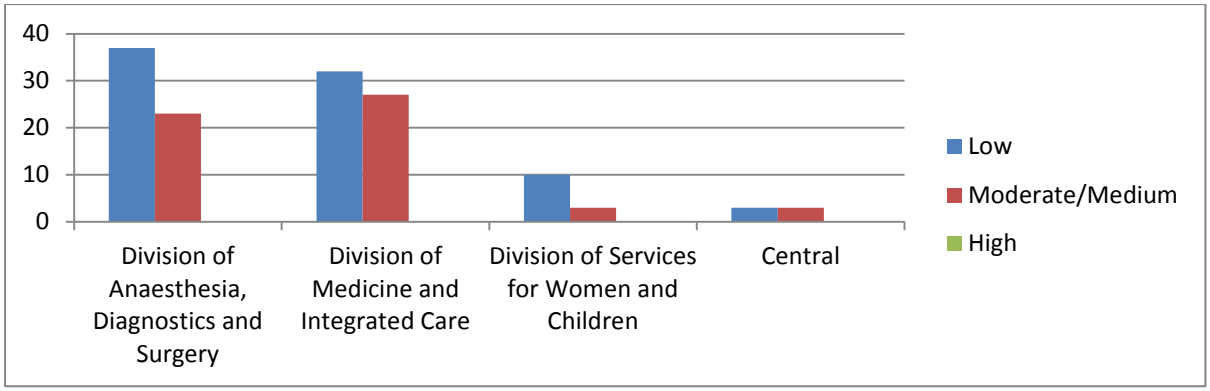

Figure 6

2.9 PALS (Patient Advocacy and Liaison Service)

The total number of Patient Advice and Liaison Service (PALS) issues continues to remain high. This trend looks to continue as the first Quarter of 2018 reported 223 PALS issues with Q4 seeing a 50% increase to 335 contacts. These numbers demonstrates the high volume of activity that the Patient Experience Team are dealing with; in many cases they are resolving at first contact and preventing issues being progressed to formal complaints.

Figure 7 provides a breakdown of the PALS issues, by speciality, Urology having previously been reported as the highest during Q3, this has reduced from N = 31 to N = 21 in Q4, which is a significant improvement. However, Central Patient Booking Service has seen an increase in the number of PALS recorded during Q4, with the contacts rising from N = 14 during Q3 to N = 23 during Q4. This data has been reported back to the department for further analysis and action as appropriate.

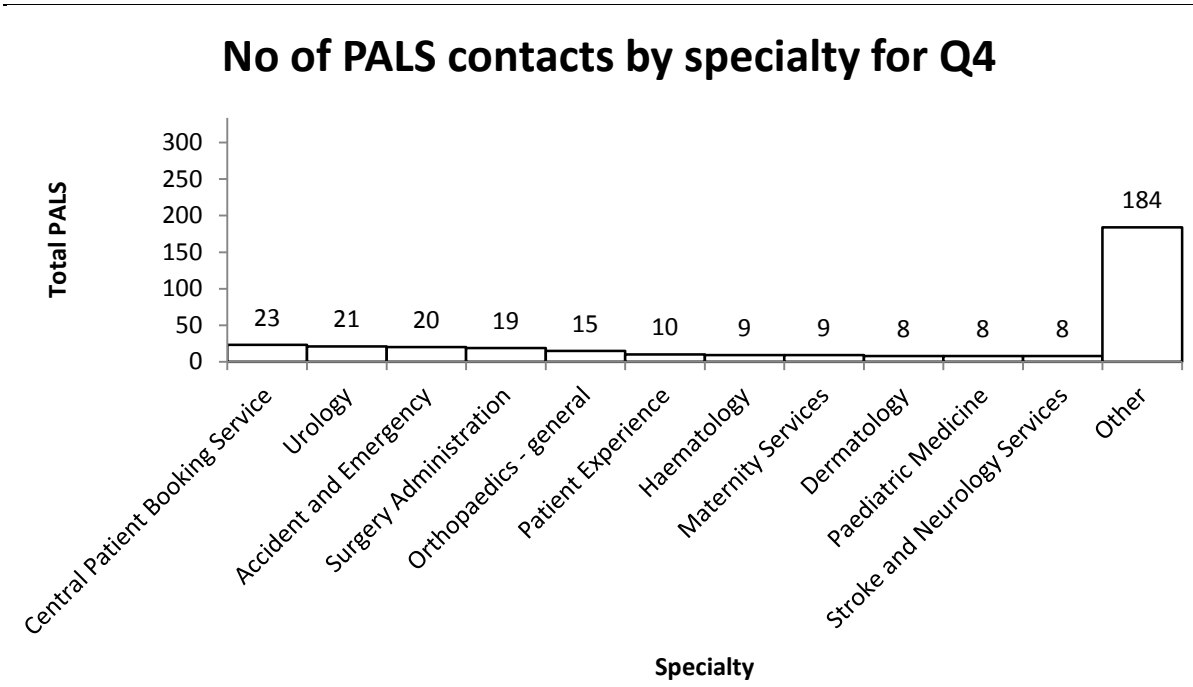

Figure 7

Figure 8 provides a breakdown of the themes of PALS due to the less complex nature only a single theme is recorded for each issue.

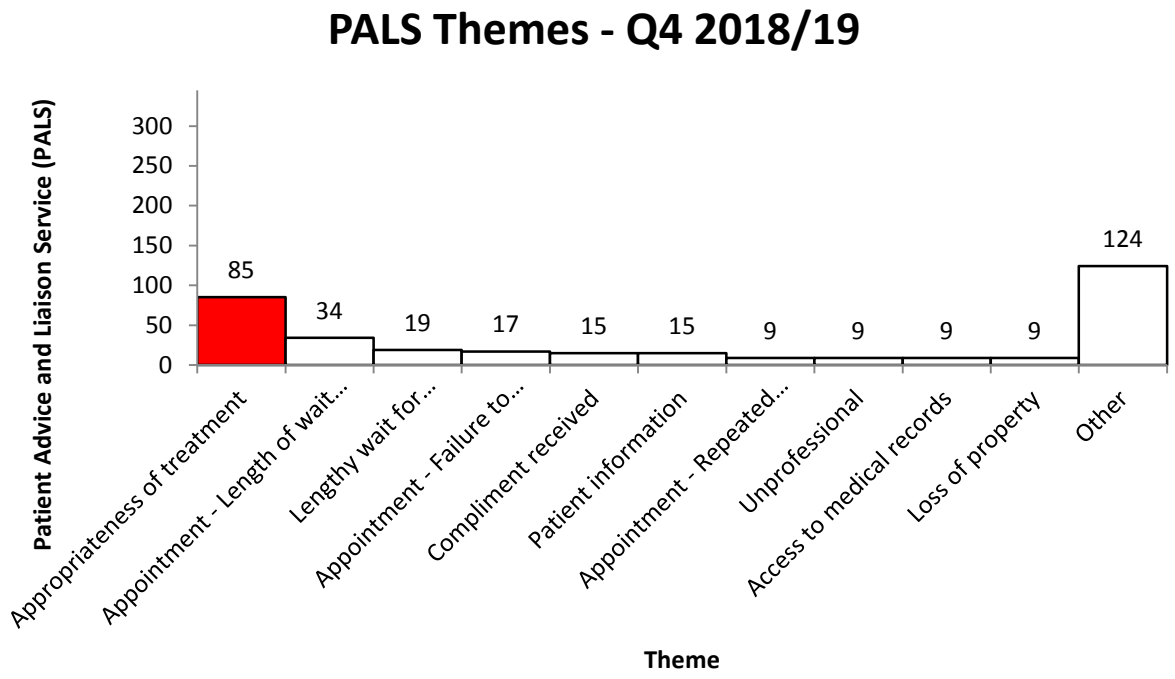

Figure 8

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3 PROPOSAL

The Patients First Sub-committee will spend the next quarter, finalising the 2019/20 Patient Experience Strategic Work Plan. This will ensure that all the work outlined in the strategy is addressed and the Patient Experience Collaboration work will help support this. A final version of the work plan will be available for the PE Annual Report for assurance, oversight and sign off.

Work with Patient Perspective will help facilitate identification of areas for improvement and support the development of action plans following National CQC survey results. Area Leads will be identified and updates of actions will be reported back via the sub-committee, specialty governance meetings and to the senior Leadership Team. This transparent accountability will help the Trust to work as one to improve Patient Experience within the Trust.

With the implementation of the Patients Experience Strategy, consideration has been given to the name of the Patients First sub-committee, which was previously named to reflect the former patient experience strategy. Given that this branding and strategy are no longer current, it is suggested that the name of the Patients First sub-committee be changed to the Patient Experience sub-committee to reflect this. The Board of Directors are asked to support this proposal.

The complaints policy will be finalised by the end of June 2019 and will reflect all the agreed changes to the sign off of complaints, the process for review and the governance around learning and requested reviews.

The overall complaints process and numbers will continue to have ongoing oversight from the central team, to enable challenge, monitoring and tracking to agreed timescales. The Central team will continue to provide support and training and assist with training and complex cases where required. To deliver on this the team will:

- Hold weekly “Grip and Control” complaints meeting between Central and CBU leads to track status of complaints and provide timelines for completion.
- Monthly complaints meetings with Heads of Nursing and Chief Nursing office.
- Lower the threshold for senior escalation where complaints are not progressing.
- Delivery of complaints training to all staff who are investigators to improve quality.
- Buddying and mentorship provided for authors of complaints responses.
- Process reviewed and guidance strengthened for complaints procedure.
- Weekly position reported to Chief Nurse.

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4 RECOMMENDATIONS

- Support is required from all areas to embrace the new PE Strategy.
- The terms of reference for the Patient First sub-committee should be changed to reflect the current Patient Experience Strategy to the Patient Experience sub-committee.
- The reporting arrangements to the sub-committee need to be amended to reflect the revised management structure.
- Future work required to ensure SOPs produced, reflecting collective approach to data submission for all annual National Surveys.
- Area leads for inpatient and other relevant surveys to arrange workshops with the Trusts contracted provider.
- Use of QI methodology for tests of change.
- Benchmark against other Trusts that are doing well or significantly better in key PE areas.
- Consider current resource within the PE team to fill vacancy and manage absence.
- There is the requirement for a *tight grip* to remain on the handling and processing of complaints to enable the trajectory to continue.
- Support from all the CBU Complaints Leads and Heads of Nursing is essential for the effective ongoing management complaints.
- The monthly meetings with Heads of Nursing and Chief Nurse Office and the complaints team to continue to ensure complaints remain on track.

5 Appendices

Nil.