Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	09.01.20	Agenda item	Bo.1.20.38

PATIENT EXPERIENCE QUARTER 1 INCLUDING COMPLAINTS

Presented by	Karen Dawber, Chief Nurse	
Author	Karen Bentley, Assistant Chief Nurse Patient Experience	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	Patient Experience Q1 (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 Experience Sub Committee (in part)	
Previously approved at:	**Committee/Group**	**Date**
	Quality Committee Q.9.19.16	25.09.19

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, care groups as well as corporate work streams during Q1. The report also includes a report of Quarter 1 (Q1) Complaints and Patient Advice and Liaison Service (PALS).

During Q1 successful recruitment has taken place to appoint to two full time vacancies within the Patient Experience team, this will expedite ongoing development work, with candidates expected to commence in post during Q2.

The Patients first Sub Committee officially became the Patient Experience Sub Committee during Q1, the Terms of Reference have been amended to reflect this change in title and the reporting structure and work streams remain the same.

During Q1 work has continued to embed the Patient Experience Strategy, ensuring that this is a key strand through all patient experience work.

It must be noted that a key risk has emerged in relation to delays in routine work plans, due to the planning and periods of Industrial action over the summer. This has been added to the Patient Experience Committee Risk Register following a risk assessment.

Analysis

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

Chief Nurse office and supported by the Transformation Team.

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Accessible Information Standard (AIS) task and finish group during Q1 have been working towards the five required standards and risk assessing against the required maturity index.

There has been an increase in the Friends and Family Test responses over Q1 of patients overall recommending the Trust.

Below are the headlines from the analysis of complaints and PALS:

- Q1 has seen 117 complaints; this is significantly lower than complaints received during the previous quarter (Q4 2018/19).
- PALS contacts remain high at (340) during Q1.
- The theme of most complaints is in relation to appropriateness of treatment which account for just under half (N=51).
- There have been no complaints graded as extreme or high during Q1.
- The areas with the highest number of complaints received are AED, Urology and Maternity, with each area in receipt of 12 during Q1.

Recommendation

- Support is required from all areas to embrace the PE Strategy.
- Area leads for Inpatient and other relevant surveys to arrange workshops with the Trusts contracted provider.
- Continued use of QI methodology for tests of change.
- AIS work to progress against the maturity standard.
- Benchmark against other Trusts that are doing well or significantly better in key PE areas.
- Continued promotion of Friends and Family data collection.
- 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 of complaints.
- The monthly meetings with Heads of Nursing and Chief Nurse Office and the complaints team to continue to ensure complaints remain on track.
- Further evidence to be produced by all CBUs via the patient experience Sub-Committee of how learning from complaints has been carried out and reviewed for assurance.
- The remedial action plan for the ward accreditation must be adhered to during Q2 for timescales to be brought back 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	☒	☐

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Regulation, Legislation and Compliance relevance	
NHS Improvement: (please tick those that are relevant)	
☐Risk Assessment Framework	☒Quality Governance Framework
☐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 Quality Committee 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 1, 2019/20 (Q1). 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 perspective, work carried out within the Trust in relation to patient experience has continued to be over seen by the Patient Experience 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 Quality Committee, 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 care groups 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 Q1
- Accessible Information Standard
- PLACE
- Patient Experience Collaboration

The work streams which provided their scheduled report to the Patients Experience Sub-committee during Q1 included:

- Cancer Board
- Nutritional Steering Group
- Learning Disability Forum
- Enhanced Care Project
- End of Life Care

Furthermore, each month, one of the care groups presents their quarterly patient experience report to the sub-committee. These reports highlight key themes from each of the areas reports presented during Q1.

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This report also provides an update on Complaints and Patient Advice and Liaison Service (PALS) for Q1.

2 CURRENT POSITION

2.1 National Survey updates

2.1.1 In-Patient Survey

The National Inpatient CQC Survey Trust results were received during Q1. A paper was produced for the June 2019 Quality Committee acknowledging the disappointing results and provided a series of actions that have been outlined to address areas of poor performance. This focused on improving multiple areas within the Trust. A separate updated paper has been provided for the September 2019 Quality Committee.

2.2 Friends and Family Test

Figure 1 shows the friends and family test results for Q1. The Trust has seen an overall 4% increased response rate from April 2019 (41%) to June 2019 (43%) with a consistent 96% saying they would recommend. Work has commenced into Q2 to look at new ways to encourage people to complete the FFT and increase this response rate further. In addition to the standard FFT questions additional supplementary question via iPads have now been encouraged in all inpatient areas to enable the Trust to identify areas for concern in a timely manner and identify where specific concerns have been reported. This allows improvements from patient feedback to take place promptly. Where negative comments have been reported, automated emails will go to the ward leader or Matron. In June 2019 the Chief Nurse office requested each CBU to take responsibility in promoting and reporting FFT as above and the Patient Experience team will feedback on this progress to the Quality Committee in September.

During the past 12 months NHS England and NHS Improvement have reviewed FFT and have just published improvement guidance. https://www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/

In summary as an organisation this means that we:

- Should ensure that all patients can give feedback if they want to.
- Should take proactive steps to allow people to give feedback whatever their communication needs.
- Should ensure staff providing care receive feedback as soon as possible after it is given.
- Should have robust mechanisms in place to ensure that action plans are developed and monitored to deal with feedback.

- Should provide visible evidence in public places to demonstrate what actions have taken place because of feedback.
- Should use feedback from the FFT alongside other measures of quality and source of insight.
- Should work with professional and clinical networks to share examples of good practice which can be replicated by others.
- Should support staff to promote the FFT to patients to get their feedback.

Work is currently underway to meet the new requirements and progress will be reported via future reports.

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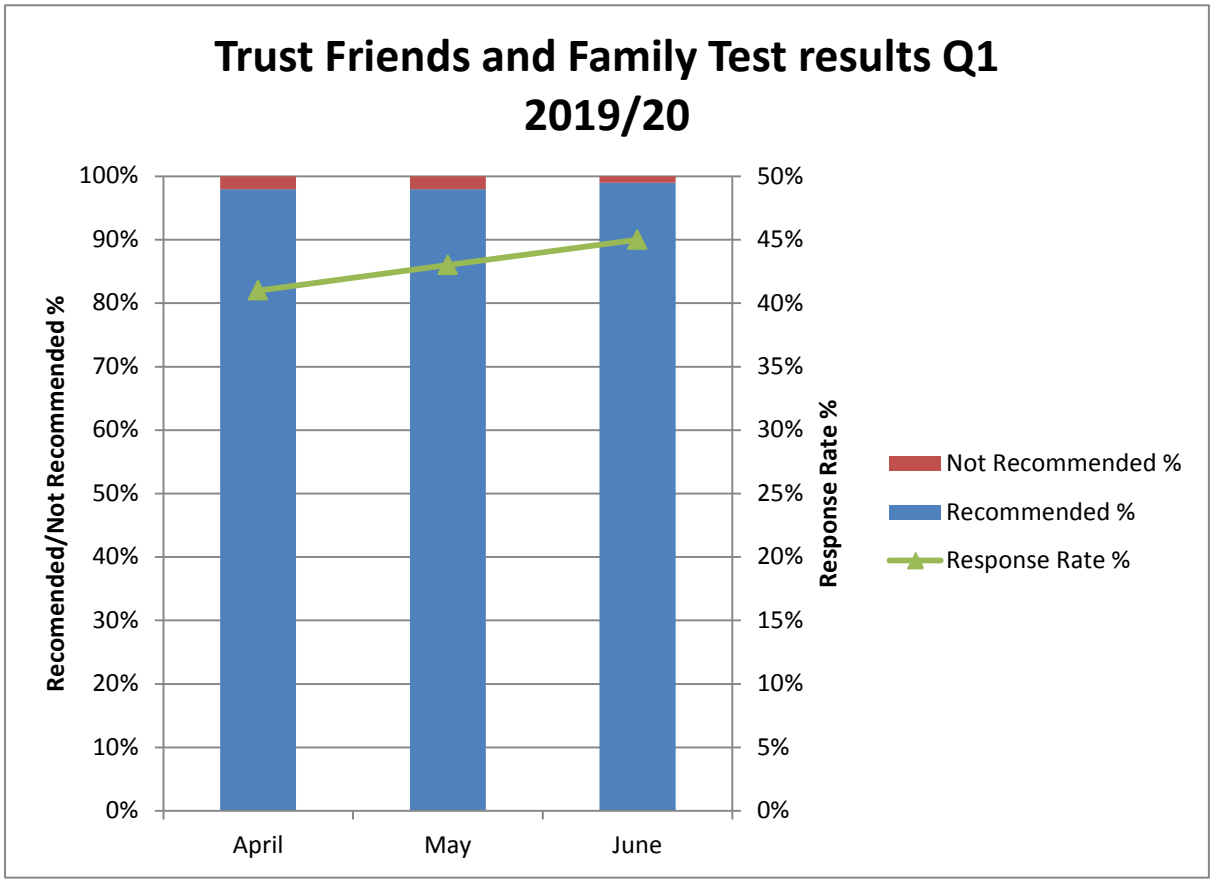

Figure 1

2.3 Accessible Information Standard

A Task and Finish group has being established to review the current position of the Trust in relation to the Accessible Information Standard (AIS). As part of the AIS, organisations that provide NHS care or adult social care must do five things. They must:

- Ask people if they have any information or communication needs, and find out how to meet their needs.
- Record those needs clearly and in a set way.
- Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how those needs are to be met.
- Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they require this.

The working group have considered the Trusts current position against the 5 standards in relation to AIS compliance. An Action Plan compliments and identifies key areas of work that are required. One of these actions includes the production of a training needs analysis for clinical and administration staff to support them to ask patients if they have any additional communication requirements. Further work includes a specific AIS policy, development of posters and the ability to provide easy read information where required. An updated position and action plan will be provided for the Q2.

2.4 Patient Led Assessment of the Care Environment (PLACE)

During the past 12 months there has been a National review of the PLACE programme led by NHS England and NHS Improvement with a steering group working alongside. The purpose of the review was to ensure that PLACE collection remained fit for purpose and relevant. The generic conclusion confirmed support for PLACE to continue with the following principles remaining:

- Patient led assessments
- Focus on the environment
- Organisations run PLACE voluntarily
- Results inform and drive improvements

From this National review the following changes have been agreed/:

- Forms have been redesigned for better flow
- A change to questions, seeing new ones added and old ones deleted
- Standardised training slides have been produced
- Web based collection tool for inputting data
- A revised and extended timetable period of 10 weeks, September onwards annually

The Patient Experience team have registered to participate in the new 2019 programme and planning is currently underway to develop training for patient and staff assessors. The assessment period opens on the 16 September 2019 and runs through to 22 November

2019. During November 2019 through to January 2020 an action plan will be developed for the organisation and following of from this the Trust will work towards meeting the actions between January-August 2020.

Due to the extent of the changes to the PLACE programme (questions and scoring system); PLACE scores for 2019 are not comparable with those from previous years.

A paper summarising the results and actions will be provided for the Quality Committee presenting the findings and recommendations. The committee is requested to note that whilst the Trusts participation in PLACE this does remain voluntary. However, results are available nationally for different organisations and benchmarking and are recognised by CQC as providing valuable information.

2.5 Patient Experience Collaboration

A new Patient Experience Collaborative (PEC) has been established and launched, this 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.

The aim of the Patient Experience Collaborative is to improve the way we gather, understand and act upon patient, carer and family feedback across BTHFT. A launch event was opened by the Chief Nurse Team during Q1 with the first wave of clinical areas (See Table 1 below). In keeping with our commitment to active patient and public involvement we also invited a patient representative to join the project to act as a critical friend and support future learning sessions.

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Table 1 Patient Experience Collaborative: Wave I - clinical areas

Care Group	Clinical Business Unit	Ward/dept.	Speciality
Planned care	Urinary Tract and Vascular	**14**	Urology
	Muscular-Skeletal, Plastics and Skin	**27**	Orthopaedics
	Muscular-Skeletal, Plastics and Skin	**28**	Orthopaedics
Unplanned care	Specialist Medicine	**23**	Respiratory
	Elderly and Immediate care	**6**	Stroke
	Elderly and Immediate care	**31**	Elderly care
	Elderly and Immediate care	**3**	Elderly care
	Elderly and Immediate care	**F5/F6**	Elderly care
	Urgent and Emergency care	**1**	AMU
	Urgent and Emergency care	**4**	AMU
	Urgent and Emergency care	**ED**	Emergency care

The 'Breakthrough Series' collaborative approach involves periods where teams take time to plan and carry out small tests of change, followed by learning sessions with an opportunity to share their improvement work.

The collaborative will run from June 2019 to July 2020 with two waves of clinical areas taking part. Wave I is running from June 2019 to Feb 2019 and Wave II will run from January 2020 to July 2020. This allows for an overlap for teams to learn about each other's successes and challenges. There are plans to share and celebrate successes throughout the project through other communication channels across the Trusts e.g. clinical governance meetings, the learning hub, QI 'pop up' events, global emails and newsletters, Trust members, public visual infographics.

2.6 Patients First Committee Work Stream Updates

2.6.1 Cancer Services

The Patients Experience Sub-Committee received a report from Cancer Services, 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.

An Electronic Holistic Needs Assessment (eHNA) has been signed off and training is now in place for all CNS teams and AHPs who are linked to cancer sites. This will assist staff to support and direct to other services as required to meet individual needs.

The group also reported that the ward liaison/pharmacy volunteers are now in place and this has helped support the earlier discharge of patients who are waiting for tablets following admission, which service users groups reported being an area where they wanted to see improvement.

2.6.2 Nutritional Steering Group

The Hospital Food and Drink Strategy has now been formulised and publicised in Let's Talk. An oversight group is now up and running to take the implementation of this work forward.

Significant work has been undertaken by a MDT within the Trust who has been working to ensure that the International Dysphagia Diet Standardisation Initiative (IDDSI) has been met. All fluid and food are now described to this standard. Catering staff and ward training has been provided to all wards by Dietetics and Speech and Language therapy. Because of this change the Trust has been able to increase the range of texture levels available and the range of meal choice at each level. Screensavers and Lets Talk articles to communicate this change have taken place.

Children's/Neonatal Nutrition Sub-group have been focusing on Breastfeeding, which has included work around catering provision for parents who are breastfeeding whilst their children are inpatients and Nutrition Education. The group noted a huge improvement in expressed breast milk storage on the NNU, which supports improved outcomes for children.

2.6.3 Learning Disability Forum

The Learning Disability Forum is chaired by the Named Nurse for Safeguarding Adults. One of the pieces of work carried out as part of the forum is to attend the *Treat Me Well* group. The group comprises of service users with a Learning Disability and providers of service. The focus of the group is ensuring that the needs of patients with a Learning Disability are considered and adjustments made to ensure their needs are met. One of the main areas of focus is training and the group are keen for the hospital to deliver specific training about learning disabilities to staff. The work plan for the forthcoming year has been devised using information from the NHS England Learning Disability standards and the audit results from the benchmarking exercise.

Part of this work for the forthcoming year is to deliver specific learning disability training to key members of staff. This will be done with the assistance of some of the service user

groups and the specialist services. A screensaver has been designed and will be on all Trust computers in September 2019, this will remind staff about making reasonable adjustments for patients with a learning disability and how small changes can make a big impact on the experience for the person.

The Treat Me Well campaign identified some of the common barriers to patients with a learning disability receiving good quality healthcare are:

- **Patients not being identified as having a learning disability;** we continually monitor and work towards ensuring we recognise patients with a learning disability and flag their records to ensure all staff is aware and therefore make necessary adjustments.

- **Staff having little understanding about learning disability ;** this is why we have committed to delivering more specific training over the forthcoming year

- **Failure to recognise that a person with a learning disability is unwell;** the training will help us to ensure we are recognising the signs of someone with a learning disability being unwell and how this does not always present in a familiar way.

- **Lack of joint working from different care providers;** by working directly with the Treat Me Well group we have access to specialist service providers who can help us work in a more effective way.

- **Not enough involvement allowed from carers;** we continually work with staff to ensure our services are flexible and care is delivered in partnership with the patient and carers.

2.6.4 Enhanced Care Project

In March 2019 it was agreed that a project could be undertaken to look at how we deliver 1-1 care and whether there was an opportunity to make this more effective. An experienced band 7 nurse was seconded into the lead post. Work has been underway to look at the current requests for 1-1 care and how this is currently assessed and arranged. Healthcare assistants have been contacted to express interest in the role.

Further training has been delivered specifically in relation to breakaway techniques and engagement/distraction techniques. Distraction and engagement tools have been obtained from existing resources such as My Life equipment, playing cards, twiddlemuffs etc. Paperwork has been devised to encourage 1-1s to monitor the patient they are with for indicators in changes of behaviour and what works well for reassuring and supporting them.

The lead nurse has been to see how enhanced care has worked in other areas to look at what has worked well and what hasn't. Staffs have been consulted as to how they think it

would work and what the purpose of the project is. Wards that currently have a high rate of requests for 1-1s have been visited and the lead has talked to the staff to look at why the requests are high and if they could do something differently. The project will be implemented for four weeks and then reviewed. It is hoped that during this time patient feedback can be obtained to see if the change in the type of 1-1 support they receive has meant they have had a more positive experience.

2.6.5 End of Life Care Group

Feedback from the end of life care group reported their findings from the Bereaved Carers Survey. The Trust began to survey carers whose relatives had died within our hospitals. The survey was carried out between January-December 2018.the results are as follows:

What you said:

- 75% of carers thought that the care given to patients in their last hours and days of life was excellent. This is an improvement on last year.
- The majority of patients were cared for in a side room in their final days, but there has been an increase in the number of patients who this was not provided for. This caused distress.
- Pain and other symptoms were well controlled in patient's final hours and days.
- Not all carers were offered a free car parking permit, Bradford Comfort Bag (containing blanket, toiletries, socks and ear plugs) or open visiting. For those carers who received these items they felt that staff really cared.
- Care after the patient has died is dealt with sensitively and the majority of death certificates were available for collection from the Bereavement Office in a timely manner. This was very important to carers and it caused upset for those that this did not happen.
- Half of carers felt that their loved one had the chance to talk to staff about care and treatment at the end of their life; this is a slight reduction from last year. Nearly all carers felt they had the chance to talk to staff.
- 91% of carers felt they were treated with sensitivity, this is an improvement.
- 98% of returned surveys were completed by White British. This does not reflect the local population.
- Similar to last year a small number of carers expressed a wish for ongoing bereavement support; this is not available from the Hospital at the moment.

What we did:

- We will continue to try to move our patients if this is their wish into a side room in their final days. If we are unable to do this we will sensitively explain the reason why.
- We have shared the results of the surveys with the doctors and nurses working in our Hospitals.
- The Hospital Palliative Care Team provide communication skills training for staff to help them support patients and their families.
- We have reminded staff to give relatives free car parking permits, Bradford Comfort Bags and open visiting.
- The survey can now be completed online at www.bradfordhospitals.nhs.uk/patients-and-visitors/patient-experience which we hope will encourage more people to complete the survey.
- We will do our best to have death certificates ready in a timely manner.
- We are in the process of making a plan to work out how we can offer bereavement support to those who feel they need this. However there are services available in the community, which your GP will know about.

2.7 Care Group Reports

During Q1, 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 and 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 Unplanned Care Group

Physiotherapy appointments: patients feel they have been unfairly treated when re-scheduled appointments in advance are treated the same as not attending.

Action Taken: Review of the DNA policy has been undertaken to differentiate between patients who re-schedule appointments and those who do not attend.

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.

AED: Patient complained about unacceptable delay in transferring patient from trolley to bed.

Action Taken: Matron now undertakes spot checks to ensure hospital policy is adhered to.

2.7.2 Examples of Learning from Planned Care Group

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.

Critical care: Complaints about noise at night.

Action Taken: Matron is working with Bradford Hospitals Charity team in relation to work within planned care to reduce noise at night "*Good Night Sleep Tight*". ICU is looking at purchase of sleep kits and sound ears to reduce noise and disturbance at night.

2.7.3 Examples of Learning from Women and Children

NNU: There are not enough breast pumps.

Action Taken: Broken pumps have been repaired and new ones ordered so now in all rooms to encourage breast feeding.

NNU: Parents reported that they would like more continuity of care by same nursing staff member.

Action Taken: Review of staffing to accommodate this where possible.

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 of change this quarter is to order more TV remotes. Overall 86% of the feedback from children direct reported this being a "Good Hospital" to come to.

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2.8 Complaints

During Q1, 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 and tight monitoring and control measures were put in place, with robust tracking, and weekly review of performance.

Figure 2 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 June 2019.

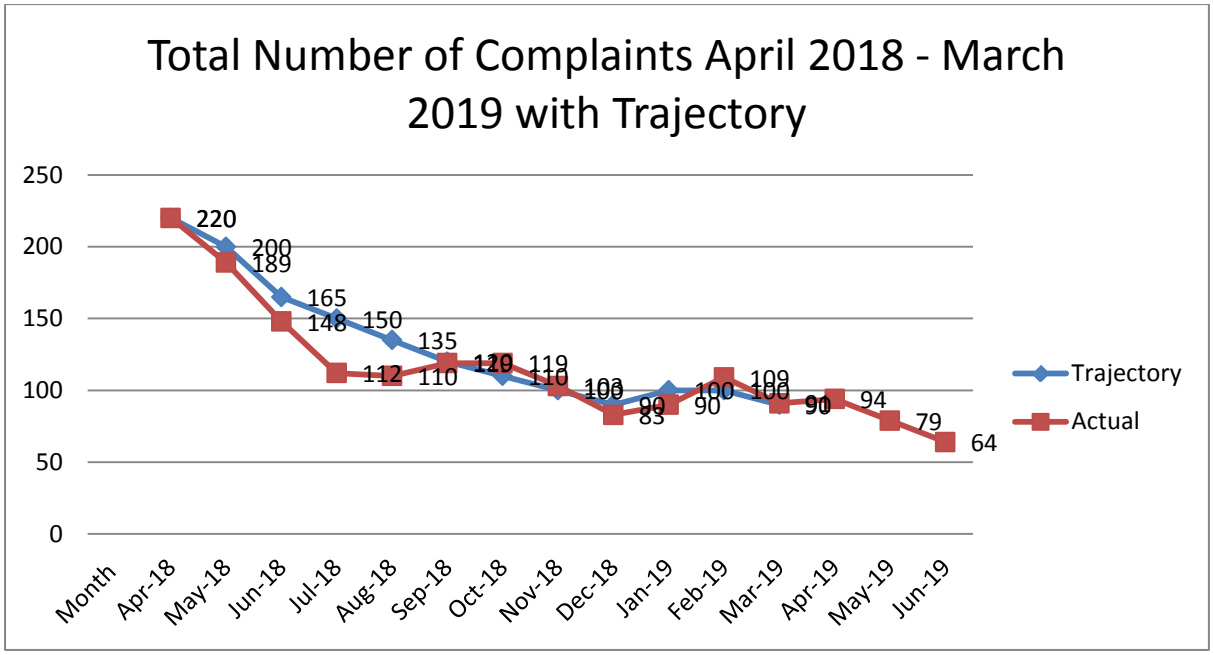

Figure 2

The number of complaints at the end of Q1 was significantly below our planned trajectory and currently sits at a total of 64 open complaints as of June 2019. This is a fantastic achievement, that the teams are proud to report.

Table 2 (below) demonstrates the Q1 figure for the number of complaints received by the new Care Group structure. Table 3 provides previous *Divisions* quarterly figures; direct comparison is difficult due to the restructure of departments. The overall number of collective complaints however remains at the lowest point recorded in recent years, with the total being (N=117) for Q1.

	2019/20 Q1
Planned Care Group	59
Unplanned Care Group	57
Central	2
Total	117

Table 2 Number of complaints per CBU

	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 3 Number of complaints per Division (pre April 2019)

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 those 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 3 shows the current position in relation to the number of complaints beyond their due date. During Q1 these complaints have continued to reduce each month. Ongoing tracking and weekly meetings to monitor current complaint status with a low threshold for early escalation to senior management has helped to reduce these numbers.

Figure 3

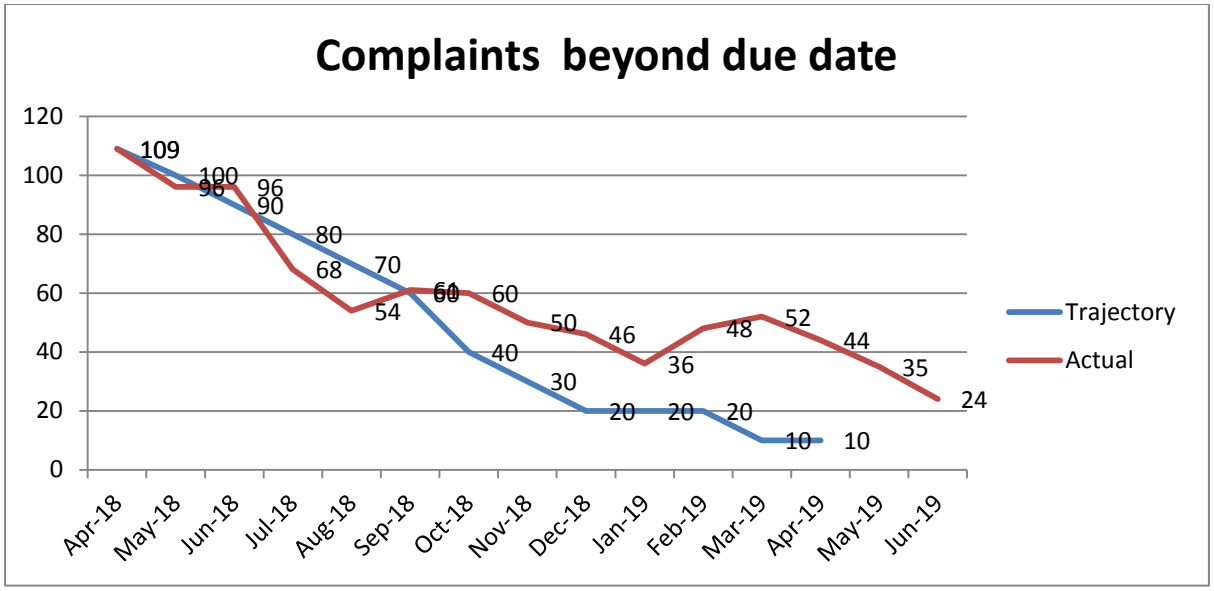

Figure 4 shows the number of complaints that are 6 months in excess of their due date. There still remains a small number above still exceeding this timeframe. In the majority of cases these have been complex complaints involving either multiple specialities or multiple issues which have taken time to investigate and respond to, and in some cases have been dependent on information being provided by 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.

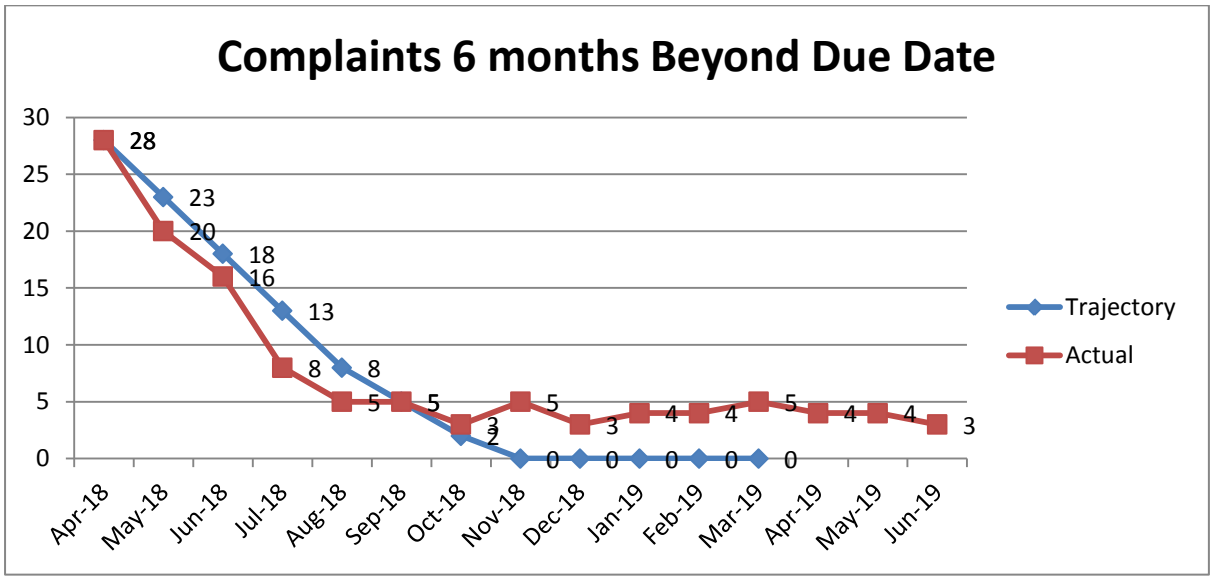

Figure 4

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 5 clearly highlights that the largest number received are received from Accident and Emergency Department, Maternity Service and Urology, with each all receiving 12 during Q1. The Chief Nurse Office requested that each of the three mentioned above areas provided an independent review of these to look for any specific concerns and themes and requested feedback via the Patient Experience Sub-Committee for further management scrutiny and learning. The feedback summary from maternity services was as follows.

Findings:

All cases were very different, with no emerging themes or trends for the cluster and raised number of complaints in Maternity Services.

Further Actions and Learning:

Some complaints may have been avoided if a need for debrief had been identified prior to discharge as the complainants were asking why things happened rather than a suggestion that care was inappropriate. Debriefs are carried out in cases of complex labour as standard and this model should be adapted to what may be considered a less complex case to identify if any further questions can be answered. This suggested improvement is to be monitored during Q2.

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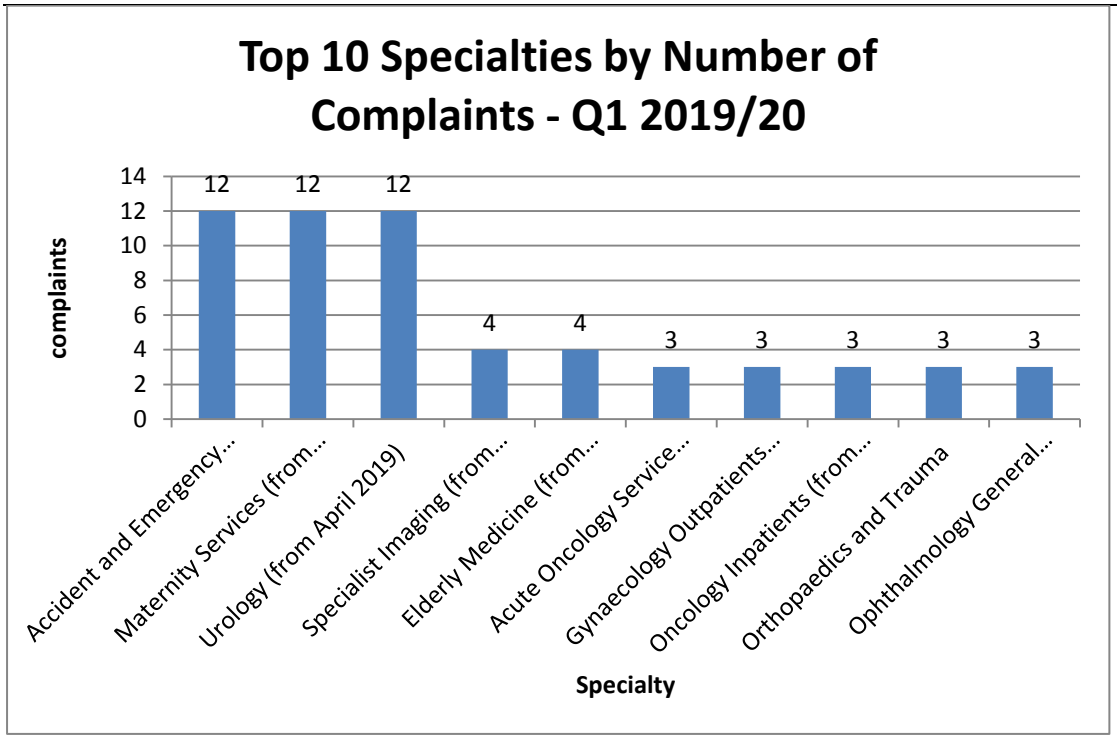

Figure 5

Figure 6 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.

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

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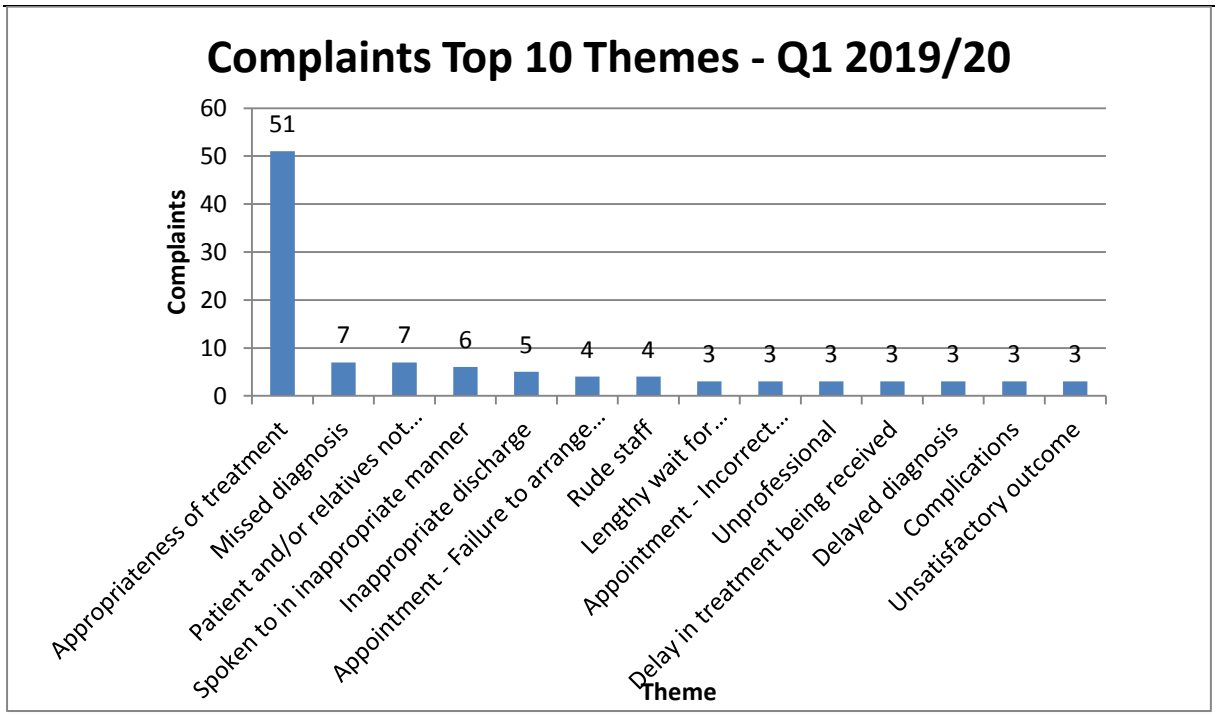

Figure 6

When complaints are received and reviewed, they are recorded and graded on the Trust Datix system. There were no complaints received during Quarter 1 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 Q1 is 46 Moderate/Medium and 71 Low. Figure 7 illustrates the grading of all complaints received during Q1 by CBU.

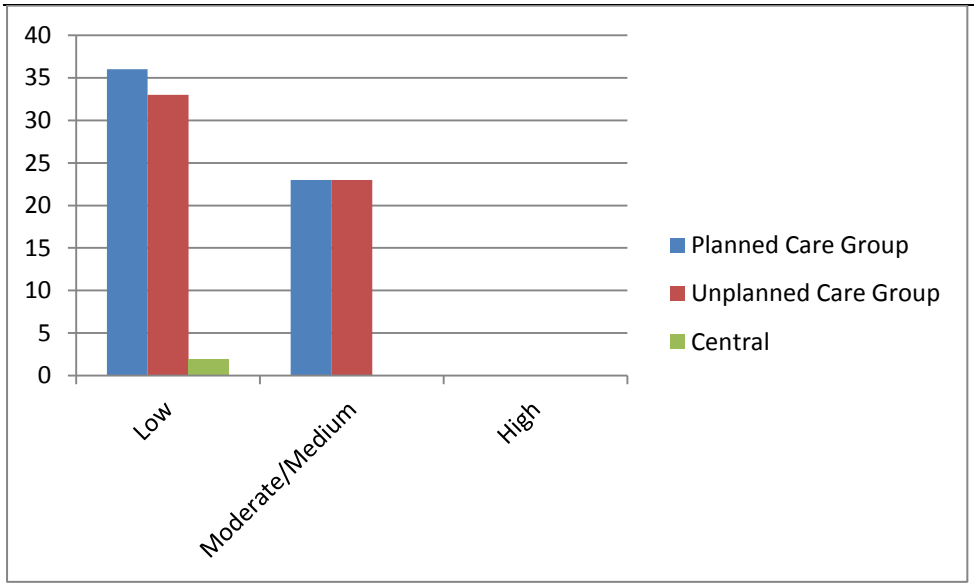

Figure 7

2.9 Learning from Complaints

Learning from complaints is taken very seriously as valuable patient feedback to enable us to identify areas for improvement. Matrons inform the wider team members via weekly newsletters of learning points and actions from complaints and this information is disseminated to medical staff in some areas for example AED. Specific cases are discussed at individual Clinical Governance meetings and actions required are monitored by the CBU responsible. The Risk and Governance team carry our sporadic spot checks and audit of complaints to ensure actions have been delivered and provide an additional level of assurance. The Patient Experience Sub Committee has asked for each CBU to provide evidence of how they have learnt from complaints and share any new initiatives they have used to deliver on this.

2.10 PALS

The total number of Patient Advice and Liaison Service (PALS) issues continues to remain high. The total number for Q1 being 340, again seeing a slight rise from Q4 2018/19. 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 8 provides a breakdown of the PALS issues, by speciality, Central Patient Booking for the second consecutive quarter remain one of the highest along with AED. This data has been reported back to the department for further analysis and action as appropriate.

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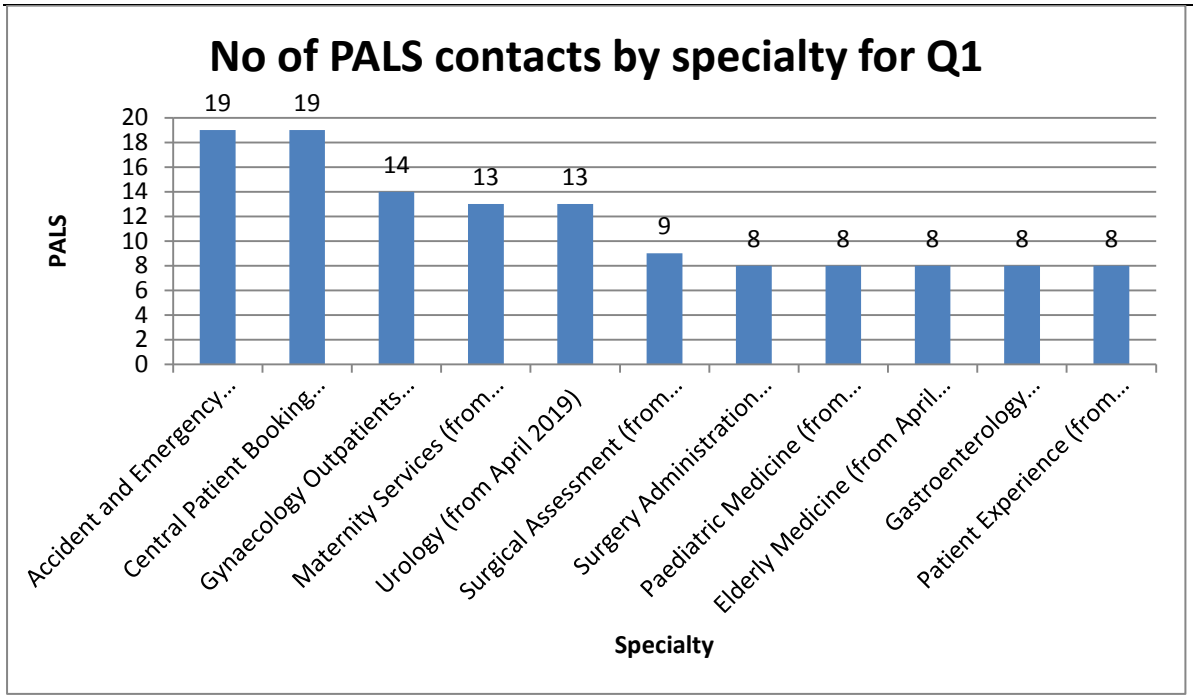

Figure 8

Figure 9 provides a breakdown of the themes of PALS due to the less complex nature only a single theme is recorded for each issue. Appropriateness of treatment remains the highest category accounting for 73 issues.

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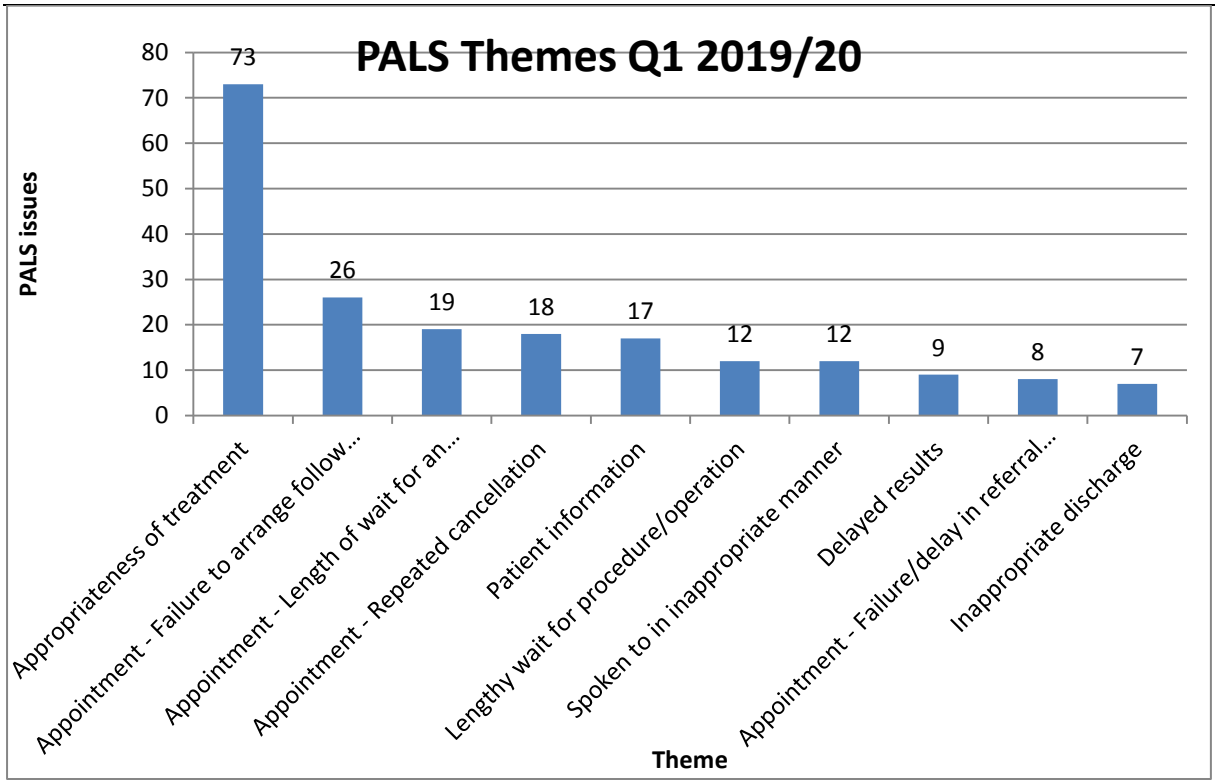

Figure 9

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.

Ongoing work with Patient Perspective and individual CBUs will help facilitate identification of areas for improvement and support the development of action plans following recent National CQC survey results. Weekly feedback sessions direct to the Chief Nurse office will continue during Q2 to allow monitoring and shared learning and improvement initiatives at a senior level. This transparent accountability will help the Trust to work as one to improve Patient Experience within the Trust.

The complaints policy is now updated and finalised and was signed off via the Chief Nurses office during Q1. This reflects the process for reviews 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.

4 RECOMMENDATIONS

- Support is required from all areas to embrace the new PE Strategy.
- 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.
- Continue the promotion of increasing the update of Friends and Family Test.
- Encourage the capture of additional questions with the FFT to support the QI work around Inpatient Surveys.
- Work towards progression with the maturity index work for Assessable Information Standard work.
- 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.
- Support is required from all areas to facilitate the remedial action plan for ward accreditation to allow the inspections to go ahead.

5 Appendices

There are no appendices.