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

PATIENT EXPERIENCE QUARTER 2 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 Q2 (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	18.12.19

Key Options, Issues and Risks

This report provides an update on the work of the Patients Experience Sub-Committee, which includes work undertaken by the central patient experience team, care groups as well as corporate work streams during Quarter (Q) 2. The report also includes details of Q2 Complaints and Patient Advice and Liaison Service (PALS).

The results for the Children and Young People 2018 CQC survey have been published and BTHFT have been identified as being an outlier. A summary of the findings are enclosed within this paper and an action plan provided by the Head of Children's services is enclosed (Appendix 1). A full report will follow to the next Quality Committee following presentation to the Patient Experience December 2019 sub-committee.

Open complaints within the Trust during Q2 are at the lowest recorded level (N=52).

The 2019 Patient Led Assessment of the Clinical Environment (PLACE) has been successfully completed with all data uploaded for analysis during Q2.

During Q2 work has continued to embed the Patient Experience Strategy, ensuring that this is a key strand through all patient experience work.

The new Quality Lead for Patient Experience, Laura Booth, has now taken up her position. The Chief Nurse Team would like to formally welcome her to the Trust.

Analysis

Promotion of the Patient Experience Strategy remains a key priority to the Chief Nurse Team. To support this work, the Patient Experience Collaborative (PEC) work continues with the support of the Quality Improvement Team to capture, interpret and act on patient feedback received, to enable sustained patient experience improvements to be made.

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

There has been an increase in the number of Friends and Family Test responses over Q2, nearly doubling to the previous quarter rising to an overall response rate of 29%. The majority of these responses state patients would recommend the Trust.

Below are the headlines from the analysis of complaints and PALS during Q2:

- Q2 has seen 109 complaints; this is significantly lower than complaints received during the previous quarters.
- PALS contacts remain high at (N=386) during Q2.
- The theme of most complaints is in relation to appropriateness of treatment which account for 33% (N= 47).
- There have been no complaints graded as extreme or high during Q2.
- The areas with the highest number of complaints received are AED (N=17), ENT General (N=9) and Gastroenterology (N=9), during Q2.

Recommendation

- Strengthen the learning from complaints to ensure clear evidence for assurance by setting up a Complaints Review Group, to be chaired by the Chair (Dr Max Mclean).
- Support the work to continue to roll-out the Patient Experience Strategy and embed this via the QI programme.
- Patient Experience Sub-Committee to monitor progress against the paediatric survey and report by exception to the Quality Committee.

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 (*)					

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

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 ☐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)
☐	☐	☐	☐	☐	☐

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

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 2, 2019/20 (Q2). 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 Experience 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. For quarter 2 this includes:

- National CQC Children's and Young Peoples Survey update 2018
- Friends and Family Test Results for Q2
- Patient Led Assessment of the Clinical Environment (PLACE)
- Patient Experience Collaboration

The work streams which provided their scheduled report to the Patients Experience Sub-committee during Q2 included:

- Dementia
- Nutritional Steering Group
- Learning Disability Forum
- End of Life Care Group

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 presented during Q2.

This report also provides an update on Complaints and Patient Advice and Liaison Service (PALS) for Quarter 2.

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

2	CURRENT POSITION

2.1 National Survey updates

2.1.1 Children's and Young People survey 2018

The National Children's and Young Peoples survey 2018 preliminary results were received during Q2 and formally published on the CQC website on the 19th of November 2019. This survey looked at the experiences of 33,179 children and young people who were admitted in November and December 2018 Nationally.
Between February and June 2019, a questionnaire was sent to 1250 recent patients who had been inpatients at BTHFT Paediatrics services. The following criteria for inclusion were followed:

- Eligibility:
  - Children and young people up to the age of 15 admitted to hospital as an inpatient, a planned day case, or an emergency patient who did not require an overnight stay.
  - Children and young people under the age of 16.

- Exclusions:
  - Babies whose mother was the primary patient or babies who were only admitted to a Special Care Baby Unit or Neonatal Intensive Care Unit.
  - Patients treated for psychiatric conditions and private patients (non NHS).

Responses were received from 276 Bradford Teaching Hospitals NHS Foundation Trust patients, which equates to a 22% response rate. The questionnaire asks a series of questions around the ward, staff, facilities and discharge as part of a postal survey and the scores are benchmarked against other Trusts nationally as follows:

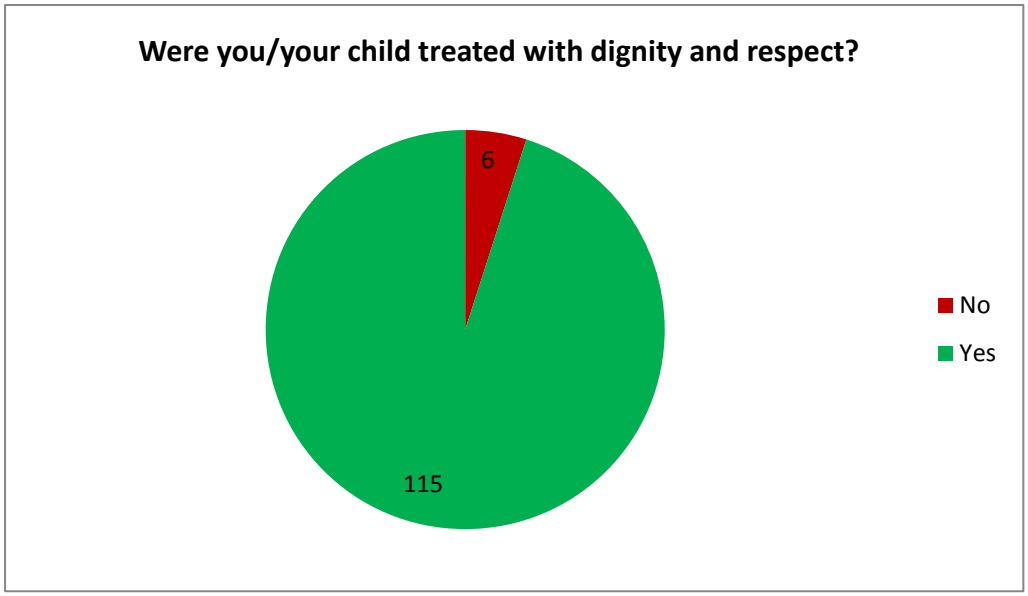
- *Better*: the Trust is better for that particular question compared to most other Trusts that took part in the survey.
- *About the same*: the Trust is performing about the same for that particular question as most other Trusts that took part in the survey.
- *Worse*: the Trust did not perform as well for that particular question compared to most other Trusts that took part in the survey.

It is disappointing to inform the Committee that the Trust has been identified as being an outlier for this survey. Of the 65 questions asked, Bradford Teaching Hospitals NHS Foundation Trust was reported to be *Worse* on 14 of those questions and *About the same* on 51.

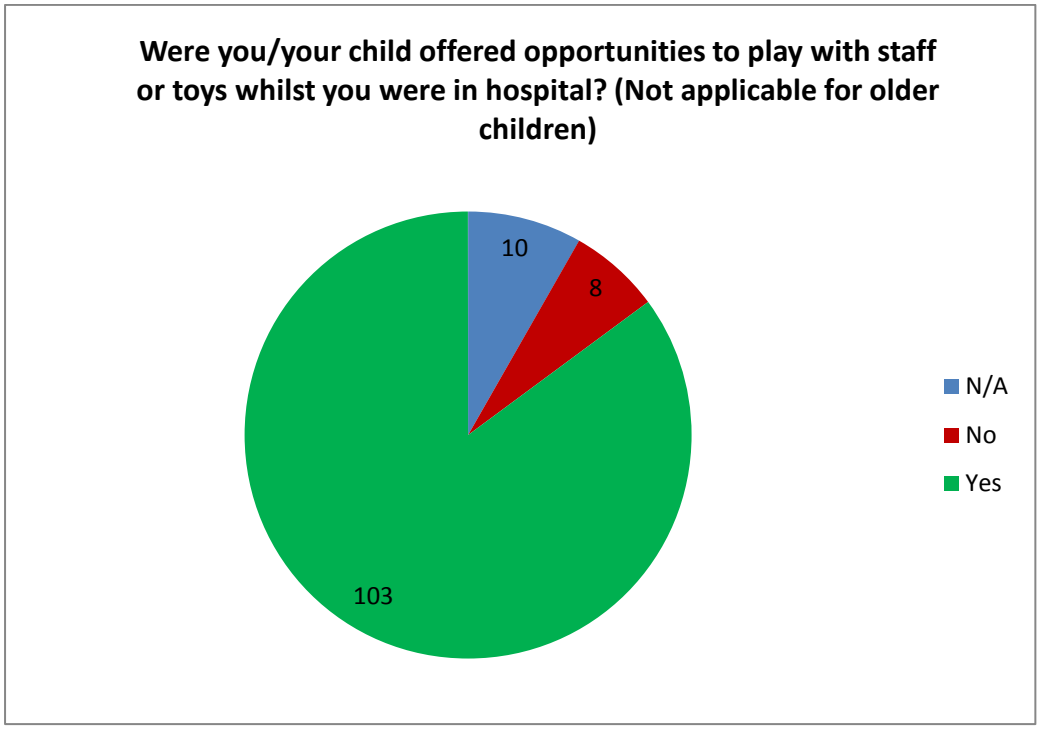
The Head of Nursing for Children has taken immediate action and produced an action plan (see Appendix 1). In addition a formal report will be presented to the next Patient Experience Subcommittee in December 2019 outlying future work and on-going patient experience initiatives in place and report to the Quality Committee will then follow.

Whilst it is recognized that improvement work is required, to learn and improve, these results represent a low response rate received from Bradford patients and accounts for a small number of feedback from children and their parents. The committee is asked to note that despite these results, other patient experience quality indicators do not reflect the same messages. To demonstrate this further a number of the questions where the Trust scored *Worse* than other Trust was asked direct to patients and their parents via iPads and the results are as follows:

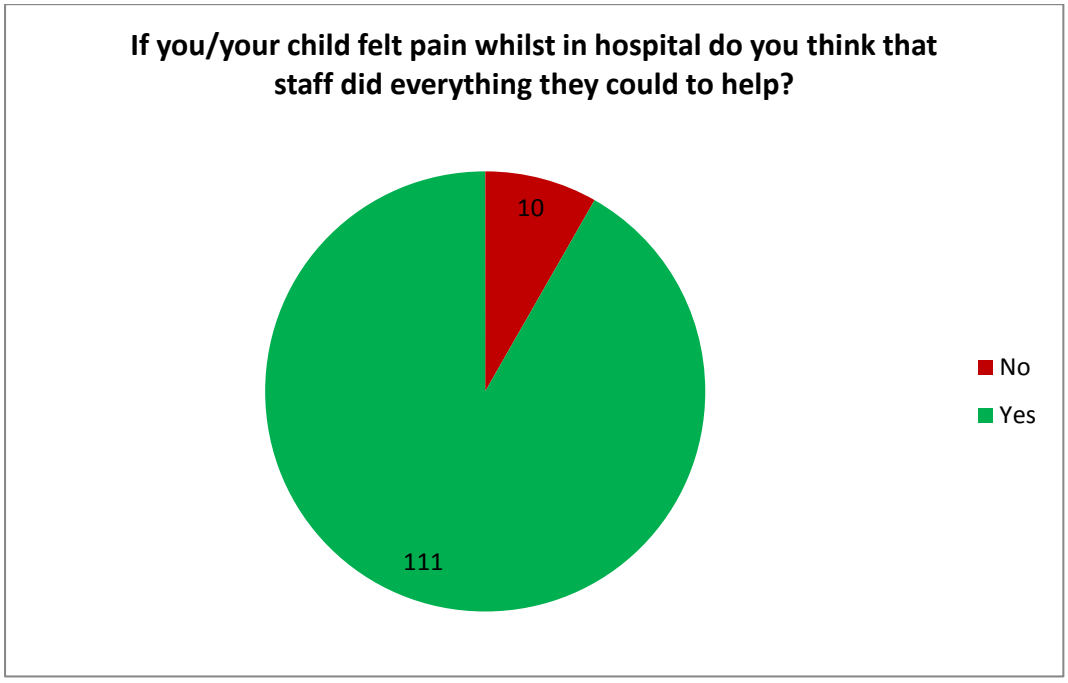
Were you/your child treated with dignity and respect?



- *Were you/your child offered opportunities to play with staff or toys whilst you were in hospital?*



- *If you/your child felt pain whilst in hospital do you think that staff did everything they could to help?*



Whilst it is acknowledged that there is still room for improvement to achieve nearer 100%, the patient experience team are working with children's services to ascertain more specific real time feedback, which allows improvements to be made during admission (via iPad reporting) and to consider on-going sustainable pieces of improvement work.

2.2 Friends and Family Test

There continues to be a drive to increase the amount of feedback collected via Friends and Family Test (FFT) feedback during Q2. Figure 1 presents FFT results received during Q1-Q2 2019/20. It is impressive to report that the overall response rate has increased from 16 % in April to nearly double at the end of Q2 (29%). Despite the increase in data, it is positive to read that the majority of the responses remain over 95% would recommend.

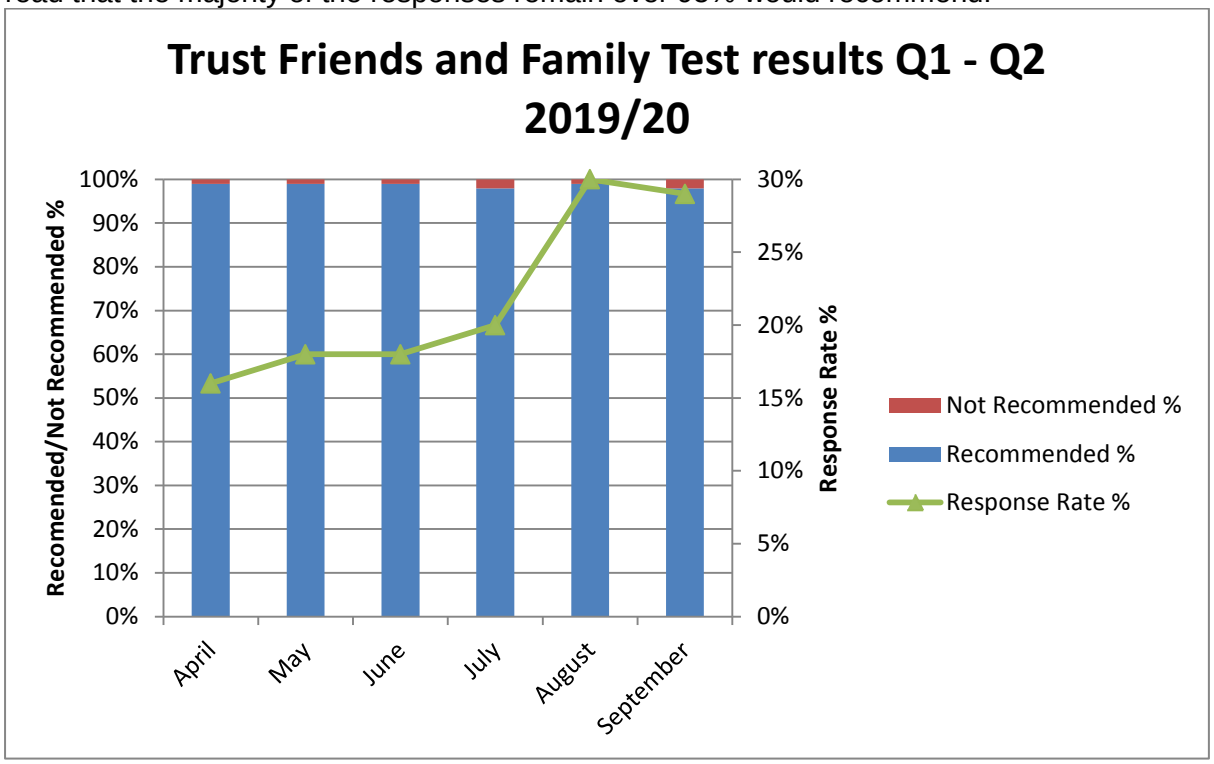


Figure 1

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 increased uptake from wards and Day case units can be seen in Figures 2 and 3 below.

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

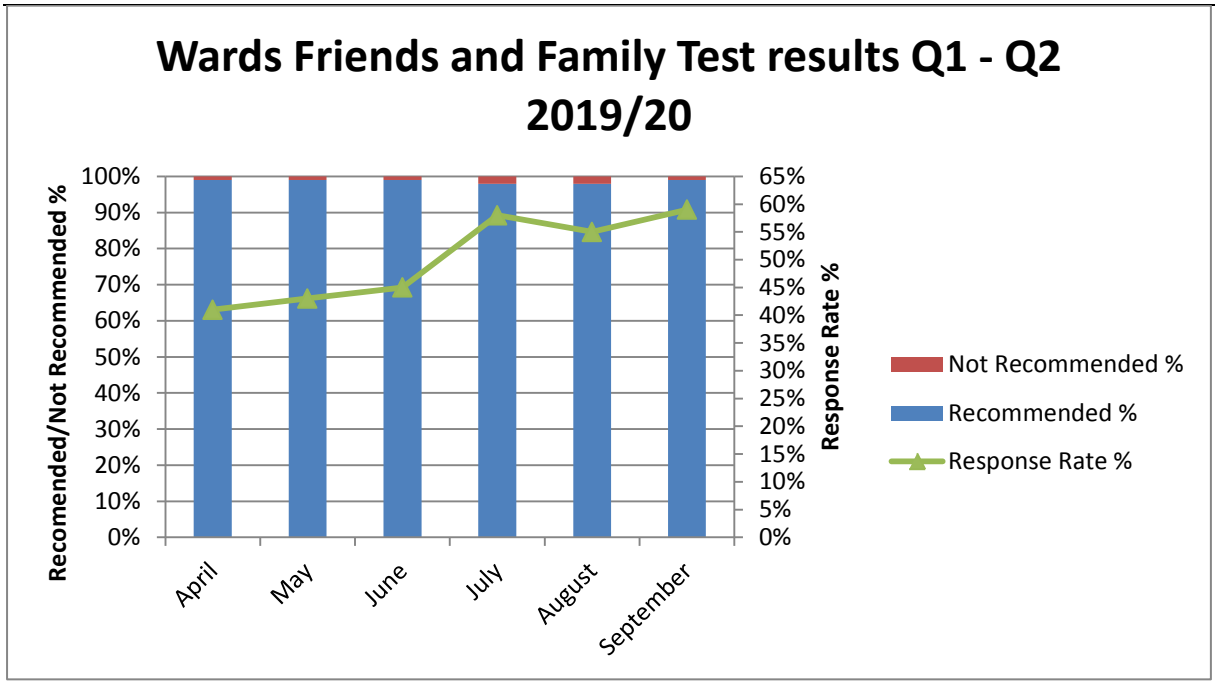


Figure 2

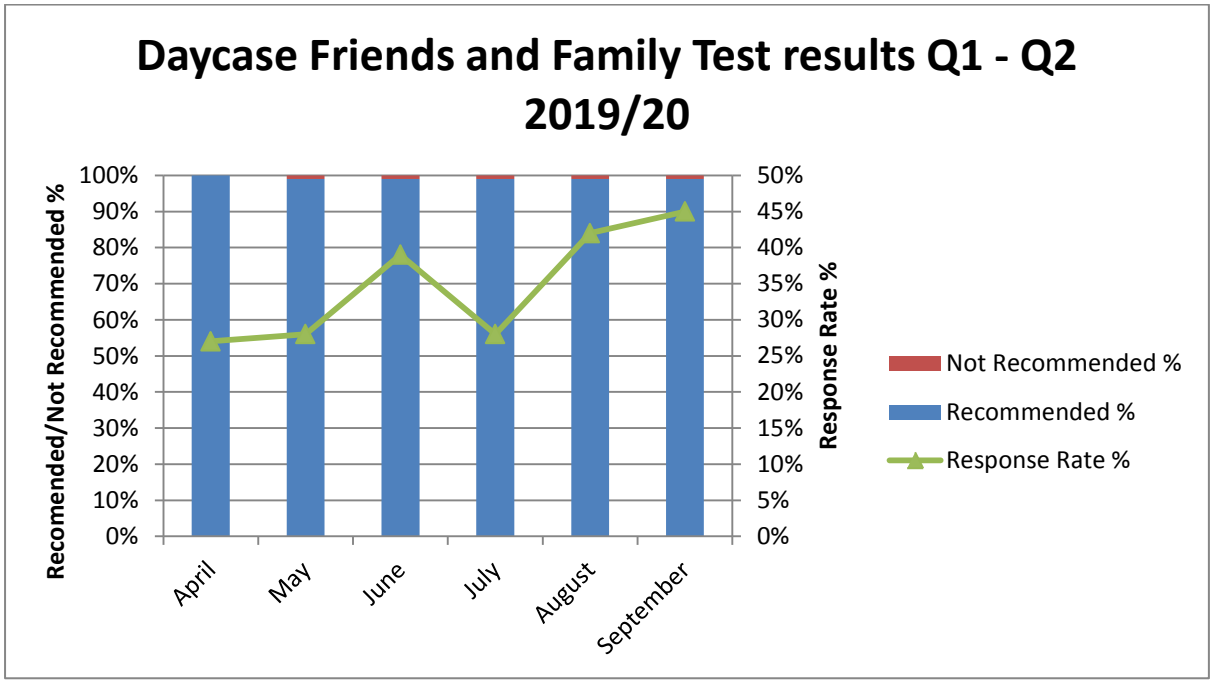


Figure 3

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 receives 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.

2.3 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 there were changes to the paperwork in some of the questions asked, training slides and the portal for the submission of data. A revised and extended timetable period of 10 weeks was introduced.

The patient experience team led the programme during Q2 and carried out all the necessary assessments. With the help from Estates and Facilities all the data has now been uploaded to the portal as required by NHS digital.

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.

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.

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

2.4 Patient Experience Collaborative

To support the implementation of the BTHFT Patient Experience Strategy the Patient Experience Collaborative (PEC) was launched in July 2019. The overall aim for this collaborative is to improve the way we capture, interpret and act on patient feedback.

There has been a range of improvement activities within the first wave of wards to improve the experience of care (See Table 1); these were shared at a recent Learning Session on 26th November. Our patient and public representative provided positive reflections on the work that has been undertaken by the wards to date. Future work involves increasing involvement at further training sessions and exploring further opportunities to support new patient experience work with Band 2 and 3 staff.

CBU	Ward	Speciality	Improvement activity
Urinary Tract and Vascular	**14**	Urology	Developing patient education for the self-administration of Tinzaparin post operatively at home
Muscular-Skeletal, Plastics and Skin	**27**	Orthopaedics	Patient Experience board display on ward
	28	Orthopaedics	Promoting 'Good night, sleep tight' initiative' – providing ear plugs/eye masks for all Providing all eligible patients the opportunity to feedback using FFT on ward iPads Piloting a new pre-assessment one-stop clinic for patients undergoing elective hip and knee surgery on the ward 28. Ward 28 –Experience Based Co-Design Project with Mr B to improve the experience of care for patient undergoing elective hip and knee surgery.
Specialist Medicine	**23**	Respiratory	Promoting 'Good night, sleep tight' initiative' – providing ear plugs/eye masks for all, addressing specific patient feedback with regard

			to doors banging at night. Providing activities for patients, games, pom-pom making, supported by Enhanced Care Lead. Improving staff morale – lots of small changes on the ward have made the ward a better place to be. Evidence suggests that staff satisfaction is closely linked to a better patient experience.
Urgent and Emergency care	**4**	AMU	Promoting 'Good night, sleep tight' initiative' – providing ear plugs/eye masks for all, addressing specific patient feedback with regard to bright lights. Since changes have been made no complaints from patients about disturbances at night from FFT feedback. Blue Badge initiative 'Tell me, how was your care today?' – facilitating conversations between patients and staff to talk about their care
Urgent and Emergency care	**ED**	Emergency care	Changes to way the team interpret and act upon patient feedback from the FFT. Sharing examples of excellent care; weekly feedback from the matron on common themes and using patient stories to understanding what matters most to patients when providing a great experience of care. Staff recognised when delivering exceptional care when directly named on FFT feedback. Patient boards in AED to tell patients about the things that have been changed - 'You said, we did' Blue Badge initiative 'Tell me, how was your care today?' – facilitating conversations between patients and staff to talk about their care

Table 1

Continued support is being provided to wards and teams including tailored Quality Improvement training for wards F5 and F6 at SLH. Learning sessions as part of the collaborative are designed to support staff to share learning and celebrate successes. There are plans to involve our patient representative in more training and learning sessions in the future, to provide direct patient led feedback. It is anticipated that by increasing patient and public involvement our improvement efforts will be shaped by the patient voice.

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

2.5 Patients' Experience Subcommittee Work Stream Updates

2.5.1 Dementia update

Education programme established:
The Trust now has 3 levels of dementia education:

- Level 1) all staff that work in the Trust are required to complete the e-learning module - currently 393 staff trained.
- Level 2) those who work directly face to face with people with dementia - currently 367 staff trained.
- Level 3) those who lead on dementia care (Dementia Champions training) - Currently 103 staff trained.

All dementia education is available to book through ESR.

Updates in practice:

- Blue wristbands for those with a cognitive impairment.
- Forget me not scheme leaflets are across the Trust (including magnet above the bed/ This is me document/ summary pack).
- Neelam's Box (activity/ distraction box) will be rolled out in all inpatient areas during Q3.
- Dementia Amazon wish list for people to donate items to areas should they wish– available to see through the Trust website.
- Launched the Trust Dementia Strategy and action plan- monitored through the Dementia Steering Group.
- Carers' information and signposting bags in all areas.
- Datix relating to dementia and lessons learnt- shared at Back to Basics session.
- My Life utilisation report- currently updating all devices, this will be done by February 2020.
- Complaints and compliments received fed back to Dementia Steering Group.
- Carer related activity- discussions to commence a dementia support group for carers.

Innovation:

- Emergency Department cubicle established, verbal feedback for this is positive, written feedback is in the process of being obtained for further evidence.
- St Luke's Outpatient department - dementia friendly environment commenced, monies from Friends of St Luke's have granted charitable funding for the café area to be dementia friendly.
- Kings Fund dementia friendly environment audit completed in areas across the Trust with individual action plans.

Updates in National priorities:

- Johns Campaign leaflets.
- This Is Me document replaced See Who I Am.
- The Trust is taking part in a regional audit on Advance Care Planning in dementia until April 2020 - need to train 40 frontline staff.
- BTHFTs 2018 National Audit of Dementia in Acute Hospitals, results were published

an action plan has been sent back to Royal College of Psychiatrists. A spotlight audit was undertaken in April 2019 for anti-psychotic use, results are pending.

2.5.2 Nutritional Steering Group

The nutritional steering group reported that the Hospital Food and Drink Strategy are now on the Trust external website as a public document.

There has been further work carried out on the training plan for the nasogastric tube feeding risk that had been identified. Due this additional training work the risk is now closed.

A nutrition audit review has been completed and three new measures will take place in the following months to strengthen nutritional audit on patients. A proposal to include nutrition in future ward accreditation work, a new fluid and nutrition audit in Meridian is taking place from October 2019 and a rolling programme of dietetic led deep dive audits. In addition work is underway to look at auditing some nutrition elements direct from EPR. Through these new developments in auditing nutrition the reporting will allow the identification of wider issue as well as at ward level issues and line of sight of audit assurance up to the nutritional steering group for development of any further actions required.

A piece of work is currently underway to improving home enteral feeding discharges from children's wards. The aim is to change practice to ensure children and their families get the correct equipment and training they need before discharge to improve patient safety and experience, reduce carer stress and save hospitals and community nursing time on troubleshooting afterwards.

2.5.3 Learning Disability Forum

There has been on-going development of work in relation to patients with Learning Disabilities.

Work with partners:

The safeguarding adult Named Nurse attends the regional A2A meeting. This meeting is for all the learning disability leads in acute care. Its focus has been on:

- The developments from NHS digital in relation to summary care records and the recording of reasonable adjustments relating to patients with learning disabilities.
- Development of the national audit and to reduce variance in interpretation of questions asked.
- Pilot of the learning disability toolkit devised by NHS Improvement.

The safeguarding adults' team attend the local Mencap Treat me well group. The group came to the hospital in June to raise awareness of their campaign. They had a stand in the concourse and met the acting Chief Executive. It has been agreed with the group that more specific training in relation to learning disability patients will be incorporated into the Safeguarding adults training. Members of the group have offered to assist with delivering training.

The Named Nurse meets with the Health Facilitation lead from BDCFT to ensure specialist services are contacted at an early stage of a patient's admission to improve their experience whilst in hospital, by ensuring any reasonable adjustments are made and where possible admissions are planned.

The CCG's Think LD campaign has been adopted, with a screen saver being devised to raise awareness.

Future work

Due to the increase demand and expectation in relation to the work relating to patients with a Learning Disability, a business case was approved for a specific Lead Practitioner post. Unfortunately despite a successful recruitment process initially, the post has not been appointed to, this will be re advertised in the New Year.

The national audit, which is the Learning Disability Standards collection, is currently live and work is on-going in relation to ensuring the Trust participates effectively.

Bespoke training is being developed with members of the *Treat me well* group and the lead from BDCFT to ensure staff have a greater understanding of the needs of patients with a learning disability and how to support them whilst they are in hospital.

Identification of patients and flagging of records to identify reasonable adjustments
Work has commenced within the paediatric teams to identify and flag patients who are diagnosed with a learning disability, to enable reasonable adjustments to be made, flagged and reflected within EPR.

Mental Health

The monitoring of patients detained under the Mental Health Act is undertaken by the safeguarding team. This ensures that the Trust is compliant with the legislative requirements and that patients who are detained have access to appropriate advocacy support and liaison is undertaken with mental health services. The safeguarding team has two mental health nurses within the team who offer guidance and support to staff. Training in relation to mental health is also delivered to staff as requested or in response to concern. As part of the Trusts student nurse placement expansion plans, the Named Nurse discussed with the Head of Education the opportunity to offer placements to mental health and learning disability students. This has been agreed and will commence in 2020.

Enhanced Care

A pilot project was commenced in September 2019 in relation to enhanced care. The purpose of this project was to explore how the Trust provides 1-1 care to individuals who may have additional needs such as a learning disability, mental health diagnosis, dementia or cognitive impairment. The staff member employed to lead this project has reviewed current paperwork and delivered training to healthcare assistants, specifically focussing on engaging with patients and utilising distraction techniques to make interactions meaningful and improve their patient experience. The project is due to be reviewed in January 2020.

2.5.4 End of Life Care Group

Feedback from the end of life care group reported that the National Audit for Care at the End of Life (NACEL) is in progress for 2019. Once the survey is completed, results will be presented to the patient experience subcommittee.

During Q2 the 4th Annual Bereavement Conference "Death is an Everyday Occurrence" took place, in June 2019. Excellent evaluation was received for this event.

As part of the work being carried out within the bereavement strategy, a pilot is currently being finalised to support bereaved families who's loved ones have died suddenly within the AED department. Work is currently taking place between the AED department, the bereavement team and palliative care team to offer families the opportunities to come and meet AED staff approximately 6 week's following an unexpected adult death of a loved one. It is hoped that this pilot will allow any unanswered question to be explored and identify any further concerns. This should assist with any future developments that may enhance the family experience during these unexpected circumstances. It is hoped this will reduce the number of complaints to AED with this proactive approach and help signpost to further support services if required.

The planning for the next shared memories is taking place for March 2020.

A snapshot DNACPR audit is underway for assurance to ensure best practice.

Finally an End of Life Education programme is currently being developed by the Hospital Palliative Care Team. Full details will be presented to the patient experience sub-committee.

2.6 Care Group Reports

During Q2, the Patients Experience subcommittee has received an update from the Associate Heads of Nursing on the activity being undertaken to improve the patient experience within the care group.

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 care groups 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.

2.6.1 Examples of Learning from Unplanned Care Group

Dietetics: Patient story to Board "Molly's story" reported poor experience for gastroenterology services and dietetic provision. Long waits to see a dietician and no pathways led to poor patient experience.

Action Taken: Following a business case approval and a new referral pathway, (which follows best practice), there, is now a new dietician led coeliac service with two dedicated gastroenterology dieticians appointed and leading. This is a fantastic result and strengthens the importance patient stories can make to contributing to improving service provision.
Radiology: As part of a programme which surveyed patients attending for adult CT in relation to Bowel Screening Services. It was identified by patients that information leaflets were not clear.

Action Taken: An action plan has been developed as a direct result of this feedback to improve the information that is being produced and shared.

MRI: It was reported that a more appropriate environment was required for children undergoing MRI to try generate a more settled and calm environment prior to scan.

Action Taken: A charity appeal was launched and a new "Snuggle room" was developed to provide a soothing and calm environment in the hope this will reduce the number of general anaesthetics required. This is part of a number of planned changes to improve the experience of young patients in Radiology.

2.6.2 Examples of Learning from Women's and Children Planned Care Group

Children's wards: reported that the food was not great.

Action Taken: created an engagement day with parents, children staff and dieticians. Food tasting was available and a sample menu was developed as a result of patient feedback.

Children's wards: not having adequate Wi-Fi.

Action Taken: Head of Children's Nursing has asked that the Wi-Fi be reviewed for children's areas to assist children to access homework projects and friend easier whilst an inpatient.

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

2.7 Complaints

During quarter 2 (Q2), 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 4 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 September 2019.

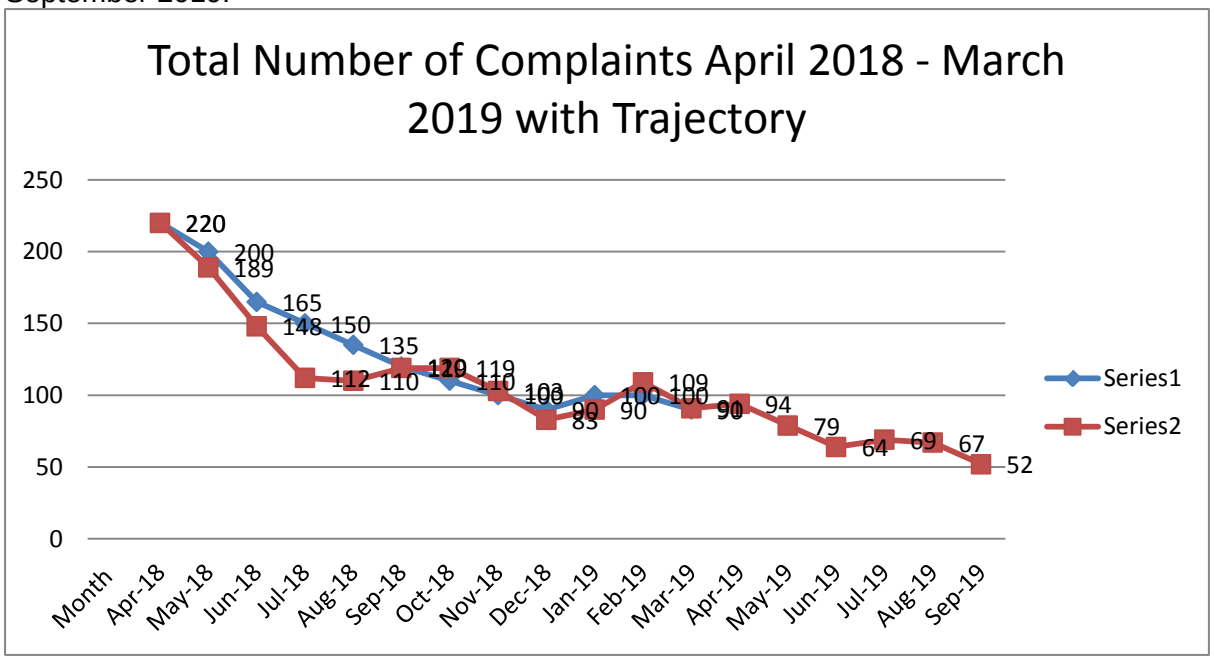


Figure 4

The number of complaints at the end of Q2 was significantly below our planned trajectory and currently sits at a total of 52 open complaints as of September 2019. This is a fantastic achievement, that the teams are proud to report.

Table 2 demonstrates the Q2 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=109) for Q2.

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

	2019/20 Q1	2019/20 Q2
Planned Care Group	60	45
Unplanned Care Group	57	63
Central	2	1
Total	119	109

Table 2

	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4
Division of Anaesthesia, Diagnostics and Surgery	55	78	49	60
Division of Medicine and Integrated Care	53	59	55	59
Division of Services for Women and Children	19	20	8	13
Central Services	7	7	7	6
Total	134	164	119	138

Table 3

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 a significant number of complaints being resolved at first contact following prompt communication with the Investigating Officer and complainants. To demonstrate this further, figure 5 demonstrates during Q2 that 21% resolved at initial contact and did not require a formal response.

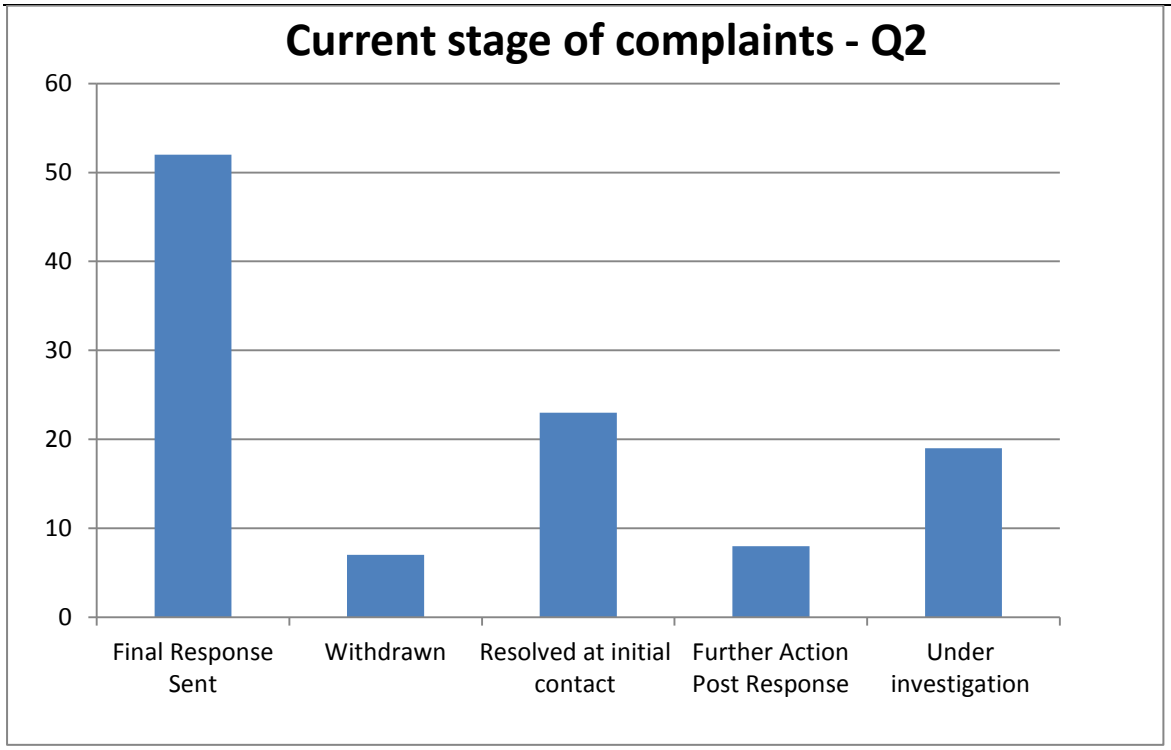


Figure 5

During the past year it had been 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 6 shows the current position in relation to the number of complaints 6 months beyond due date. During Q2 for two consecutive months there were no complaints over 6 months, which is an excellent achievement given the previous position and complexity of some of these complaints.

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

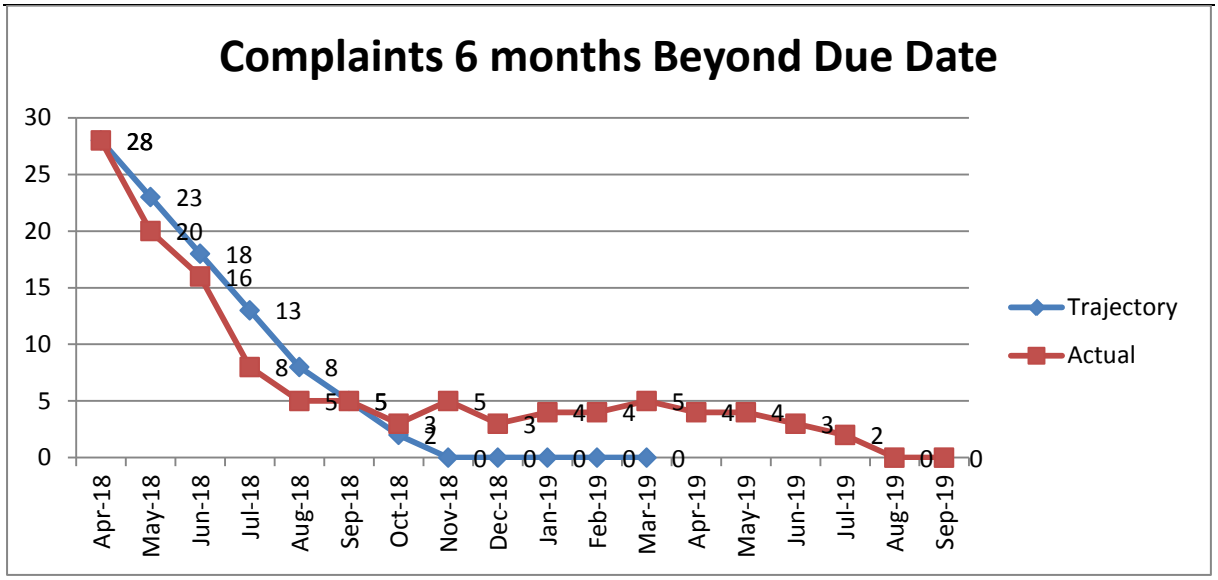


Figure 6

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 7 clearly highlights that the largest number received are received from Accident and Emergency Department (N=17), ENT General (N=9) and Gastroenterology (N=9), during Q2.
Where clusters of complaints are identified the Chief Nurse and executive lead for complaints requests that independent reviews of these are carried out to look for any specific concerns and themes and requests feedback via the Patient Experience Sub-Committee for further management scrutiny and learning. The feedback summary from Gastroenterology was reported to patient experience subcommittee in September and in summary report the following:

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

Findings:

Issues	Root cause	Action's
Booking process: •Patient receiving incorrect letter of the procedure date •Patients booked on the incorrect Endoscopist list •Patient not receiving DNA rebook in timely manner	Admin bookers not checking for specific instructions in the comments section	Bespoke Intensive competency training for all admin bookers SOPs booking process and guidelines
Removals from waiting list:: Implementation of EPR system created a number of duplicated waiting list entries, requiring review and correction	Whilst undertaking this corrective action this generated an automatic letter informing patient of this via removal from waiting list letter	This has since been resolved Trust wide
Incorrect bowel and dietary prep given to patients	No TCI available at time of PAC…therefore patient given 3 differing options to commence bowel prep	All patients now have confirmed TCI date at time of PAC
Discharge process	Patient not given option to have NOK present at time of discharge.	All patients asked and at admission if wish for NOK to be present at time of discharge. This is documented in EPR.

Figure 7 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 CBUs and at performance meetings.

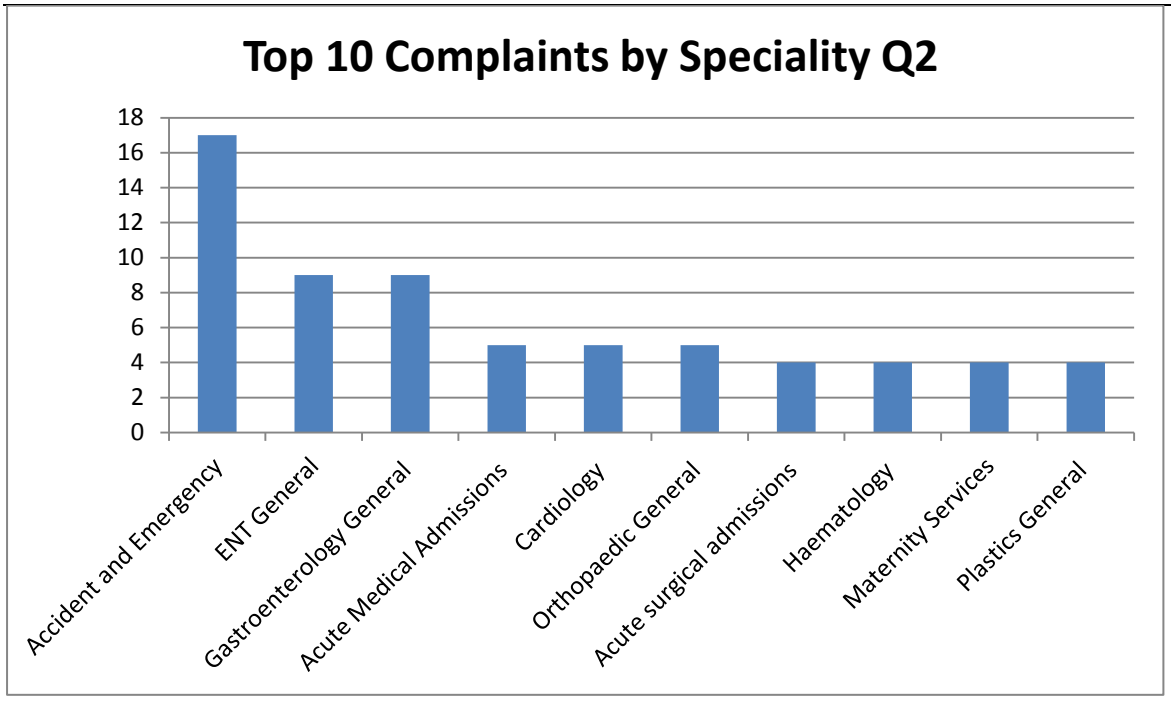


Figure 7

Reporting of themes is monitored at the patients experience subcommittee, 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 8).

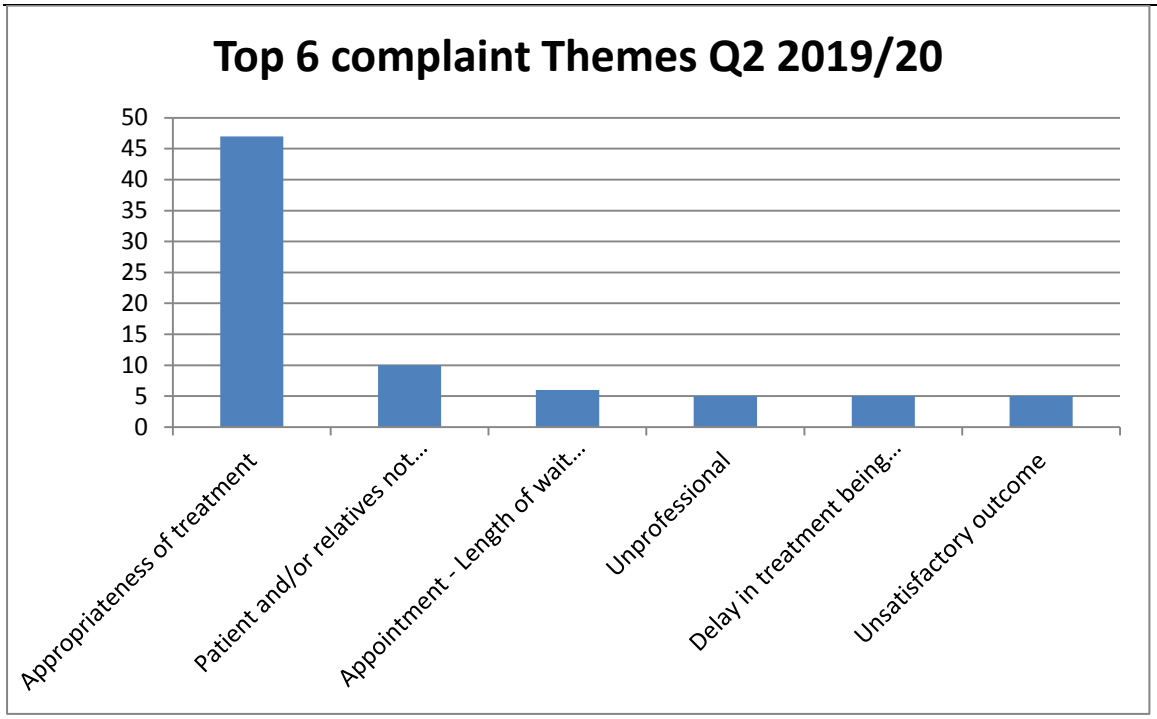


Figure 8

When complaints are received and reviewed, they are recorded and graded on the Trust Datix system. There were no complaints received during Quarter 2 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 Q2 is 24 Moderate/Medium and 85 Low. Figure 9 illustrates the grading of all complaints received during Q2 by CBU.

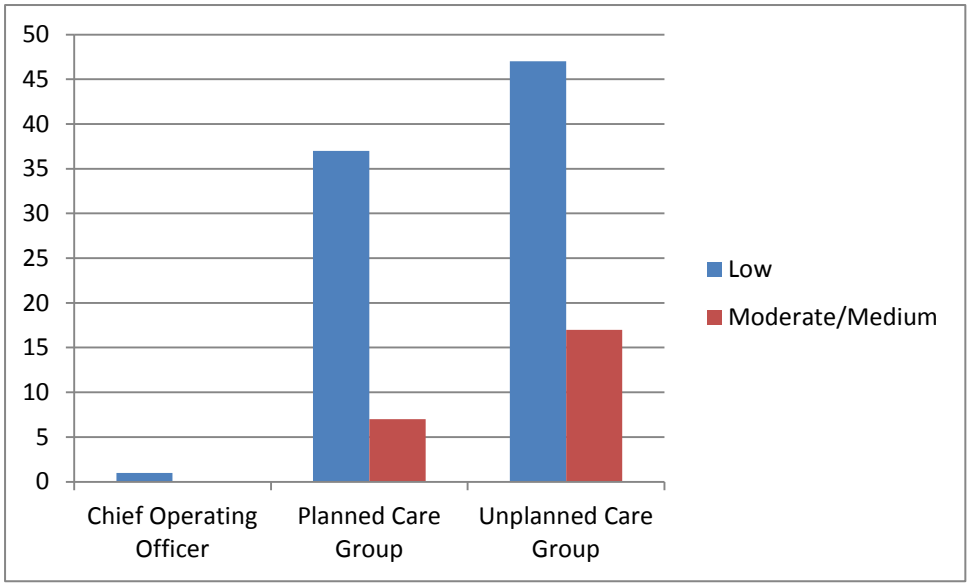


Figure 9

2.8 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.

2.9 PALS (Patient Advocacy and Liaison Service)

The total number of Patient Advice and Liaison Service (PALS) issues continues to remain high. The total number for Q2 being 386, again seeing a slight rise from Q1 2019/20. 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 10 provides a breakdown of the PALS issues, by speciality, AED and orthopaedic and trauma remain the highest. This data has been reported back to the department for further analysis and action as appropriate.

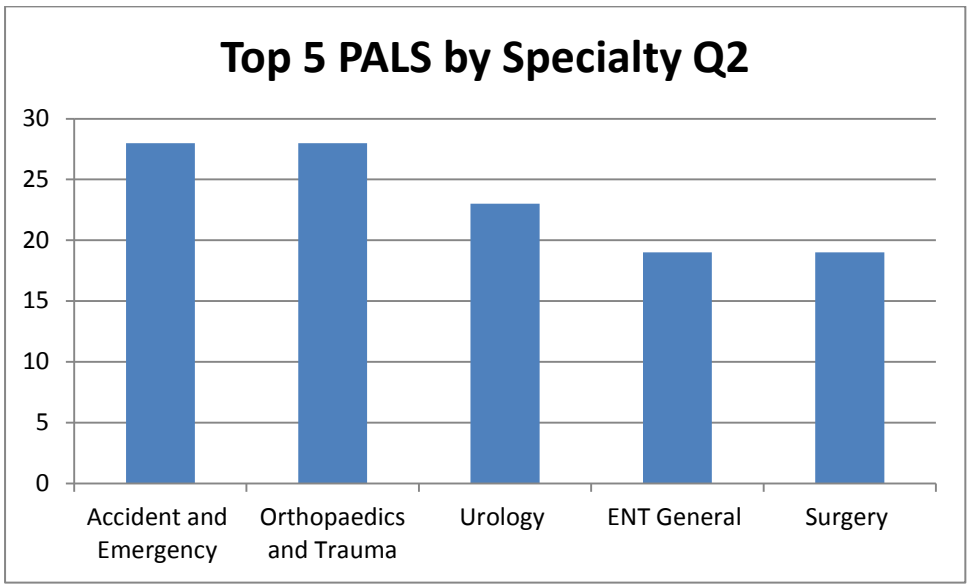


Figure 10

Figure 11 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 92 issues.

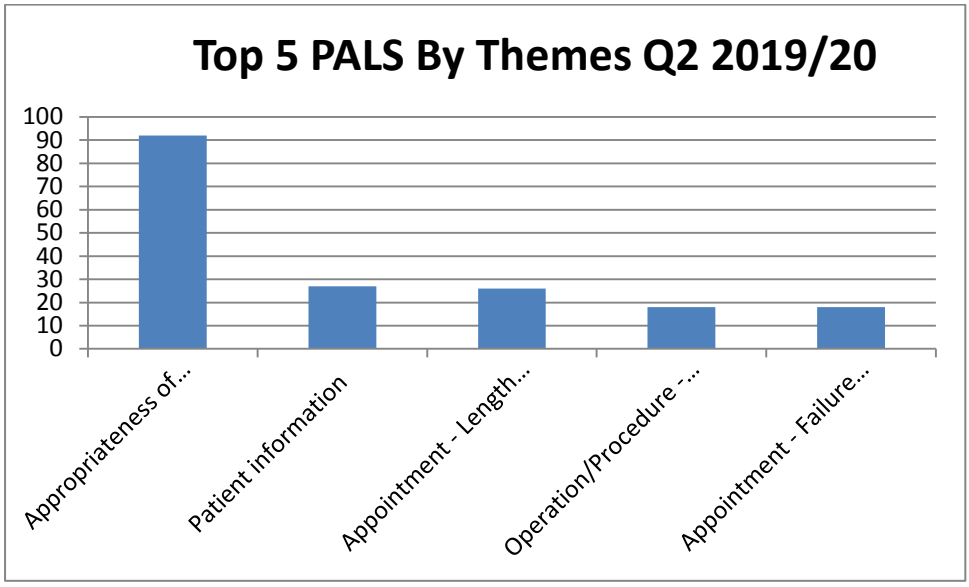


Figure 11

3 PROPOSAL

The Patients First Sub-committee will spend the next quarter, continuing to work towards objectives set in 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. 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 CYP 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.

During Q3 learning from complaints will be scrutinised further to ensure that learning is shared and that new PE initiatives are maintained. 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 is 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.
- Quarterly learning from complaints meeting to commence during Q3.

4 RECOMMENDATIONS

- 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 to develop actions plans for improvement.
- 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.
- 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

Appendix 1 action plan to support work required for CYP CQC survey.