

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

PATIENT EXPERIENCE QUARTER 3 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 Q3 (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	26.02.20	

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) 3. The report also includes details of Q 3 Complaints and Patient Advice and Liaison Service (PALS).

The results for the Maternity 2019 CQC survey have been published in January 2020. Overall this was a much improved survey result for BTHFT from 2018. The average mean score rating, across all questions, was 82 % (78.9% in 2018). A summary of the findings are enclosed within this paper. The results will be presented to the February Patient Experience Subcommittee by the Head of Midwifery. A full report will follow to the next Quality Committee.

Open complaints within the Trust during Q3 hit the lowest recorded level in October 2019 (N=47).

The 2019 Patient Led Assessment of the Clinical Environment (PLACE) has been successfully completed and result received. These results cannot be compared to previous years due to the extent of the changes to the PLACE program. Of the 8 domains measured, the Trust is marginally above average on 3, about average for 2 and below average on 3.

During Q3 work has continued to embed the Patient Experience Strategy, ensuring that this is a key strand through all patient experience work.

The Patient and Public Involvement Officer, Samina Fayyaz has now taken up her position. This is a welcomed appointment to enable this vital area of work to develop and progress. The Chief Nurse Team would like to formally welcome her to the Trust.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

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.

There has been a decrease in the number of overall Friends and Family Test responses over Q3. However, significant improvements have been seen in the Maternity response rate and the percentage of people who would recommend.

Below are the headlines from the analysis of complaints and PALS during Q3:

- Q3 has seen 96 complaints; this is significantly lower than complaints received during the previous quarters.
- PALS contacts remain high at (N=348) during Q3.
- The theme of most complaints is in relation to appropriateness of treatment which account for 41% (N= 47).
- There have been no complaints graded as extreme or high during Q3.
- The areas with the highest number of complaints received are AED (N=16), Urology (N=9), Maternity services (N=7) and Acute Medical Admissions (N=7), during Q3.

Recommendation

- Strengthen the learning from complaints to ensure clear evidence for assurance by setting up a Complaints Review Group, to be chaired by (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.
- Heathwatch *shifting the mindset 2020* report. Implementation of recommendations.
- PLACE results to be noted and consider financial implications required for future improvement work in relation to dementia and disability.

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		

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

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		
Explanation of variance from Board of Directors Agreed General risk appetite (G)	Risk (*)					
Benchmarking implications (see section 4 for details)					Yes	No
Is there Model Hospital data relevant to the content of this paper?					<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?					<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?					<input checked="" type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal/regulatory implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant)
<input type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> 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)

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

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 3, 2019/20 (Q3). 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 overseen 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 is a Patient and Public Voice Representative appointed as a member 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 3 this includes:

- National CQC Maternity Survey update 2019
- Friends and Family Test Results for Q3
- Patient Led Assessment of the Clinical Environment (PLACE)
- Patient Experience Collaboration
- Complaints Healthwatch report: *shifting the mindset* 2020.

The work streams which provided their scheduled report to the Patients Experience Sub-committee during Q3 included:

- Dementia
- Cancer Board
- Learning Disability Forum

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 Q3.

This report also provides an update on Complaints and Patient Advice and Liaison Service (PALS) for Quarter 3.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

2	CURRENT POSITION
---	------------------

2.1 National Survey updates

2.1.1 National Maternity Survey 2019

The National Maternity Survey carried out by the CQC commenced in 2007 and initially ran every 3 years. From 2017 this survey has been run annually. The survey consists of a postal survey of approximately 50 questions that is sent out to every mother who has had a live birth in February of that year. The survey is in English, with a covering letter of how to access the survey in different languages.

Preliminary results for 2019 were embargoed until 28 January 2020. A small maternity team met with Patient Perspective, the Trusts appointed contractor for analysis and formulate actions required for improvement.

A total of 358 surveys were posted to eligible women in Bradford. The response rate was low at **23%** but as noted by Patient Perspective, the national response rate was lower in 2019 than previous years.

Overall this was a much improved survey results for BTHFT from 2018. The average mean score rating, across all questions, was 82 % (78.9% in 2018).

Outcomes are measured nationally and Trusts are noted as being in the top 20%, about the same as other Trusts, or in the bottom 20% of Trusts on the questions asked. BTHFT scored in the **top 20%** of Trusts on **19** questions, two of which were the top scorers in the antenatal sections.

This is a marked improvement from 2018, where BTHFT scored in the top 20% for only 8 questions. Of the questions asked, 3 showed at least a 10% improvement on the 2018 score. 1 question showed a 10% or more worsening of score. This was around delay in discharge postnatal from the maternity wards where BTHFT scored about the same as other Trusts nationally. The remaining questions showed less than 10% change in score since 2018.

Following review of the results, 5 areas of improvement were identified for BTHFT Maternity Services. This work required actions to improve scores on following questions;

- Cleanliness of all areas within the hospital maternity services.
- Women not seeing a midwife as much as would have liked postnatal.
- Being left alone in labour when worried the woman or her partner.
- Skin to skin immediately post birth.
- Timely postnatal discharge from the maternity wards.

Overall results and an action plan will be presented to the Patient Experience Subcommittee in February 2020 and a paper will be submitted to the March Quality Committee.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

2.2 Friends and Family Test

The Friends and Family Test (FFT) core question is a standard contractual feature for all organisations providing NHS services. The Foundation Trust monitors response rates in eligible areas to ensure a sufficient proportion of patients are participating to give the data reasonable validity.

Each specific area has a 'would recommend' and 'would not recommend' percentage score calculated each month, which is aggregated to provide an overall score for the organisation. Some services with specific sub-specialties (e.g. imaging) have scores calculated for individual areas as well as an aggregated, and CBUs can request further analysis from the Performance team or our contracted provider for the test in Outpatients and Community Services.

The Trust currently has two methods for collecting FFT information, postcards and through Meridian via tablet devices on ward areas.

During the past 12 months NHS England and NHS Improvement have reviewed FFT and have recently 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.

- The Patient Experience Team will be visiting clinical areas during the implementation phase to promote the new changes and work with individual clinical areas to determine what process suits the area best.
- We will continue to work with clinical areas to ensure that their feedback is clear through boards such as "you said: we did".
- FFT data will be feedback through the patient Experience Sub-committee.
- Staff will have a point of contact through the Patient and Public liaison Officer for advice and support.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

Alongside these changes is a revision to the question and response scale. The new FFT will now ask "Overall, how was your experience of our service?"

The new question has a new response scale:

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Don't know

Providers are still required to include at least one free text question alongside the standard fixed question and can choose locally what question or questions to ask. The guidance suggests that the following questions could be included:

Please can you tell us why you gave your answer?

Please tell us about anything that we could have done better?

Staff continue to pro-actively promote the test, and facilitate participation e.g. by offering assistance from a volunteer or interpreter, to those groups known to be under-represented, and seeking different ways to promote engagement.

Despite some significant improvements in response rates for FFT during the first two quarters of 2019/20. Q3 has seen a decline from 29% overall response rate to 16% in December 2020. This reduction can be accounted for in the main by a significant reduction in responses received via AED. A combination of winter pressures and change in workforce has contributed to this and immediate steps have been taken to address this with the Head of Service for AED (Figure 1)

Despite this decrease in response rate, it is positive to read that the majority of the responses remain over 96% would recommend.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

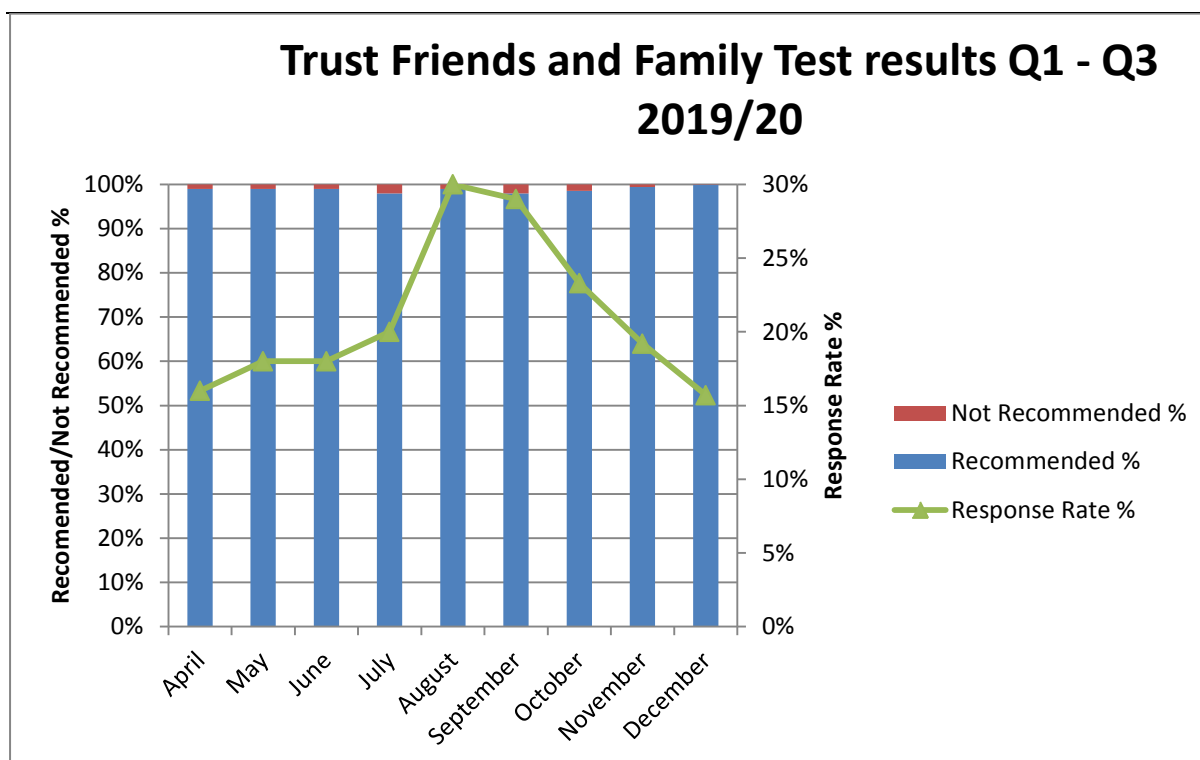


Figure 1

An area which has seen overall improvements in FFT is Maternity (Figure 2). Not only have maternity reached a 32% response rate in December 2019, but of this significant amount received 100% scored that they would recommend.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

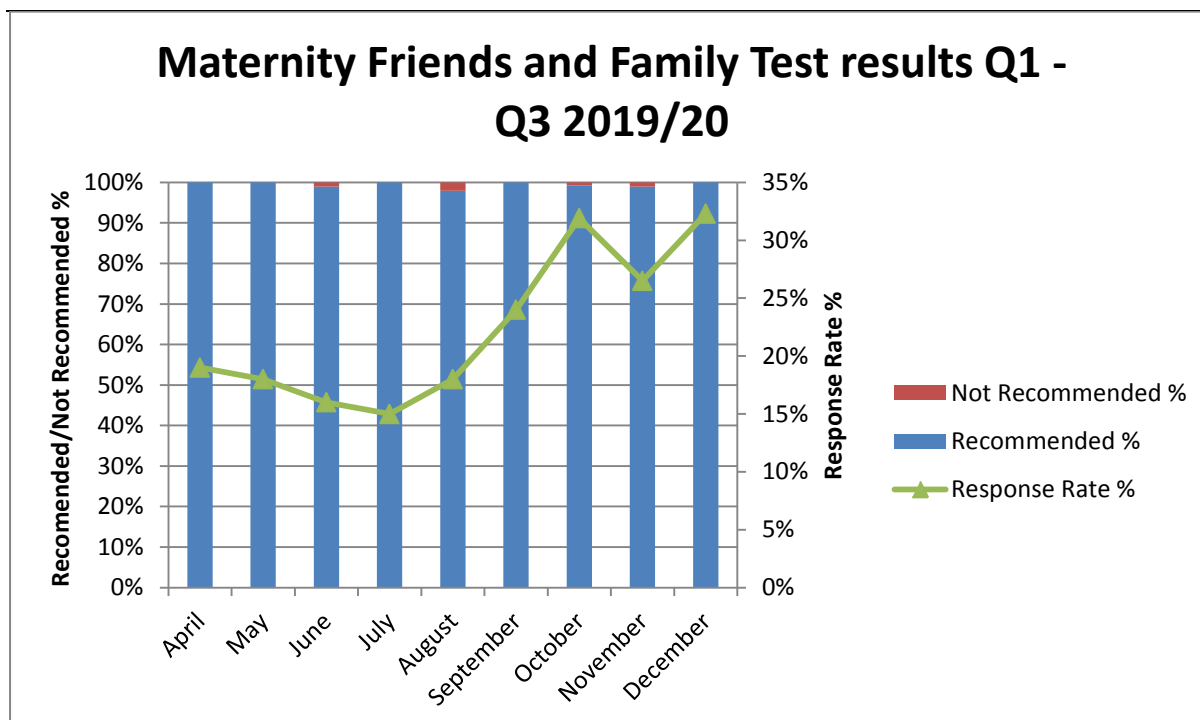


Figure 2

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.

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.

The Trust is now in receipt of the results and presents scores in a number of domains which include:

- Cleanliness
- Food general

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

- Ward food
- Privacy and dignity
- Disability
- Organisational facilities
- Communal areas
- Dementia

As a general comparison between other local similar sized Trust BTHFT is marginally above average on 3 domains, on average for 2 and below average on 3 domains. The regional score for dementia and disability are below the national average; however BTHFT sits at the lower end of this range. A brief analysis of the data providing these dementia score indicates that the reason the Trust scores badly for dementia and disability is generally due to:

- Signage and heights (particularly for toilets).
- Door colours and contrasts
- Handrails
- Local artwork on walls.

Work is currently underway between Chief Nurse Office and Estates and Facilities to fully analyse results down to specific area level and a paper will go to the February Patient Experience subcommittee and follow to the next Quality Committee. The action plan produced will differentiate between what changes can be made at no cost. Where changes can be made at a cost to the organisation and will require some capital funding and identify where changes are not possible due to the age of the estate or not owned by the Trust.

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 2019. Our patient and public representative provided positive reflections on the work that has been undertaken by the wards to date

CBU	Ward	Speciality	Improvement activity
Urinary Tract and Vascular	14	Urology	<p>Developing patient education for the self-administration of Tinzaparin post operatively at home</p> <p>Matron exploring themes from complaints – Change ideas to improve communication between patients and staff</p> <p>Developing peer support groups for patients undergoing cystectomies</p>

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

			Improving follow up appointments
Muscular-Skeletal, Plastics and Skin	27	Orthopaedics	Patient Experience board display on ward
	28	Orthopaedics	<p>Promoting 'Good night, sleep tight' initiative' – providing ear plugs/eye masks for all</p> <p>Providing all eligible patients the opportunity to feedback using FFT on ward iPads</p> <p>Piloting a new pre-assessment one-stop clinic for patients undergoing elective hip and knee surgery on the ward 28.</p> <p>Ward 28 –Experience Based Co-Design Project with Mr Bobak to improve the experience of care for patient undergoing elective hip and knee surgery. Patient film created –sharing their experiences of care. Joint co-design meeting held on 24th January to identify priorities for improvement. Planning for small co-design meetings March/April 2020</p>
Specialist Medicine	23	Respiratory	Improving staff morale – lots of small changes on the ward have made the ward a better place to be. Support with writing up improvement work.
Urgent and Emergency care	4	AMU	<p>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.</p> <p>Sustaining improvements to response rates for FFT and improvements to a better night-time environment.</p>
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

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

			<p>on FFT feedback. Patient boards in ED to tell patients about the things that have been changed - 'You said , we did' board</p> <p>Blue Badge initiative 'Tell me, how was your care today?' – facilitating conversations between patients and staff to talk about their care</p>
--	--	--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Table 1 Patient Experience Collaborative - Improvement Activity Q3

Improvement work has continued across wards taking part in the Patient Experience Collaborative. Patient Experience training has been developed with the QI team and Matron for Radiology for Band 2 and 3 non-clinical support staff and Healthcare Assistants. This was tested in December 2019 with a small group of staff from estates and facilities. This training will be delivered on a wider basis from January 2020, to support staff members to make changes, improve the experience of care for patients and families and facilitate joy at work. Staff will be encouraged to use the "15 seconds 30 Minutes" concept, and testing ideas using PDSA cycles. An example of this is the use of the Hospital Hi-Fives, which includes the five fingers which represent 'who, what, when, where, why' and the palm represents 'how'. When interacting with patients this simple acronym acts as a reminder for staff to think about important simple messages like introductions.

Further wards and departments from planned care CBU will join the collaborative in February/ March 2020. The next planned learning session for the collaborative is March 2020. This will allow opportunity for staff to showcase work to date, learn from each other and talk about sustainability and spread of beneficial changes. The senior management team for Estates and Facilities have all been invited to a bespoke QI training session in relation to patient experience as part of the collaborative.

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 403 staff trained.
- Level 2) those who work directly face to face with people with dementia - currently 377 staff trained.
- Level 3) those who lead on dementia care (Dementia Champions training) - Currently 110 staff trained.

The figures above reflect to and include Q3. All dementia education is available to book through ESR.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

Updates in practice:

- New Advance Care Plan document published for Bradford- this is used in new pilot for ACP's to frontline staff.
- On-going work as one team work to ensure timely discharges.
- John's Campaign passports now in use.
- Clinical referrals to mental health liaison team under review, discussions as to whether this is through EPR.
- Work with security staff to enhance their understanding of dementia and offer distraction techniques as a primary option.
- Review of clinical pathways, to establish if there can be improved pathways between the dementia assessment unit and BRI.
- Blue wristbands for those with a cognitive impairment reviewing well.
- Trust Dementia Strategy and action plan- monitored through the Dementia Steering Group.
- My Life utilisation report- currently updating all devices, this will be done by April 2020.
- Carer related activity- discussions to commence a dementia support group for carers.

Innovation:

- Emergency Department cubicle established, to now look at other areas including the surgical assessment unit.
- 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.
- Community Hospitals looking to make garden area dementia friendly at WWP and also balcony area of WBG.

Updates in National priorities:

- The Trust is taking part in a regional audit on Advance Care Planning in dementia until April 2020 - need to train 40 frontline staff.
- National Audit of Dementia in Acute Hospitals, Carers Questionnaire will commence in May 2020 to September 2020.

2.5.2 Cancer Services

Key headlines

- **Cancer Care Education Programme** – currently under development, with the aim of delivering two formal study days to increase knowledge and skills in cancer care for trained health care professionals and untrained/care co-ordinators (provisionally scheduled 12 June & 25 September 2020).

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

- **Appointment of Cancer Care Co-ordinator band 4** - to support Haematology CNS .Due to commence in post January 2020. Funding bid submitted to Cancer Alliance to support the extension of Care Co-ordinators in UGI/LGI service to support the timely signposting of cancer patients in their cancer pathway. All teams now have care co-ordinators in place.
- **Successful bid submission to Cancer Alliance** - 20k secured to support the delivery of chemotherapy training (Royal Marsden Oxford) which is a recognised accredited training module for chemotherapy training. The training will be for staff on chemotherapy DCU in Oncology/Haematology service supporting timely progression cancer treatment pathways, staff retention and patient experience.
- **The number of long patients waiting over 62 days** on cancer specialty pathway was reduced from 159 in September 2018 to an average of 30 in 2019/20. The daily review of cancer patient tracking list (PTL) by specialty has supported and facilitated the targeted action and oversight, with current position of 18 patients Sunday 15 December 2019.
- **National Cancer Patient Experience survey** - (NCPES) demonstrate areas of sustained improvement, with Trust scoring within the expected range of results in 53 of the 59 areas.
- **Extension of Bradford Personalised Care pilot** – funding for x 2 WTE band 4 support coordinators fixed term contracts at Cancer Support Yorkshire (CSY), facilitating the roll out of cancer sites into lung and breast service. Benefit realisation metrics developed to be discussed through established steering group with CSY, MacMillan Cancer Support, Cancer Alliance, Trust staff, patient representation and Commissioning colleagues in support of securing long term funding for posts

2.5.3 Learning Disabilities

Key headlines

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

- **Learning Disability National Audit**
Changes to the national audit following last year's pilot, include service user questionnaires being provided with stamped addressed envelopes. Data collection due end of January, this has been submitted by the Trust, patient and staff survey still open.
- **Policy, VIP passport now updated and on the intranet**
The safeguarding team have ensured all ward areas have seen the new document and are familiar with it.
- **Joined the Transforming lives partnership.**
This will hopefully allow for more partnership working specifically in identification of patients with a Learning Disability and reasonable adjustments.
- **Mandatory training in relation to Learning Disabilities.**
Recent announcement and publication of "Right to be Heard" the Governments response to the consultation on mandatory Learning Disability and Autism training.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

Waddiloves are assisting in looking at supporting the delivery of more Learning Disability training across the Trust.

Areas of development or concern

- **Further work in relation to identifying patients with a learning Disability**
Ongoing work with partners in accessing learning disability registers; this will hopefully be progressed with the assistance of the partners of the Transforming Lives Board.
- **Training**
Committed to Treat as One group that we would have a focus within our Safeguarding Adults training on Learning Disabilities and they have kindly offered to support us with this. This is currently being reviewed looking for opportunities to add in further training
- **The Learning Disability Practitioner post**
This post was recruited to, however the candidate then declined the offer. We have undertaken a further recruitment process and hope that this will be successful and have someone in post by summer.

2.5.4 Complaints

Healthwatch; *Shifting the Mindset*. (2020) Summary and gap analysis.

Healthwatch is an independent champion for individuals who access health and social care services. Following the failings at Mid Staffordshire there has been great emphasis on how Trusts report and manage complaints. The main finding of previous Healthwatch reports is that NHS Trusts do not consistently use complaints as an aid to learning and that NHS Trusts are not complicit in sharing learning with the general public in an open and transparent forum.

At Bradford Teaching Hospitals Foundation Trust (BTHFT) there has been immense hard work over the past year to improve how we manage and report on complaints. BTHFT continues to include complaints data in a number of forums:

- Weekly report to senior leadership.
- Weekly review and oversight by CBU/central/CN team.
- Reported via performance and clinical governance.
- Reports to the Patient Experience subcommittee (includes patient representatives and examples of learning from complaints via CBU).
- Quarterly reports to the Quality Committee.
- Complaints steering group at ADN level.
- Quarterly learning review planned with NED for independent scrutiny.

The above include data around numbers received, specialities, themes and learning.

Healthwatch sets out a number of comparative measures to assess how compliant NHS Trusts are with their recommendations for reporting and dealing with complaints.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

Healthwatch asks:

“How transparent are NHS Trusts with reporting on complaints”

At BTHFT complaints are reported across all the Clinical Business Units on a weekly basis via a tracker. The tracker allows each Matron to assess what complaints they have within their areas, how the investigations are going and if the complaints are being dealt with in the correct time frames. Additional to this the patient experience reports provide further information on complaints and themes and the subcommittee meet monthly. At this meeting each CBU reports back on the complaints received within each area, the themes and any learning that has occurred and what changes have been made as a result. Bi monthly a patient story is also presented to the Board and is available for staff to access via the patient experience team and on the Trust intranet. Work is presented to the senior management team via the quarterly Patient Experience reports to the Quality Committee. All high level complaints are discussed at QUOC and the Trust operates a robust duty of candour process.

Future development is planned to include learning from complaints on the new intranet website. In the first instance this will include a summary of the learning that has already taken place following patient stories following complaints, for the public to see and include a “you said we did section”.

Healthwatch recommends that to meet patient’s expectations and encourage patients and relatives to complain there needs to be clear publically available evidence of how the Trusts have learnt from complaints feedback and provide concrete and specific examples of changes made. It is acknowledged that there is work to be done to strengthen this area during 2020 and this will form part of the Patient Experience subcommittee work plan to enable shared learning and improvement.

There are however, already examples shared in smaller forums with the public and individuals how the Trust has developed process. The team welcomes the recent Healthwatch report and is keen to develop work with the public and partners to continually improve practice, and patient experience.

2.6 Care Group Reports

During Q3, 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.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

-
- 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

Oncology Haematology Day Case Unit: Patient attended for treatment and had a 2 hour wait and subsequently had a reaction to medication. Communication and waiting time were unsatisfactory.

Action Taken: New improved system Bookwise now in place which has reduced the waiting times. Staffs are allocated their own patients and are responsible for informing them of any delays.

Competencies of staff have been reviewed and staff members are having discussions with patients regarding their treatments and side effects.

2.7 Complaints

During quarter 3 (Q3), 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 3 demonstrates performance to reduce the total number of open complaints within the system at any one time from April 2018 to the latest position in December 2019.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

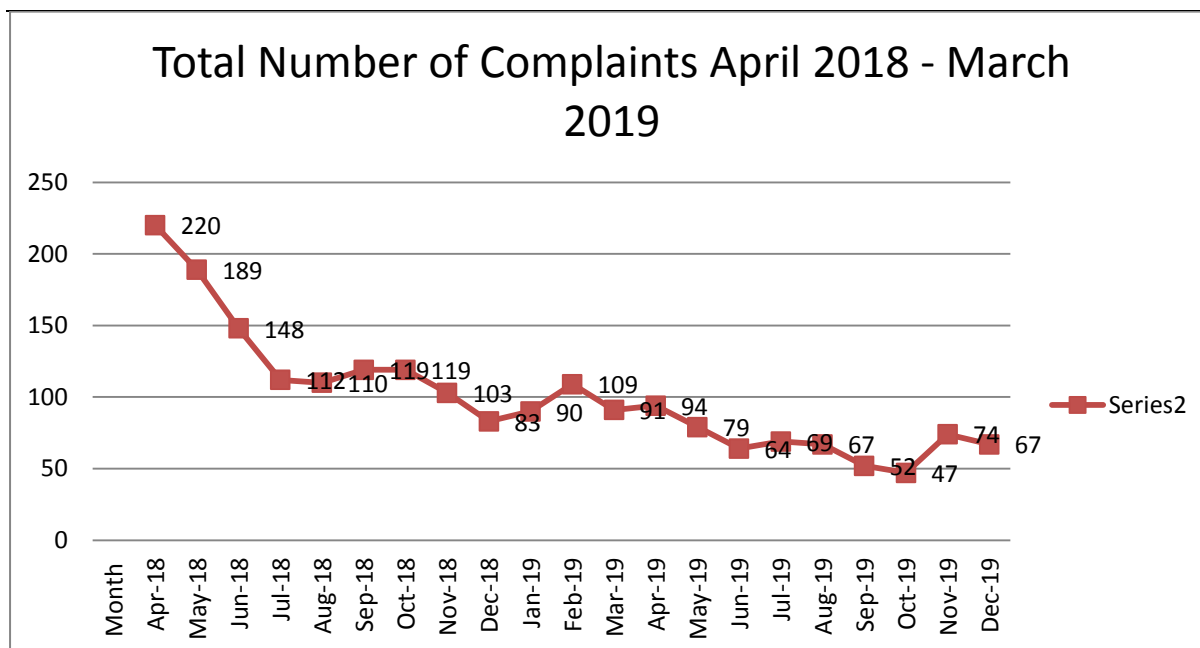


Figure 3

The number of complaints at the end of Q3 was significantly below our planned trajectory and currently sits at a total of 67 open complaints as of December 2019. This is a fantastic achievement, that the teams are proud to report. Despite the reduction in numbers, the team recognise the importance and value complaints bring to the Trust in relation to the opportunity to learn.

Table 2 demonstrates the Q3 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=96) for Q3.

	2019/20 Q1	2019/20 Q2	2019/20 Q3
Planned Care Group	60	45	42
Unplanned Care Group	57	63	51
Central	2	1	3
Total	119	109	96

Table 2

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

	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 4 demonstrates during Q3 that 22% resolved at initial contact and did not require a formal response.

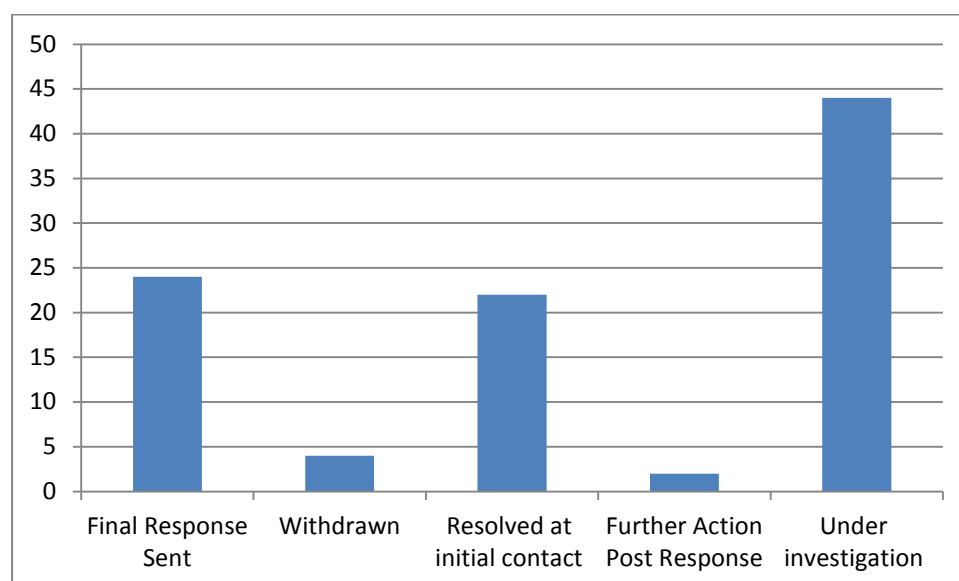


Figure 4

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.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

Figure 5 shows the current position in relation to the number of complaints 6 months beyond due date. During Q3 a total of 3 complaints breached our expected standard. Moving forward there will be a requirement by the CBU's to feedback individual rational for individual cases at the complaints steering group.

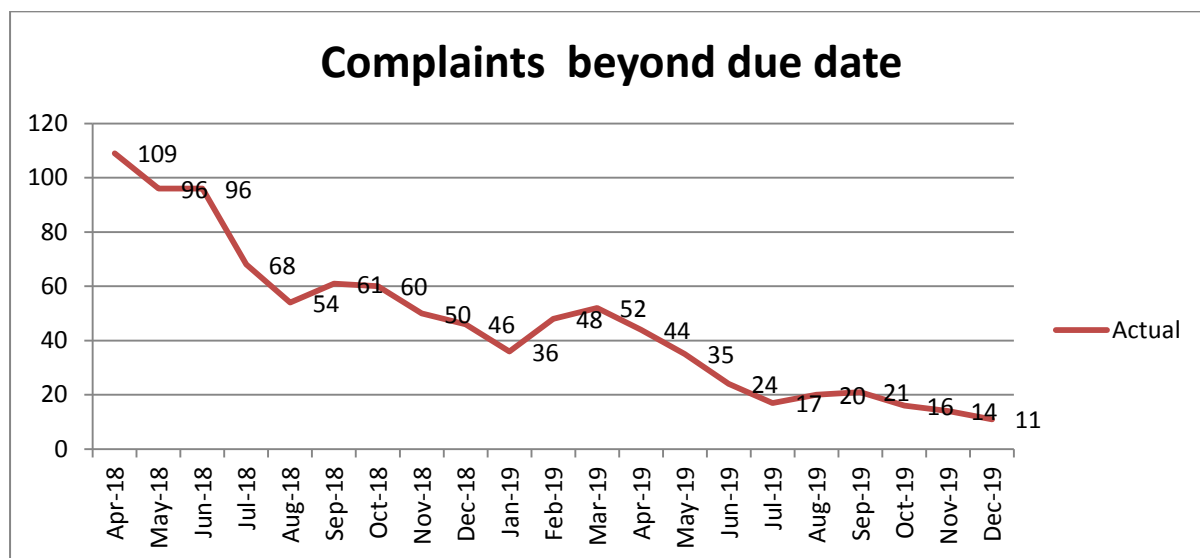


Figure 5

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 6 clearly highlights that the largest number received are received from Accident and Emergency Department (N=16), Urology (N=9) Maternity services (N=7) and Acute Medical Admissions (7), during Q3.

Where clusters of complaints are identified the Chief Nurse team 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. Feedback was received from Urology by the matron from the area. There was no overall theme from all of the urology complaints; however there was some administration issues identified in a number. It was reported that there had been a senior medical secretary and support medical secretary recruited to post, which would help support the urology administration processes.

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 CBU's and at performance meetings.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

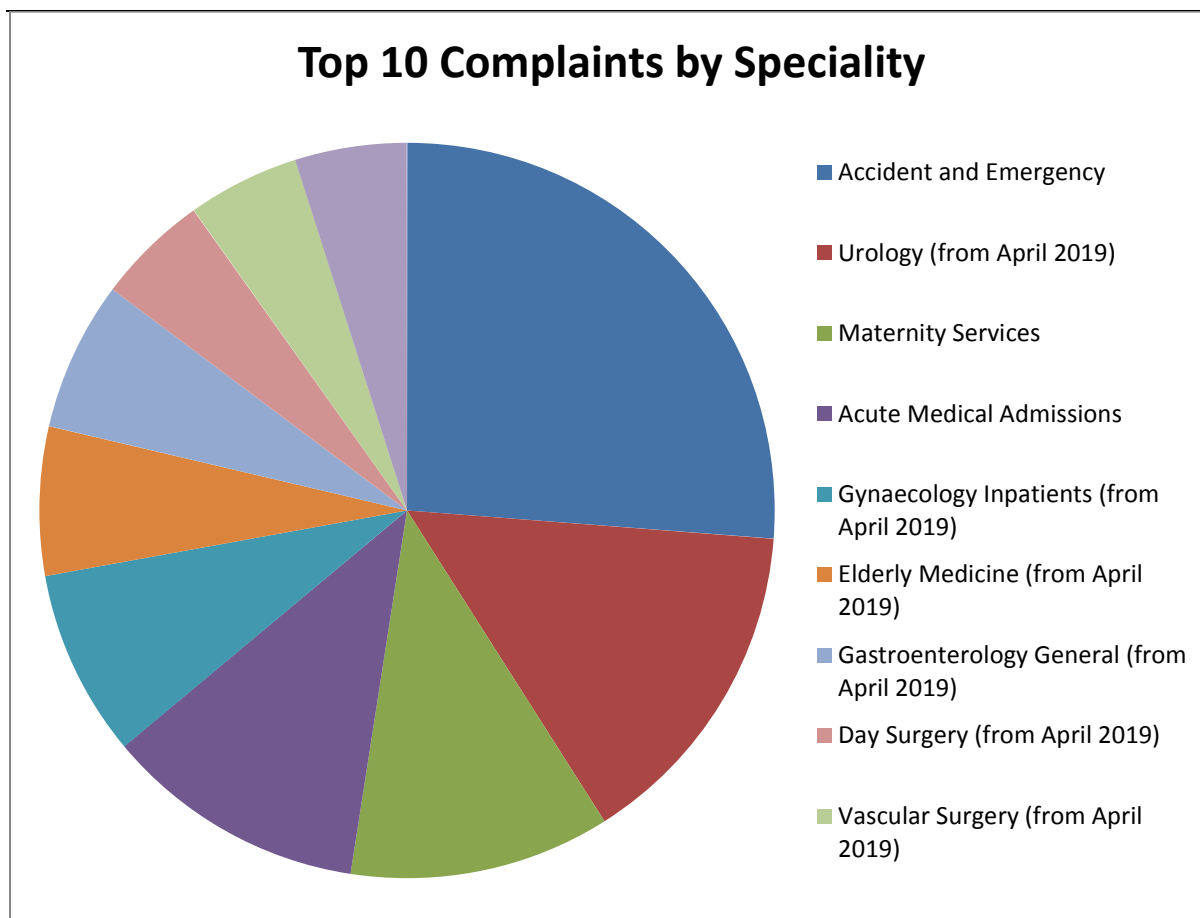


Figure 6

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 7).

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

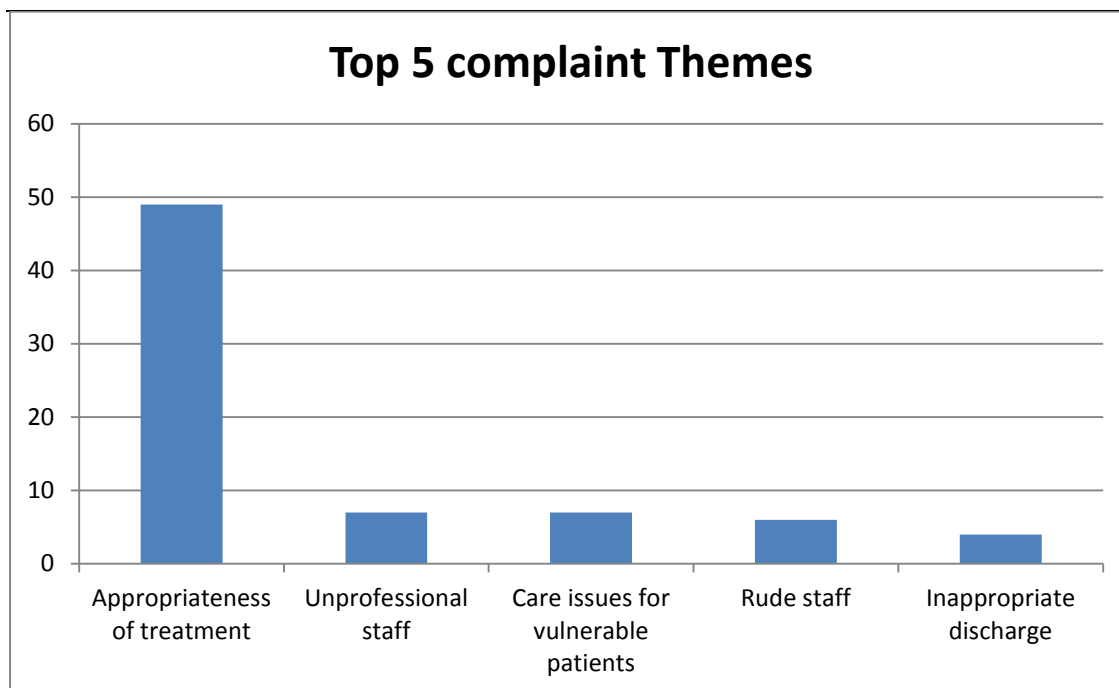


Figure 7

When complaints are received and reviewed, they are recorded and graded on the Trust Datix system. There were no complaints received during Quarter 3 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 Q3 is 29 Moderate/Medium and 67 Low. Figure 8 illustrates the grading of all complaints received during Q3 by CBU.

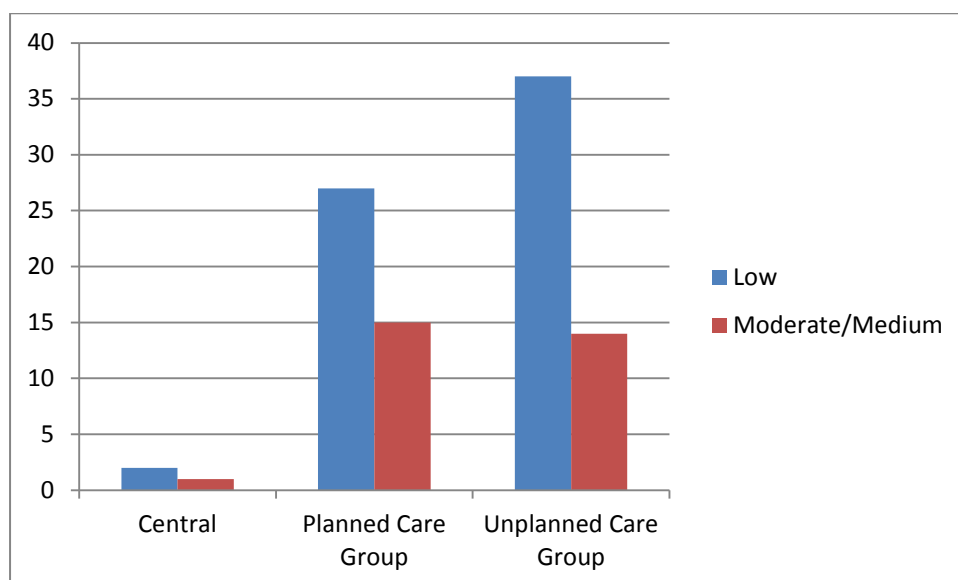


Figure 8

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

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 out 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 Q3 being 348. This number 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 9 provides a breakdown of the PALS issues, by speciality, AED, Urology and ENT remain the highest. This data has been reported back to the department for further analysis and action as appropriate.

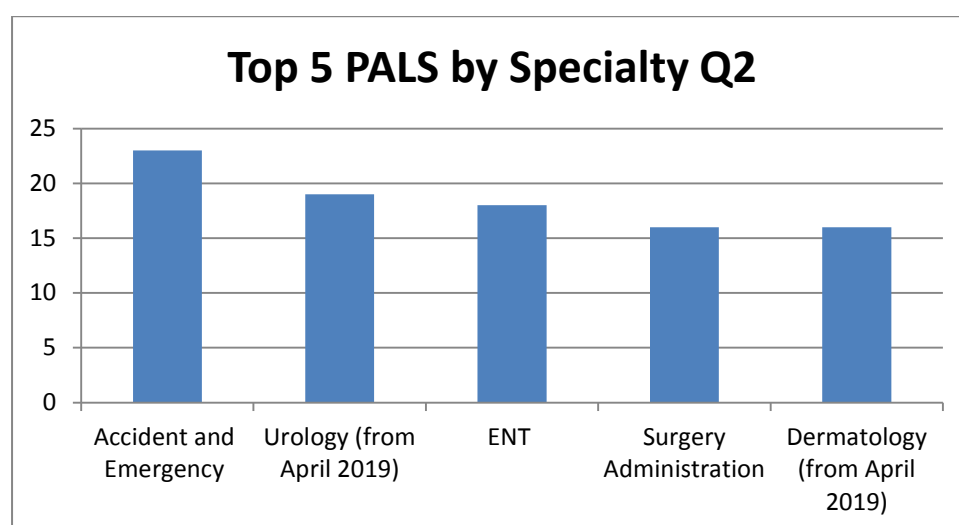


Figure 9

Figure 10 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 86 issues.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

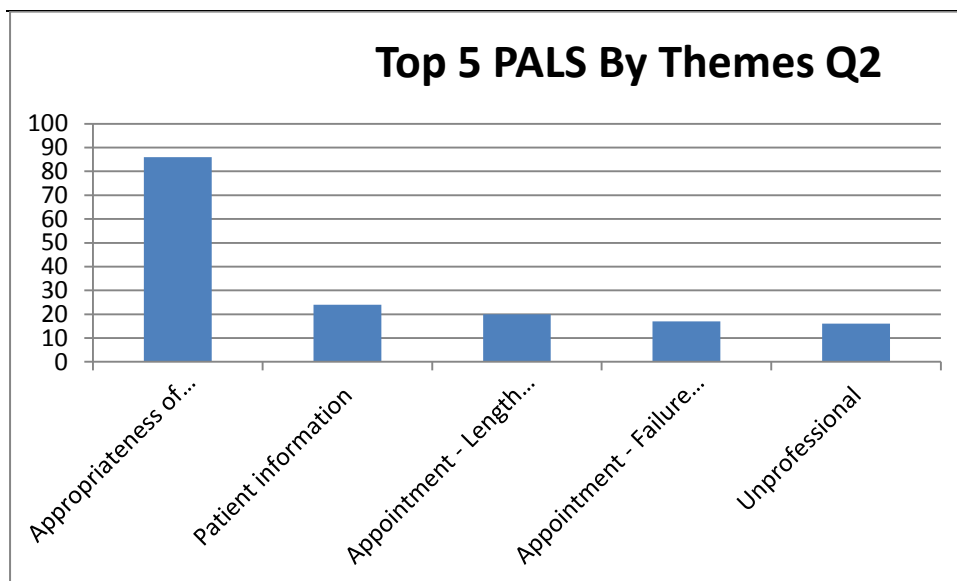


Figure 10

Work is currently underway to look at the category *appropriateness of treatment*, for complaints and PALs as recorded in Datix to further breakdown into more specific themes. This should facilitate learning on more specific areas in the future.

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 Maternity will help facilitate and identify areas for improvement and support the development of action plans following recent National Maternity CQC survey results.

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.
- Quarterly learning from complaints meeting to commence during Q3.

Meeting Title	Board of Directors		
Date	12.03.20	Agenda item	Bo.3.20.31

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
----------	-------------------