MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Report of:	Professor Cheryl Lenney – Chief Nurse
Paper prepared by:	Sue Ward, Director of Nursing Debra Armstrong, Deputy Director of Nursing (Quality) Stephen Hodges, Head of Patient Services Caron Lappin, Acting Director of Nursing WTAW
Date of paper:	October 2017
Subject:	Former CMFT and USHM Q1 and Q2 complaints legacy reports
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Patient & Staff Experience
Recommendations:	To note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	Name: Debra Armstrong – Deputy Director of Nursing (Quality) Tel: 0161 276 5061

1. Executive Summary

1.1 Members of the Board of Directors are asked to note the legacy complaints reports for the former Central Manchester University Hospitals NHS Foundation Trust and University Hospitals South Manchester NHS Foundation Trust covering the period April 1st 2017 – September 30th 2017.

1.2 Notably, the style and format of the reports differs, however, the overall content is not dissimilar in terms of providing a commentary on complaints and PALS cases received and managed during the reporting period. The reports also provide examples of the learning that has taken place as a result of the patient and service user feedback that complaints provide.

1.3 Both former Trusts had measures and KPIs in place to monitor complaints and PALS performance, however, as these measures were different in each Trust it is not possible to undertake a comparison of performance over the first six months of 2017/18. Over the course of Quarters 3 and 4 2017/18, work will be undertaken to integrate the two central complaints functions and develop a set of single performance metrics. This will enable comparisons to be made between the Hospitals/MCS across the Group in the future. The baseline Group report for the Manchester University NHS Foundation Trust will commence April 1st 2018 with key outcome and performance measures provided for each hospital/MCS.

1.4 During Quarters 3 and 4 it is intended that aspects of the complaints management process will be devolved from corporate services to the Hospitals and Managed Clinical Services. This will include delegation of the Chief Executive's sign off of complaint responses to Hospital Chief Executives. Receipt, acknowledgement, escalation, monitoring and reporting, will, however, remain central functions within the Corporate Service. Parliamentary Health Service Ombudsman (PHSO) cases and complaints received via Members of Parliament (MP) will also continue to be handled centrally to ensure consistency.

1.5 As the Trust's complaints service is integrated and developed over the next six months, there will also be an opportunity to work with the PHSO's office to inform national work programmes on improving the management, handling and learning from complaints. This follows a successful visit to the Trust by the new PHSO, Professor Rob Behren on 19th October 2017.

1.6 Complaints remain a key indicator of the quality of the Trust's services and, accordingly, complaints processes and services have been prioritised in the Post Transaction Integration Plan (PTIP) to ensure the continued development and transformation of complaints services.

1.7 The Board of Directors is asked to note the information within the reports and plans for integration and devolution of the processes from April 1st 2018

Central Manchester University Hospitals NHS Trust Legacy report April 1st – September 30th 2017

1. Summary

1.1 This report provides an overview of the Complaints and PALS performance for the first six months of 2017/18; reporting period 1 April 2017 to 30 September 2017.

1.2 During the first six months of 2017/18, there were a total of 506 formal complaints received. This equates to 234 complaints received in Quarter 1 and 272 complaints received in Quarter 2, 2017/18. This compares to 296 in Quarter 4 2016/17. There was a 16.2% increase in formal complaints (increase of 38 in number) received in Quarter 2 compared to Quarter 1, 2017/18, which is within normal variation.

1.3 Clinical Scientific Services had a 200% increase (numerically an increase of 8 cases) and University Dental Hospital Manchester had an increase of 125% (numerically an increase of 5 cases) from Quarter 1 to Quarter 2, 2017/18. The largest numerical increase in complaints over this period was in Specialist Medical Services who had an increase of 14 cases (41.2%). The only division which experienced a decrease in complaints from Quarter 1 to Quarter 2, 2017/18 was the Manchester Royal Eye Hospital who had a reduction of 17.4% (4 cases).

1.4 There was a 1.5% increase (positive) in the proportion of complaints closed within 25 working days, with 24.4% of the total complaints closed in Quarter 1 compared to 25.9% of the total closed in Quarter 2, 2017/18. This compares to 21.4% in Quarter 4, 2016/17. There was a decrease (positive) of 2% of the proportion of cases closed at 41 or more days between Quarter 1 and Quarter 2, 2017/18. Numerically, this equates to a decrease of 14 cases.

1.5 At the end of Quarter 2, there were 191 unresolved formal complaints, compared to 196 at the end of Quarter 1, 2017/18; this compares to 209 unresolved formal complaints at the end of Quarter 4, 2016/17. The number of cases unresolved at the end of Quarter 2 at 41 days or more days was 37 cases, compared to 51 at the end of Quarter 1, 2017/18 and to 44 at the end of Quarter 4, 2016/17.

1.6 There was a 12.5% increase in PALS contacts (increase of 133 in number) received in Quarter 2 compared to Quarter 1, 2017/18.

1.7 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days after the complaint is received. The Trust achieved 100% compliance with this Key Performance Indicator during the first six months of 2017/18.

1.8 The Patient Services Team continue to work with Divisional Teams to identify and develop service improvements informed by complaints; details are discussed in Section 7 of this report.

1.9 During the first six months of 2017/18, formal staff support sessions were introduced for staff working in the PALS and Formal Complaints Teams. Further developments and service improvements are reported upon in section 8.

1. Overview of Quarter 1 Performance

PALS

2.1 During the first six months of 2017/18, there were a total of 2,265 PALS contacts received. This equates to 1,066 PALS contacts received in Quarter 1 and 1,199 contacts received in Quarter 2, 2017/18. This compares to 1,092 in Quarter 4 2016/17. There was a 12.5% increase in PALS contacts (increase of 133 in number) received in Quarter 2 compared to Quarter 1, which is within normal variation.

2.2 As appropriate, and in agreement with the complainant, the Complaints Team de-escalated 9 formal complaints during the first 6 months of 2017/18. This equates to 2 in Quarter 1 and to 7 in Quarter 2. During Quarter 4 2016/17, no formal complaints were de-escalated. The rationale for de-escalation, where appropriate, is that this can provide a more timely response to the person who has raised concerns and improve the outcome of the care experience, in real time.

2.3 Conversely, 96 PALS contacts were escalated to formal complaints during Quarters 1 and 2, 2017/18. With 60 PALS contacts escalated during Quarter 2 and 36 PALS contacts escalated to formal complaints during Quarter 1, 2017/18. This compares to 49 in Quarter 4 and 53 in Quarter 3, 2016/17. The reason for the majority of these escalations is as a result of the PALS Case Managers and the divisional teams recognising the complexity of the concerns raised and the need for a formal investigation.

2.4 The division with the highest number of PALS concerns raised during the first 6 months of 2017/18 was Specialist Medical Services with 390 concerns (17.2%), followed by Surgery with 364 concerns (16.1%) and Royal Manchester Children's Hospital which had 290 concerns (12.8%) of the 2,265 total PALS concerns received.

2.5 The majority of PALS contacts in Quarters 1 and 2, 2017/18 related to Outpatient areas, which accounted for 1,673 (73.9%) concerns. This equates to 781 concerns raised during Quarter 1 and to 892 concerns raised during Quarter 2, 2017/18. This compares to 842 concerns that were raised in relation to the Outpatient areas in Quarter 4, 2016/17.

2.6 **Table1** shows the timeframes in which PALS concerns have been resolved during the previous three Quarters. Performance relating to the number of cases closed within the Trust internal target of 5 working days has improved by 38% (207 cases) from Quarter 1 to Quarter 2, 2017/18.

Table 1: Closure of PALS concerns within timeframes.

	Quarter 4, 2016/17		**Quarter 1, 2017/18**		**Quarter 2, 2017/18**	
Days to close	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe
0-5	554	54%	545	51.1%	752	58.7%
0-7	672	65.5%	656	61.5%	887	69.2%
8-14	247	24%	271	25.4%	296	23.1%
15+	107	10.5%	140	13.1%	98	7.7%

2.7 In Quarter 2, the number of cases taking longer than 14 days to close reduced to 98, compared to 140 cases in Quarter 1, 2017/18. This represents a 30% decrease in the number of long-standing cases. The timely resolution and closure of PALS concerns continues to be closely monitored.

2.8 The oldest PALS case closed during the first six months of 2017/18 was within the Division of Specialist Medicine. The case was opened on 3rd July 2017 and the case was 34 days old when it was closed on 18th August 2017. In order to address this PALS concern comments were required from the Division, however some delays were experienced in obtaining this information. Where cases take longer to resolve, this is mainly due to delays with divisional investigations or where patients specifically request their concerns are dealt with informally.

Formal Complaints

2.9 During the first six months of 2017/18, a total of 506 formal complaints were received. This equates to 234 complaints received in Quarter 1 and 272 complaints received in Quarter 2, 2017/18. This compares to 296 in Quarter 4 2016/17. There was a 16.2% increase in formal complaints (increase of 38 in number) received in Quarter 2 compared to Quarter 1, 2017/18.This variation is within expected limits and is closely monitored by the Head of Patient Services.

2.10 The largest divisional percentage increase in complaints from Quarter 1 to Quarter 2, 2017/18 was within Clinical Scientific Services who had a 200% increase (numerically an increase of 8 cases) and University Dental Hospital Manchester who had an increase of 125% (numerically an increase of 5 cases). The largest numerical increase in complaints over this period was within Specialist Medical Services who had an increase of 14 cases (41.2%). The only division which experienced a decrease in complaints from Quarter 1 to Quarter 2, 2017/18 was the Manchester Royal Eye Hospital who had a reduction of 17.4% (4 cases). It is, however, important to note that where a relatively small number of complaints are received, large percentage variations can be caused by relatively small numerical fluctuations.

2.11 During the first six months of 2017/18, there were 208 complaints made relating Inpatient services and 224 in relation to Outpatient services. For Inpatient services, this represents a reduction of 7.4% from Quarter 1 (108) to Quarter 2 (100) and for Outpatient Services, this represents an increase of 7.4% from Quarter 1 (108) to Quarter 2, 2017/18 (116).

2.12 The National Statutory Requirement for the acknowledgement stage of formal complaints handling, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. The Trust achieved 100% compliance with this Key Performance Indicator (KPI) during Quarters 1 and 2, 2017/18. This compares to 99.7% in Quarter 4, 2016/17.

Current Complaints

2.13 At the end of Quarter 2, there were 191 unresolved formal complaints, compared to 196 at the end of Quarter 1, 2017/18. This is a 2.6% decrease (positive) at the end of Quarter 2, compared to the end of Quarter 1 equating to 5 fewer unresolved complaints. The unresolved complaints comprised 101 (53%) which had been registered between 0-25 days, 53 (28%) between 26-40 days and 37 (19%) had been registered for 41 or more days. The number of cases unresolved at 41 or more days

decreased by 14 in number in Quarter 2 compared to the position at the end of Quarter 1.

2.14 All formal complaints over 35 days old are subject to an internal KPI meeting within Patient Services; over 41 day cases are discussed weekly within the divisions and performance is also monitored by the Trust Quality Committee, chaired by the Chief Nurse. All cases over 41 days old are also subject to a fortnightly Complaint Key Performance Indicator meeting, chaired by the Chief Nurse or Director of Nursing on her behalf and attended by the Divisional Directors.

2.15 The oldest complaint case closed during the first six months of 2017/18 was registered within the Division of Surgery. The case was opened on 28th November 2016 and the case was 157 days old when it was closed on 13th July 2017. An initial meeting took place between the complainant and members from the Divisional Team in February 2017. More concerns were raised at the meeting, which involved a further investigation within Manchester Royal Infirmary and the arrangement of a second meeting. Difficulties were encountered in making the arrangements for the second meeting; therefore a decision was made with the complainant to provide a written response to the outstanding concerns.

2.16 The Division of Surgery had the highest number of unresolved cases at the end of Quarter 2 with 34 open cases, of these 13 (38.2%) were within 0-25 days, 10 (29.5%) were between 26-40 days old and 11 (32.3%) were over 41 days old. At the end of Quarter 1 the Division of Surgery had 39 open cases, 18 (46.2%) of these were within 0-25 days, 10 (25.6%) were between 26-40 days old and 11(28.2%) were over 41 days old.

Complaint Key Performance Indicator (KPI) Meeting

2.17 The Complaint KPI meeting was established in November 2015, by the Chief Nurse, in response to an increase in complaints unresolved over 41 days in 2015/16. Divisional Directors attend on a fortnightly basis to review all longstanding complaints. The objectives of the Complaint Key Performance Indicator Meeting are to identify:

- The progress of each complaint;
- Any blockages that through discussion and escalation can be resolved;
- A date for closure of each complaint case.

2.18 Prior to the commencement of the performance meeting, in November 2015, there were 76 complaints unresolved at 41 or more days; at the end of Quarter 2, 2017/18 there were 37 complaints that remain unresolved at 41 or more days. This is a decrease of 14 cases compared to the end of Quarter 1, 2017/18, when there were 51 cases unresolved at 41 or more days.

Resolved Complaints

2.19 **Table 2** provides a comparison of formal complaints resolved within each timeframe from Quarters 3, 2016/17 to Quarter 2, 2017/18.

Table 2: Comparison of formal complaints resolved by timeframe

	Quarter 3 2016/17	Quarter 4 2016/17	Quarter 1 2017/18	Quarter 2 2017/18

Formal complaints resolved	300	285	283	263
Resolved in 0-25 days	82 (27.3%)	61 (21.4%)	69 (24.4%)	68 (25.9%)
Resolved in 26-40 days	97 (32.3%)	116 (40.7%)	89 (31.4%)	84 (31.9%)
Resolved in 41+ days	121 (40.3%)	108 (37.9%)	125 (44.2%)	111 (42.2%)

2.20 Whilst the number of cases resolved within 0-25 working days was similar in Quarter 1 and Quarter 2, 2017/18 compared to Quarter 4, 2016/17 there was a 27.6% reduction in the number of case resolved between 26-40 days between Q4, 2016/17 and Q2, 2017/18.

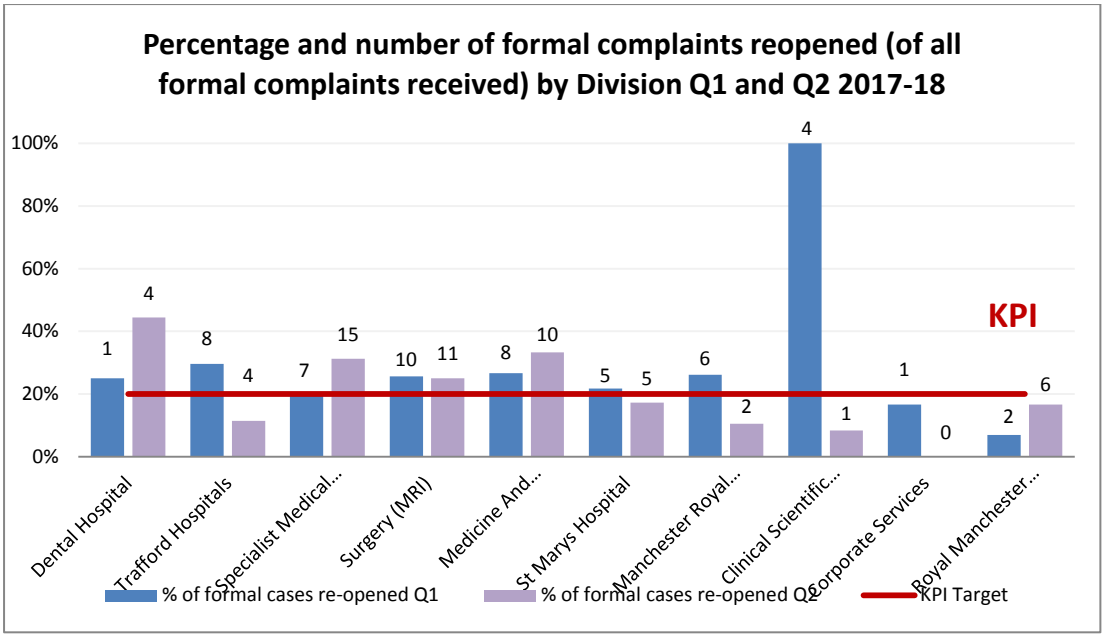
2.21 The number of cases resolved at 41 or more days has decreased (positive) during Quarter 2 to 111 cases, compared to Quarter 1 when there were 125 cases; this represents a reduction of 11.2%. The number and percentage of complaints resolved at 41 or more days will continue to be monitored by the Trust Quality Committee, and the fortnightly Complaint Key Performance Indicator meeting chaired by the Chief Nurse or Director of Nursing will continue to work with the Divisional Directors to support them to focus on improving response times.

Reopened Complaints

2.22 Re-opened formal complaints are used as a proxy indicator to measure the quality of the initial response. In the first instance, an internal tolerance threshold of 20% has been agreed by the Chief Nurse. The number of formal complaints re-opened (dissatisfied) during the first six months of 2017/18 was 110 (21.7%). During Quarter 2, 58 (21.3%) complaints were reopened, compared to 52 (22.2%) in Quarter 1, 2017/18 and 58 (19.6%) in Quarter 4, 2016/17.

2.23 **Graph 1** illustrates divisional performance against this threshold in Quarters 1 and 2, 2017/18. Trafford (11%), St. Mary's Hospital (17%), Manchester Royal Eye Hospital (11%), Clinical Scientific Services (8%), Corporate Services (0%) and Royal Manchester Children's' Hospital (17%) demonstrated performance below the 20% threshold (positive) during Quarter 2, 2017/18. The University Dental Hospital Manchester (44%), Specialist Medical Services (31%), Division of Surgery (25%) and Medicine and Community Services (33%) were above the threshold. It should be noted, however, that small fluctuations in the **total number** of complaints received by a division can result in large percentage changes for Divisions with overall low number of complaints.

Graph 1: Percentage and number of re-opened Formal Complaints (Quarter 1 and 2 2017/18).



Trust-Wide Compliments

2.24 The registration of compliments received by the Chief Executive is managed by the PALS Team and the Divisions manage registration of locally received compliments on the Safeguard Complaint Management System. All responses are managed locally by the Divisions and signed off by the Divisional Director.

2.25 Weekly reports are circulated to Divisions detailing compliments that are registered both corporately and locally. The weekly reports include number, detail and progress of the compliments.

2.26 The Trust receives many compliments from patients, their families and friends and action continues to be undertaken to increase recording of such invaluable feedback. **Table 3**, below, shows the numbers of compliments registered for each Division. The number of compliments registered during the first six months of 2017/18 was 376. This equates to 224 in Quarter 1 and to 152 in Quarter 2, 2017/18. This compares to 218 in Quarter 4, 2016/17. This represents a decrease of 72 (32.1%) between Quarter 1 and Quarter2, 2017/18.

Table 3: Distribution of Compliments received from Quarter 2, 2016/17 to Quarter 1, 2017/18.

Number of Compliments received by Division				
	Q3	**Q4**	**Q1**	**Q2**
Division not recorded	24	30	33	26
Clinical Scientific Services	3	8	31	11
Corporate Services	0	1	2	1
University Dental Hospital of Manchester	3	3	1	5
Manchester Royal Eye Hospital	4	13	4	14
Medicine And Community Service	41	35	17	15
Royal Manchester Children's Hospital	7	8	2	11
Specialist Medical Services	13	14	31	11

St Marys Hospital	2	8	4	18
Surgery (MRI)	7	7	10	12
Trafford Hospitals	120	91	89	28
Total	224	218	224	152

3.0 Patient Opinion and NHS Choices feedback

3.1 Patient Opinion and NHS Choices are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services.

3.2 The number of Patient Opinion and NHS Choices responses by category; positive, negative and mixed positive and negative comments, are detailed in **Table 4**.

3.3 The Patient Opinion and NHS Choices feedback demonstrates that more than half of the overall comments (56.4%) received in the first six months of 2017/18 were positive. This represents an improvement compared to Quarter 4, 2016/17 when the overall positive comments represented 51% of the total. Negative comments equate to 30.3% of the overall total received during the first six months of 2017/18, which compares to 35% during Quarter 4, 2016/17.

Table 4: Number of Patient Opinion postings by division in Quarters 1 and 2, 2017/18.

Number of Patient Opinion Postings received by Division (Q1 and Q2)			
Division	Positive	Negative	Mixed
Clinical Scientific Services	3	3	1
Corporate Services (Estates and Facilities)	0	3	1
Dental Hospital	4	1	1
Manchester Royal Eye Hospital	9	4	1
Medicine And Community Service	9	2	3
Royal Manchester Children's Hospital	9	7	0
Specialist Medical Services	11	14	6
St Marys Hospital	20	3	2
Surgery (MRI)	17	7	3
Trafford Hospitals	28	15	8
Total	110	59	26

3.4 **Table 5** provides two examples of the feedback received and the subsequent responses posted on Patient Opinion and NHS Choices websites during Quarters 1 and 2, 2017/18.

Table 5: Example Patient Opinion Postings and Reponses

Surgery (MRI) – Quarter 2, 2017/18.
Outstanding Care from Wards 9 and 10 I had a live donor kidney transplant from my husband in July 2017, I was on Ward 10 and he was next door on Ward 9. Every aspect of the hospital stay was absolutely outstanding.

All the staff, HCAs, catering staff, porters, nurses, students, junior doctors, registrars, consultants, anaesthetists and surgeons were totally professional, dedicated and caring. They all worked so hard but always had time for patients.

Pain relief, which I was worried about, was excellent. I was regularly asked my pain level and if I needed pain relief. I was given codeine and paracetamol to come home with but only needed paracetamol.

I was able to recover at my pace, I did not feel up to getting out of bed the day after surgery but managed it the next day with lots of help, and the wash I was given that day felt wonderful! I was asked when I felt ready to go home, and drains etc. were removed in order that I could do so. I was pleased to (be) asked to take responsibility for recording my fluid balance as it helped me have ownership of my care. I would like to see the "Hello, my name is" initiative more comprehensively rolled out across all staff, but this is a minor point.

My opinion was taken into consideration around my treatment and aftercare and I felt valued as an individual. I felt cared for physically, mentally, and emotionally (and my emotions were all over the place.) My family and friends who visited were also treated with care and compassion.

Nothing was too much trouble whether it was help to walk to the toilet, fresh water or a cup of tea, or extra towels for a shower. The wards, toilets and showers were all perfectly clean.

I know NHS food gets a bad rep, but I found it excellent! I had no appetite at all before transplant and it came rushing back! As a vegetarian I was worried about what I would eat but had plenty of options. The desserts were especially delicious! Food ordering and mealtimes were very anticipated!

"Thank you" really does not say just how grateful I am for the attentive, dedicated, caring and professional staff on wards 9 and 10 and for the marvellous NHS!

Response

Thank you for taking the time to share your feedback via the NHS Choices website about your positive experience at the Manchester Royal Infirmary.

We were pleased to read that you found you and your Husband’s care and treatment to be an outstanding standard. We understand that this must have been an anxious time for you and your Husband and we were especially pleased that all of our staff were able to contribute to your experience by helping to keep you comfortable and ensuring that you were able to play an active role in your own care, helping you to feel valued.

It was good to know that our Trust values were present in every part of your journey and that you were treated with compassion.

It is always great to receive feedback which highlights the dedication and hard work of all of our staff members. It was also good to learn that you found our facilities clean and that you were happy with the dining provisions provided during your stay.

Once again, thank you for taking the time to share your experience and we hope that both you and your Husband are recovering well. We will ensure that your feedback is passed on to the Clinical Effectiveness Manager of Surgery so that it can be shared with the teams involved in your care.

CSS /SMS – Quarter 1, 2017/18

Recent Aortic Valve replacement
I was admitted on 24th April 2017, for elective aortic valve replacement on the 25th April 2017, under the care of my consultant. The care I received was exceptional on ward 14 before my operation and then on CICU, where I was under the care of a nurse, from there I was taken to HDU where the care was exceptional and nothing was too much trouble to keep me comfortable After two days, I went on ward 3 where I stayed until I was discharged. The staff on this ward was so caring and never stopped Day or Night. The consultant came to see me several times during my stay morning and night There isn't one thing I can fault about my stay at the royal and they altogether helped me through a very anxious time Thank you to each and every one of you. You know who you are. Visited in April 2017. Posted on 06 May 2017
Response
Thank you for taking the time to share your kind feedback on the NHS Choices website about your positive experience at the Manchester Royal Infirmary. We were very pleased to read that you were happy with your care and treatment during your stay and that you found the service to be to an exceptional standard. We were especially pleased that you found our staff caring and that they were able to keep you comfortable and reassure you during this anxious time. It is always good to receive feedback which highlights the dedication of our staff. We hope that you continue to recover well from your procedure and we will ensure that your feedback is passed on to the teams who were involved in your care

4. Themes from Complaints and PALS contacts

4.1 In Quarter 2, the medical staffing group were cited in 29.9% of all PALS contacts, compared to 38% in Quarter 1 and to 33% in Quarter 4, 2016/17. This group was also cited in 56.6% of formal complaints in Quarter 2, compared to 54% in Quarter 1 and to 53% in Quarter 4, 2016/17. Recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff. Actions in relation to this trend are undertaken on a case by case basis by the relevant Division. In addition, the Customer Services Manager provides educational input with regard to customer service and complaints management to the New Consultants Programme.

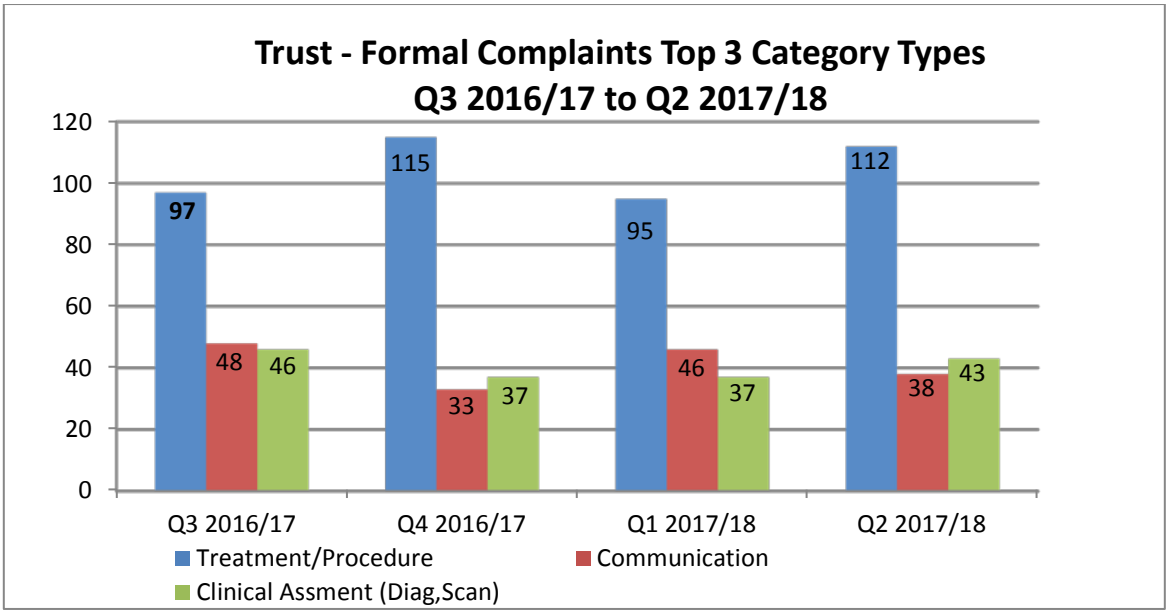
4.2 The Trust-wide top three category types for Formal Complaints in Quarter 4, 2016/17 to Quarter 2, 2017/18 are shown in **Table 6** and in **Graph 2** below.

Table 6: Top 3 Formal Complaints Themes (Quarter 4 compared to Quarter 1)

	Quarter 4	Quarter 1	Quarter 2
Treatment/Procedure:	115	95	112
Communication:	33	46	38
Clinical Assessment:	37	37	43

4.3 Treatment/Procedure, Communication and Clinical Assessment categories are all consistently within the top 3 category types for Formal Complaints. Communication and professional excellence are underpinning themes in the ***'What Matters to Me'*** Patient Experience Programme. Future ***'What Matters to Me'*** initiatives will be developed with a view to impact on the themes, an example of which is the development of a 'First Impressions' training programme, which has been co-designed with staff and will be rolled out in Quarter 3 of 2017/18.

Graph 2: Formal Complaints – Top 3 Categories (Quarter 3, 2016/17 to Quarter 2, 2017/18)



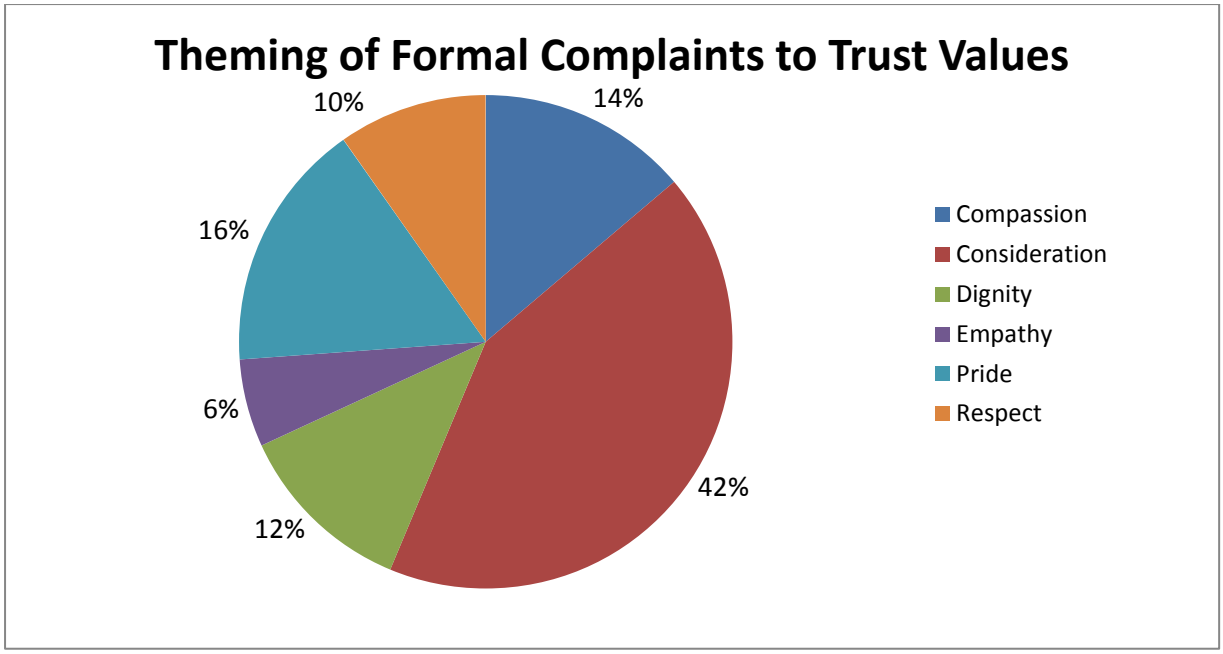
4.4 Development of Complaint Theming

As previously reported, in addition to the categories above, complaints can also be categorised and monitored in relation to Dementia Care, End of Life Care and Pain Management. These categorisations assist in the monitoring of quality for these specific areas of care. During the first six months of 2017/18 there were a total of 14 formal complaints registered in relation to Pain Management, this equates to 5 in Quarter 2 and to 9 in Quarter 1, 2017/18. This compares to 11 in Quarter 4, 2016/17; there were 11 Complaints registered related to End of Life/ Palliative Care in during the first six months of 2017/18 with 1 complaint registered in relation to Dementia Care. These have in turn been reported to the specialist teams for review, monitoring and identification of improvements.

4.5 Theming complaints based on association with the Trust Values and Behaviours:

Graph 3 shows the percentage of formal Complaint cases registered against each Trust Value at the end of Quarter 2, 2017/18. The quality of this data has improved over the past 6 months and will be shared with the Learning and Organisation Development team with a view to this data informing future training and development work relating to the Trust's Values and Behaviours.

Graph 3: Percentage of cases registered to each organisational value.



5. Complaints Scrutiny Committee

5.1 In accordance with the agreed schedule, the Complaints Scrutiny Committee, which is chaired by a Non-Executive Director, met a total of 3 times during the first six months of 2017/18; with six Divisions attending to present cases. The Division of Specialist Medical Services and the Division of Surgery each presented a case at the May 2017 meeting. Clinical Scientific Services, Division of Medicine and Community Services and Royal Manchester Children's Hospital presented in July 2017 and Specialist Medical Services and St. Mary's Hospital presented at the September 2017 meeting.

5.2 The learning identified from the cases presented and the actions discussed and agreed at the meeting are outlined in **Table 7**. All Divisions are asked to identify and share the transferable learning from complaints.

5.3 The actions agreed at each of the Complaints Scrutiny Committee Meetings continue to be recorded and provided to the respective Divisions following the meeting in the form of an action log. Progress is monitored at subsequent meetings.

Table 7: Actions identified at the Trust Complaints Scrutiny Committee during the first six months of 2017/18.

Division	Learning	Actions
Specialist Medical Services	Learning Disability Passports not fully utilised.	▪ Reminders concerning use of learning disability passports shared at CICU handovers for an 8-week period. ▪ Patient Story shared at CICU Staff meeting.

	Concerns regarding nursing knowledge and empathy for patient's communication and medication needs.	▪ Complaint has informed amendments to Divisional Learning Disability plans. ▪ Patient Story shared with ACHD team. ▪ Improved preparation and awareness of this patient's needs.
Division of Surgery	Issues regarding communication of patient needs.	▪ Ward round handover checklist has been initiated. ▪ Poster providing name and contact details of senior staff for patients to make contact developed. ▪ Training provided to staff re dealing with challenging patients and their families.
	Poor handover from one Trust to CMFT	▪ Informatics piloting a referral pro-forma which senior doctors are to complete when a patient is transferred into CMFT from another Trust.
Clinical Scientific Services	Issues relating to the management of complex complaints across multiple divisions.	▪ Implementation of local database to monitor dates and to chase responses in a timely fashion ▪ To ensure all questions are allocated for responses and that there is a central location for the medical records.
	Issues relating who to contact regarding corporate element of complaint	▪ Clarity provided regarding escalation procedure for corporate elements of complaints
Division of Medicine and Community Services	Concerns relating to nursing care, nutrition, inconsistent mobilisation, visiting relative being able to support patient.	▪ Introduction of open visiting hours ▪ Increased partnership working with families involved in patient care ▪ Widespread feedback to clinical teams following complaint
	Delays in accessing medical records and complexity due to number of external agencies involved.	▪ Implementation of complaints triage system allows complex cases to be identified early in the process and for necessary steps to be implemented to prevent delays as far as possible.
Royal Manchester Children's Hospital	Delays relating to child requiring Hickman line insertion	▪ Electronic listing system introduced for CEPOD theatres ▪ Second 'line' theatre list to be run by interventional radiology will reduce need to go to 'emergency' theatre for the procedure.
	Communication with parent and child relating to delays.	▪ Complaint shared with ward teams on ward 84 regarding communication.

Specialist Medical Services	Patient expectations regarding where treatment should be undertaken.	▪ Leaflet to be provided to NWAS to provide to patients with reassurance that they are being given the correct care in the appropriate setting. ▪ Doctor to continue on-going communications with NWAS to support them in communicating well with patients about where they are being taken and why, and what might happen if they do not need the emergency service they are being taken to.
	Complainant became 'vexatious' during the complaints process	▪ Early recognition of and implementation of Trust 'Vexatious and Persistent Complainants' procedure.
St. Mary's Hospital	Delays in complaints process due to clinician having conflicting priorities.	▪ Ensure complaint case work is identified where individual circumstance change to ensure complaints timeline is maintained.
	Communication and attitude of staff involved.	▪ Ensure complaint letter is shared with team as well as the 'acknowledgement' letter. ▪ Complaint shared at clinical effectiveness meeting.

6. Parliamentary and Health Service Ombudsman (PHSO)

6.1 The Trust had 15 cases under the review of the Parliamentary and Health Service Ombudsman at the end Quarter 2, compared to 10 under review at the end of Quarter 1. **Table 8** provides details of the progress of each PHSO case and shows the distribution of PHSO cases across the Divisions.

Table 8: Overview of PHSO Cases open as at 30th September 2017

Division	Case/s	Progress
SMS	2	Investigations on-going – Awaiting draft report
CSS	2	Investigations on-going – Awaiting draft report
RMCH	2	Investigations on-going – Awaiting draft report
TGH	4	Investigations on-going – Awaiting draft report
DMACS	1	Investigations on-going – Awaiting draft report
Surgery	3	Investigations on-going – Awaiting draft report
MREH	1	Investigations on-going – Awaiting draft report
Total	**15**	

6.2 The PHSO closed 7 cases relating to CMFT, during the first six months of 2017/18. Of these closed PHSO cases, 1 case was fully upheld, 1 case was partially upheld and 5 cases were not upheld.

Table 9: PHSO cases closed in the first six months of 2017/18 presented by outcome.

Division	Outcome	Date original complaint received	PHSO Decision	Recommendations
TGH	Not Upheld	06/01/17	No failings found	None
TGH	Partly upheld	12/01/17	Failings in: ▪ Consenting ▪ Documentation ▪ Nursing care (removal of cannula) ▪ Provision of follow up appointment	Offer the complainant £500 as a financial remedy for the distress caused Write to the complainant to acknowledge the failings identified and apologise for the impact of those failings. Create an action plan detailing what has been done to ensure that such failings will be prevented in the future
SMH	Not Upheld	19/10/16	No failings found	None
Dental	Upheld	13/01/17	Failings in the Trust's management of the complaint, specifically around poor communication in relation to complainants NHS and private treatment.	Acknowledge failings identified and issue an apology specifically for the distress caused by providing conflicting information. Create an action plan detailing how the Trust will ensure that such failings in complaint handling will be prevented in the future. Create an action plan detailing how the Trust will ensure that records clearly identify if care is NHS funded or privately funded to avoid confusion.

				Provide financial compensation to the amount of £100 for the distress caused.
DMACS	Not upheld	23/01/2017	No failings found	None
SMS	Not upheld	08/11/2016	No failings found	None
Surgery	Not upheld	31/03/2017	No failings found	None

PHSO National Data

6.3 No national quarterly complaints data was published during the first six months of 2017/18. Future publications will be summarised within the relevant quarterly complaints reports as this becomes available.

Newly appointed Parliamentary and Health Service Ombudsman appointed

6.4 During Quarter 1, 2017/18, Professor Rob Behrens was appointed to the role of Parliamentary and Health Service Ombudsman and Chair of the organisation on Thursday 6th April 2017.

On the day of Professor Behren's appointment, the PHSO's office advised that he would work in partnership with the PHSO's Chief Executive and staff to lead the modernisation and continuous improvement of the PHSO, as demand for the service increases.

CMFT was approached by the PHSO's office in Quarter 2, advising that Professor Behrens would like to visit the Trust, as part of a series of visits to trusts to learn about NHS delivery, the current challenges faced by the sector and to hear views from the service regarding what needs to improve at the PHSO.

The Trust responded positively and arranged for Professor Behren to visit MFT on 19th October 2017. An outline of the visit schedule and feedback from the visit will be detailed in the Quarter 3 Complaints Report.

7. Learning from Feedback

Implementing Learning to Improve Services

7.1 All Divisions regularly receive their complaint data and review the outcomes of complaint investigations at the Divisional Quality or Clinical Effectiveness Committees. **Table 10** demonstrates how learning from a selection of complaints has been applied in practice to contribute to continuous service improvement within the divisions.

Table 10: Examples of the application of learning from complaints to improve services

Division	Learning & Improvements
CSS Q2	**Medication Dispensing Packs:** A complaint was received from the daughter of a patient, who identified that the medicines blister pack that her mother was given on discharge was very difficult for her to use, based on the design of the pack due to her mother's vision impairment. The blister pack was navy blue plastic with the days of the week etched out in clear plastic and as such the days of the week were not clearly legible. The daughter also explained that her mother struggled to fully see how the packet opened. She requested that the hospital pharmacists review how practical this type of blister pack was for other vision impaired patients. There is more than one type of blister pack available. The Ward Pharmacists usually assess patient's requiring a blister pack, to determine the preferred option. Unfortunately, as the request for a blister pack was only made on the morning of discharge the Ward Pharmacist did not have the opportunity to undertake the options appraisal with the patient. In response to the patients' daughter highlighting this issue, the Pharmacy Team will ensure that in future Ward Pharmacists check that patients who are issued with blister packs, are able to manage with the type supplied.
DMACS Q1	**Adult Integrated Medicine:** A review of complaints received relating to Wards AM1 and AM2 in the Division of Medicine identified a number of emerging themes. The review identified that the complaints were all lengthy and involved patients who had complex health needs. The formal complaints had initially started informally while the patients were inpatients on the wards. Unfortunately, despite significant input from both the Divisional and Corporate management teams the rapport between the ward team and the patients' families broke down, leading to the receipt of the formal complaints. In response, an action plan for both wards was developed to support staff to implement a number of improvements across the wards, focusing on the key findings of the complaint investigations. Key findings of one complaint case related to the acquisition of a Grade 4 avoidable pressure ulcer. Associated with this investigation was the identification of a knowledge gap within the team. The investigation identified a lack of documentation to evidence the actions taken by the ward team to address the deterioration of the pressure sores. There was also no documented evidence that that the deteriorating pressure ulcer had been discussed with the patient's family within on-going treatment discussions. Additionally, while it was known that the patient was non-compliant with some of the pressure ulcer prevention techniques; this was not escalated to the divisional senior nursing team, nor was this information consistently documented or shared via the ward huddle. There was also an acknowledged delay in referring the patient to the Tissue Viability team for advice. As a direct result of the investigation into the concerns raised within the complaint the following actions have been taken: ▪ Delivery of pressure ulcer refresher training workshops to ensure that all staff have the underpinning knowledge about best practice in relation to prevention, management and monitoring of pressure sores.

	▪ Matron reviews of all pressure ulcer incidents to establish any trends. ▪ Development of crib sheet to support staff in understanding pressure ulcer recording processes, monitoring expectations and the management of pressure ulcer. This provides clear guidance on the escalation processes to include both the senior management team and the Tissue Viability team in the care of pressure ulcer. ▪ Implementation of weekly audits to ensure compliance with documentation and appropriate actions. ▪ Weekly review meetings, for an initial 4 week period, with the Tissue Viability nurses to ensure any pressure ulcers were being appropriately managed, with the identification and review of patients who are considered to be 'at risk' of developing a pressure ulcer. The learning and expert advice provided during this period has continued to be implemented. ▪ Requirement to discuss any patient who is non-compliant with prevention techniques at the ward huddles. ▪ Nurse in Charge is now responsible for ensuring that both families and the medical team are involved with patients who are non-compliant to treatment. To date the actions taken have demonstrated compliance with the documentation made in relation to pressure ulcers. Additionally, via observed handovers, the quality of the information being shared with the teams via the ward huddles meets the expected standards. To date 85% of staff have attended the refresher training with further sessions being arranged for September/October 2017 for the remaining staff.
MREH Q2	**Responding to Patient Personal Needs.** Information contained within a referral letter from a local optician, outlined that the patient had specific mobility requirements. The information was not acted upon by staff at the Withington Community Hospital. This resulted in the unavailability of appropriate equipment and assistance and ultimately the patient's surgery being cancelled on the day. The patient complained that the information in the referral was not acted upon, as the nursing staff were unaware until the patient's arrival of her personal mobility requirements. **Lessons Learnt:** As a direct result of the investigation into the concerns raised by the patient the following actions have been identified: ▪ Amendments are required to patient admission letter to include an invitation to patients and carers to contact the Unit Manager to discuss specific personal needs with the nursing staff prior to admission. ▪ Staff require training in the use of specific moving and handling equipment i.e. hoist ▪ Portable diagnostic equipment (i.e. slit lamp) is required for patients with who are wheelchair users.
RMCH Q2	**General Accident** A mother of patient was seated on the parents' pull down bed. As she got up, the bed unit came away from the wall and fell onto the patient's mother catching her on the shoulder and arm. The patient's mother was pushed to

	the floor by the bed unit which caught her right hip. The father of the patient complained about the incident raising concerns about who sanctioned the installation of the beds, were risk assessments completed prior to installation and what level of monitoring and maintenance is carried out on such furniture. The Trust, via a nationally recognised contractor, arranged for the beds to be installed and monies were donated by a benefactor. The benefactor specified that the beds were for the benefit of parents/guardians/carers to enable them to stay in the same room as their child and following a survey and risk assessment of locations within the rooms the beds were installed in the best possible locations. The beds were placed on the only available walls and these had previously installed electrics, however the electrics were made safe prior to the beds being fitted. The fixings are those used by the contractor who had experience of installing this type of bed in several Trusts nationally. Following this incident a number of actions were identified: ▪ A visual inspection of all 240 beds was undertaken by the Estates and Facilities Management Team immediately after the incident. ▪ A full investigation of all beds has been conducted by the manufacturer of the pull down beds. ▪ Arrangements have been made to fit an additional 2 wall fittings to all beds even though the manufacturer reports that these should not be required. ▪ An annual inspection and maintenance contract is being prepared which the Trust hopes to implement following completion of the work identified above.
SMS Q1	**Delayed Procedure & Communication:** A patient was scheduled for a stent procedure and raised concern regarding the delay and the poor communication regarding the delay, as well as the lack of response from PALS. The patient was scheduled for a Stent procedure on 2nd May 2017 and advised to attend at Cardiac Catheter Laboratory 7.40am. The patient arrived on the day, was first in the queue and booked in straight away. The patient was asked to take a seat in the waiting room and then waited two hours during which time no member of staff approached them to inform them of either what was happening or why there was a delay. Whilst waiting patient called the Cardiology Booking Department to ask why was a delay. A member of staff from the Booking Department advised the patient to enquire at the Cardiac Catheter Reception. The patient followed this advice but when he approached the Reception staff the informed the patient that they did not have any information. After waiting for over 3 hours the patient was advised that a bed would not be available and that therefore his procedure could not be undertaken. The patient contacted the PALS Department via email, however by 17.40 hours he had not had received a reply. The patient also tried to call the PAL department but reported that the phone lines were permanently busy and they therefore he was unable to speak to anyone about his complaint. Issues of concern included identified within this complaint involved a clear lack of communication from department **Lessons Learnt:**

	As a direct result of the investigation into the concerns raised by the patient the following actions have been identified: As part of improving outpatients' standards improvement programme the seating area and information boards in the Cardiac Catheter Laboratory Waiting Room will be updated and changed to promote a better patient experience whilst waiting for admission and clinic appointments. This work is being undertaken by the Manchester Heart Centre Outpatients Clinic Task and Finish Group, led by the Operational Manager and Catheter Laboratory Activity Co-ordinator. All staff involved in bed allocation have been reminded of the escalation process should there be pressure on flow through the department, so that information can be widely shared with patients in a timely fashion. This has been completed via e-mail, team meetings and Catheter Laboratory communication meetings by the Deputy Directorate Manager. The telephone line within PALS is open from 09:00 - 16:00 hours Monday to Friday; however during periods of high call volumes, there can be occasions when callers encounter delays. The Customer Services Manager responsible for PALS was able to advise the patient that in order to improve the experience for people accessing PALS, she has recently recruited three additional staff members of staff. This increased capacity will enable the team to be more responsive responding to email correspondence and answering telephone calls as soon as the additional staff members have commenced in their roles
St Mary's Q1	**Positive Communication:** Individual emotions colour how people perceive and react to situations and to each other. To deliver the best patient care therefore, health professionals need to be cognisant of those triggers that can cause a negative emotional response in themselves, their colleagues and their service users. Failing to communicate clearly, consistently and comprehensively will result in poor patient outcomes, satisfaction and experience. **Summary of Complaint:** Within the Obstetric Unit, a lady underwent an elective caesarean section however she felt that the Midwifery staff in the Enhanced Recovery Program area were not helpful in the post-delivery period, when she required assistance changing her baby. She felt that one member of staff spoke to her very harshly when she accidentally pressed the call bell. The lady also felt that the expectations to mobilise so soon following surgery was unrealistic. **Local Resolution** The Lead Midwife apologised to the lady and her husband for the attitude of staff and confirmed that the Ward Manager would be advised of the incident who would discuss this with the individual member of staff. The Lead Midwife discussed the Enhanced Recovery Pathway with the lady and her husband including the importance of early mobilisation, the expectations of post-operative pain levels and pain relief options were also discussed. The lady agreed that her knowledge of the pathway was limited and she had different expectations. The Lead Midwife informed the couple that she would discuss the concerns raised the Ward Manager. Specifically, the importance of ensuring that families in our care receive full information about the Enhanced Recovery Pathway, how the care Pathway works in practice is understood and

	ensuring patients expectations are understood and managed. The lady and her husband were happy with this plan of action.
Surgery Q1	**Poor nursing and medical care, poor communication and documentation, delay in scan being undertaken and delay in follow-up appointment: Urology:** A patient was admitted from the Emergency Department to Ward 10 (via ESTU) at Manchester Royal Infirmary with acute pyelonephritis. The patient was admitted for intravenous antibiotics (Gentamycin). The patient's creatinine levels were high; when patient's creatinine levels are high Gentamycin should not be administered. The nurse administered the Gentamycin. The administration of the Gentamycin delayed the patient's discharge as she required a period of observation and administration of saline due to the concern about kidney damage. The patient was discharged but then re-admitted the following month as she was still feeling unwell. During this subsequent admission the consultant undertook a consultation with the patient, with a cleaner in the room, with no consideration of respect or confidentiality for the patient. The patient was advised that she was to undergo an ultrasound scan, the patient was advised of the scheduled date of the scan however it transpired she was not on the list of patients to undergo a scan on that day. On another occasion during this admission, the patient enquired why she had not received pain relief or antibiotics that she believed were due to be administered and she was advised that her drug prescription chart could not be found and that she could not receive any medication. At the time of discharge, the patients Discharge Notification Form (DNF) included the wrong diagnosis and list of procedures that the patient had not undergone The patient was shown blood test results and an ultrasound report for a different patient with the same name; ultimately a breach of confidentiality. On another occasion it took a member of staff six attempts to insert a cannula, despite the patient asked the doctor to stop after three failed attempts. The patient did not receive a follow-up outpatient clinic appointment that she understood should have been 2-3 weeks after her discharge. The appointment was received and scheduled for a few months after her discharge. **Lessons Learned:** The investigation into the concerns raised by the patient identified: ▪ The importance of effective communication between all disciplines and the need to improve communication channels. There is now a ward specifically for Urology and a consultant of the week system is now in place, which has made significant improvements to the communication on the ward ▪ The importance of undertaking consultations in a private environment has been reiterated to al staff, as the exact member of staff cannot be identified. ▪ The importance of confidentiality needs reiterating. ▪ Lack of awareness of what drugs can be given when creatinine is high, which requires additional training for the individual member of staff concerned ▪ The need for clear documentation in patient's notes and communication

	with the patient regarding any delays or cancellations in regard to their treatment/procedures. ▪ Although it is not understood entirely what happened how the prescription chart was misplaced, there should have been expedited attempts to create a replacement prescription chart so that the patient was able to receive her medication and painkillers in a timely manner. ▪ Medical staff now use patient district numbers when accessing electronic records for test results instead of using a patient's name as the identifier, as such errors retrieving the incorrect patient details/results should not happen. This should also prevent issues with incorrect information being populated into patient DNF. ▪ The Consultant Urologist has reiterated to all junior staff that after two failed attempts of catheter insertion they should escalate to a more senior member of staff and not to continue to attempt insertion. ▪ At the time of the patient's discharge in 2015, the Urology Department were lacking in secretarial support and acting upon DNF instructions and making arrangements for outpatient appointments were unfortunately delayed, this has now been rectified and there is now more staff in post. In addition the Urology team have established Hot Clinics, which are accessible to patients at short notice after discharge. The clinics provide the patient the opportunity to be reviewed if they are unwell rather than wait until an outpatient appointment is available.
Trafford Q1	**Communication and Discharge:** A complaint was received by Trafford Day Surgery Unit from the parent of a young adult with regards to medication discharge instructions. The patient had been discharged with Co-Codamol 30/500 mg for pain relief and told that she could take two tablets every 4 – 6 hours, as required. The concern raised was that the patient had not been told that they could not exceed more than 8 tablets in 24 hours. On return home the patient's mother calculated the doses every 4 hours and administered the tablets every 4 hours for the next 40 hours, there for significantly exceeding the maximum daily dose. The patient's mother only noticed the instruction on the medication package, not to exceed 8 tablets in 24 hours 2 days later. NHS Direct were contacted and they advised attending the Accident & Emergency. The patient's aminotransferase (ALT) levels were abnormal; the alanine ALT test is done to identify liver disease, especially cirrhosis and hepatitis caused by alcohol, drugs, or viruses. The patient was admitted to hospital for 36 hours for observation and follow up blood tests. **Identified Improvement:** All Day Surgery Unit staff have been advised to emphasis to patients the maximum number of tablets that can be taken in 24 hours and the importance of reading medication advice leaflet/packaging before taking any medication. The Day Surgery Unit Team are also designing a new discharge leaflet to include advice on take home medication – to include advice on reading enclosed medication advice notices.
UDHM Q1	**Communication** A complaint was received regarding the lack of communication relating to treatment in the Postgraduate Department. The Postgraduates are qualified dentists but are undertaking further training in a specialist area and as such

	require supervision. The patient advised that he was unaware who had been identified to treat him, what qualifications the clinician had and what supervision would be provided by the consultant. The complaint highlighted that information about the Postgraduate Department Services was lacking. As a direct result a leaflet has been developed that explains fully what Postgraduate treatment involves. In addition a consent form for patients to sign when they are placed on the Postgraduate waiting list has been developed and introduced that records the explanation to the patient about what treatment is to be provided, by whom and with what supervision. A Patient Listening Event is scheduled for the 30th August 2017 and the team at UDHM will be seeking patient and carer feedback on these two documents before finalising. Once agreed these will be placed on the UDHM website under the patient information section. An issue was also raised about continuity of care and cancellation of appointments within the Postgraduate Department. Previously Postgraduate students were individually responsible for the booking of follow up appointments and these were not entered onto the Patient Administration System (appointment booking database). From September 2017, when the new intake of Postgraduate students commences, all appointments will be made via the Out Patient Clerks and entered on to PAS, to ensure full audit trial of appointments.
Estates and Facilities **Q2**	**Meal Ordering** A number of complaints have highlighted some training gaps in the meal ordering processes for inpatients, specifically for special dietary requirements. In response the Facilities Management Matron has developed an on-line guide for the clinical teams as resource to demonstrate how to use the Trust's electronic food ordering system for patients (MAPLE).

8. Developments and Service Improvements

Educational Sessions

8.1 Following on from a successful series of educational sessions for Divisional staff in 2016/17, a further Complaints Educational Session was arranged by the Patient Services team and externally facilitated during Quarter 1. During Quarter 2, the Corporate Complaint and PALS team held a Safeguard Master Class for divisional staff to support the effective use of the electronic system used to record complaints activity.

8.2 The ***Effectively Handling Verbal Complaints Course*** that was undertaken in Quarter 1 focused on developing delegates' communication and mediation skills, in order to equip those involved in complaint management, with the skills to effectively resolve and manage complaints. The course enabled delegates to identify and learn skills to overcome the common barriers to verbal complaint resolution and work towards reducing the number of complaints the Trust receives.

Feedback from the course was very positive with staff reporting their 'Average Skills and Knowledge Level before and after the Course' had improved from 52% to 87%.

Specific feedback included:

- "Cath was awesome – knows her stuff and has seen and heard it all. Great to have that huge wealth of knowledge shared. Excellent training, highly relevant and up to date." PALS Case Manager

- "The course was truly excellent –video clips were really eye opening for me – Julie's story tells me a lot. Group discussion and exercise openers with other staff from different departments were brilliant. From today onwards I will be more confident to deal with all situations." Sister

- "Feel more prepared to have face to face meetings with complainants and patients after this course. It has made me think about the words I use in my everyday language. Really enjoyed this course, it would be beneficial for all staff to attend." Senior Sister

- "Excellent course, presented in an interesting and participatory way –really gets your thinking." Ward Manager

8.3 The ***Safeguard Master Class*** was undertaken and facilitated by the Customer Services Manager and a PALS Case Manager during Quarter 2, 2017/18. The Master Class focused on deepening divisional staff knowledge and skills in relation to using Safeguard for divisional management and reporting of complaints.

The Master Class demonstrated to the delegates the value of reporting directly from Safeguard and provided technical information and insights about strategies and procedures for reporting. This has enabled the delegates to effectively extract their own Customer Service reports for use within the Divisions.

Complainant's Satisfaction Survey

8.4 The new National Complaints Satisfaction Survey commenced for all complaints responded to from 1st November 2016. The survey, which is based upon the ***'My Expectations'*** [1] paper has been developed by the Picker Institute and is sent to complainants 4 weeks after the final Trust response and followed up with a two-week reminder.

Since implementation, the response rate for the new survey has consistently been between 23-29%. This represents a significant improvement when compared to the response rate of the previous satisfaction survey which had an 8% response in Quarter 2, 2016/17.

8.5 Results from the first six months of 2017/18 from the survey indicate:

- 91% confirmed that the outcome of their complaint was explained in a way they could understand.
- 89% felt confident to complain again if required.
- 85% of complainants found it easy to make a complaint.
- 85% felt their updates relating to their complain were personal to their complaint
- 80% of complainants felt their complaint was taken seriously when first raised.
- 78% of complainants felt their complaint was handled professionally by the organisation.
- 63% understood how their complaint would be used to improve services.

[1] http://www.ombudsman.org.uk/__data/assets/pdf_file/0007/28816/Vision_report.pdf

- 62% of complainants felt they were updated enough about their complaint.

8.6 Comments received include the following:

- "The professionalism of the PALS office."
- "I was happy with the correspondence received updating me about the complaints procedure."
- "I thought the outcome letter was thorough; clearly covered each point, how services could be improved."
- "I felt my complaint was taken seriously."
- "I was treated with respect. The outcome was such that all issues were dealt with, procedures appeared to be put into place being put into place to improve care, procedures."
- "The responses were mostly within time limits and where this did not happen an explanation was given."
- "Staff involved were helpful and interested in understanding detail of the complaint. Correspondence was easy to follow and offered option to discuss/clarify and respond."
- "I am left convinced your complaints procedure is taken seriously. Thank you."
- "Personal attention."
- "The friendly manner of all the people concerned at PALS."
- "Speed and efficiency of response impressive."

Staff support

8.5 In recognition that working within the Complaints and PALS teams can be personally challenging, and to support the health and wellbeing of team members, formal Staff Support sessions were introduced during Quarter 1, 2017/18. The sessions are available to both the PALS and Formal Complaints Teams and are facilitated by the Trust's Staff Support Service.

The sessions offer staff the opportunity to talk with trained counsellors and psychologists about some of the cases they may have found difficult to manage and offer peer support in a safe and confidential environment. Feedback from staff has indicated that these sessions have been well received and are a welcome addition to the psychological support offered to staff working in this area. An evaluation of the service will take place during Quarter 4, 2017/18.

Single Hospital Service

8.6 Work commenced during the first six months of 2017/18 to start the process of scoping and assessing how the Complaints and PALS functions at CMFT and UHSM might begin to work more closely together as part of the Single Hospital Service. Part of this work entailed looking at how Manchester University NHS Foundation Trust (MFT) will establish a complaints process that is compliant with the NHS Complaints regulations (2009) from day one, whilst maintaining the status quo prior to the two complaints functions being integrated as a single service.

A Complaint Policy Addendum has therefore been developed and ratified for implementation on 1st October 2017. This interim complaints addendum refers to the two respective incumbent complaint policies for CMFT and UHSM and draws together a unified process for the escalation, grading and reporting of complaints. This will remain in place until such a time that a new overarching complaints policy is developed for the Trust.

The next stage of the work is looking at how joint reporting will be undertaken for internal and for external reports and how the complaints management system, Safeguard, will be developed to enable the consistent management of complaints at all sites across MFT.

9. Equality and Diversity Monitoring Information

9.1 **Table 12** provides Equality and Diversity information gathered from complainants for the first six months of 2017/18. The collection of Equality and Diversity data has improved since the introduction of the new Complaints Satisfaction Survey, however it is clear from the data that some complainants are not currently choosing to share this demographic detail.

9.2 As this data set becomes more representative of the complainant population, it is anticipated that it will enable Patient Services to monitor whether any specific patient group is making a disproportionate number of complaints, or if any group is under-represented, thereby enabling the Trust to ensure services are fair and equitable.

Table 12: Quarter 1 and 2, 2017/18 Equality and Diversity monitoring information

Disability	
Yes	42
No	71
Not Disclosed	393
Total	**506**
Disability Type	
Learning Difficulty/Disability	0
Long-Standing Illness Or Health Condition	10
Mental Health Condition	9
No Disability	0
Other Disability	5
Physical Impairment	15
Sensory Impairment	2
Not Disclosed	465
Total	**506**
Gender	
Male	235
Female	257
Transgender	0
Not disclosed	14
Total	**506**
Sexual Orientation	
Heterosexual	105
Gay man	5
Bisexual	1
Do not wish to answer	8
Not disclosed	387
Total	**506**
Language	
English	6
Not disclosed	500

Totals	**506**
Religion/Belief	
Buddhist	0
Christianity (All Denominations)	66
Do Not Wish To Answer	8
Muslim	4
No Religion	34
Other	2
Sikh	0
Jewish	4
Hindu	1
Not disclosed	387
Total	**506**
Ethnic Group	
White – British	209
White – Irish	5
White - Other	9
Asian or Asian British - Bangladeshi	0
Asian or Asian British - Indian	4
Asian or Asian British - Pakistani	11
Asian or Asian British – Other Asian	2
Black or Black British - Caribbean	7
Black or Black British – Other Black	1
Mixed – White and Asian	2
Mixed - White and Black Caribbean	4
Mixed – Other Mixed	2
Any other ethnic group	2
Do not wish to answer	2
Not stated	246
Total	**506**

10. Recommendation

10.1 The Group Board of Directors is asked to note the content of the Quarter 1 and 2, 2017/18 Complaints Report and the on-going work of both the Corporate teams and the Divisions to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to improve the patient's experience when accessing services or when raising complaints, concerns or providing complimentary feedback about the Trust's services.

University Hospitals South Manchester Legacy Report
April 1st – September 30th 2017

1. Summary

1.1 This report provides an overview of the Complaints and PALS performance for the first six months of 2017/18 (Quarter 1 and Quarter 2) reporting period 01 April 2017 to 30 September 2017.

1.2 The number of formal complaints received by UHSM in the first six months was 227. The number of complaints received in Quarter 2 increased compared to Quarter 1, with receipt of 128 formal complaints in Quarter 2, compared to 99 in Quarter 1. This represents an increase of 29.2%.

1.3 Scheduled care (including women's and children's) received the largest number of complaints during the six month period, with an increase in Quarter 2 of 23% (29 complaints). Unscheduled care remained the same in Quarter 1 and Quarter 2. (40). Clinical support services had an increase of 14% (3 complaints).

1.4 During the first six months of 2017/18 95.28% of complaints were answered within the agreed timescale. This equates to 92.66% in Quarter 1 and 98.63% in Quarter 2

1.5 During Quarter 1 and Quarter 2 there were 24 dissatisfied responses. The number of dissatisfied cases decreased in quarter 2 to 16 from 18 in Quarter 1.

1.6 The number of PALS received in the first six months was 728, with receipt of 367 in Quarter 1 and 361 in Quarter 2. In essence PALS contacts decreased by1%n Quarter 2 compared to Quarter 1.

1.7 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days after the complaint is received. During the six months there was 92.66% 2.5% increase (positive) of acknowledged complaints within 3 days in Quarter 1 t and 95.2% in Quarter 2. There was an increase of 6.7% of complaints responded to in the agreed timeframe from Quarter 1 (91.93%) to Quarter 2 (98.63%).

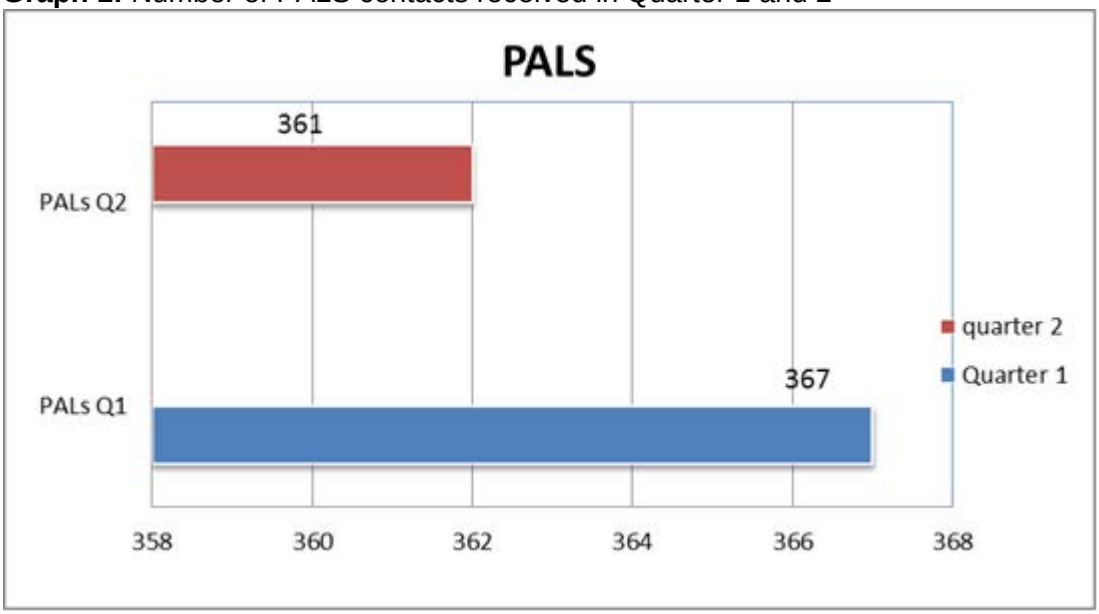
1.8 The Patient Services Team continues to work with Divisional Teams to identify and develop service improvements informed by complaints.

Overview of Quarters 1 and 2

1. **PALS**

1.1. There were a total of 728 PALS contacts during the first 6 months of 2017/18; with 367 PALS contacts recorded in Quarter 1 compared to 361 in Quarter 2 (a decrease of 6 in number)

Graph 1: Number of PALS contacts received in Quarter 1 and 2



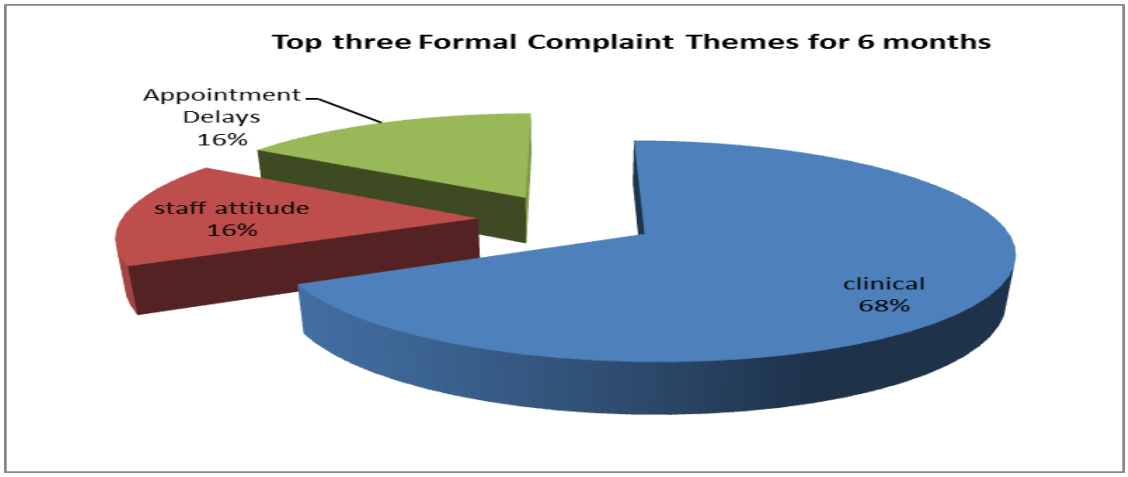
1.2 The majority of PALS contacts within the first 6 months of 2017/18 were related to appointment delay and communication. There was a slight increase (2%) in Quarter 2 of concerns relating to appointment delay compared to Quarter 1.

1.3 Issues have recently been identified relating to the logging of PALS concerns and the data available to measure KPI's. This has been identified by the Acting Deputy Director of Nursing and will be the focus for improvement during Quarter 3.

2. Formal Complaints

2.1 The number of formal complaints received in the first 6 months was 227. The number of complaints received in Quarter 2 increased compared to Quarter 1, with receipt of 128 formal complaints in Quarter 2, compared to 99 in Quarter 1. This represents an increase of 29.2%. This is out with normal variation. There has been a marked increase in complaints within Scheduled care in Quarter 2 and needs further analysis to understand why.

2.2 The increase in the number of formal complaints received in Quarter 2 compared to Quarter 1, 2017/18 is mainly attributed to an increase in scheduled care complaints (23% increase in Quarter 2 from Quarter which equated to 29 in number). Unscheduled care remained the same (40) and Clinical Support services had a slight increase of 14% (3 in number).



2.3 During the last six months the main reason for complaints were clinical (114 complaints) Staff attitude (27 complaints) and appointment delays (27).

2.4 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days after the complaint is received. During the six months there was a 2.5% increase (positive) of acknowledged complaints within 3 days from Quarter 1 to Quarter 2. There was an increase of 6.7% of complaints responded to in the agreed timeframe from Quarter 1 to Quarter 2.

2.5 During the first six months and previous to this all formal complaint response times were monitored through Divisional performance reviews which were held monthly and attended by the senior divisional teams. Each complaint was discussed with Divisional teams weekly/ fortnightly by the corporate complaints team. Monthly complaint reports were discussed at Clinical Standards Sub- committee which was chaired by the Director of Nursing. There is a monthly complaints panel which previously was chaired by a Non-Executive Director and is now chaired by the Director of Nursing and Medical Director.

3. Complaint Key Performance Indicator (KPI) Meeting

3.1 Each division holds a weekly/ fortnightly complaints meeting with the Corporate Team Divisional teams attend led by either Head of Nursing or Deputy Divisional Medical Director to review all complaints. The objectives of the meeting are to:

- The progress of each complaint;
- Any blockages that through discussion and escalation can be resolved;
- A date for closure of each complaint case;
- The need to highlight divisional delays early in order to take appropriate mitigating actions.

3.2 Complaints are also monitored through Divisional performance reviews led by the Executive Team. Monthly monitoring is also through the previously authorised Clinical Standards Sub-committee where lessons learnt are discussed.

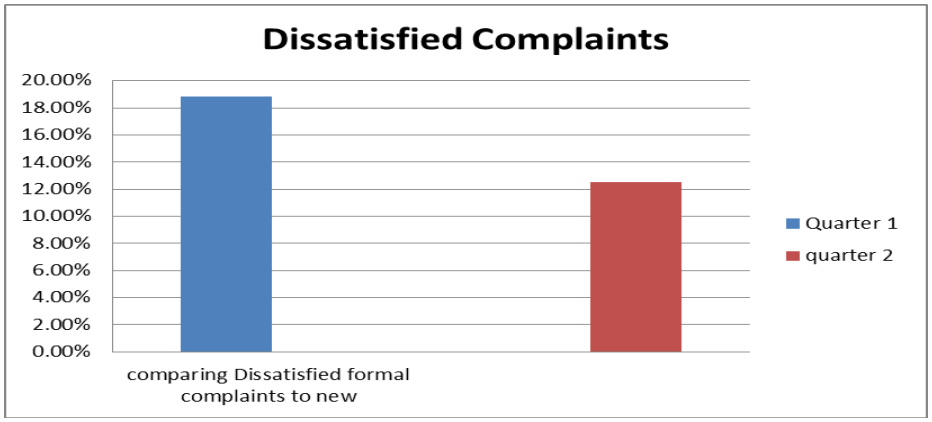
4. Dissatisfied Complaints

4.1 Dissatisfied formal complaints are used as a proxy indicator to measure the quality of the initial response. The number of formal complaints (dissatisfied) compared to the

number of new complaints received for Quarter 1, 2017/18 was 18 (18.8%), compared to 16 (12.5%) in Quarter 2, which is a decrease (positive) of 6.3%.

4.2 During the first six months of 2017/18 there were 34 dissatisfied responses. There were was a decrease of 2 Quarter 2 from Quarter 1.

Graph 3: Dissatisfied Complaints



5. Compliments

5.1 The registration of compliments is managed by the PALS team. It has become apparent that not all compliments have been registered through the PALS team during the first six months of 2017/18 which has highlighted inaccuracies in the recording and subsequently the reports. The Acting Deputy Director of Nursing has reviewed the processes and put in place a system to ensure that registration, monitoring and reporting improves moving forwards.

5.2 Monthly reports are circulated to Divisions detailing compliments that are registered both corporately and locally. However a more robust process needs to be in place to ensure the divisions receive these. So they can be monitored through their governance structures and respond.

5.3 The Trust receives many compliments from patients, their families and friends and action continues to be undertaken to increase recording of such feedback. The number of compliments registered in Quarter 1, 2017/18 (53) compared to Quarter 2, 2017/18 (17) reduced considerably, the reasons for this are currently being investigated by the Acting Deputy Director of Nursing.

5.4 The data can be broken down by division but currently this is not reported.

6. Patient comments and NHS Choices feedback

6.1 Patient Opinion and NHS Choices are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services.

6.2 There is no data available for patient feedback from NHS choices. The information has been archived since the merger and monthly reports did not indicate robustly the feedback from NHS choices for the last six months.

6.3 Comment cards are collected from wards and department During the last 6 months there have been 76 comments cards collected from areas in Quarter 1, 32 comment cards were received and Quarter 2, 44 comment cards were received

Table 1: Example of Patient Comments

Unscheduled Care
Sexual Health Clinic: 'Absolutely fantastic service. Very efficient. On time appointments. Non-judgemental staff, thorough and knowledgeable. Really appreciated the whole experience and feel thankful to the NHS''
Clinical Support services
Theatres: 'All the staff were very professional during my procedure, everything was explained professionally and I was put at ease'
Scheduled Care
Cardiology: Very impressed by the efficiency, professionalism and courtesy of all the staff. Every effort was made to ensure a thorough and in depth investigation and staff went out of their way to put me at ease. Thank you

7. Themes from Complaints and PALS contacts

7.1 During the first six months 2017/18 clinical reasons were cited in 25% of PALS contacts. Clinical reasons were also cited in 50% of formal complaints. This data is not currently broken down by report.

7.2 The top three category types for Formal Complaints for Wythenshawe in Quarter 1, 2017/18 and Quarter 2, 2017/18 are shown below in Table X, with complaint themes being discussed within individual Divisional teams and actions monitored through their governance structure

Table 2: Top 3 Formal Complaints Themes (Quarter 1 compared to Quarter 2

	Quarter 1	**Quarter 2**
Clinical	47	67
Staff attitude	12	15
Appointment delays	15	12

8. Complaints Scrutiny Committee

8.1 In accordance with the agreed schedule (monthly meetings), the Complaints Scrutiny Committee, which is chaired by a Non-Executive Director, met once per month in Quarter 1, and Quarter 2 with Divisions attending to present cases. The learning identified from the cases presented and the actions discussed and agreed at the meeting are disseminated across divisions. All Divisions are asked to identify and share the transferable learning from complaints.

8.2 The actions agreed at each of the Complaints Scrutiny Committee meetings continue to be recorded and provide to the respective Divisions following the meeting in the form of an action log. Progress is monitored at subsequent meetings.

8.3 Actions identified at the Trust Complaints Scrutiny Committee in Quarter 1 and Quarter 2, 2017/18 include ; Failed discharges- Unscheduled care, Staff attitude and staffing levels- Scheduled care and Radiology complaints- Clinical Support services.

Board Patient Stories

At each Board of Directors meeting Quarter 1 and Quarter 2 a patient story was presented.

Examples of patient stories from Board Story's – Quarter 1 and Quarter 2	Actions
A patient described his experience on the urology ward. He explained that he observed tension at times when the nursing staff changed shifts at night and the lack of privacy he felt was evident with patients overhearing all discussions held between patients and nursing staff.	The Chief Nurse explained that arrangements had been put in place to address the nursing acuity levels and staffing.
The bereavement manager presented a patient story in respect of a family who had expressed concern with the turnaround time of admin information being released which had delayed funeral arrangements. She explained that the family were concerned that some religions received quicker turnaround times than others by the Coroner's office.	The bereavement manager has developed a bereavement action group which would include looking at one system for all patients.
A patient and his wife gave their experiences of being a patient at the trust. They paid tribute to the service a described it as premier league. Specifically research	The board thanked them and highlighted the importance of Manchester's involvement in research and development.

9. Parliamentary and Health Service Ombudsman (PHSO)

9.1. There were 15 cases referred to PHSO in Quarter 1 & Quarter 2; 8 of these are still under investigation, 2 did not require further investigation, 2 cases are currently being reviewed by the PHSO.

9.2 The PHSO closed 7 cases relating to UHSM, during the first six months of 2017/18. Of these closed PHSO cases, 2 were not upheld and 1 was upheld.

10. Red phone (Real-time concerns)

10.1 The red phone enables families and patients to escalate concerns in real time, via a dedicated phone number, to a senior manager so that issues can be resolved, the patients experience improved and potentially a complaint averted. The phone is held by patient experience team in office hours and via the duty manager out of hours. There is no record of any logging of any interactions in the first six months. From Quarter 3 any phone calls and actions will be logged.

11. Learning from Feedback

11.1 Implementing Learning to Improve Services - This is undertaken within all Divisions to enable local teams to regularly receive their complaint data and review the outcomes of complaint investigations at the divisional Governance or Clinical Standards Subcommittee

12. Staff support

12.1. There have been several challenges within the PALS and Formal Complaints Teams over the last six months involving consultation processes, attendance management and environmental issues. It is recognised that the roles within these teams is a challenging role and it is also acknowledged that there is a lot of work to be undertaken to support the teams through change whilst also ensuring the correct processes are in place to ensure correct recording of information and that the team fee valued for the work that they do. Further work is required around feedback for divisions regarding informal concerns and compliments.

13. Recommendations

13.1 The Group Board of Directors is asked to note the content of the Quarter 1, and Quarter 2 2017/18 Complaints Report from the former UHSM and the on-going work of both the Corporate teams and the Divisions to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to improve the patient's experience when accessing services or when raising complaints, concerns or providing complimentary feedback about the Trust's services.