MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

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Report of:	Group Chief Nurse
Paper prepared by:	Emma Dodd, Assistant Chief Nurse, Quality and Patient Experience Niall Bancroft, Customer Services Manager
Date of paper:	July 2024
Subject:	Annual Complaints report 2023/24
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	MFT must prepare an annual report which: • Specifies the number of complaints received. • Specifies the number of complaints upheld. • Specifies the number of complaints referred to the PHSO. • Summarises the themes of complaints. • Summarises how the complaints were handled. • Summarises lessons learned, as a result of complaints.
Recommendations:	The Board is asked to note this Complaints Report for 2023/24 and, in line with statutory requirements, provide approval for the report to be published on the Trust website.
Contact:	Name: Emma Dodd, Assistant Chief Nurse, Quality and Patient Experience Tel: 0161 276 8862

1.   Introduction

1.1   The Trust adheres to the UK Statutory Instruments No. 309, which requires NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This annual report reflects all complaints and concerns made by (or on behalf of) patients of MFT, between 1st April 2023 and 31st March 2024.

1.2   Our aim is to provide timely resolutions when people raise concerns or complaints about their experiences of the care they have received. We aim to remedy the situation as quickly as possible, ensuring the individual is satisfied with the response they receive. Learning from complaints provides a rich source of information to support sustainable change.

1.3   This report provides:

- A summary of activity and thematic analysis of PALS concerns and Complaints across the Trust during 2023/24.
- A summary of PALS and Complaints compliance with response deadlines.
- A summary of complaint outcomes and lessons learned to improve patient care and experience.
- A summary of PALS and Complaints improvement activity.
- A summary of PHSO investigations into MFT complaints.
- PALS and Complaints Equality and Diversity information.

1.4   The report refers to all Hospitals/Managed Clinical Services (MCS)/ Local Care Organisation (LCO) and Corporate Services across the MFT Group.

2.   Summary of PALS and Complaints activity 2023/24

- In 2023/24 the Trust received 8,964 PALS concerns; a 3.4% increase from the 8,673 received in 2022/23.
- The Trust received 2,107 complaints during 2023/24; an increase of 4.3% from the 2,021 received in 2022/23.
- 11.8% (243) of complaints were 'fully upheld', 71.5% (1,479) were 'partially upheld' and 16.7% (345) were 'not upheld'.
- 'Communication', 'Appointment Delays/Cancellations' and 'Treatment/Procedure' were the main themes of PALS concerns; 'Treatment and Procedure' was the main complaint theme, followed by 'Communication' and 'Clinical Assessment'.
- 99.9% of complaints were acknowledged within 3 working days and 89.0% of complaints were responded to within the agreed timescale; 93.3% of PALS concerns were closed within 10 working days.
- During 2023/24 the Parliamentary and Health Service Ombudsman (PHSO) opened new investigations into 10 MFT complaints. The PHSO also informed the Trust of 15 completed investigations into MFT complaints; 1 (7%) case was 'fully upheld', 3 (20%) cases were 'partially upheld', 4 (27%) cases were 'not upheld' and 7 (46%) were resolved by 'early dispute resolution'.

3.0   An overview and thematic analysis of PALS contacts

3.1   There was an increase of 3.4% in PALS concerns received at the Trust from the previous year, with 8,964 PALS concerns being received compared to the 8,673 received in 2022/23. **Graph 1** below shows the number of PALS concerns received by month for 2023/24 compared to the previous year.

Total Number of PALS Concerns by Month 2022/23 - 2023/24
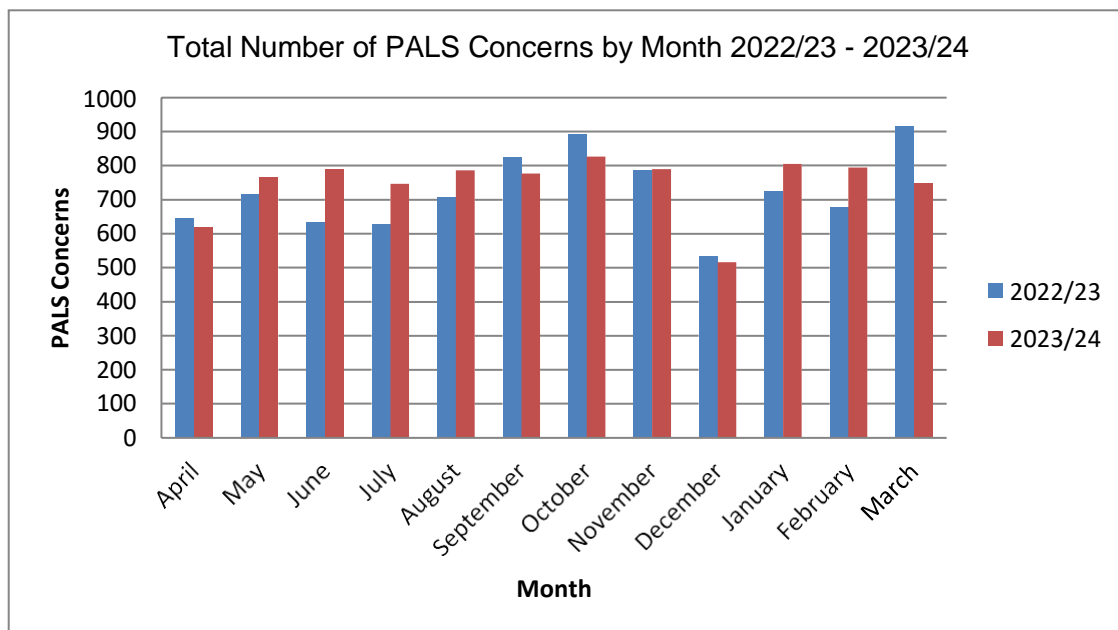
Graph 1: Total number of PALS concerns received by month 2022/23 - 2023/24

3.2   **Graph 2** shows the number of PALS concerns received by each Hospital/MCS/LCO during 2022/23 and 2023/24. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) and Manchester Royal Infirmary (MRI) received the greatest number of PALS concerns, receiving 2,433 and 2,161 respectively.

3.3   Overall, the greatest increase in PALS concerns was in Corporate Services, with a 49.7% increase being noted compared to 2022/23. This rise was mainly due to concerns relating to 'Hospital Facilities' and 'Patient Documentation'. In response to this a weekly corporate KPI meeting has been introduced to discuss complaint response times and identify themes for addressing.

3.4   Manchester and Trafford Local Care Organisation (LCO) and Clinical Scientific Services (CSS) also received greater PALS numbers than the previous year, with increases of 34.0% and 32.6% respectively. The increase in PALS at the LCO was attributable to 'Appointment Delays/Cancellations', whilst the CSS rise was due to a high number of concerns relating to the reporting of diagnostic/scan results.

3.5   PALS concerns for Saint Mary's Managed Clinical Service (SM MCS) University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH) decreased by 12% during 2023/24. These were due to a reduction in the number of concerns related to communication for these MCSs.
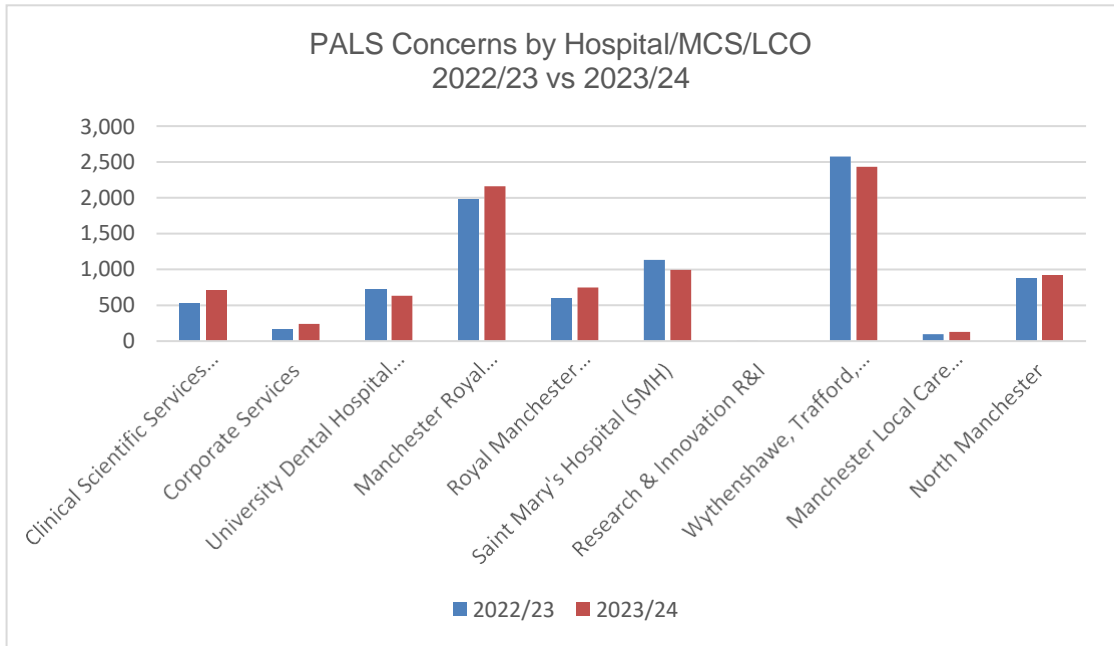
Graph 2: PALS concerns received by Hospital/MCS/LCO 2022/23 vs 2023/24

3.6 **Chart 1** and **Graph 3** below show the distribution of the main PALS themes and indicates that the greatest proportion of PALS concerns relate to 'Appointment Delays/Cancellations', 'Communication' and 'Treatment and Procedure'. The greatest increase in PALS concerns during the year was in relation to 'Attitude of Staff' with a 43.4% increase in PALS concerns, relating to this category, compared to 2022/23.
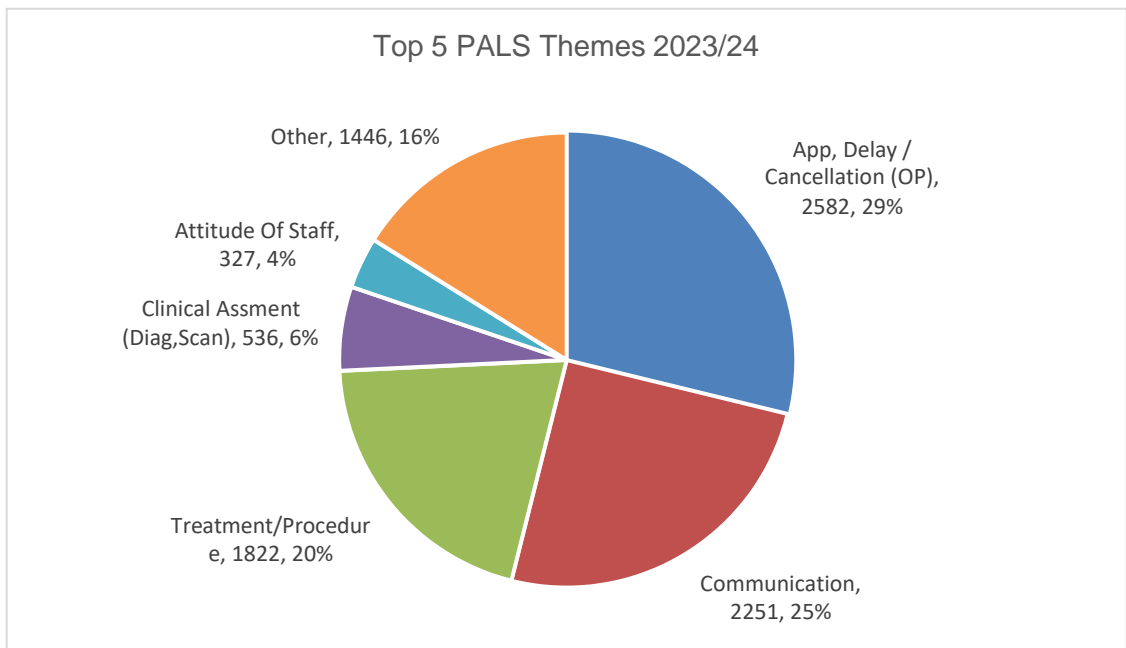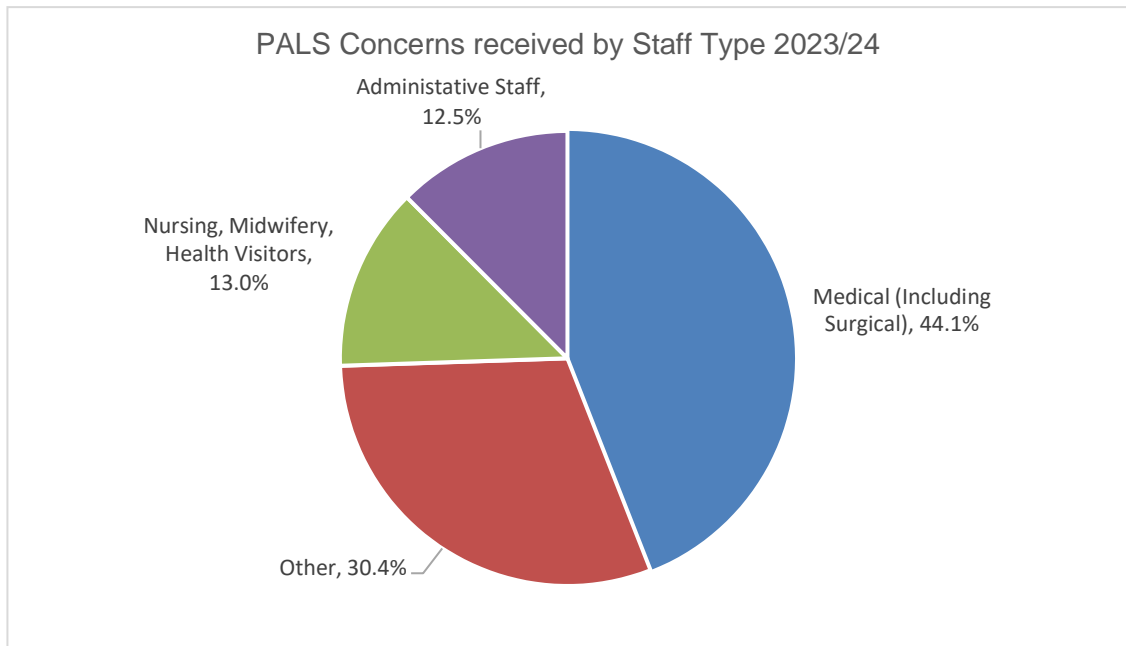

Chart 1: Top PALS categories 2023/24
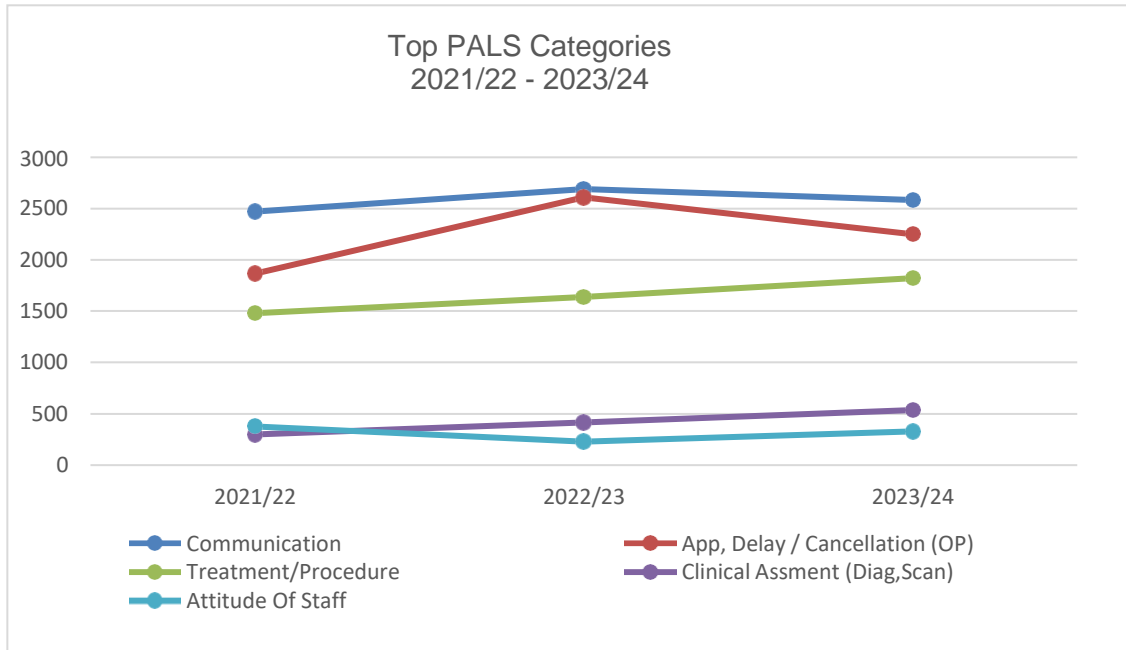
Graph 3: Top PALS categories 2021/22 to 2023/24

3.7 **Chart 2** below highlights the top 3 professions referenced in PALS concerns. As in previous years, medical staff are the highest group referenced with a total of 3,434 PALS concerns.

Chart 2: PALS concerns received by staff type 2023/24

3.8 **Table 1** below provides a breakdown of the sources of PALS concerns received. Email and telephone were the most common methods for patients and their representative to raise concerns, with an increase in the number of concerns received via telephone (17.2%)**.** This is due to successful improvement work related to the PALS telephone system installed in Q4 22/23.

Category	2022/23	2023/24	% change
Email	4879	**4660**	-4.5%
Face to Face	464	**537**	15.7%
Letter	20	**9**	-55%
Telephone	3165	**3709**	17.2%
Other	127	**49**	-61.4%
Total	**8673**	**8964**	**3.4%**

Table 1: Sources of new PALS concerns 2022/23 – 2023/24

3.9 The PALS & Complaints Department have been working to make the service more accessible, and this is shown with a continued rise (15.7%) in the number of PALS concerns raised in person (Face to Face).

3.10 This has been supported by new PALS posters displayed across the Trust, to advertise the different ways patients and representatives can access the service. In addition to this, throughout 2023/24 the PALS Team Leaders attended Heads of Nursing Forums and Team Leader/Senior Clinician Training Programmes to raise staff awareness of PALS and their freedom to actively seek feedback to improve services and seek local resolution.

3.11 This work is to continue during 2024/25 and a new PALS & Complaints Accessibility Working Group has been established to identify and drive further improvements to service accessibility and awareness.

4.0   PALS responsiveness and KPI

4.1 During 2023/24, the average response rate to PALS concerns was 4.6 days, which is an improvement in comparison to 22/23 when the average was 5.3 days. In total, during 2023/24, 93.0% of PALS cases were closed within 10 working days. This is a marked improvement from the 87.4% of 2022/23. As can be seen from **Table 2**, PALS responsiveness was consistently above 90% throughout the year.

4.2 Improvements in responsiveness has been supported by PALS cases being discussed at weekly Hospital/MCS/LCO/Corporate Services PALS Key Performance Indicator (KPI) meetings with senior ownership and escalation in place to ensure timely responses.

	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Resolved in 0-10 days	1998	2239	2070	2168
Resolved in 11+ days	173	127	179	155
% Resolved in 10 working days	**92.0%**	**94.6%**	**92.0%**	**93.3%**

Table 2: Closure of PALS concerns within timeframe 2023/24

4.3 **Table 3**, below, shows the number of PALS concerns resolved within the Trust's 10-day response timescale, by each Hospital/MCS/LCO/Corporate Services.

	<10 days Q1 23/24	<10 days Q2 23/24	<10 days Q3 23/24	<10 days Q4 23/24	<10 days 2023/24
CSS	94.1%	92.8%	93.6%	95.1%	**93.8%**
Corporate	86.7%	86.0%	86.8%	84.5%	**85.9%**
LCO	97.1%	97.1%	94.3%	100%	**96.9%**
MRI	87.9%	92.1%	87.4%	91.9%	**89.8%**
NMGH	91.0%	97.0%	94.2%	92.5%	**93.8%**
RMCH	90.7%	93.8%	90.7%	88.7%	**90.9%**
SM MCS	92.5%	96.1%	94.1%	96.6%	**95.0%**
WTWA	95.1%	96.6%	94.9%	96.5%	**95.8%**
UDHM/MREH	96.8%	95.7%	92.9%	89.8%	**93.9%**
MFT Overall	**92.0%**	**94.6%**	**92.0%**	**93.3%**	**93.0%**

Table 3: Closure of PALS concerns within timeframe by Hospital/MCS/LCO/Corporate Services 2023/24

4.4 **Table 4**, below, shows the number of PALS concerns that were escalated to formal complaints and the number of complaints de-escalated to PALS, during 2023/24. Responding to PALS concerns in a timely manner can prevent concerns being escalated to formal complaints. This has been achieved via the PALS escalation SOP and weekly PALS KPI meetings, but also via improved training and awareness of the positive effect closing PALS cases in a timely manner can have for both patients and staff.

4.5 The PALS and Complaints Department have made a concerted effort to seek timely resolution of concerns and are supporting clinical staff to achieve this, via their new Local Resolution Training sessions. This has been a success so far, as seen by the reduction in escalations and large rise in de-escalations during Q4. This will continue to be a focus for the department, through 2024/25.

	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	2023/24
PALS cases escalated to complaints	14	27	24	13	**78**
Complaints de-escalated to PALS	27	45	36	76	**184**

Table 4: Number of PALS & Complaints escalations and de-escalations 2023/24

5.0 **An overview and thematic analysis of Complaints contacts**

5.1 There were 2,107 complaints received during 2023/24, an increase of 4.3% from the 2,021 received in 2022/23.

5.2 **Graph 4** below shows the increasing number of complaints the Trust has received since 2020/21. The large rise in complaints in 2021/22 correlates with a large increase in the number of patient attendances (as seen in **Table 5**). Complaints have continually risen since then, but at a lower rate.

MFT Complaints Received 2019/20 - 2023/24
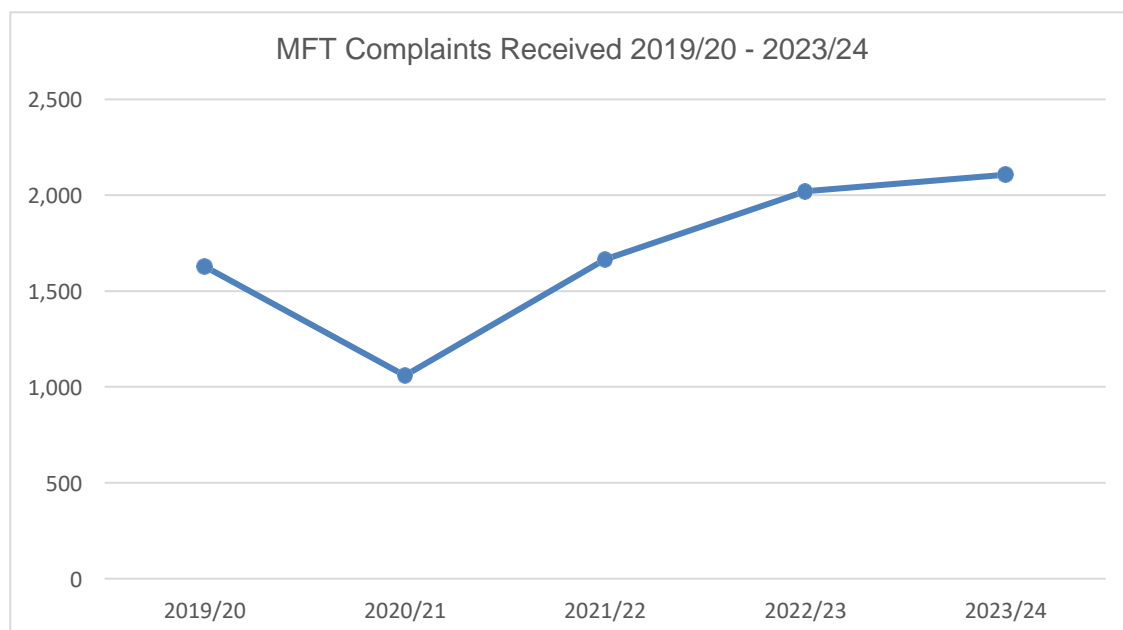
Graph 4: MFT complaints received 2019/20 - 2023/24

5.3 As a measure of performance, the number of complaints should be considered in the context of organisational activity. **Table 5** below shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2023/24 compared to previous years. It is acknowledged that the Trust has seen not only an increase in the number of complaints but also in the rate of complaints per inpatient consultant episodes. There was a decrease, however, in the number of complaints received per outpatient appointment and A&E attendance.

		2020/21	**2021/22**	**2022/23**	**2023/24**
Inpatient	Formal Complaints Received (FC)	419	531	624	**632**
	Finished Consultant Episodes (FCE)	337,049	455,841	450,081	**415,093**
	Rate of FCs per 1000 FCEs	1.24	1.16	1.39	**1.52**
Outpatient	Formal Complaints Received (FC)	380	665	919	**1062**
	Number of Appointments	1,293,384	1,470,442	1,854,418	**2,644,348**
	Rate of FCs per 1000 Appointments	0.29	0.45	0.50	**0.40**
A&E	Formal Complaints Received (FC)	105	270	314	**315**
	Number of Attendances	267,867	482,908	483,880	**515,260**
	Rate of FCs per 1000 attendances	0.39	0.55	0.65	**0.61**

Table 5: Number of complaints received by patient activity 2020/21 – 2023/24

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5.4 **Table 6**, below, details the number of complaints received by Hospital/MCS/LCO/Corporate Services for 2023/24. WTWA and MRI received the most complaints, with 564 and 491, with both of these numbers much higher than the previous year. The main themes for both, were the same as the Trustwide top themes of 'Treatment/Procedure', 'Communication' and 'Clinical Assessment'. Of note, however, was that both WTWA and MRI had a much higher proportion of complaints relating to 'Attitude of Staff' than other Hospitals/MCSs/LCO.

5.5 It is recognised that there is an increase in complaints for CSS, UDHM/MREH, MRI and WTWA with the greatest percentage increase in complaints was in CSS (27.5%). This data shows that this is due to an increase in complaints related to reporting of diagnostic/scan results, the same cause for the associated rise in CSS PALS concerns. In response to this the senior leadership team in CSS will utilise the complaints dashboard for discussion in their governance meetings.

Hospital/ MCS/LCO	2019/20	2020/21	2021/22	2022/23	2023/24	% change from 2022/23 to 2023/24
CSS	103	67	96	120	**153**	27.5%
Corporate Services	68	44	54	66	**51**	-22.7%
UDHM/MREH	96	39	103	95	**116**	22.1%
MRI	419	283	356	450	**491**	9.1%
RMCH	189	111	167	237	**200**	-15.6%
SM MCS	194	160	243	286	**273**	-4.5%
WTWA	515	317	406	496	**564**	13.7%
LCO	44	38	56	50	**43**	-14.0%
NMGH	-	-	184	221	**216**	-2.3%
MFT Total	**1,628**	**1,059**	**1,665**	**2,021**	**2,107**	**4.3%**

**Table 6:** Complaints received by Hospital/MCS/LCO 2019/20 to 2023/24.

5.6 The greatest decrease in complaints was in Corporate Services (-22.7%), in contrast to the increase in PALS for Corporate Services. RMCH and LCO both also experienced reductions in the number of complaints received year-on-year, with decreases of -15.6% and -14.0%. RMCH decrease due to a reduction in complaints relating to 'Treatment/Procedure' and 'Communication' and LCO due to a decrease in complaints related to 'Clinical Assessment'.

5.7   The opportunity to learn from complaints is an effective way of improving patient care and experience. Complaints are categorised by themes, and staff work to improve the quality of care in areas where recurring complaint themes emerge, or where practice is identified as requiring improvement. **Graph 5** below demonstrates the most prevalent categories of complaints raised in 2023/24. 'Treatment and Procedure' was the main theme of complaints received, followed by 'Communication' and 'Clinical Assessment'. These top 3 themes were the same as 2022/23.
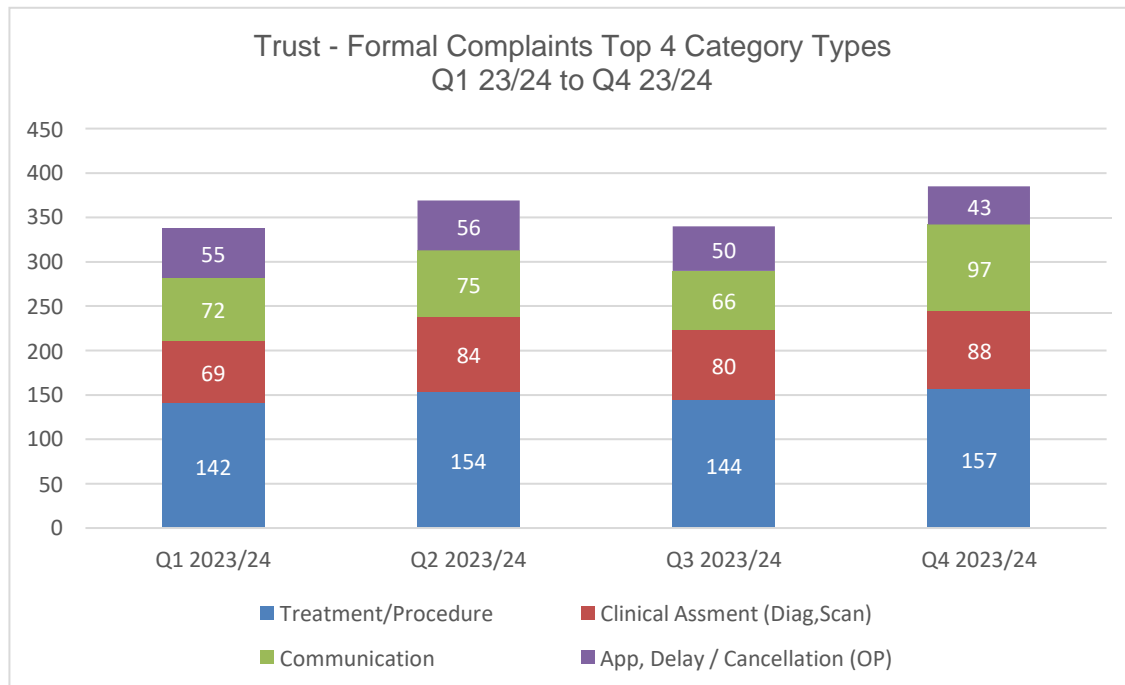

Graph 5: Top Complaint Themes Q1 – Q4 2023/24.

5.8   **Graph 6** shows the breakdown of complaint themes by Hospital/MCS/LCO. WTWA received the most complaints relating to 'Treatment / Procedure' (155), 'Communication' (90), 'Clinical Assessment' (78), and 'Attitude of Staff' (59), whilst MRI received the most complaints relating to 'Appointment Delay/Cancellation (50).
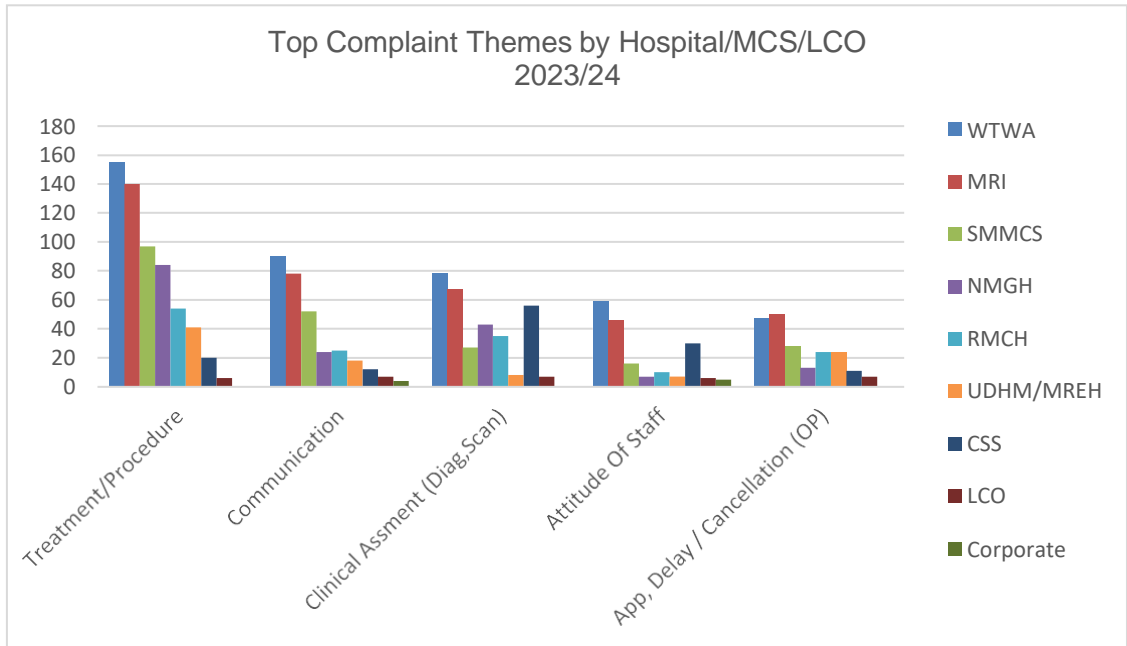
Graph 6: Top complaint themes by Hospital/MCS/LCO 2023/24.

5.9   Chart 3 below highlights the top professions referenced in complaints. As in previous years, medical staff are the highest group referenced with a total of 1,713 complaints, followed by nursing, midwifery, health visiting staff who are referenced in 535 complaints. There has been an increase in complaints regarding medical staff this year, whilst there was a decrease in complaints related to nursing, midwifery, health visiting staff.
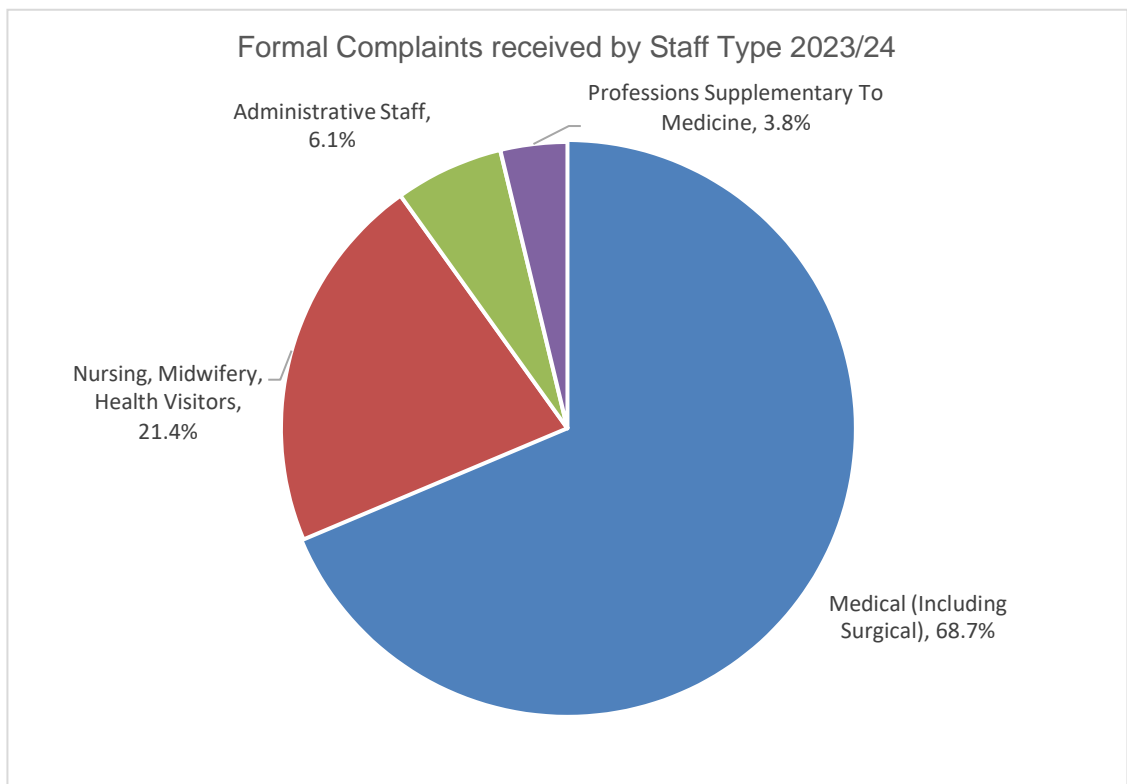
Chart 3: Complaints received by staff type 2023/24.

6.0   Complaints responsiveness and KPI

6.1   The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 place a statutory duty up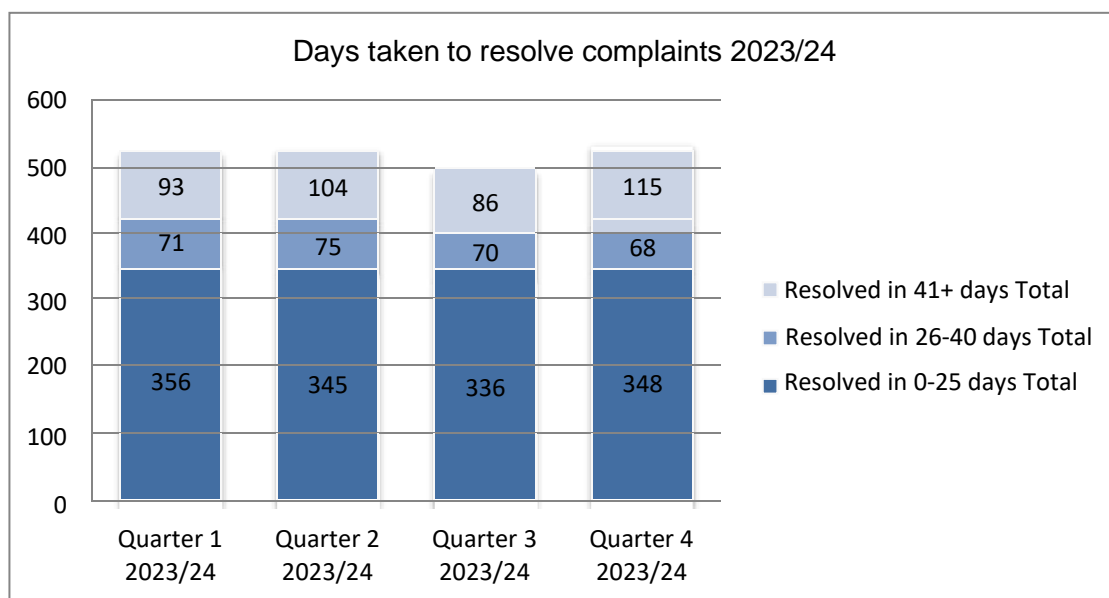on the Trust to acknowledge complaints within 3 working days. **Graph 7** below shows the Trust's adherence with this requirement on a monthly basis. Throughout the year, the Trust acknowledged 99.9% of all new complaints within 3 working days.

% of Complaints Acknowledged within 3 working days 2023/24
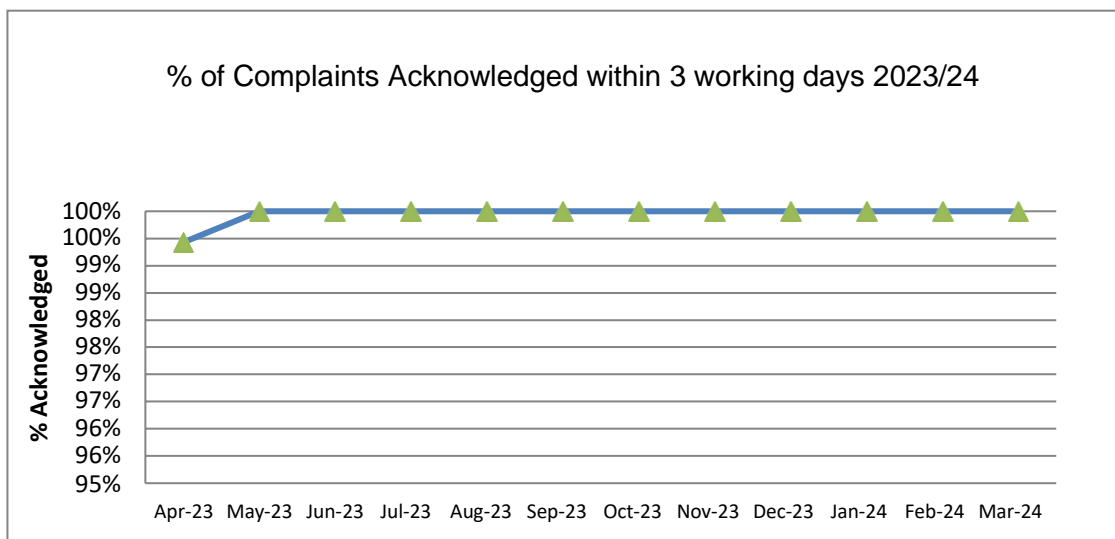
Graph 7: Percentage of complaints acknowledged ≤ 3 working days during 2023/24.

6.2   **Graph 8** shows the number of days taken to resolve each complaint, with the majority of complaints responded to within 25 working days. Some complaints are assigned 40 or 60 working days, if there are a large number of issues, input is required from an external organisation or if there is a local resolution meeting.

Days taken to resolve complaints 2023/24

	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Resolved in 41+ days Total	93	104	86	115
Resolved in 26-40 days Total	71	75	70	68
Resolved in 0-25 days Total	356	345	336	348

Graph 8: Number of days taken to resolve complaints during 2023/24

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6.3 Against the Trust's target of 90% of complaints being responded to within the agreed timescale, the Trust achieved a success rate of 89.0% of complaints within the agreed timescale, which is similar to the 88.7% rate achieved during 2022/23. **Graph 9** depicts the number of complaints responded to within time, and breaches, throughout each quarter.
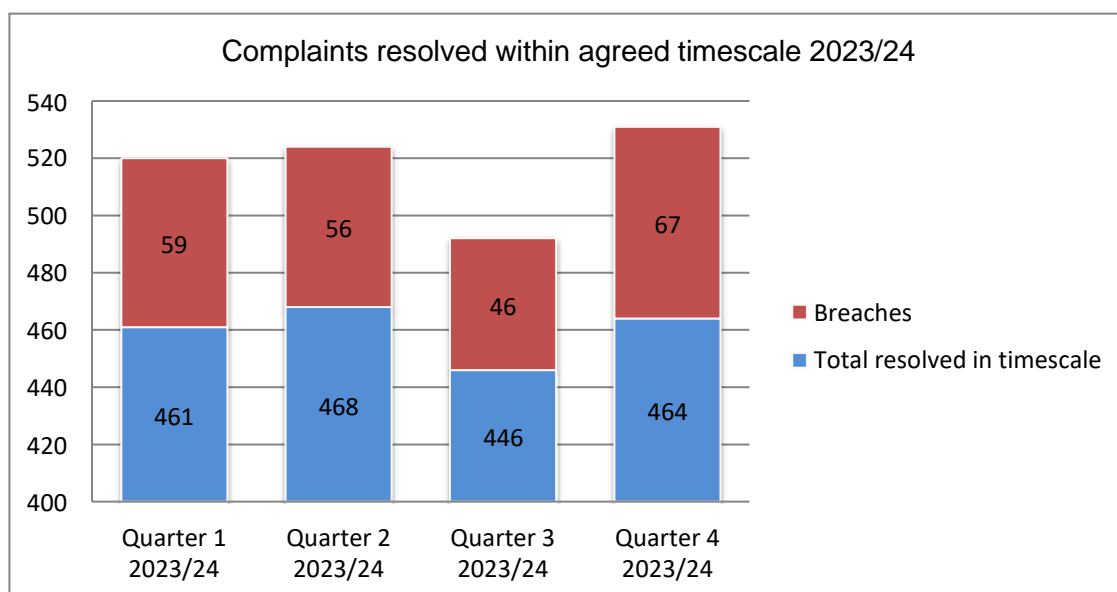
Graph 9: Complaints responded to within agreed timescale 2023/24

6.4 The reason for the Trust not meeting its target of complaints responded to within the agreed timescale, was due to hospitals low responsiveness to meeting the allocated timeframes for completion of complaint responses. This was particularly evident for Corporate Services and SM MCS, seen in Table 7 which details the breakdown of complaint responsiveness by Hospital/MCS/LCO. To improve compliance with complaint response deadlines, Corporate Services has instilled a new weekly Complaints KPI meeting, chaired by the Assistant Chief Nurse – Quality and Patient Experience, with all complaints monitored to ensure they are on track to be responded to in time.

6.5 SM MCS's complaint responsiveness has been on a downward trend since Q1 2022/23. In order to address this, SM MCS has refocussed efforts on timely completion, and increased support within the gynaecology division. This has included strengthening of the senior leadership team, increased oversight of complaints position at weekly meetings and early escalation to barriers to responding to complaints. SM MCS continues to reinforce the importance of timely complaints completion and expects an improved position each month during 2024/25, to be monitored via both SM quality and safety committee and SM management board.

6.6 WTWA was the best performing Hospital/MCS/LCO, responding to 97.5% of their complaints within the agreed timescale, with NMGH, UDHM/MREH and CSS also achieving excellent rates of compliance (95.4%, 95.0% and 94% respectively).

Hospital/MCS/LCO	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	2023/24
CSS	89.5%	91.9%	97.6%	97.1%	**94.0%**
Corporate	46.7%	25.0%	63.6%	50.0%	**46.4%**

LCO	100%	80.0%	88.9%	88.2%	**91.7%**
MRI	88.4%	94.7%	91.5%	85.5%	**89.9%**
NMGH	90.0%	95.3%	96.4%	100%	**95.4%**
RMCH	95.7%	93.5%	84.3%	81.0%	**88.6%**
SM MCS	63.6%	69.5%	73.1%	62.1%	**66.9%**
WTWA	98.6%	95.6%	96.4%	99.3%	**97.5%**
UDHM/MREH	90.0%	100%	92.9%	90.6%	**95.0%**
MFT Overall	**88.7%**	**89.3%**	**90.7%**	**87.4%**	**89.0%**

Table 7: Complaints responded to within agreed timescales by Hospital/MCS/LCO 2023/24

7.0 Complaints outcomes

7.1 Complaints often relate to more than one issue. In line with the NHS complaints regulations, if failings are found in all the issues raised and substantive evidence, based on which a fact is proven, is identified to support the complaint then the complaint is recorded as 'upheld'. If failings are found in one or more of the issues, but not all, the complaint is recorded as 'partially upheld'. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as 'not upheld'.

7.2 During 2023/24, 243 (11.8%) of the complaints MFT investigated and responded to were 'upheld', 1,479 (71.5%) were 'partially upheld' and 345 (16.7%) were 'not upheld'. **Table 8** demonstrates the outcome status of all complaints.

7.3 The main themes of 'upheld' complaints were 'Treatment/Procedure' (49), for which NMGH had the most complaints; and 'Clinical Assessment' (39), with most attributable to CSS.

| **Number of Closed Complaints**		**Upheld**	**Partially Upheld**	**Not Upheld**
Q1 23/24	520	60	379	81
Q2 23/24	524	59	383	82
Q3 23/24	492	54	365	73
Q4 23/24	531	70	352	109
2023/24	**2067**	**243**	**1479**	**345**

Table 8: Outcome of MFT complaints 2023/24

8.0 Re-opened complaints

8.1 A complaint is considered 're-opened' if any of the following categories can be applied:
- Where there is a request for a local resolution meeting, following receipt of the written response.
- When new questions are raised, following information provided within the original complaint response.
- The complaint response did not address all issues satisfactorily.
- The person raising the complaint expresses dissatisfaction with the response.

8.2 The number of re-opened complaints is used as an indicator to measure the quality of the initial response. A total of 428 (16.9%) cases were re-opened during 2022/23, against the Trust's tolerance threshold of 20%. This compares to 399 (19.7%) re-opened in 2022/23. **Graph 10** demonstrates the percentage of complaints re-opened by month during 2023/24.
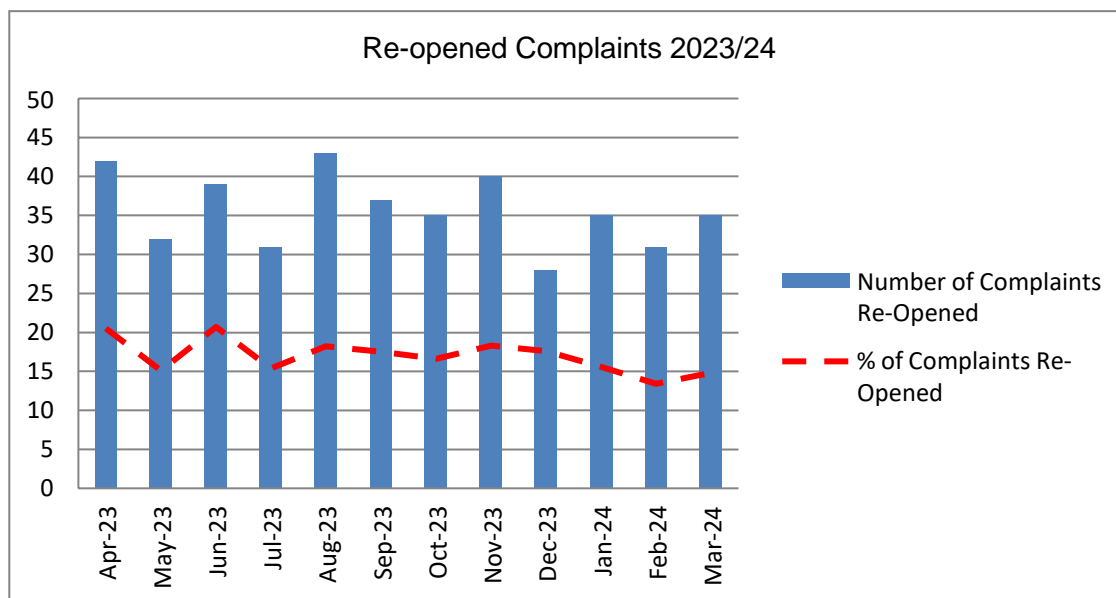
Graph 10: Number and % of re-opened complaints 2023/24.

8.3 The reduction in percentage of complaints re-opened has been supported by a drive to improve the quality of complaint responses through complaints investigation and response writing training. The Complaints Team delivered 36 training sessions, to a mixture of over 300 medical, nursing and administrative staff across the Trust during 2023/24, in addition to presenting at ACE days throughout the year. Training is to continue throughout 2024/25 with a focus on new staff and Hospitals/MCSs/LCO with high rates of re-opened complaints.

8.4 In 193 of the 428 complaints requiring re-opening, the primary reason was due to the 'Not all issues addressed/Unresolved issues', with WTWA (which received the largest number of overall complaints) receiving the greatest number for this reason. The Director of Nursing for WTWA has been informed of this increase and the Corporate Complaints Team have scheduled several sessions complaints investigation and response writing training at WTWA during the first half of 2024/25 to support staff with complaint investigations and improve the quality of responses.

9.0 Parliamentary Health Service Ombudsman (PHSO)

9.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO make final decisions on complaints that have not been resolved fairly and without taking sides. The PHSO considers and reviews complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly, or has given a poor service, and has not put things right. In addition to outcomes and reports from PHSO investigations being shared with the senior leadership teams from the respective Hospitals/MCS/LCO they relate to,

for ownership of the actions, they will also be shared the Trust's executive team for oversight of the findings and recommendations.

9.2   During 2023/24 the PHSO opened new investigations into 10 MFT complaints (4 for WTWA, 2 for MRI, 1 for NMGH, 1 for CSS, 1 for RMCH and 1 for SM MCS).

9.3   PHSO informed the Trust of 15 completed investigations into MFT complaints. **Table 9** below shows the outcomes of the PHSO investigation resolved in 2022/23 and 2023/24.

	2022/23	**2023/2024**
Fully upheld	1 (9%)	**1 (7%)**
Partially upheld	6 (55%)	**3 (20%)**
Not upheld	4 (36%)	**4 (27%)**
Early dispute resolution	0 (0%)	**7 (46%)**

Table 9: Outcome of PHSO investigations into MFT complaints 2022/23 and 2023/24.

9.4   A MREH complaints was partially upheld due to failings in relation to the Trust's provision of information to a patient about the possible side-effects of steroid medication. The PHSO recommended the Trust send an apology letter to the patient, complete an action plan to address the failings identified and pay the patient £700 in recognition of the distress and worry they experienced when they suffered steroid-induced psychosis.

9.5   The PHSO partially upheld a SM MCS complaint, due to failings in relation to the Trust not considering the patient's mental health birth plan and inadequate communication with the patient during their care. The PHSO recommended the Trust send an apology letter to the patient, compensate them £500 and explain what the Trust has done or will do to prevent a recurrence of these issues in the future.

9.6   The PHSO also partially upheld a WTWA complaint in which failings were identified in the care provided to a diabetic patient, in relation to their antibiotic treatment during an admission in 2019. The Trust acknowledged this and sent an apology letter to the patient's husband (patient is deceased and husband complained on their behalf). The Trust also agreed to pay £500 to the patient's husband, in recognition of the failings in care and completed an action plan to detail the actions taken to address the lessons learned from this case.

9.7   A RMCH complaint was 'Upheld', in which the PHSO identified failings in relation to staff not preparing for or managing the patient's disabilities nor pain and hydration levels and an inappropriate discharge from hospital. The PHSO recommended the Trust compensate the patient £950 and develop an action plan to address the failings identified, which RMCH are currently working on.

10.0   Lessons learned

10.1   Patient complaints offer intelligence that can be used to change practice and improve patient experience and outcomes. Whilst the focus on the performance of managing and responding to complaints is important, it is paramount that there is a clear intent to ensure

that learning from the outcomes of complaints is shared and improvements are acted upon and disseminated widely to improve the quality of patient care and patient experience.

10.2 Each Hospital/MCS/LCO hold regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement. In addition to this, the Complaints Review Scrutiny Group (CRSG), chaired by the Corporate Director of Nursing for Quality and Patient Experience, and supported by a nominated Non-Executive Director and Governor, met on 15 occasions during 2023/24 reviewing 23 complaints in total.

10.3 The CRSG process scrutinises complaints investigated and responded to by MFT and contributes to the learning from these complaints, to improve patient experience and positive change through open dialogue and reflection. The management teams from the Hospitals/MCSs/LCO presented cases based upon a complaint they had received. Learning and associated actions identified from the cases were discussed, and assurance was provided that complaints are investigated with appropriate action taken when needed. The Assistant Chief Nurse – Quality and Patient Experience and Customer Services Manager, are planning to work with senior governance, nursing and medical staff from Group and all Hospitals/MCSs/LCO, to identify how the Trust can strengthen Trustwide learning from CRSGs during 2024/25.

10.4 Each Hospital/MCS/LCO also feed into the quality and patient experience forum, which is constituted as a sub-group of the group quality and safety committee and NMAHP professional board. The overall purpose of the group is to provide the corporate strategic direction in relation to quality and patient experience, ensuring patients and families are at the core of all we do. This forum supports the collaboration of services, shares best practice, and provides a clear link to triangulate themes across the Trust.

10.5 Detailed below, in **Table 10**, are some examples of how learning from complaints has led to changes that have been applied in practice.

You said…	We did…
Concerns regarding patient's care and treatment, including communication failures, pain management, lack of clinical/risk assessment, results delays, general nursing and medical care.	Training was delivered at the beginning of each shift for one month. Following completion of the training, Ward Manager completing weekly audits to provide assurance that the ward nursing team are assessing and evaluating patients pain management in line with the Trust policy. Nurses have completed learning reflections regarding the administering of mediation, and this has also been discussed in the ward safety huddle and team meeting to ensure wider learning. Nurses have completed learning reflection and received one-to-one training regarding the importance of timely communication with families when patients are transferred to other areas of the hospital.

Concerns raised about the lack of compassion shown by the nurse visiting the patient and the lack of communication about the time of visit, communication about involvement and waiting times for the multi-disciplinary team.	New service leaflet has been developed to support patients and families to ensure access to information about the service, including who to contact. Website resources have been reviewed to include up to date contact details, information and links. Learning opportunities for staff in relation to supporting patients with emotional regulation changes, as well as ensuring all aspects of patient's care and condition are discussed at the core assessment. Communication with regards to waiting times and when the patient will be visited has been reviewed and revised. The process for advising the patient when they will be seen has been included in a communication log and 'team hand over' to ensure patients are contacted and updated appropriately. The service is continuing to report the waiting times through the relevant channels including a regular update of the risk assessment.
Concerns raised by patient in relation to not receiving a letter summarising the findings from their outpatient appointment and difficulties contacting the department by telephone.	Telephone lines have been updated allowing the transfer telephones to manned offices when staff members are absent. Process developed with the secretariat for checking colleagues' mailboxes, when absent, to ensure messages are responded to and mailboxes are kept clear and checking the letters awaiting sign-off are processed in a timely manner. Complaint shared at team meeting to improve services delivered by the secretariat.
Concerns raised about lack of follow-up appointment provided and onward referral, in addition to appointment cancellations.	Further training for Booking and Scheduling staff on MyMFT functionality. Hospital clinical cancellation information to be passed on to patients, with any queries raised by the patient to be escalated to the relevant consultant.
Concerns regarding a patient scheduled for a scan but their name was not on the list upon arrival.	The issue with imaging scans being referred incorrectly is being addressed with the IT Department, to prevent any repeat of this situation. Imaging have requested IT generate a 'hard stop', to prevent a recurrence. Operational Manager escalated the issue with the clinical teams, to identify any training needs.

Concerns received regarding lack of communication regarding referral waiting times, signposting to other services, and lack of knowledge of a patient's treatment plan and care journey.	Communication strategies developed to manage waiting time expectations with patients and families.
	Patients now informed of change of case manager via a letter.
	Improved information/letters being explored, to ensure patients are fully informed prior to attending appointments in relation to being their treatment plans being goal focused.
	Service Manager educated staff of provision of information of internal and external services that patients and their families can access.
Concerns regarding Perinatal Mortality Review Tool (PMRT) report.	Education and training for all staff working within triage, regarding management of women with reduced foetal movements.
	Junior Doctors reminded of process for acting on blood results and raised alanine transaminase (ALT) results.
	The importance of partogram completion has been reiterated to delivery suite staff, via core huddles (a communication aid for staff to disseminate key information and updates held at the beginning of each shift).
	Doctor involved met with their educational supervisor, for a reflective discussion surrounding the explanation of results to women and appropriate escalation of blood results in relation to obstetric cholestasis.
	Triage ward manager shared anonymised experience at triage team meeting to emphasise the importance of communication and empathy with patients/families.
Concerns regarding patient managing to self-harm in the Emergency Department, following a long wait to be seen and use of restraint.	ED Tracker Role now in place 24 hours a day, to support with escalation to specialities and to track patients' progress within the department.
	Patients experiencing a long-wait to see the Mental Health Liaison Team are now re-assessed based upon on their presentation, and tracked through HIVE, with a rollcall to ensure they are checked-upon.
	Re-design of MRI Emergency Department will include a dedicated Mental Health Area.
	Staff made aware not to leave sharps, such as scissions, unattended when seeing patients and restraint training and policy under review, in

	accordance with the Restraint Reduction Network, Trust's Security and Safeguarding Teams and Greater Manchester Police.

Education programme for Mental Health awareness for staff on the Trust's learning hub, with attendance monitored.

MRI Mental Health Care Group established, with a focus on the current risk, workforce, education and training. |
| Concerns raised in respect of poor communication, decision-making and lack of appropriate support both pre and post-birth of twins | All parent information leaflets reviewed to ensure they are up-to-date and Medical Team made aware of the information available to share with families. Leaflets available on the website via a QR code, and in different languages.

Member of staff to be identified to be the designated point of contact for the parent(s) and parents to be allowed to transfer with their baby/babies, when moving units, to empower the parents and provide assurance that their baby/babies is being cared for.

Clear and robust process developed to ensure families are supported in the contribution to the Perinatal Mortality Review Tool (PMRT) process.

SMH working with Chaplaincy Team to enhance bereavement support. |
| Concerns regarding nutrition and hydration patients received on wards, in particular a patient with coeliac disease being provided with food that caused diarrhoea and sickness. | The ward commenced a quality improvement project related to nutrition and hydration and mealtime audits completed to ensure patients' nutritional needs are met.

Daily senior nurse review will be conducted to include all patients who are nil by mouth.

A new mealtime menu is being launched, overseen by the Head of Nursing for Quality.

Ward staff to complete nutrition and hydration awareness training. |

Concerns regarding the long delays waiting for patient's surgery and lack of communication between referring hospital and MFT regarding cancellations.	Divisional leadership team will ensure all service line agreements with district general hospitals are delivered by more than one individual consultant to ensure the service does not become over reliant on any one individual.
	Operational manager shared concerns and feedback with team to reflect on the impact that short notice cancellations have on patients and their families, and the clinical Lead discussed the impact of the delay in adding the patient to the waiting list for surgery with lead consultant.
	Operational manager revising the referral process from external Trusts to ensure they are not solely reliant on clinicians and can also be managed by administrative and operational staff going forwards.
	Clinical lead undertaking a complete review of the paediatric orthopaedic service delivered at the external Trust to address the backlog of referrals and lengthy delays.
	A long-term locum for the external service has been secured, who has already begun work on clearing backlogs in triage and clinics.
	Meetings are ongoing and the operational teams from both sites hope to have a plan to reduce backlogs agreed by the start of the 2024/2025 financial year, at which point the revised pathway and service delivery plan will commence.
Concerns regarding a patient's hygiene needs not always met in a timely manner and heel pressure sore not always managed appropriately.	Concerns shared with the ward team and staff asked to document exact times that incontinence pads are changed, to raise awareness and improve continence care on the ward.
	Daily review established, with the head of nursing, matron and ward manager to review all vulnerable patients to ensure all aspects of care considered and completed.
	Ward manager and nurse in charge will conduct daily risk assessment checks and review of actions, to ensure timely implementation are in place for all ward areas.
	Teaching has been provided on the ward, in relation to pressure care and the management of pressure related

| | injury, including repositioning regimes and care plan documentation.

Tissue viability nurse team has provided bespoke wound management training on the ward. |
|---|---|

Table 10: Examples of learning and actions resulting from complaints during 2023/24

11.0 Complaints improvements in 2023/24

11.1 To address the low number of returns of complaints Equality Diversity and Inclusion (ED&I) monitoring forms, the complaints ED&I was updated, in line with the data fields on the Trust's electronic patient administration system (HIVE) to capture the protected characteristics under the Equality Act. ED&I data for complaints received during 2023/24 is included in **Appendix 1.** The Customer Services Manager attends equality and diversity patient groups across the Trust, to identify and address any barriers to accessing PALS and Complaints that exist, as well as working with the Trust's Consultant in Public Health to address health inequalities, with a focus on health literacy. Further work is planned during 2024/25, in collaboration with teams across Patient Services and the wider Trust, to address health inequalities and to make it as easy as possible for all patients and representatives to provide feedback.

11.2 The PALS office at Trafford General Hospital re-opened, improving face-to-face access to PALS for local residents and patients accessing care and treatment at the hospital.

11.3 Improvements made to the PALS and Complaints services to meet NHS England's 'Ask, Listen, Do' commitment, to improve the experiences of people with a learning disability, autism or both. Improvements include a new PALS poster, a PALS and Complaints Accessibility Working Group and an awareness of health literacy and simple English in PALS and Complaints communications and responses.

11.4 Implementation of changes to the complaints process in accordance with the new PHSO NHS Complaints Standards, which set out how organisations providing NHS services should approach complaint handling. The Complaints Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service. They have a strong focus on: early resolution by empowered and well-trained people; all staff, particularly senior staff, regularly reviewing what learning can be taken from complaints; and how all staff, particularly senior staff, should use this learning to improve services.

11.5 A new complaints satisfaction survey has been developed and is now in use, which can be completed online, via the post or over the telephone, to make it easier for patients and representatives to provide feedback on complaints handling at the Trust.

11.6 Standardised monthly complaints dashboard reports have been created, providing Hospitals/MCSs/LCO/Corporate Services with a detailed breakdown of their complaint numbers, themes and responsiveness at an organisational, divisional and departmental level.

12.0 Complaints improvements to be made in 2024/25

12.1 Continued areas for improvement and development during 2024/25 include:

- The Assistant Chief Nurse for Quality and Patient Experience and Customer Services Manager have planned a Complaints and PALS workshop on the 22nd July to include members of the senior nursing teams and governance managers. The aim of the workshop is to review the complaints and PALS process in relation to the management of complaints and compliance with the 25-day response target. This will also have a focus on increased local resolution meetings lead to a reduction in the overall number of complaints.
- Updated PALS and Complaints section of MFT website, including the implementation of a new online PALS contact form.
- Standardised Trust compliments process.
- New PALS leaflets.
- Audit and review of PALS process to identify areas for improvement, with further training and support to achieve local resolutions.
- Continued focus on a digitally led approach to handling complaints to improve responsiveness, including investigations, reports and communications.
- Strengthening shared Trust learning from PALS and Complaints to drive improvements to patient experience and care and treatment, through work alongside Safeguarding, Governance and Legal Departments.
- The Chief Nurse has commissioned the Assistant Chief Nurse for Quality and Patient Experience to undertake a Complaints Review to identify areas to improve efficiencies in the process ensuring complaints/PALs are dealt with in a timely manner and Hospitals/MCS/LCO are accountable for the complaint's compliance management within their respective areas and introduce assurance processes for executive oversight.

13.0 An overview of Compliments

13.1 Compliments received from people who use our services provide valuable feedback and an opportunity to learn from positive experiences. It is important to acknowledge only a fraction of the overall compliments received within the Trust are captured and recorded on the Trust's Customer Service Database. The majority of compliments received verbally, and as thank you cards directly by staff, are not currently logged or tracked by the Hospitals/MCSs/LCO/Corporate Services.

13.2 **Graph 11** below shows the number of compliments, received from members of the public about MFT Hospitals/MCSs/LCO, recorded on the Trust's Customer Services Database.
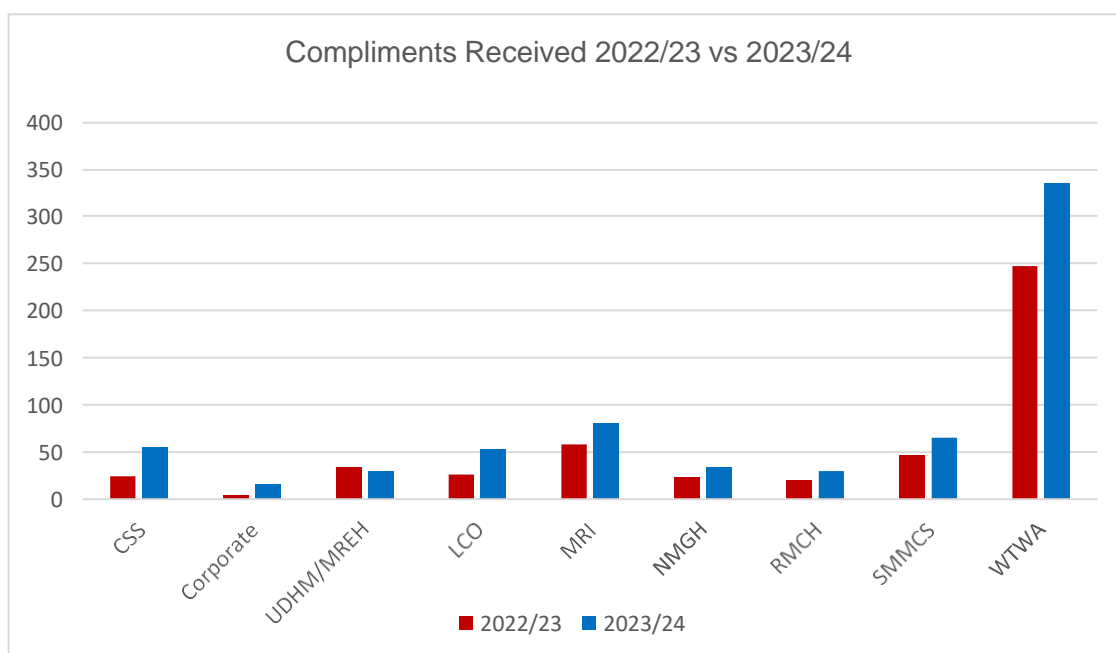
Graph 11: MFT compliments received 2022/23 vs 2023/24

14.0   Conclusion and recommendations

14.1   The Trust is grateful to those patients, families and carers who have taken the time to raise their concerns, complaints and compliments and acknowledges their contribution to improving services, patient experience and patient safety.

14.2   The Quality & Performance Scrutiny Committee are asked to note the content of this report, the work undertaken by the Corporate and Hospital/MCS/LCO teams to improve the patient's experience of raising complaints and concerns and, in line with statutory requirements, provide approval for the report to be published on the Trust's website.

14.3   The Complaints and PALS workshop is planned for 22nd July 2024, process improvements will be monitored and reflected in the quarterly complaints report to the Board of Directors.

APPENDIX 1

	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Disability				
Yes	55	74	51	69
No	97	103	76	80
Not Disclosed	340	360	359	443
Total	**492**	**537**	**486**	**592**
Disability Type				
Learning Difficulty/Disability	1	3	1	4
Long-Standing Illness Or Health Condition	21	30	10	18

Mental Health Condition	10	6	7	9
No Disability	0	0	0	0
Other Disability	4	2	2	2
Physical Disability	10	16	15	20
Sensory Impairment	7	5	4	2
Autism	0	0	0	3
Not Disclosed	439	475	447	534
Total	**492**	**537**	**486**	**592**

Gender

Man (Inc Trans Man)	210	213	227	243
Woman (Inc Trans Woman)	274	322	256	334
Non-Binary	0	0	0	0
Other Gender	2	0	1	0
Not Specified	5	2	2	14
Not Disclosed	1	0	0	1
Total	**492**	**537**	**486**	**592**

Sexual Orientation

Heterosexual	128	157	99	130
Lesbian / Gay/Bi-sexual	10	6	9	5
Other	2	0	14	10
Do not wish to answer	7	13	11	11
Not disclosed	345	361	353	436
Total	**492**	**537**	**486**	**592**

Religion/Belief

Buddhist	1	0	1	1
Christianity (All Denominations)	90	102	66	74
Do Not Wish To Answer	5	12	6	11
Muslim	18	16	12	13
No Religion	48	53	47	62
Other	3	3	6	0
Sikh	0	1	0	0
Jewish	3	3	5	3
Hindu	1	0	0	1
Not disclosed	322	344	343	426
Humanism	0	3	0	0
Paganism	1	0	0	1
Total	**492**	**537**	**486**	**592**

Ethnic Group

Asian Or Asian British - Bangladeshi	0	0	0	2

Asian Or Asian British - Indian	3	4	4	8
Asian Or Asian British - Other Asian	5	5	5	7
Asian Or Asian British - Pakistani	15	12	8	10
Black or Black British – Black African	3	10	1	9
Black or Black British – Black Caribbean	4	9	10	8
Black or Black British – other Black	4	2	2	3
Chinese Or Other Ethnic Group - Chinese	0	1	2	3
Mixed - Other Mixed	2	2	7	3
Mixed - White & Asian	1	0	0	0
Mixed - White and Black African	0	1	1	3
Mixed - White and Black Caribbean	2	2	2	3
Not Stated	116	166	142	165
Other Ethnic Category - Other Ethnic	6	5	8	16
White - British	202	219	177	235
White - Irish	7	9	9	6
White - Other White	6	12	9	9
Not disclosed	116	78	99	102
Total	**492**	**537**	**486**	**592**

Table 11: Equality and Diversity Monitoring Information for complaints during 2023/24.