

**Trust Board Meeting in Public: Wednesday 11 November 2015**  
**TB2015.127**

<b>Title</b>	<b>PALS and Complaints Annual Report and Complaints Policy</b>
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<b>Status</b>	For information and discussion
<b>History</b>	This is an annual report to Trust Board

<b>Board Lead(s)</b>	Ms Catherine Stoddart: Chief Nurse			
<b>Key purpose</b>	Strategy	<b>Assurance</b>	Policy	<b>Performance</b>

## **PALS and Complaints Annual Report and Complaints Policy**

### **1. Purpose**

- 1.1. This is the cover paper for the Annual PALS and Complaints Report in 2014/15.
- 1.2. The PALS and Complaints Annual Report is written in a format that is accessible to a public audience.

### **2. PALS and Complaints Annual Report**

- 2.1. This report provides a summary of formal patient complaints and PALS contacts received in 2014/15.
- 2.2. This includes details of the numbers of formal complaints and PALS contacts received during the financial year, and compliance performance in responding to complaints.
- 2.3. In addition, this report also presents the Trust's improvements to both the complaints service and the PALS team as a result of national guidance and local feedback.

### **3. Recommendation**

- 3.1. The Trust Board is asked to receive and discuss the report.

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November 2015

**Patient Advice and Liaison Service (PALS)**

**and Complaints Service**

**Annual Report 2014/15**

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## Executive Summary

This report provides a summary of formal patient complaints and PALS contacts received in 2014/15. This includes details of the numbers of formal complaints and PALS contacts received during the financial year, and compliance performance in responding to complaints. In addition, this report also presents the Trust's improvements to both the complaints service and the PALS team as a result of national guidance and local feedback.

### National context

Five national reports were published during 2014 in relation to NHS complaints. These reports all identified the importance of sensitive, efficient, honest, accurate complaints co-ordination and investigation. They linked patient safety, quality and with an organisation's culture to embrace patient feedback and improve services as a result.

The Parliamentary and Health Ombudsman published their review of 150 complaints where serious harm and patient safety was a grave concern. Two of the Trust's complaints, investigated and upheld by the PHSO in 2014, were included in this report.

The 2014/15 annual complaints information report (KO41a) was submitted on 7 May 2015 and published on 26 August 2015. This information is designed to monitor written Hospital and Community Health Services' complaints received by the NHS in relation to its services<sup>1</sup>. The data is used by NHS Trusts and other agencies to benchmark and comment on the trends and themes within NHS complaints, thus supporting the commitment within the NHS Plan to improve patient experience.

### Key information and data

- 1012 formal complaints received and investigated, this was a marked increase of 12.8% and is higher than the national average.
- 3324 PALS contacts recorded.
- 780 formal complaints were upheld or partially upheld following investigation.
- 163 formal complaints not upheld following investigation (589 complaints remain open for 2014/15 at the point of writing this report, 10 complainants withdrew their complaint prior to investigation).
- 9 complaints have been investigated by the Parliamentary and Health Services Ombudsman (PHSO) IN 2014/15.

### Learning

The Trust and PALS and Complaints Team have learned and developed considerably over the year. This was aided by the publication of the national reports

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<sup>1</sup> <http://www.hscic.gov.uk/home>

and the appreciation of the need for a more personal and humane approach combined with clear, transparent reporting.

## The PALS and Complaints Team

The Trust's Team is managed by a PALS and Complaints Manager; the service forms part of the Patient Services Team and are within the Chief Nurse's Directorate.

### 1. PALS

PALS are a NHS recognised service providing advice, information and guidance to those wishing to raise a concern or as a way of signposting the enquirer to the relevant service.

The Trust's Patient and Advice Liaison Service (PALS) comprises of four full time members of staff. A day to day Supervisor was appointed in early 2015; this role has enabled the team to implement a clear method of resolving patients' and families' issues appropriately. The members of the team are based at the John Radcliffe Hospital; one at the Nuffield Orthopaedic Centre and one at the Churchill Hospital. The Complaints Co-ordinator based at the Horton General Hospital also provides the face to face PALS service for that site.

The purpose of the PALS team is to offer an 'on the spot' open door service for patients, relatives and carers. This provides an opportunity for patients, relatives and carers to discuss their concerns, enabling the issue(s) to be appropriately identified and provide a timely response, in a manner that will support a suitable resolution. If necessary, PALS escalates the patient's concerns for action through the formal complaints process. PALS also provide a means for patients and relatives to share their compliments with Trust staff.

### 2. Complaints Team

The Complaints Team are based at the John Radcliffe Hospital, with each division supported within the team by at least one Complaints Co-ordinator, who works closely with the Division's Clinical Governance team and Management team. This ensures complaints receive a comprehensive investigation and an appropriate response at divisional level.

The Complaints team is comprised of 5.93 whole time equivalent staff and consists of full time and part time members of staff. The purpose of the Complaints Team is to implement a complaints procedure according the NHS Complaints Regulations 2009<sup>2</sup>. This is designed to ensure that:

- An efficient and thorough investigation is conducted.
- Patients and families are supported courteously and with respect.
- Patients are assisted to enable them to understand the complaints procedure in relation to complaints, or advised on where they may obtain such assistance.

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<sup>2</sup> <http://www.legislation.gov.uk/ukxi/2009/309/contents/made>

- All complainants receive a timely and appropriate response; informing them of the outcome of the investigation of their complaint and any action taken if necessary in the light of the outcome of a complaint.

## Patient Advice & Liaison Service (PALS)

In 2014/15 there were 3324 PALS contacts recorded for the Trust. These are presented by Division in Table 1 below comparing the figures recorded for 2013/14.

### PALS contacts in 2013/14 and 2014/15

Division	Number of PALS contacts 2014/15	Number of PALS contacts 2013/14
Neurosciences, Orthopaedics, Trauma, Specialist Surgery ( <b>NOTSS</b> )	1309	1751
Surgery and Oncology ( <b>S&amp; O</b> )	496	676
Children's and Women's ( <b>C&amp;W</b> )	205	290
Medicine, Rehabilitation, Cardiac ( <b>MRC</b> )	625	857
Clinical Support Services ( <b>CSS</b> )	160	268
Corporate	529	1089
<b>TOTAL</b>	<b>3324</b>	<b>4931</b>

Table 1: Source OUH Complaints Management System

The table demonstrates a decrease of 32.6% in PALS activity from the previous year, and the reasons for this decrease include:

- A marked increase in the number of formal complaints the Trust received in 2014/15 compared to 2013/14, suggesting more patients have a better understanding of how to raise their concerns formally.
- Review of issues PALS had been recording previously against what should be recorded.
- Issues with staff recruitment and retention.

The majority of the PALS enquiries relate to NOTSS Division and include the difficulties encountered by patients in relation to making an outpatient appointment. These issues are high on the Trust's quality agenda for improvements through the implementation of the outpatient appointment review process, and improvements to the telephone access. The high number of PALS issues recorded for NOTSS is mirrored by the number of formal complaints received.

## Complaints received during 2014/15

The Trust received 1012 formal complaints in 2014/15. This compared to 887 in 2013/14 and is an increase of 12.8% from the previous year. This is reflected across the wider NHS and is in part attributable to the increased public awareness in the complaints process, following the national reports published in 2014/15 into the NHS Complaints system. A reference to these reports is often mentioned in letters of complaint received which shows that people are aware of the publicity surrounding them. There are many factors which have influenced the increase in complaints throughout the year.

- The Trust has seen an increase in total patient activity during 2014/15. This equates to an increase of 5.45% for outpatient attendances and 3.86% for inpatient admissions.
- The reports published by Health Watch, the Parliamentary and Health Service Ombudsman and the Care Quality Commission in 2014 in relation to complaints, have generated significant, important and much welcomed publicity. This also may account for some of the increase in complaints received. The Trust has continued to actively promote and publicise how to make a complaint, or compliment, to patients, visitors and partners
- There have been notable difficulties experienced by patients in relation to access and cancelled procedures. This has particularly been experienced within the Neurosciences, Orthopaedics, Trauma and Specialist Surgery Division (NOTSS), and most significantly within Specialist Surgery Directorate. In addition, there have been noticeable access issues within the Urology Department.

### Seasonal Trends in complaints:

The numbers of complaints received by the Trust have fluctuated considerably throughout the year. This is presented in Table 2 below. This has not always followed the previous year's Trust or national trends, with some months much lower than the expected trend. For example, in October 117 complaints were received; this is traditionally a 'quiet' month for complaints and this number is compared with 63 in 2013. In October 2014, the reason for the increase in complaints was due to difficulties in accessing services. In contrast, the Trust usually receives a higher number of complaints during January; this is a national seasonal trend. However, this year the Trust received 70 complaints during January in comparison with 81 for the same period in 2014.



## Seasonal Trends in Complaints

	01 April to 30 June 2014  Q1	01 July to 30 September 2014  Q2	01 October to 31 December 2014  Q3	01 January to 31 March 2015  Q4	Total
Formal Complaints	249	242	267	254	1012

**Table 2: Source OUH NHS Trust Complaints Management System**

### Complaints Grading

All formal complaints are graded using the Department of Health Matrix System displayed in Table 3 below. The system assesses the seriousness of the complaint versus the likelihood of recurrence which equals the category of risk.

### Department of Health Matrix System

Seriousness	Likelihood of Recurrence				
	Rare	Unlikely	Possible	Likely	Almost Certain
Low	Low				
		Moderate			
Medium					
			High		
High				Extreme	

**Table 3: Source Department of Health**

Ten formal complaints were initially graded as red (extreme) in 2014/15, six were for the Neurosciences, Orthopaedics, Trauma and Specialist Surgery Division, one was for the Medicine, Rehabilitation and Cardiac Division, one for the Children's and Women's Division, one was for the Surgery & Oncology Division and one was for the Clinical Support Services Division. Each complaint was managed and resolved through the divisional governance processes and the key issues identified, actions implemented and monitored and wider learning facilitated through sharing with the relevant teams.

### The Trust's complaints themes and subjects:

Complaints are reported monthly to Trust Board and Quality Committee by subject, and the numbers of complaints by subject are displayed in the dashboard presented in Appendix 1. The Trust received very few complaints about the Trust's facilities, transport, documents and records. The key issues facing the Trust have been identified as appointments, admission and discharge, outcome of surgical and medical care and communication, information and consent. The consistent theme throughout these complaints is communication and the Trust's day to day clinical and organisational interaction with patients and relatives. This is reflected nationally for

all clinical professions and administrative services across the NHS. It remains a key priority for the delivery of the Trust's values of delivering compassionate excellence.

Charts 1, 2 and 3 presented in Appendix 2 present the most common issues identified by patients and their families received by the Trust. Neurosciences received the highest number of complaints relating to appointments, admission, discharge, communication, information and consent.

### **Complaints by staff group:**

The number of complaints received in 2014/15 recorded by staff group is provided to the Department of Health in the annual national complaints return. This is presented in Appendix 3. The medical profession received the highest number of complaints; this is in the context of patient activity throughout the year and represents 0.08% of Trust activity (Inpatient, Outpatient and A&E episodes). It is important to note that a proportion of these complaints will have included additional clinical and non-clinical staff. To date it has only been possible to assign one clinical group to a complaint; the new KO41a guidelines enable more than one profession to be assigned to a complaint. This gives a more accurate depiction of the professionals and services involved in a complaint.

The highest number of complaints was received by Doctors (n=396, 39%), Administration (n=216, 21%) and Nursing (n=176, 18%). Doctors received fewer complaints compared to 2013/14 (n= 522, 59%) when the number was higher than the national average. The number of complaints received by Nursing (n=147, 17%) and Administration (n=110, 12%) has increased. These proportions appear to be a more accurate reflection due to the introduction of Standard Operating Procedures for recording a complaint. This has ensured a consistent approach to all complaints.

## **The Complaints and PALS received by each Division during 2014/15**

Each division has summarised their priorities to improve patient experience following the analysis of PALS and complaints during the year.

### **1. Neurosciences Orthopaedics Trauma and Specialist Surgery (NOTSS)**

The numbers of formal complaints for NOTSS by month are displayed in the dashboard presented in Appendix 1.

NOTSS Division received the highest number of complaints (n=358) by a single division in 2014/15. Of the 358 complaints received, 183 were related to Appointments, Admission and Discharge (51%). The division recognises that learning from complaints is an important way of improving services for patients and as a result of the complaints received by NOTSS, the following actions have been implemented:

- Additional staffing to support Outpatient access and lead the multidisciplinary team.

- Six days a week operating at the Nuffield Orthopaedic Centre (NOC).
- Recruitment of Consultants, Nurses and Theatre staff underway at the NOC to support the six days a week operating.
- Full review of the Muscular Skeletal (MSK) Triage process telephone assessment undertaken, in conjunction with the Oxfordshire Clinical Commissioning Group, resulting in ceasing the telephone assessment element. All referrals are triaged appropriately once activated by the GP electronic referral.
- Weekly meetings between senior divisional staff and the Administration team to identify early on any issues around excessive waiting times for outpatient appointments, discharge letters and outpatient clinic letters.
- An additional £2.5M funding has been awarded to the Division to address the gap between demand and capacity around the Neurosciences services.

## 2. **Medicine Rehabilitation and Cardiology (MRC):**

The numbers of formal complaints for MRC by month are displayed in the dashboard presented in Appendix 1. The division received 200 formal during the year. The highest proportion of complaints (n=72, 36%) relates to Appointments, Admission and Discharge, with the second highest number of complaints received (n=71, 35.5%) relates to the Outcome of Surgical and Medical Care. The division recognises that learning from complaints is an important way of improving services for patients and as a result of the complaints received by MRC, the following actions have been implemented:

- Inform families that their relative's health is deteriorating, even if death is not imminent.
- Advise patients to deliver specimens to their GP.
- The principle and practice that inadequate pain relief is not acceptable.
- Explicitly increase the regularity of regular toileting support to improve the management of patients' continence needs.
- When Next of Kin is unknown, retrieve old medical records to establish if they exist.
- Patients are more likely to complain if they have to be readmitted the same day as discharge.
- Offer the patient a second clinical opinion.
- A review of communication processes. Sleep Clinic are trialling the recording of all messages received and details of actions taken in the Sleep Clinic.
- A review of the system for receiving referrals, sending appointments and general communication within Clinical Genetics.
- Replacing the process of faxing Therapy referrals with an electronic system, as well as introducing telephone confirmation on receipt of referrals.

### 3. Children's and Women's Division (C&W):

The numbers of formal complaints for C&W by month are displayed in the dashboard presented in Appendix 1. The division received 116 formal during the year. The highest number of complaints received (n=59, 51%) related to the Outcome of Surgical and Medical Care. The overarching themes related to communication with the patient/relative including consent discussions and during post-operative care. The Division recognised that this theme crosses a broad range of scenarios. In many cases, however, the complaint could have been avoided had more time and care been taken in the communication with the patient and/or their family. The Division also identified delays in assessment or treatment, resulting in either a poor clinical outcome and/or sub-optimal patient experience as a noticeable problem.

The division recognises that learning from complaints is an important way of improving services for patients and as a result of the complaints received by MRC, the following actions have been implemented:

- Additional midwives have undergone training to aid the discharge process.
- Reception staff have attended Conflict Management training.
- Protocol on correctly identifying patients has been introduced. This compliments the Trust's Identification policy).
- Additional training now provided for specialty doctors on miscarriage care.
- Information leaflet for parents to advise on safeguarding Children and Adults.

### 4. Surgery and Oncology:

The numbers of formal complaints for Surgery & Oncology by month are displayed are displayed in the dashboard presented in Appendix 1. The division received 181 formal complaints during the year. Of these complaints, 79 (43.6%) were related to the outcome of Surgical and Medical Care. The remaining complaints break down into the following themes with a key lesson for each theme outlined as part of the report:

- Communication: The need for clear and effective communication with regards to appointments and other queries. The action has been to ensure staff receive training on SOP for answering telephone calls and answer phone messages.
- Waiting times in outpatients: Staff keeping patients and families informed of clinic delays. The action has included use of VDU screens to provide waiting times, provide support staff to keep patients informed and use of handset devices to allow individuals to leave the department when there is a long wait.
- Patient Information: Ensure correct information is given out at right time and in an understandable way. The action has been a review of leaflets providing contemporary information to be reviewed as per required date.
- Transport: Engaging with providers and meeting with them regularly has resulted in a review transport complaints with providers, and supported learning from errors.

## 5. Clinical Support Services:

The numbers of formal complaints for CSS by month are displayed in the dashboard presented in Appendix 1. During 2015/15 85 formal complaints were received by the Division. Of these 29 formal complaints were related to Appointments, Admissions and Discharge (34%). The division recognises that learning from complaints is an important way of improving services for patients and as a result of the complaints received by NOTSS, the following actions have been implemented:

- A review of the Pain Relief Unit's administration staff was undertaken which has resulted in an increase in the number of appointments available, with improved contact details and options for patients.
- A service review of Radiology was undertaken which resulted in reception staff and Care Support Workers undertaking Customer Care training.
- Processes have been implemented to monitor and track the reporting of scans.
- Theatre staff now work with Operational Service Managers within different specialties to improve the planning and co-ordination of booking patients onto theatre lists.
- Actions have been put in place to ensure TTO's are written sooner in the discharge process.
- Clinical Pharmacy service has been reconfigured to allow Pharmacy staff to support and promote TTO process at ward level.

### Managing the performance of the Trust's complaints service

#### The number of complaints acknowledged within 3 working days:

The Trust's first agreed key performance indicator (KPI) states that 95% of all formal complaints should be acknowledged within three working days (either by telephone, email or letter). The compliance with this KPI is reported quarterly to Oxfordshire Clinical Commissioning Group (OCCG). The acknowledgement timescales are presented in Table 5 below:

**The acknowledgement timescales**

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
93	81	75	85	76	81	117	81	69	75	85	94
97%	99%	97%	97%	97%	100%	98%	98%	96%	99%	100%	100%

Table 5: Source OUH NHS Trust Complaints Management System

#### Percentage of complaints responded to within 25 working days (or agreed extension) by quarter:

The second KPI reported quarterly to OCCG requires the Trust to respond to 95% of all formal complaints within 25 working days (or an agreed extension with the complainant). The Trust met this KPI for the first three quarters of 2014/15 but not in the last quarter of 2014/15, and is presented in dashboard in Appendix 1 and Table

6, below. The main reason for not meeting the KPI in quarter 4 is a combination of delays in the Clinical Divisions returning their draft responses to the Complaints team in a timely manner, alongside staffing issues within the Complaints team. Further work will be undertaken with the Clinical Divisions to ensure this KPI is met consistently in 2015/16.

This will be further strengthened by the Complaints team agreeing to appropriate, more realistic timescales with complainants when planning and commencing the investigation process. In addition, the Complaints team will implement an internal KPI of one extension to the original deadline set to respond to the complaint. Complaints that are considered to be uncomplicated in nature will continue to be investigated and responded to within 25 working days. Any complaints that appear more complex, where there are multiple issues to be addressed, span more than one division or organisation, will be investigated and responded to over a longer timeframe such as 35 working days, in agreement with the complainant.

The Complaints team will negotiate with the divisions at an earlier juncture if divisions are unable to respond to the complaint within the required timeframe, so that a new timescale can be negotiated with the complainant. This will continue to be monitored quarterly by the PALS and Complaints Manager.

**Percentage of complaints responded to within 25 working days (or agreed extension) by quarter**

Quarter 1	Quarter 2	Quarter 3	Quarter 4
96.8%	97.1%	95.8%	92.3%

Table 6: Source OUH NHS Trust Complaints Management System

**Number of reopened formal complaints by Division:**

This performance indicator is to indicate the effectiveness of the management of complaints.

The dashboard within Appendix 1 presents the number of reopened complaints, for the year 2014/15. Work will be carried out in conjunction with the divisions and the Complaints team to examine the reasons surrounding reopened complaints, i.e. issues not being responded to appropriately initially, or the first response generating further questions rather than providing answers.

**Referral to Parliamentary and Health Service Ombudsman (PHSO) and outcome of their investigation:**

Seven formal complaints were referred to the PHSO in 2014/15. Of the seven complaints, four remain under investigation by the PHSO at the time of writing this report. Three were not upheld by the PHSO following their investigation.

All complainants receive information from the Trust regarding the PHSO. It is expected that more complaints will be investigated by the PHSO in the future, following recent announcements by the PHSO of their intention to investigate more complaints.

## KO41 (a) Annual Complaints submission and comparison

### The National Picture

The Health and Social Care Information Centre publish a national comparative report in relation to complaints<sup>3</sup>. The annual report was published on 26 August 2015; the annual format has been replaced by a quarterly submission from April 2015. The first report in this format will be published on 4 November 2015. The detail pertaining to the 2014/15 report is presented in Appendix 3.

The total number of all reported written complaints in 2014-15 was 205,000. This is the equivalent of more than 3,900 written complaints a week and equivalent to 562 per day.

The total number of all Hospital and Community Health Services (HCHS) written complaints has increased by 6,470 (5.7%) from 114,000 in 2013-14 to 121,000 in 2014-15.

By profession, complaints for *Trust Administrative staff* have seen an increase of 23.2% from 8,320 in 2013-14 to 10,300 in 2014-15.

The number of complaints for the subject area *appointments, delay/cancellation (outpatient)* has increased by 1,720 (19.1%) from 9,040 in 2013-14 to 10,800 in 2014-15.

The biggest proportion of HCHS written complaints by profession were for the *Medical profession* (which includes hospital doctors and surgeons) with 45.4% (54,900) of all HCHS written complaints. *Nursing, Midwifery and Health Visiting* accounted for the second biggest at 21.1% (25,400). For 2013-14 the proportions were 45.6% and 21.7% respectively.

44.1% (53,400) of all HCHS written complaints reported are for the subject area *all aspects of clinical treatment*. This is a slightly lower proportion than last year's figure of 45.6% (52,300).

The service area with the highest number of complaints was *inpatient hospital acute services*, with 34,600 (28.7%), an increase of 200 (0.6%) from 2013-14 (34,400).

By Area Team, Shropshire and Staffordshire has the lowest percentage of *Medical (including surgical)* written complaints at 36.5%, with Leicestershire and Lincolnshire having the highest at 78.4%.

Source: Health and Social Care Information Centre.

### Comparison and Benchmarking

The Trust was placed 17th highest across the country in terms of the number of complaints received. Please note this includes all health services and is not restricted to Acute Hospitals. The Trust was placed third highest when compared to the Shelford Group; with Imperial College London and Central Manchester NHS Foundation Trust placed first and second highest respectively. The Trust received

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<sup>3</sup> The national NHS Complaints Report. <http://www.hscic.gov.uk/catalogue/PUB18021/data-writ-comp-nhs-2014-2015-rep.pdf>

the highest number of complaints for Acute Hospital Trusts within the Thames Valley.

The Trust's complaints have increased by 12.8% compared with the national increase of 5.7%. This is higher than the national average by 7.1%. The Trust's clinical activity has increased by 5.45% for outpatient attendances and 3.86% for inpatient admissions.

This increase could be in part due to

- The national complaints reports published by Health Watch, the Parliamentary and Health Service Ombudsman and the Care Quality Commission in 2014. These reports have generated significant, important and much welcomed publicity
- The Trust's active promotion and publicising on how to make a complaint or compliment to patients, visitors and partners
- The difficulties experienced and reported by patients in relation to access and cancelled procedures; this has particularly been experienced within the Neurosciences, Orthopaedics, Trauma and Specialist Surgery Division (NOTSS), and most notably within Specialist Surgery Directorate. In addition, there have been noticeable access issues within the Urology Department. The increase in complaints does not solely pertain to these services.

The largest number of complaints related to outpatient services (n=514, 51%). This was contrary to the national trend although a similar trend was experienced within West Yorkshire, London, Leicestershire and Lincolnshire, Surrey and Sussex, and the Essex Area Teams. This is coupled with the Trust's complaints pertaining to appointments was 13.5% (n= 136) and significantly higher than the national average of 8.9%.

The number of complaints for inpatient services was lower than the national average (416, 41%). The Emergency Departments received 54 (5.3%) complaints. This was lower than the national average of 8.3%.

The number of complaints received by the Trust's Doctors was below the national average (Trust n=396, 39% compared to national 45.4%). This is significantly lower than the 2013/14 (n= 522, 59%). The number of complaints received by doctors nationally has remained broadly the same from the previous year.

The number of complaints received for the Trust's administrative staff was 216 (21%). This was higher than the national average at 8.5%. This could in part reflect the difficulties discussed earlier in relation to making an appointment or attempting to talk to a member of staff about an appointment.

The Trust's nurses received 176 (18%). This is below the national average of 21.1%. The number of complaints received by nurses nationally has reduced by 0.6%.

These proportions appear to be a more accurate reflection due to the introduction of Standard Operating Procedures for recording a complaint. This has ensured a consistent approach to all complaints.

The national average for complaints relating to clinical treatment was 44.1%. The Trust compared favourably with 37.2% (n=375). The national average for complaints relating to admission and discharge was 20.1% with the Trust receiving 14% (n=138) complaints expressing concerns of this nature. This does suggest that despite the



recent negative Health Watch report and continuing issues with delayed transfers of care, admission and discharge is less of a problem than elsewhere in the country. The number of complaints relating to attitude is similar to national figure of 11.4%, with the Trust was 11% (n= 108) complaints. Complaints surrounding written and verbal communication was higher than the national average at 11.3% (n= 114), whereas the national average was 10.3%.

### **Complaints about acute trusts 2014-15: Parliamentary and Health Service Ombudsman (PHSO)**

The *Complaints about acute trusts 2014-15* report provides a summary of the key statistics collected about the enquiries received and the investigations undertaken by the PHSO involving 144 acute trusts in England. This was published on 22 September 2015.

Eight out of ten of PHSO investigations are about the NHS in England; the rest are about UK government departments and other UK public organisations. Of those NHS complaints investigated, just under half relate to acute trusts, while the remainder are spread across GPs, mental health trusts, clinical commissioning groups, independent.

Source: *Complaints about acute trusts 2014-15*: Parliamentary and Health Service Ombudsman (PHSO)

It is important to note that although the Trust’s complaints are markedly higher than the national average, the number of complaints investigated and upheld by the PHSO is relatively low.

The PHSO received 21,371 enquiries about the NHS; of these 8853 related to acute Trusts, with 1853 referred for investigation and 1635 investigations were completed. The following seven reasons for complainants requesting a further investigation by the PHSO are presented in Figure 1, below:

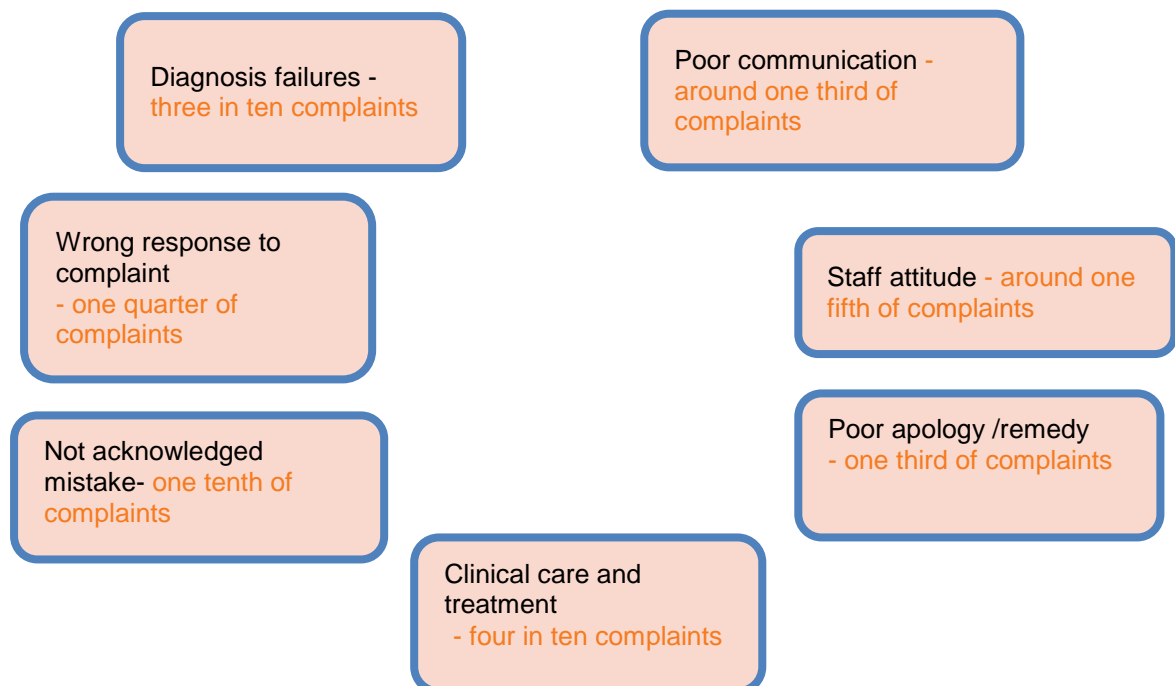


Fig. 1: Source: The *Complaints about acute trusts 2014-15*: Parliamentary and Health Service Ombudsman 22 September 2015

The PHSO received 78 enquiries regarding further investigating a complaint investigated by OUH. Of these 11 were accepted for investigation, with 5 (45.4%) either fully or partially upheld.

On average, the PHSO investigated 6.2 complaints for every 100,000 clinical episodes in each acute trust during 2014-15. The PHSO investigated a much lower number of 2.71 OUH complaints per 100,000 clinical episodes.

The Trust was the 5<sup>th</sup> highest in terms of clinical episodes; with Newcastle upon Tyne NHS Foundations Trust (495,000), Sheffield NHS Foundation Trust (490,000), Kings College London (475,000) University of Leicester NHS Trust (467,000), and Leeds Teaching Hospitals NHS Trust (407,000) undertaking more clinical activity. It is also important to note that the Trust was placed 17<sup>th</sup> in terms of receiving the highest number of complaints.

The Trust was the lowest in the Shelford Group; and nationally was placed 39<sup>th</sup> in terms of enquiries to the PHSO. The Trust was placed joint 3<sup>rd</sup> lowest in the Shelford Group and nationally joint 50<sup>th</sup> in terms of complaints upheld or partially upheld by the PHSO.

Therefore it can be determined that although the complaints received were higher than envisaged; and rose disproportionately to the increase in clinical episodes undertaken, the proportion of complaints compared to clinical activity was lower than initially expected when benchmarking with national peers.

This paints a positive picture in terms of the complaints investigation especially against a backdrop of an increase of the number of complaints investigated by the PHSO. It is also testimony to the investment, diligence and commitment by investigative clinicians, managers and the complaints team in resolving the complainants concerns as soon and comprehensively as possible.

## National Reports relating to Complaints

In 2014/15 five national reports were published in NHS complaints. These reports all identify the importance of sensitive, efficient, honest and accurate complaints co-ordination and investigation. Additionally, the reports highlight that complainants received by a Trust give an indication of patient safety and quality and its culture to embrace patient feedback and improve services as a result.

- ***Suffering in Silence: Health Watch England***

Suffering in Silence was published by Health Watch England on 14 October 2014. The report recognised the changes made by the NHS to reform complaints, however, described the reforms as slow, cumbersome and focused on minor adjustments as opposed to culture change. An overview of the problems encountered when complaining to NHS or social care organisations is given and the report shares personal stories to illustrate the concerns. The links to the full report and the executive summary are listed in the references. The report presented detailed recommendations, which are organised in following three headings.

- Make it easier to complain

- Ensure a compassionate response and resolution
- Hold to account those who fail to listen.
- **My expectations for raising concerns and complaint: Local Government Ombudsman, Health Watch England and the Parliamentary and Health Service Ombudsman**

The report, 'My expectations for raising concerns and complaints', was published by the Local Government Ombudsman, Health Watch England and the Parliamentary and Health Service Ombudsman on 18 November 2014. This report described that, although actions have been taken to improve the complaints system, there is a long way to go before people who use services, and those close to them, feel an improvement. The report describes a user led vision for raising complaints and concerns in the NHS and social care. This vision is presented as a diagram in Appendix 4.

- **Report on Complaints about Acute Trusts: The Parliamentary and Health Service Ombudsman (PHSO)**

The Parliamentary and Health Service Ombudsman (PHSO) report on complaints about Acute Trusts, and the review of Q1, Q2 nationally for 2014-15, published on 26 November 2014. This report was presented to the Trust Board by the Chief Nurse on 14 January 2015.

- **Complaints Matter: Care Quality Commission (CQC)**

The CQC published the Complaints Matter report on 8 December 2014. This report explores how both patient and staff complaints and concerns are handled across health and social care.

The early findings showed that it is crucial to improve the data available to present a more accurate picture of the state of complaints. CQC are planning to continue to work closely with partners so that everyone makes the shift to a listening culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.

CQC acknowledged that complaints handling is an excellent indicator of an open, transparent and learning culture expected in well-led organisations. Embedding complaints and concerns in CQC's regulatory model has two aims, which are presented in Chart 1, below. These aims mirror the Parliamentary and Health Service Ombudsman's report on Complaints about Acute Trusts published on 26 November 2014.



- **Complaints and Raising Concerns: The Parliamentary Health Select Committee**

The Health Select Committee published the Complaints and Raising Concerns report on 21 January 2015. This report provided a follow-up review of the handling of complaints and concerns in the NHS since the Committee's initial Complaints and Litigation inquiry in 2011.

The 2011 report examined the working of the NHS complaints system, the treatment of staff that raised concerns about NHS services, and the procedures in place to encourage NHS staff to raise concerns without fear of detriment.

The Complaints and Raising Concerns report examined progress in implementing the relevant recommendations made in the Committee's 2011 report and Government response. The Committee recommended that:

- The complaints system be simplified and streamlined by establishing a single complaints gateway across the NHS, for both providers and commissioners. This streamlined process needs to be "adequately resourced"
- Trusts must remain the leads in handling complaints made against their organisation. There is, however, a greater role for commissioners to work constructively with providers on delivering improvements to services and to hold providers to account for delivering a well-functioning complaints system. CQC should remain responsible for examining the culture of complaints handling by providers.
- To meet the Francis recommendation that Trusts be assessed on how well they are handling complaints, Trusts should be required to publish at least quarterly, in anonymised summary form, details of complaints made against the Trust, how the complaints have been handled and what the Trust has learnt from them
- The service-user led vision for complaints, 'My expectations for raising concerns and complaints', developed by the Parliamentary and Health Services Ombudsman in co-operation with system partners and stakeholders, was praised as best practice for first tier complaints handling.
- There should be clear commissioning and consistent branding of PALS and NHS Advocacy services, to make them as visible and effective as possible to any patient seeking assistance through the complaints process.
- The Government should complete a progress report on the functioning, funding and budgets of local Health watch organisations. This is due to concerns regarding the lack of ring-fencing of the funding provided for their use.
- Reform of the primary care complaints system, currently centralised by NHS England.
- The Committee agreed with the GMC that people wishing to give information about poor practice should be able to do so anonymously. It was envisaged

that the GMC's 'Hooper Review' would ensure that its practices and investigations adequately support registrants who genuinely raise patient safety concerns in the public interest, and protect them from retaliatory action.

- "Essential" progress towards linking together professional regulation, system regulation and the complaints system should be monitored by the successor Committee in the next Parliament.
- Establishment of a single health and social care ombudsman, as a first step towards the integration of social care complaints into a single complaints system.

- ***The PHSO reported a review of 150 previously investigated complaints on 7 February 2015***

The review included both previously upheld and not upheld cases. It looked at the quality of NHS Acute Trusts' investigations into

- Complaints alleging avoidable harm
- Complaints about events where a Serious Incident Requiring Investigation (SIRI) had taken place.

The Department of Health states where a serious incident is alleged in a complaint it must initially be treated in the same manner as a serious incident.

The PHSO concluded 3,189 investigations about the NHS in 2014, which included 333 allegations of avoidable death. Of these complaints, 150 were reviewed which demonstrated issues of serious avoidable harm or death. The PHSO upheld or partially upheld 88 complaints and did not uphold 61. The remaining complaint was discontinued by the complainant.

The key lines of enquiry included:

- Did the original investigation have access to all the relevant clinical records?
- Were written statements obtained and key staff interviewed?
- Was an independent clinical review obtained?

The PHSO main findings were:

- 28 of the 150 cases were sufficiently serious to justify an investigation as a Serious Incident Requiring Investigation (SIRI). Of those 28 cases, 20 complaints did not trigger an SIRI investigation
- There was significant variation in the quality of NHS investigations. Investigations weren't carried out when they should have been and when they were carried out, they did not find out or explain why failings happened.
- 40% (n=60) of the NHS' investigations were inadequate and didn't identify the occurrence of serious avoidable harm.
- One of the two Trust's complaints, investigated and upheld by the PHSO in 2014, was anonymously featured in this press release. The complaint was in relation to the care a mother and her baby received during labour and the subsequent complaints investigation.

- The PHSO has recently announced that it will be publishing case summaries to describe its role in the complaints process and to highlight patient and families experience of NHS services.
- The Ombudsman is appearing before the Public Administration Select Committee (PASC) on Tuesday 10 February. The Committee is examining the effectiveness of investigating and addressing safety issues within the NHS and the possible benefits of a new clinical accident investigation body.

CQC and Monitor regard the type of complaints received by an NHS Trust and its response as an indication of the organisation's approach to quality, safety and patient engagement. This inspired the Trust to review and benchmark its complaints practice to ensure a humane and thorough complaints service.

## **Learning, improvements and looking forward to 2015/16**

Following the publication of aforementioned reports, the Complaints team reviewed the Trust's complaints process and benchmarked against other Acute NHS Trusts, both from the Shelford Group and the national NHS Complaints network. The following activity was implemented as a result.

- The Trust's Management Executive approved the review, algorithm and new risk grading approach. The Complaints Policy to accompany the detailed algorithm will be reviewed by the Trust's Policy Group using the Trust's governance procedures.
- The Trust introduced new guidance for resolution letters which reflected the strength of feeling and recommendations made in the five reports.
- The Trust is also undertaking a complainant satisfaction survey in collaboration with the NHS Benchmarking Team and the Patients' Association. This survey asks 19 questions which are similar in format to the Health Watch and '5 steps to making a complaint' presented in Appendix 3.
- The Trust has delivered two training programmes and will be delivering a further training course later this year.
- The Trust will be delivering mediation training for senior managers and clinical leaders in September and October of this year.
- The PALS team instigated an improved level of escalation when managing inpatient complaints that require a formal process, which has been well received by both internal colleagues and service users. This process will be further implemented to address outpatient queries during 2015/16 to ensure these are dealt with as quickly and efficiently as possible
- The Trust will record all complaints received against the newly designed subjects/sub-subject codes introduced by the Department of Health for all NHS Trusts. This will ensure that more targeted analysis can be achieved with all complaints recorded and allow Divisions to focus on the trends that arise to ensure actions can be appropriately formulated.

## Areas of required improvement

- Learning from complaints and positive action to reform healthcare both for individuals and at service level, for example access to ENT phones, cancelled surgery.
- Demonstration of cross organisational learning between services.
- The Trust's assurance in relation to all aspects and stages of the complaints process needs to be more robust.

## Looking forward to 2015/16

Bespoke training has been commissioned to take place in September and October 2015 to equip staff with the most appropriate way of co-ordinating a resolution meeting with complainants. This will be opened to all staff within Complaints and PALS, as well as Divisional representatives.

A pilot scheme will be looked at to provide complainants who have been through the process to feed back their experience to one of the Trust's Non-Executive Directors. This will allow the Trust to review the process, and make changes as required.

The PALS and Complaints team will continue to build expertise in data analysis that improves insights into complaints, and reinforce the strong working partnerships with divisional staff throughout the Trust. The aim is to ensure a seamless and efficient way of resolving issues for patients and their relatives, in a timely and compassionate manner.

The PALS and Complaints Team will implement and produce the divisional level dashboards on a quarterly basis. Thus enabling the divisions to review and analyse directorate level complaints and PALS queries in more detail. In addition the PALS and Complaints Team will implement action logs to enable the divisions to monitor and report the resulting actions within the Divisional Quality Reports.

The PALS and Complaints policies will be completed and presented to Quality Committee and Trust Board during the autumn.

## Conclusion

This annual report has provided a summary of formal patient complaints and PALS contacts received in 2014/15. This has included details of the numbers of formal complaints and PALS contacts received during the financial year and compliance performance in responding to complaints.

In addition, this report has presented the Trust's improvements to both the complaints service and the PALS team as a result of national guidance and local feedback.

The report demonstrates the significance the Trust places on the feedback it receives from patients and their families through PALS and/or complaints, and demonstrates how this feedback assists in shaping the services in the future.

The Trust has embraced the learning and recommendations within the key national reports to develop a responsive and humane complaints service.

**Catherine Stoddart**

**Chief Nurse**

Authors:

Katie Harris, PALS and Complaints Manager

Caroline Heason, Head of Patient Experience

14 October 2015



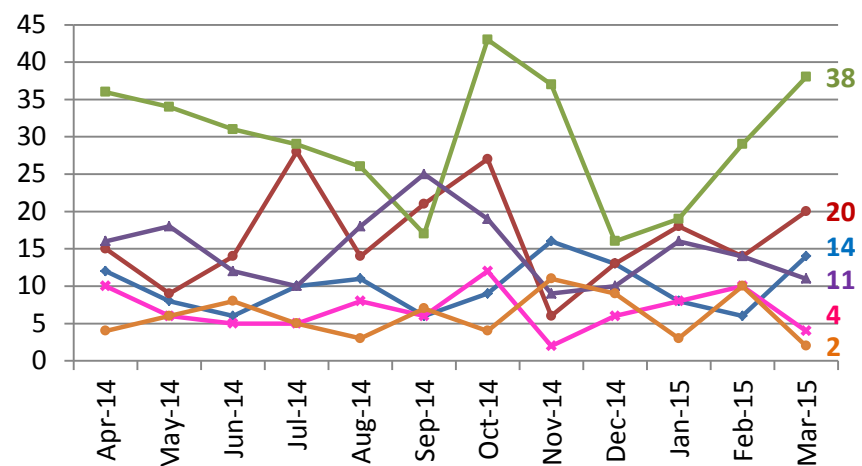
## **Appendix 1: PALS and Complaints Dashboard for 2014/15**

Please refer to the attached sheet.

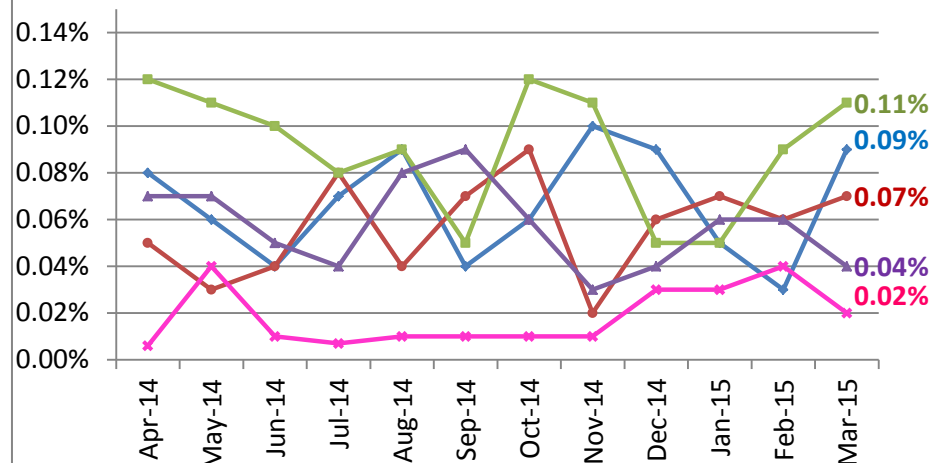
**Complaints** C&W MRC NOTSS S&O CSS Corporate Trust

**New complaints**

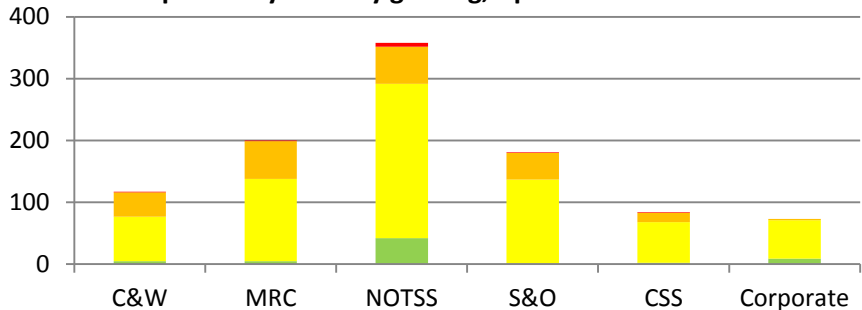
**New Complaints Opened**



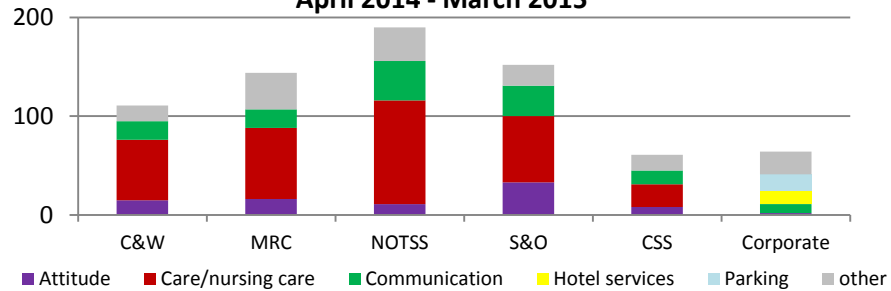
**% Complaints against Finished Consultant Episodes (FCE)**



**Complaints by severity grading, April 2014 - March 2015**

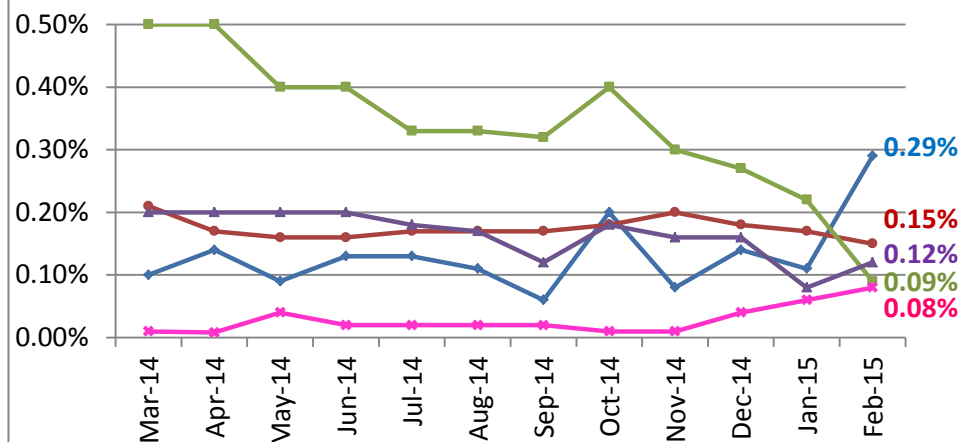


**Top complaints themes by division April 2014 - March 2015**



**New PALS enquiries**

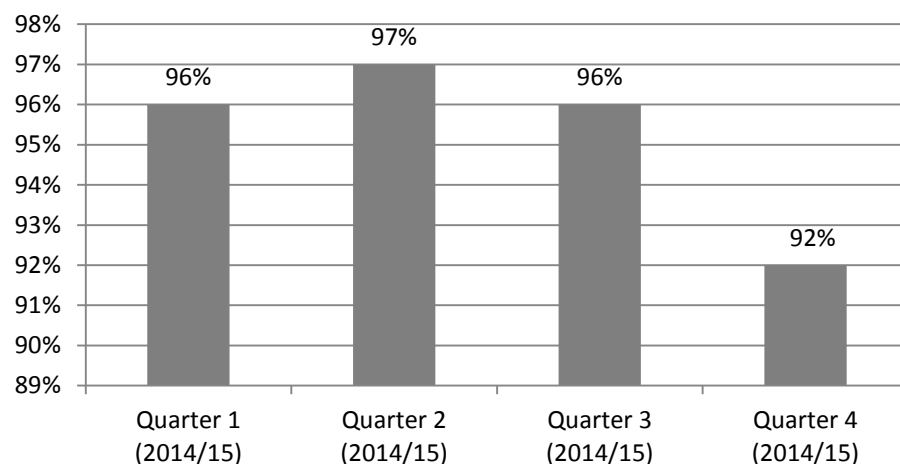
**% PALS against FCE**



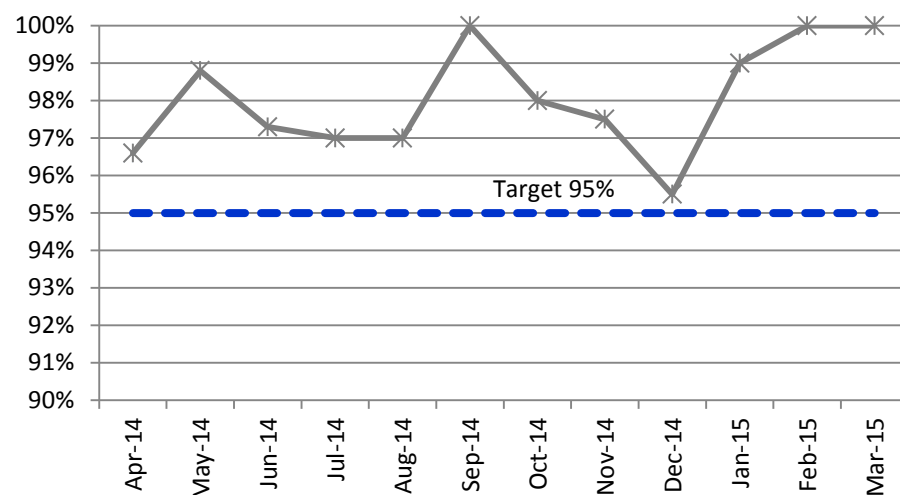
This includes all PALS enquiries and issues: positive, negative, or mixed feedback; issues for resolution; and advice or information requests.

**Managing complaints**

**% complaints investigations completed within agreed timescales**

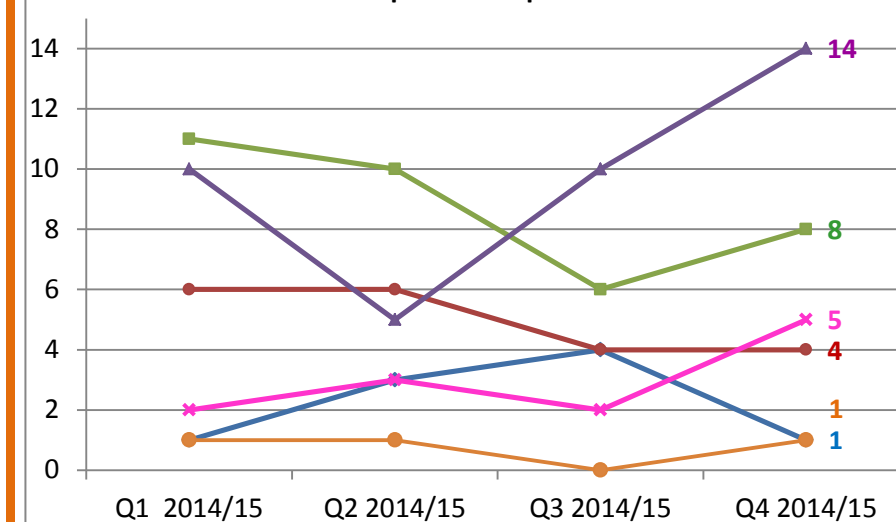


**% complaints acknowledged within 3 days**

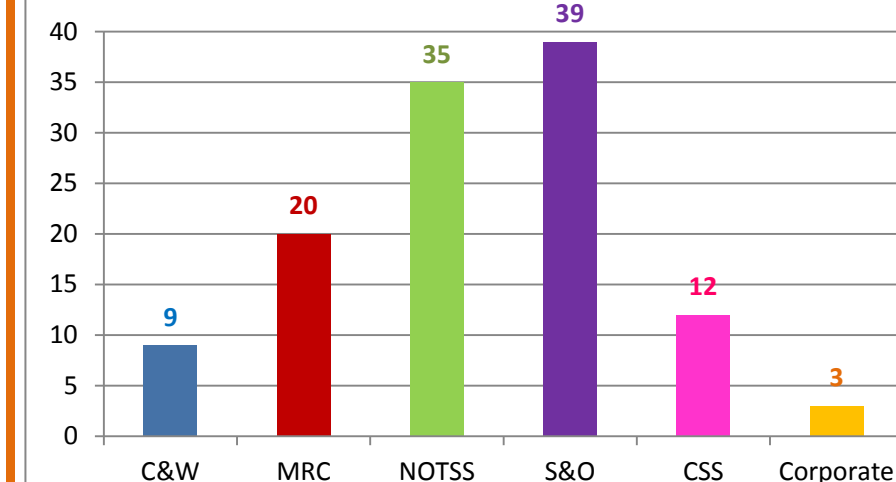


**Closed complaints**

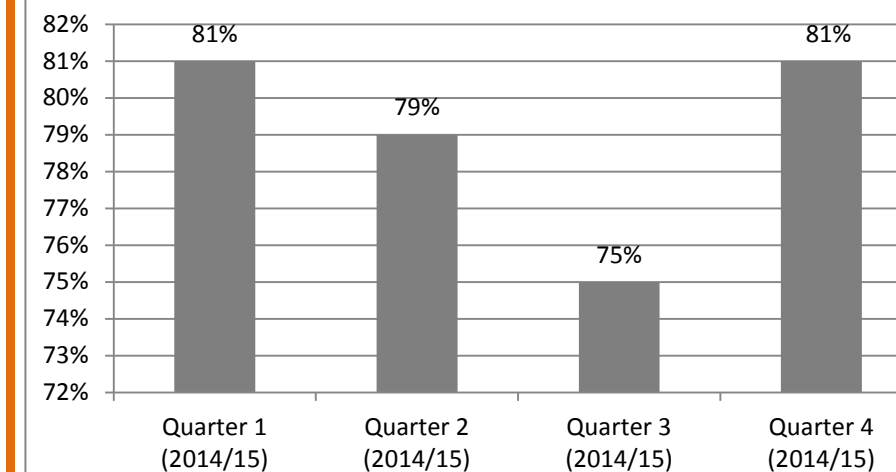
**Reopened complaints**



**Reopened complaints: 2014/2015**



**% Complaints upheld or partially upheld**





## Appendix 2

### Complaints relating to Appointments, Admission and Discharge

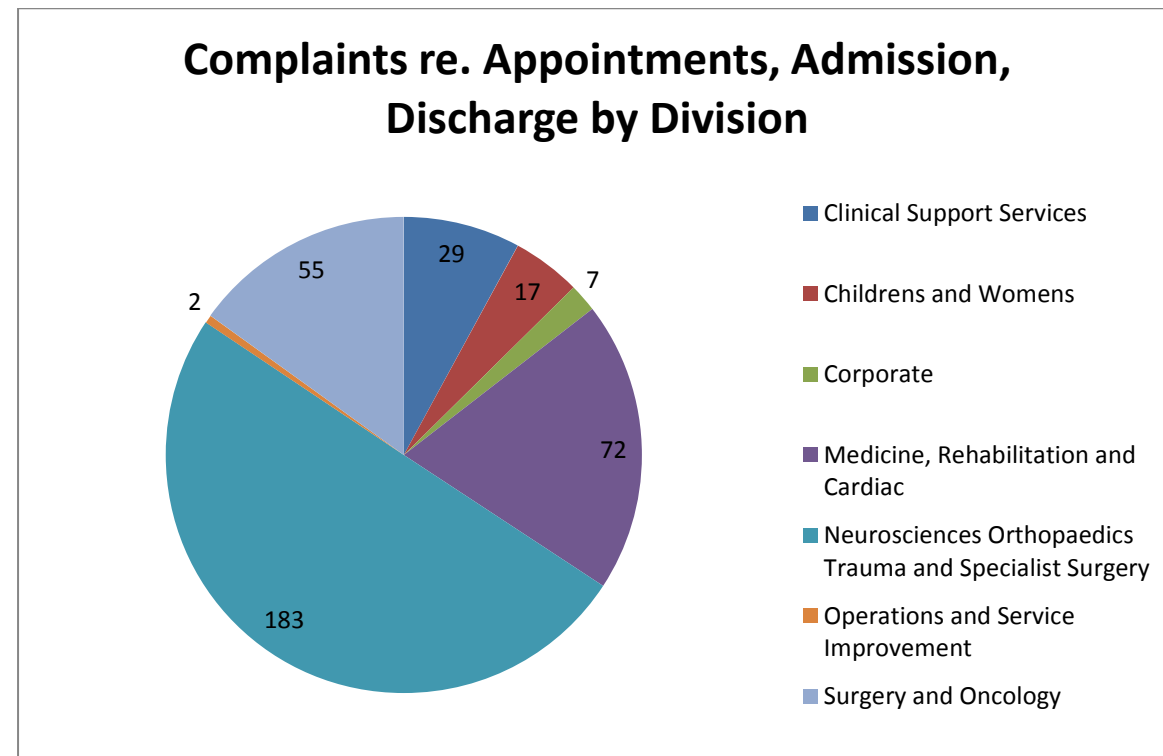


Chart 1: Source OUH NHS Trust Complaints Management System

### Complaints relating to Communication, Information and Consent

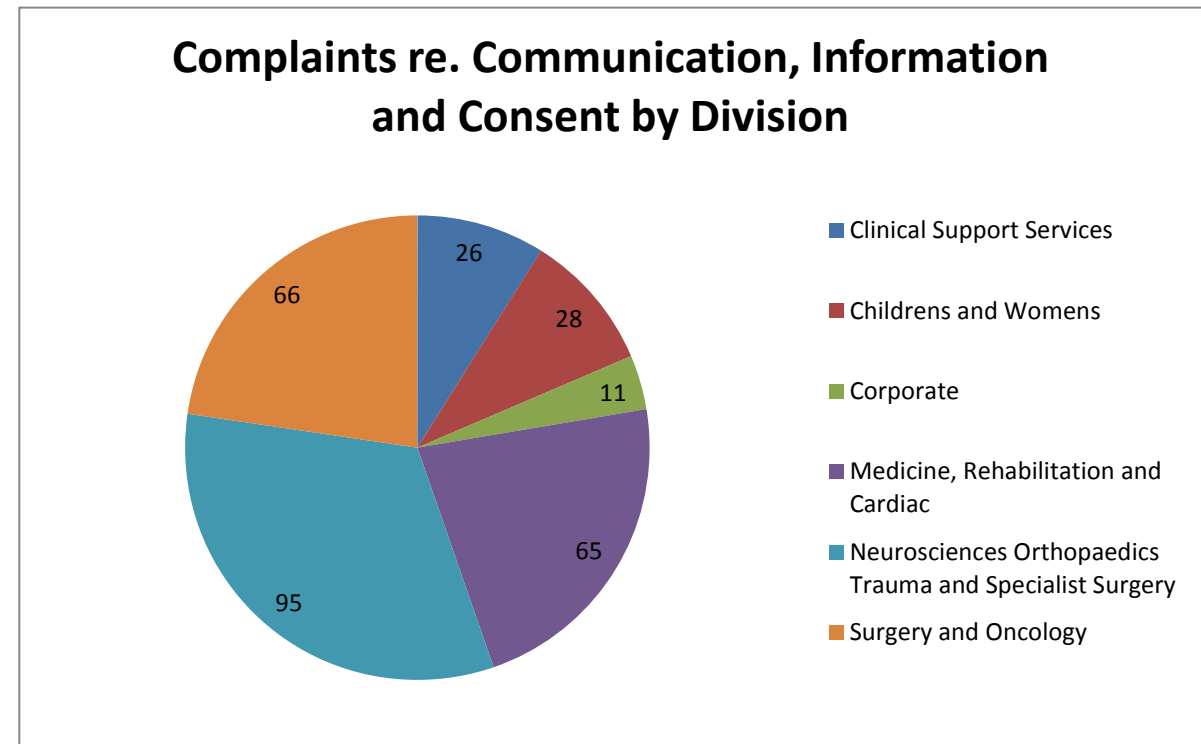


Chart 2: Source OUH NHS Trust Complaints Management System

### Complaints relating to Outcome of Surgical/medical care

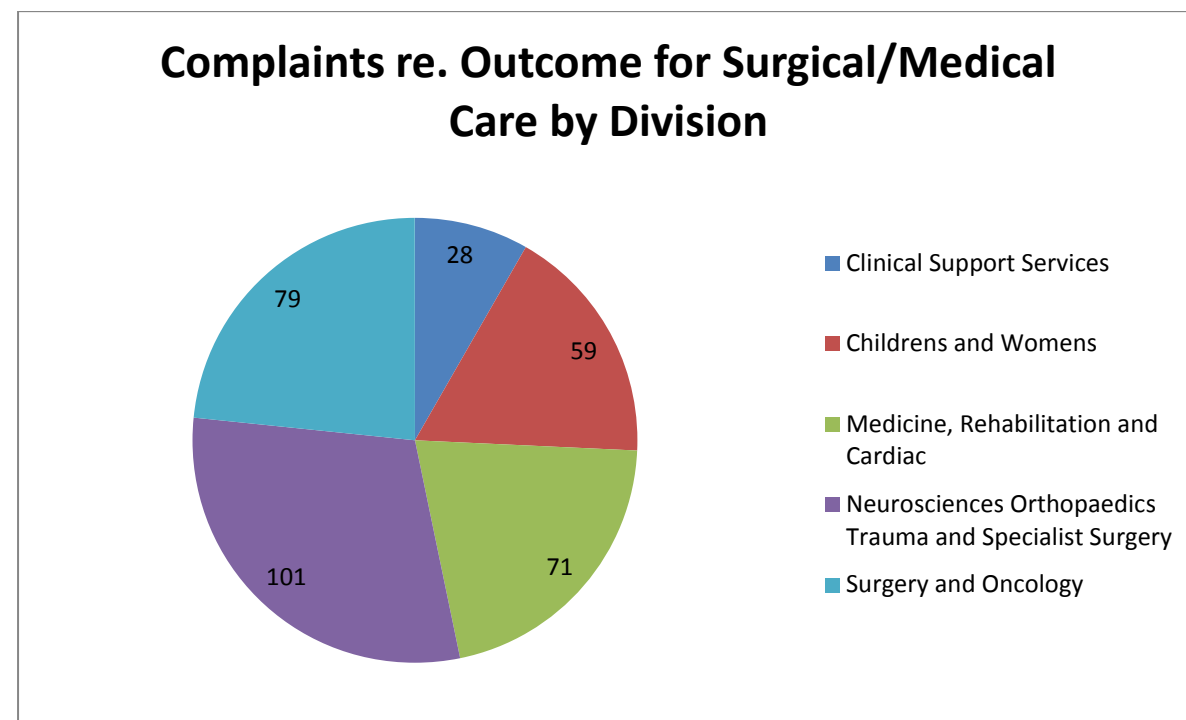


Chart 3: Source OUH NHS Trust Complaints Management System

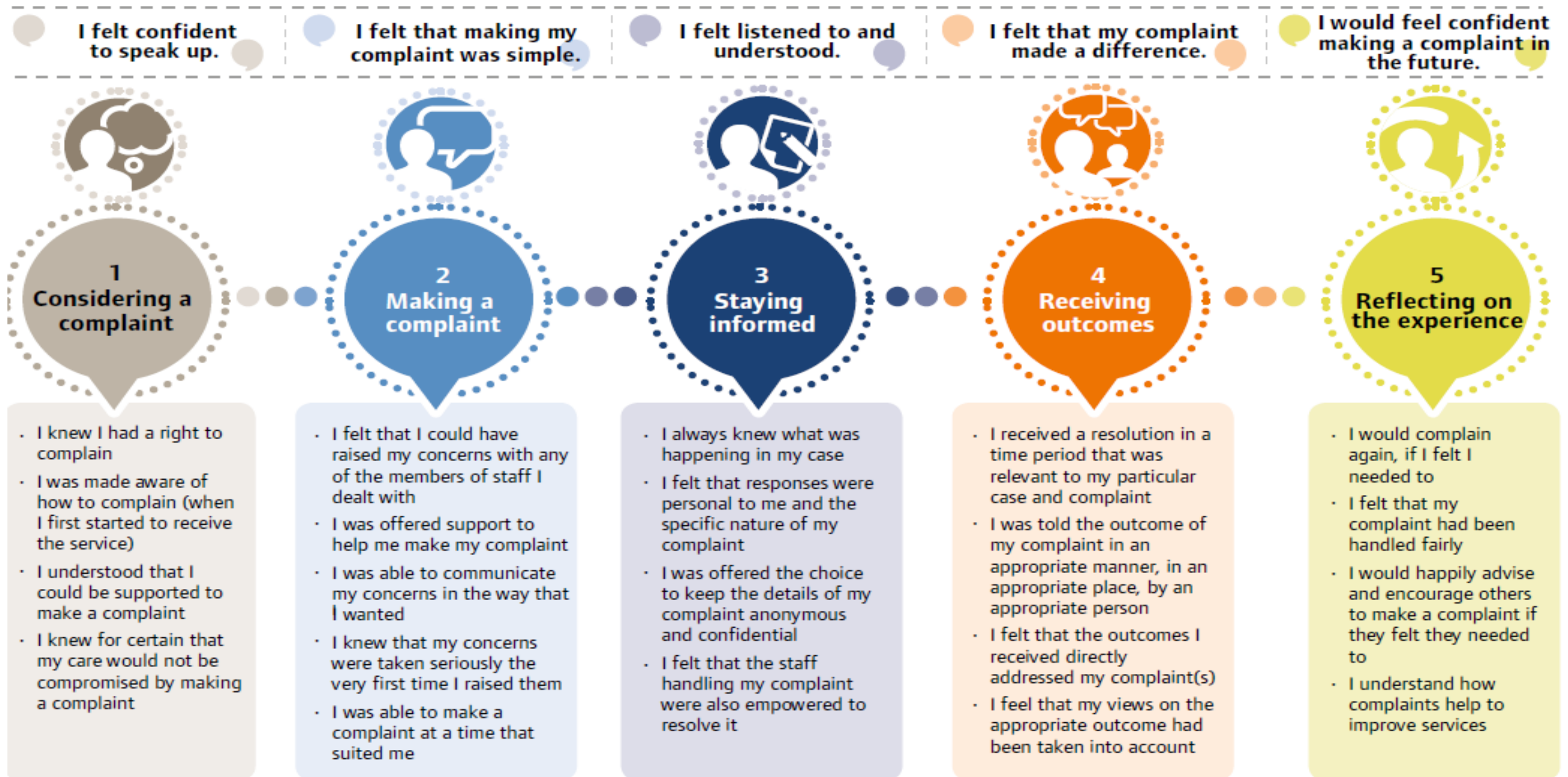
Examples of issues relating to **appointments, admission or discharge** include cancellation of appointment / operation, difficulties following discharge, long wait in clinic, delayed referral to specialist

Examples of issues relating to **communication, information or Consent** include communication failure, lack of information (patients/relatives), difficulty contacting department, delayed correspondence

Examples of issues relating to the **outcome of surgical or medical Care** include infection linked to surgery or treatment, poor outcome of surgery or treatment, clinical treatment inadequate/insufficient

### Appendix 3

**My expectations for raising concerns and complaint:** Local Government Ombudsman, Health Watch England and the Parliamentary and Health Service Ombudsman. The report sets out the five steps for what good looks like for people raising a complaint or concern. This is presented below.



## Appendix 4: The KO41a results

### 1. Complaints by service area.

	NHS service areas	Total number of complaints received	Total number of complaints upheld
1	Hospital acute services: Inpatient	416	304
2	Hospital acute services: Outpatient	514	378
3	Hospital acute services: A&E	54	34
4	Elderly (geriatric) services	2	2
5	Mental health services	0	0
6	Maternity services	20	19
7	Ambulance services	0	0
8	Community hospital services	3	3
9	NHS Direct	0	0
10	Walk in centres	0	0
11	Other community health services	0	0
12	CCG commissioning	0	0
13	Other	0	0
	<b>TOTAL</b>	<b>1009</b>	<b>740</b>

## 2. Complaints by Profession

	Profession	Total number of complaints received	Total number of complaints upheld
1	Medical (including surgical)	396	268
2	Dental (including surgical)	13	7
3	Professions supplementary to medicine	26	20
4	Nursing, Midwifery and Health Visiting	176	144
5	Scientific, Technical and Professional	13	10
6	Ambulance crews (including paramedics)	2	2
7	Maintenance and Ancillary staff	37	19
8	CCG Administrative staff/members (exe GP admin)	10	8
9	Trust administrative staff/members	216	172
10	Other	120	90
	<b>TOTAL</b>	<b>1009</b>	<b>740</b>

## 3. Complaints by category

	Category	Total number of complaints received	Total number of complaints upheld
1	Admissions, discharge and transfer arrangements	138	86
2	Aids and appliances, equipment, premises (including access)	20	12
3	Appointments, delay/cancellation (outpatient)	136	115
4	Appointments, delay/cancellation (inpatient)	51	43
5	Length of time waiting for a response, or to be seen: NHS Direct	2	2
6	Length of time waiting for a response, or to be seen: Walk in centres	1	0
7	Attitude of staff	108	78
8	All aspects of clinical treatment	375	270
9	Communication/information to patients (written and oral)	114	96
10	Consent to treatment	3	3
11	Complaints handling	2	0
12	Patients privacy and dignity	4	2
13	Patients property and expenses	10	6
14	CCG commissioning (including waiting lists)	2	0
15	Independent sector services commissioned by CCGs	0	0



	<b>Category</b>	<b>Total number of complaints received</b>	<b>Total number of complaints upheld</b>
16	Independent sector services commissioned by trusts	0	0
17	Personal records (including medical and/or complaints)	6	5
18	Failure to follow agreed procedures	6	6
19	Patient's status, discrimination (e.g. racial, gender, age)	2	1
20	Mortuary and post mortem arrangement	0	0
21	Transport (ambulances and other)	3	1
22	Policy and commercial decisions of trusts	8	2
23	Code of openness - complaints	0	0
24	Hotels services (including food)	15	12
25	Other	3	0
	<b>TOTAL</b>	<b>1009</b>	<b>740</b>