South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

Board of Directors	Agenda Item 11.5	Enc N

Document Title:	Annual Report and Thematic Review of the Service Relations and Patient Advice and Liaison Service 2012/13
Sponsoring Director:	Neil Brimblecombe, Chief Operating Officer/Director of Nursing
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Date of Meeting:	Thursday 31st October 2013

Executive Summary

- The aim of this fourth Thematic Review Report is to outline national guidance, the work that has been undertaken during 2012/13, including statistical information, and to identify priorities for future work. It was presented to the Quality Governance Committee on 10th October 2013.

- The aim of the report is to:
  - ensure that the Board of Directors is briefed on impacts of relevant legislation and national guidance surrounding complaints and PALS
  - provide an annual report on key statistical information
  - produce an action plan for 2013/14 and an update on the actions from the year under review

- The Trust adheres to the statutory instrument 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public. This report provides an overview of the Trust's Patient Advice and Liaison Service (PALS) and complaint activity between the 1st April 2012 and the 31st March 2013.

- The Trust recorded a decrease in the number of contacts made to PALS and an increase in the number of formal complaints received during 2012/13. The Trust considers all of these contacts to be valuable opportunities to receive feedback from service users and carers, contributing to a culture of continuous improvement

- Following the publication in February 2013 of the Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, chaired by Sir Robert Francis (Referred to hereafter as the Francis Report); there has been a renewed focus on both raising and responding to concerns. However, an increase in the number of formal complaints or contacts with the PALS team has not been evident within the Trust.

- The PALS department responded to 1282 contacts during the last financial year, a decrease of 5.6% compared to 2011/12. In the vast majority of contacts PALS, in liaison with the Divisions, were able to provide a timely and proportionate resolution to the enquirers query or concerns.

- During 2012/13, 151 complaints were received by the Trust representing an increase of 18 (13.5%) from the previous year.

- 94% of formal complaints received during 2012/13 were acknowledged within the required statutory timescale and 98% were responded to within the timescale agreed with the complainant.

- Complaint themes have remained consistent over the year, however concerns relating to staff attitude in complaints have increased on last year's figure by 144% although there was a decrease in this category in PALS concerns by 8.8% over the same period.

- Mental Health (Staffordshire) received the highest number of PALS concerns during 2012/13, but also had the highest number of compliments.

- Quarterly reports have been provided to Divisions to ensure consistent reporting and sharing of thematic learning across the Trust. In line with our contractual obligations this information is also shared with commissioners.

- The PHSO has indicated that the threshold for investigating concerns will reduce following recommendations by the Francis Report and the Trust anticipates a greater involvement of the PHSO in following up cases in the future.

- The Trust can demonstrate a number of noteworthy improvements developed from learning identified from complaint investigations.

- It has been identified that behavioural and cultural change will support the enhancement of quality and service improvements which will address and reduce a wide range of issues which lead to complaints and PALS concerns being raised by service users and carers and will be key focus for action into to the future. **The overarching aim will be to turn data into intelligence and act on it.**

- This report provides information for planned improvements to the complaints process for the year 2013/2014 and also sets out the progress made by both the Divisions and the PALS and complaints team. Both work in partnership to meet the needs of patients and their families to ensure that complaints are used to improve services and where possible ensure that lessons are learned once and once only.

Recommendations

The Quality Governance Committee is asked to:

- Receive and approve the document for submission to the Board of Directors
- Agree the recommendations for 2013/14

Monitoring	✓	Details
Care Quality Commission Compliance	✓	Regulation 19, Outcome 17: People and those acting on their behalf, have their comments and complaints listened to and acted on effectively and know that they will not be discriminated against for making a complaint
Monitor Compliance		
Other (add details)		

Assurance	Ref	Details
Risk Register		N/A
Assurance Framework	✓	Ref:QHS10,
Link to Strategic Aims	✓	Ref: 1, 2, 3, 4, 6
Board Sub Committee	Quality Governance Committee (10th October 2013)	

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Annual Report and Thematic Review of The Service Relations and Patient Advice and Liaison Service 2012/13

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1 Introduction

The Trust adheres to the statutory instrument 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public. This report provides an overview of the Trust's Patient Advice and Liaison Service (PALS) and complaint activity between the 1st April 2012 and the 31st March 2013.

The 2013 Francis Report on the inquiry into the failings in Mid Staffordshire hospitals uncovered shocking standards of basic clinical care and management. But it also highlighted serious failures with the complaints process and the performance of the Trust Board. The report said: 'It [the Board] did not listen sufficiently to its patients or its staff or ensure the correction of deficiencies brought to the Trust's attention …' .

> *'A poor complaints system has a negative impact on the patients and others who seek to use it. Inadequate responses cause distress and may exacerbate bereavement.'*
>
> *From the final report of the Mid Staffordshire NHS Foundation Trust Inquiry (6 February 2013), chaired by Robert Francis QC.*

1.1 National Guidance and Reports:

The Parliamentary and Health Service Ombudsman (PHSO) had produced three important reports in recent months:

1.2.1 Mid Staffordshire NHS Foundation Trust Public Enquiry (The Francis Report)[1]

In March 2013, a review of the recommendations of the report specific to complaints handling, was undertaken and evidence gathered to support compliance against the recommendations and to highlight any action which required to be taken. This was collated into a report for assurance purposes and is replicated at appendix 1. Outstanding actions from this work has been built into the action plan for 2013/14.

1.2.2 NHS Governance of Complaints Handling (June 2013)[2]

The report on NHS Governance of Complaints Handling (June 2013) outlines research carried out on behalf of the PHSO by IFF Research with the following objectives:

- To what extent do Trusts empower patients to make complaints?
- To what extent are Boards involved in complaints handling?
- What does current practice look like?
- Do Boards use complaints information to drive service improvements; and is Board level learning from complaints shared?
- How can Boards improve their use of complaints information; and what does best practice look like?

The key findings from the report were:

[1] http://www.midstaffspublicinquiry.com/report
[2] http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/20897/PHSO-IFF-Governance-of-Complaints-Handling-research-UNDER-EMBARGO-5-JUNE-0001.pdf

- For nearly all Trusts, the complaints process is driven by a defined core purpose, is supported by Board level engagement, and has resulted in service improvements in the past 12 months.
- This does not, however, translate into high levels of perceived effectiveness: almost nine out of ten explicitly say there is room for improvement (11 percent rate the way information is currently used as very or fairly *ineffective*, 75 percent say it is fairly *effective*, only 15per cent very *effective*).
- Key concerns include Trusts' current ability to use complaints information to identify and mitigate against risks (nearly a fifth of respondents feel this is ineffective currently).
- There are several practices associated with greater perceived effectiveness in identifying risks early: Board use of patient stories and individual case reports; Board members inviting feedback during walkarounds; support for staff subject to complaints; and comments cards/boxes on Trust premises. These are, however, not all consistently in use.
- Standardised templates for reviewing complaints information, systems to review satisfaction with complaints handling and measures to test the effectiveness of complaints procedures are not consistently in place –and even where these are in place, there is little evidence of consistent approaches across the sector.
- There is a concern that Trusts are dealing with complaints information in isolation: nearly half of respondents feel they cannot effectively benchmark; nearly half do not share complaints learning externally; and over four in five believe that sharing of complaints information between Trusts is ineffective.
- Lack of sharing may curtail effectiveness: those who share learning from complaints externally as well as internally are significantly more likely to rate their use of complaints information as 'very effective'.
- Improved timeliness of sharing information, improved data quality and detail, and addressing defensive organisational cultures are also perceived to be key to improving effectiveness.

This thematic review demonstrates that the Board can gain reasonable assurance that the Trust has in recent years made significant progress towards addressing many of the issues highlighted within this report and that overall complaints handling within the Trust is robust, effective and focused on learning and improvement. Further areas identified for improvement during 2013/14 are reflected in the action plan at appendix 1.

1.2.3 The NHS hospital complaints system - A case for urgent treatment? (April 2013)[3]

This report provides a summary of the PHSO's description of the patient experience journey through the complaints process based on their experience and the reasons they have recorded for complaints about NHS hospital complaint handling during 2012/13. The report illustrates that the top five things that people complain to them about are;

Poor explanation (19%)
No acknowledgement of mistakes (18%)
Inadequate financial remedy (9%)
Inadequate systemic remedy (7%)
Unnecessary delays (7%)

[3] http://www.ombudsman.org.uk/__data/assets/pdf_file/0018/20682/The-NHS-hospital-complaints-system.-A-case-for-urgent-treatment-report_FINAL.pdf

The report also calls for changes “from ward level to Board level” in the areas of governance, records, accountability, standards and practice.

- **Governance:** If complaints are to have an impact, this needs to be led at board level. Hospital boards need to understand what good practice looks like and identify the levers that will drive good practice into the organisational culture. They also need to appreciate the perspectives of staff, patients and their families. The questions boards should be asking are not simply about the number of complaints. They should be considering the subject matter of complaints and listening to patients’ stories. They should be checking the necessary actions are taken to resolve issues. The leadership role of chief executives should include overseeing complaints, ensuring the quality of responses and being open and honest about learning from mistakes.

- **Records:** Keeping accurate records is essential in order to learn from the volume and nature of complaints and people’s experiences of complaining. Records will enable benchmarking against other organisations. If this happens then governors, staff and patients can be told what has changed and improvements can be monitored.

- **Accountability:** Accountability for complaints must run from ward level to board level. There should be clarity around who is responsible for listening and putting things right from ward to board level. Trusts should make their complaint handling an integral part of how they report progress to patients, their carers and families, governors, commissioners and regulators. Only by making complaints everyone’s business can we make progress.

- **Standards:** The PHSO’s Principles of Good Complaint Handling include being customer focused, being open and accountable, acting fairly and proportionately, seeking continuous improvement and, above all, putting things right. These principles are the criteria the PHSO use to assess whether something has gone wrong. They should be just the starting point for any complaints process. Setting clear expectations of complaint handling across the organisation and measuring performance against them is essential.

- **Practice:** Dealing with issues as they arise is best for the patient and the hospital. There are areas of practice where our analysis of complaints points to room for improvement. Hospitals need to ensure staff at all levels have the skills to listen to patients, learn from them and put things right. They need the confidence and humility to say ‘sorry’ in a meaningful way and nurture a culture of openness at all levels. This needs to extend from reception and administrative staff, to doctors and nurses, to chief executives and non-executive directors. Accreditation for complaint handlers could help drive up the quality of practice.

The findings and recommendations of this report is also reflected in the action plan to identify and address areas for action and improvement during 2013/14.

1.2.4 Designing good together: transforming hospital complaint handling (August 2013)[4]

The third piece of research produced by the PHSO emerged from a collaborative two-day workshop on 31 May 2013 and 1 June 2013 with patients, families, staff and experts to consider what good complaint handling would look like in the NHS. Within this overarching aim, the research had the following objectives:

- to understand views of the current complaints system, including strengths and weaknesses, amongst patients and carers, complainants and NHS staff; and
- to develop a model of good complaint handling that reflects the differing needs of these groups, who share an interest in hospitals delivering excellent service and standards

Whilst this report was wholly hospital (in-patient) focused the report contains some useful recommendations against each of the four main themes:

- Towards and open culture of feedback and improvement
- A focus on putting things right on the ward
- From deferential to collaborative approaches to care and complaining
- Standardise entry points and branding across all Trusts.

The findings and recommendations of this report is also reflected in the action plan to identify and address areas for action and improvement during 2013/145.

2. Complaints and PALS

In reporting on the annual statistics for both complaints and PALS for 2012/13, it is important to reflect on research findings, which demand caution in translating data into intelligence. Highlighted as a major challenge to achieving goals relating to quality and safety was that of ensuring that high quality intelligence was available to organisations, boards, teams, and individuals about how well they were doing and where the deficits and risks in organisational systems lay. NHS organisations studied typically used a combination of routinely collected data, specific data collection initiatives and the degree to which data collection efforts translated into actionable knowledge, and then into effective organisational responses was hugely variable between organisations.[5]

In particular, the research highlights the importance of data gathering to support the principle of 'problem-sensing' or actively seeking out weaknesses in organisational systems compared with comfort-seeking behaviours which are defined as being focused on external impression management and seeking reassurance that all was well. In this respect it is important to apply "problem sensing" through a focus on multiple sources of data including softer intelligence to provide fresh, more penetrating insights to complement the quantitative data provided in this report. The Board has access to these data sources through other thematic reviews, patient stories, reports on essential standards visits and the monthly Trust Assurance Report. A further report is scheduled for presentation to the Board in October or November 2013, commissioned from Engaging Communities Staffordshire, which will aim to put the data presented below into some additional context and improve the ability of the Trust,

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[4] http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/22013/Designing_good_together_transforming_hospital_complaints_handling.pdf

[5] Dixon-Woods M, et al. (2013) Culture and Behaviour in the English National Health Services; overview of lessons from a large multimethod study. BMJ Qual Saf.

Board, teams and individuals to apply the principles of 'problem-sensing' in a more focused and informed way.

2.1 Annual Statistics: Overview of Complaints

All complaints received by the Trust are administered centrally by the Service Relations Department, based at Trust Headquarters in Stafford. This report contains details of all complaints received during 2012/13.

During this period 151 complaints were received by the Trust; this represents an increase of 18 (13.5%) from the previous year.

The Trust concluded 138 complaint cases during the year, which included 30 from the previous year.

Of the total number of complaints received and concluded during 2012/13, the outcomes were as follows:

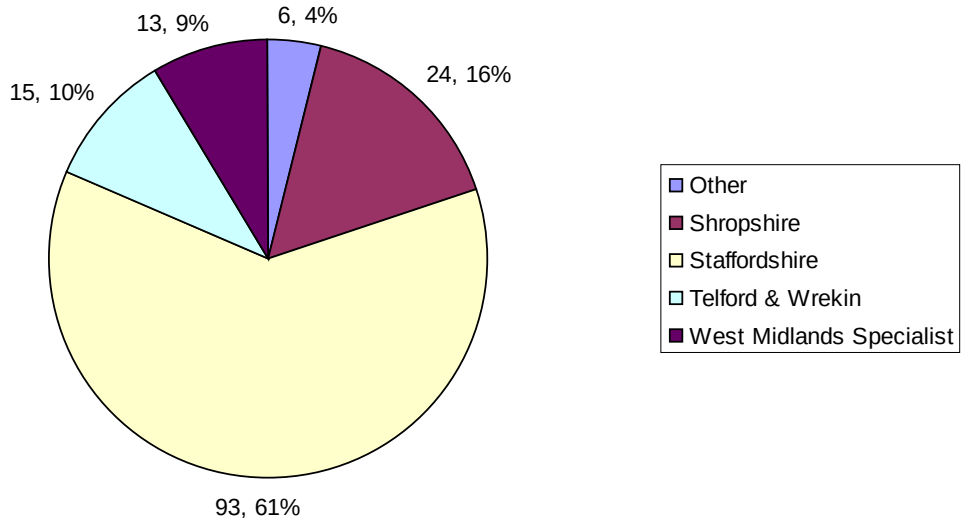
	Not Upheld	Partially Upheld	Fully Upheld	Withdrawn	No 3rd Party Consent Received	Other
Complaints Received 2012/13	51	55	14	19	8	4
Complaints Received 2011/12 but concluded 2012/13	9	19	2	0	0	0
Total	60	74	17	19	8	4

It is acknowledged that if a complaint is withdrawn or third party consent is not received, the Complaints Procedure ends although the Division is asked to internally review the issues raised by the complainant in order to provide assurance and learning internally.

2.2 Number of Cases Received by Commissioners

In order that Clinical Commissioning Groups (CCGs) and other organisations, who commission our services, can assess the type of complaints received, the final resolution and lessons learnt, the Trust reports this information on a monthly and quarterly basis.

As a result of providing this information, the Commissioners consider trends, which may influence future commissioning requirements. The chart below shows the number of complaints received by number and percentage of the total.



South Staffordshire continues to receive proportionately more of the formal complaints made than would be expected statistically although the actual number has remained static with one fewer complaint received in 2012/13 compared with the previous year. The numbers for the Shropshire County and Telford and Wrekin Primary Care Trust saw increases of 3 for Telford and Wrekin and double the number from Shropshire at 24 compared with 12 in 2011/12. Further analysis shows an even spread of complaints across in-patient and community teams in each of the commissioning areas.

Publicity leaflets and posters are displayed throughout the Trust, together with appointment cards with details of how to make a formal complaint or raise a PALS issue.

2.3 Complaints by Directorate

This table also includes a comparison with figures for the previous two years.

Directorate	**10/11**	**11/12**	**12/13**
Chief Operating Officer	1	4	0
Children's Services	12	7	8
Forensic Mental Health	5	5	9
Developmental Neurosciences and LD	5	5	3
Mental Health: Shropshire	28	22	34
Mental Health: Staffordshire	66	76	85
Specialist Services	13	14	12
Quality and Professional Practice	2	0	0
TOTAL	132	133	151

There has been an overall increase in complaints within the Mental Health Division across both Staffordshire and Shropshire of 21 (16%) between 2011/12 and 2012/13.

2.4 Complaints by Team 2012/13

Department	**Total**	**Upheld**	**Partially Upheld**
136 Suite Stafford	1	0	0
Ashley House	4	0	0

Department	Total	Upheld	Partially Upheld
Assertive Outreach Team	1	0	0
Baswich Ward	1	0	1
Berrington Suite	1	0	0
Birch Ward - Redwood	7	0	1
Brockington	3	0	0
Brocton House	7	0	2
Bromley Ward	3	1	0
CAMHS - Stafford	2	0	0
Castle Lodge Dawley	1	0	1
CDC Stafford	1	0	1
CDC Tamworth	1	0	0
Chebsey House	6	0	3
Children's Centre	1	1	0
CMHT - Burton & Uttoxeter	5	0	0
CMHT - Cannock	7	0	2
CMHT - East Wrekin	2	0	2
CMHT - Lichfield	7	0	5
CMHT - North Shrewsbury	2	0	2
CMHT - North Wrekin	1	0	1
CMHT - South East Shrewsbury	1	0	1
CMHT - South Shrewsbury	1	0	1
CMHT - South Shropshire	3	0	1
CMHT - South Staffordshire	3	2	0
CMHT - Stafford	8	1	3
CMHT - Tamworth	3	2	0
CMHT - West Wrekin	1	0	1
CMHT OP - Ludlow	1	1	0
CMHT OP - Shrewsbury	1	0	0
Community Paediatric	3	1	1
CRHT - Shropshire In	1	0	0
Crisis - EAST Staffs	5	0	2
Crisis - WEST Staffs	2	0	1
Crisis Resolution &	3	0	1
DN&LD Shropshire - Community	1	0	0
Early Intervention Team	1	0	1
East Wing	1	0	1
Ellesmere House	1	0	1
Hospital Co-ordinator	1	0	1
Inclusion -CARATS	1	0	0
Inclusion - Drug Service	1	0	1
Inclusion - IAPT Liverpool	2	2	0
Inclusion - IAPT Sefton	2	0	0
Kinver Ward	1	0	0
Liaison Psychiatry	2	0	1
Memory Clinic	2	0	1
Milford	2	0	1
MSC - Adult Acute	2	0	1
MSC OAP	3	0	2
Newport House	1	0	0
Norbury House	4	2	0
Norton House	2	0	1
Oak Ward - Redwoods	2	0	1

Department	Total	Upheld	Partially Upheld
PCMHT South Staffs	1	0	0
Pine Ward - Redwoods	2	0	1
Prison Inreach	2	0	2
Psychological Therapies	1	0	0
Radford House	1	0	1
Substance Misuse	1	0	0
West Wing	11	1	5

When considering the above table, it is noted that West Wing and Stafford CMHT received the most complaints during the year at 11 and 8 respectively, although not all of these were upheld or partially upheld. Quarterly reviews are undertaken throughout the year, and any apparent clusters are examined, brought to the attention of the relevant manager and reported thereon in the Quarterly Combined Risk Management Report. With regard to both teams, all complaints were distinct in terms of circumstances and staff member.

Complaints in relation to inpatient services equated to 45% of the total complaints received compared to 38% for the previous year.

Work will continue throughout the forthcoming year in relation to providing staff awareness training on complaints and PALS, focusing on any hotspot areas identified through complaints analysis, any trends or issues identified in year or in response to specific requests from Divisions, Directorates or Teams.

The Team is also planning the introducing volunteers to act as PALS Liaison Officers, in order that regular visits to all inpatient areas can be facilitated and unrepresented groups and areas can receive additional focus and support.

2.5 Complaints by Staff Group

	2011/12	2012/13
Facilities and Estates	1	1
Medical	60	23
Nursing	48	120
Allied Health Professions	7	1
Other	6	3
Administration	11	3

A large rise in complaints relating to nursing staff and a decrease in those relating to medical staff are evident over the previous two years with 39% of complaints relating to medical staff upheld or partially upheld, compared with 44% of complaints relating to nursing staff. There was no pattern evident in the professions complained about in terms of whether the complaint related to community or in-patient services.

2.6 Main Issue of Complaint Raised by Category

The table below details the main category of each complaint received during 2012/13, in comparison with the previous two years. This year, the main areas of complaint have included attitude of staff, communication/information, clinical treatment issues and medication. Small reductions are evident in a number of categories although a large increase can be seen in the categories of attitude of staff and clinical treatment. Further analysis of this is provided below.

Category	09/10	% of Total	10/11	% of Total	11/12	% of Total	12/13	% of Total
Access To Services	4	2.25	0	0	3	2.25	0	0
Admission Arrangements	4	2.25	0	0	0	0	2	1.32
Appointment (OP) Cancellation	2	1.12	1	0.75	3	2.25	1	0.66
Appointment (OP) Delay	9	5.05	7	5.30	2	1.50	3	1.99
Attitude of Staff	29	16.29	24	18.00	16	12.03	39	25.83
Bed Management	1	0.56	0	0	0	0	0	0
Change Of Consultant Request	0	0	0	0	1	0.75	0	0
Clinical Treatment	33	18.53	29	22.96	32	24.06	45	29.80
Communication/Info to Patients	28	15.73	28	21.21	26	19.54	24	15.89
Confidentiality	7	3.90	3	2.27	6	4.51	4	2.65
Diagnosis Problems	4	2.25	8	6.06	5	3.75	5	3.31
Discharge Arrangements	8	4.49	6	4.54	4	3.00	2	1.32
Equality and Diversity	0	0	2	1.51	0	0	1	0.66
Failure to Follow Procedures	3	1.68	2	1.51	0	0	0	0
Failure To Visit Patient	2	1.12	0	0	0	0	2	1.32
Hotel Services – Food Choice	0	0	0	0	0	0	1	0.66
Commissioning	13	7.30	2	1.51	6	3.75	1	0.66
Medication	15	8.42	10	7.57	15	9.02	10	6.62
Mental Health Act	0	0	5	3.78	7	5.26	4	2.65
Other	1	0.56	1	0.75	3	2.25	1	0.66
Patient Choice	0	0	0	0	1	0.75	0	0
Patient's Privacy & Dignity	5	2.80	3	2.27	2	1.50	1	0.66
Patients Property	4	2.25	2	1.51	1	0.75	1	0.66
Patient Status – Discrimination	0	0	0	0	0	0	1	0.66
Personal Records (Health)	2	1.12	0	0	1	0.75	0	0
Premises - General	0	0	0	0	1	0.75	0	0
Staffing Levels	2	1.12	0	0	1	0.75	1	0.66
Transfer Arrangements	1	0.56	0	0	0	0	1	0.66
Visiting Arrangements	1	0.56	0	0	0	0	0	0
Waiting List	0	0	0	0	0	0	1	0.66
TOTAL	178		132		133		151	

Based on the main categories of staff attitude, communication/information and clinical treatment more closely, the following table details the overall outcomes:

Outcome	Staff Attitude			Clinical Treatment			Communication/Information		
	10/11	11/12	12/13	10/11	11/12	12/13	10/11	11/12	12/13
Upheld	3	0	4	2	2	2	7	1	3
Partially Upheld	6	6	15	17	11	15	12	14	9
Not Upheld	7	5	16	7	8	15	7	7	8
Third Party Consent not Received	1	2	2	1	4	4	1	0	0
Withdrawn	6	3	2	2	2	5	0	2	4
Referred for SI Investigation	0	0	0	0	0	1	0	0	0

Outcome	Staff Attitude			Clinical Treatment			Communication/Information		
	10/11	11/12	12/13	10/11	11/12	12/13	10/11	11/12	12/13
Referred to HR	1	0	0	0	1	0	1	0	0
Remains under Investigation	0	0	0	0	2	3	0	2	0
TOTAL	**24**	**16**	**39**	**29**	**32**	**45**	**28**	**26**	**24**

In interpreting these statistics it is important to recognise the thousands of positive experiences and interactions between staff, service users and carers each day. The following illustrates examples of the occasions where the services fell short of what was expected. In all cases of upheld or partially upheld complaints, apologies were made to the complainant and where appropriate remedial action was taken.

Staff Attitude:

Although 16 of the 39 complaints were not upheld, a total of 19 complaints were either partially or wholly upheld in this category during 2012/13. Further investigation revealed that there were three teams where there were two complaints each upheld/partially upheld and in one team the same team member was the subject of both complaints. With the remainder of upheld/partially upheld complaints, there was one complaint per team.

The issues prompting the individual complaints which were upheld or partially upheld included:

- Failure to return telephone calls
- Poor interaction with carers around care plans
- Inappropriate use of confidentiality as a reason for not providing information to relatives/carers
- Visibility and accessibility of staff on ward areas
- Use of too much jargon and failure to provide clear explanations
- Examples of service users perceiving communications as rude or insensitive, both during informal conversations and during therapeutic interventions and both face to face and over the telephone.

Discussions have taken place with the Training and Development Team regarding the provision of Customer Care training. The topic is included as a priority area for some services in the training plans, and discussions are taking place with divisional managers about how they wish this to be delivered so that resources can be prioritised. In the meantime, the Training and Development team are ensuring they weave key messages within existing training and also to ensure the principles are reinforced through work with teams. In addition, training within the leadership programme includes reference to 'honest conversations' to help managers discuss issues with staff, recognising that a key element in changing culture is through the examples set by leaders and that traditional 'customer care' training has limited benefit when the focus must be on embracing our core values, clarifying quality standards and expectations of behaviour and then ensuring this is reinforced in practice through effective management and leadership. Teams that feel they are 'in trouble' or need help with some of this can also approach the HRODE team for assistance in working through the issues and customised and focused interventions.

Clinical Treatment:

Although there was an increase in the number of complaints in this category during 2012/13, the increase was found principally in the number not upheld or withdrawn although there was an increase in the number partially upheld.

The issues prompting the individual complaints which were upheld or partially upheld included:

- Robustness of care planning in the areas of monitoring of medication, physical healthcare needs and engagement and involvement of relatives/carers.
- Continuity of care between individuals and teams, particularly during sick leave
- Provision of practical support on discharge from in-patient care
- Recording and evidencing of service users' and relative/carers' views in the health record and/or care plan.
- Delay in diagnosis and referral to appropriate treatment/professionals
- Trust services unable to meet the needs of individuals with Autistic Spectrum Disorder

Communication/Information to Patients:

Numbers have remained static in this category over the past three years, although there was a increase the number of complaints upheld, from one to three.

The issues prompting the individual complaints which were upheld or partially upheld included:

- Length of time to complete an investigatory process
- Absence of timely communication about impending service changes
- Timeliness, effectiveness and accuracy of communication with relatives/carers

2.7 Ethnicity of complainants

The complaints listed below, exclude those which were withdrawn.

A - White : British	104
B - White : Irish	2
C - White : Other White	4
D - Mixed : White & Black Caribbean	1
E - Mixed : White & Black African	0
F - Mixed : White & Asian	0
G - Mixed : Other Mixed	1
H - Asian or Asian British : Indian	2
J - Asian or Asian British : Pakistani	0
K - Asian or Asian British : Bangladeshi	0
L - Asian or Asian British : Other Asian	1
M - Black or Black British : Black Caribbean	2
N - Black or Black British : Black African	0
P - Black or Black British : Other Black	0
R - Other Ethnic : Chinese	0
S - Other Ethnic : Other Ethnic Category	0
Z - Not Stated	8
	125

83% of complaints were from those classified as 'White British' which correlates well with the population of service users where 82% are in the category 'White British'.

Using the data available, the largest service user groups within the Trust (not including White-British) are the 'White-Other' and 'Pakistani' groups. From the Census data we

can see that population numbers from these groups have also increased over the last 10 years. Pakistani populations have increased by 46% and the 'Other White' population has increased by 149%. 'White-Other' would include those from elsewhere in Europe. It can therefore be expected that increases in numbers of complaints within these ethnic groups can be expected to rise and that attention must be paid to the cultural needs of individuals in these groups. This finding is reflected and supported in the section in this report on interpreting/translating services.

3. Parliamentary and Health Service Ombudsman

Over the year, the PHSO notified the Trust that it had received 10 cases for consideration. No further action was required on 6 cases, 3 cases were withdrawn and 3 were referred back for local resolution. One complaint was referred to the CQC by the PHSO, in line with a memoranda of co-operation in that the CQC considers complaints who have raised issues in relation to their detention. No further action was identified.

4. Publicity

During the year, all publicity material was revised and widely circulated.

5. Investigating Officer Training

Throughout the past year, the Service Relations Department has delivered four training sessions for complaint investigating officers with 23 individual's completing the training. The department has also provided 1:1 training on an ad hoc basis and a further programme of training is in progress for the current year.

6. NHS Choices – www.nhs.uk

Patient Opinion – www.patientopinion.org.uk

Both these websites allow hospital patients to provide feedback on their hospital experience. All feedback is pre-moderated by an independent company and the Trust is given an opportunity to provide a reply to each comment. From last year, any feedback received by Patient Opinion, not only featured on that individual website, but was also included on the NHS Choices website. However, it is apparent that responses to the Patient Opinion website are not uploaded to the NHS Choices website in a timely manner, thus giving the impression that the Trust has not responded. In addition, the Trust has incurred problems, at times, in being alerted of new entries on the Patient Opinion website, as without the alert, the Trust has been unable to post a response. Both these observations have been raised with Patient Opinion and appropriate action by the website has been promised.

Last year, the Trust received a total of 13 entries on the Patient Opinion website of which 6 were compliments for Inclusion Matters Liverpool (four entries), prompt referral to external providers of Autistic Spectrum Disorder services (one entry) and Assertive Outreach (1 entry).

The concerns received covered the following issues:

- Three month wait to see CPN (no information provided about team involved)
- Lack of support from CAMHS
- Lichfield – CMHT - found the referral and assessment process frustrating

- Memory Service – Staff communicated with service user using first name
- Didn't feel safe (no information provided about team involved)
- Absence of provision of a service for individuals with Aspergers and Autistic Spectrum Disorder within the Trust

A further neutral comment was received expressing a wish to work collaboratively with the Trust regarding personality disorder services.

All entries were responded to. Those that could not be fully addressed, mainly due to lack of detail, were invited to contact either Service Relations Department or the Patient Advice and Liaison Service to provide further information, but no further contact was received.

7. Actions and Learning Undertaken to Improve Service Delivery

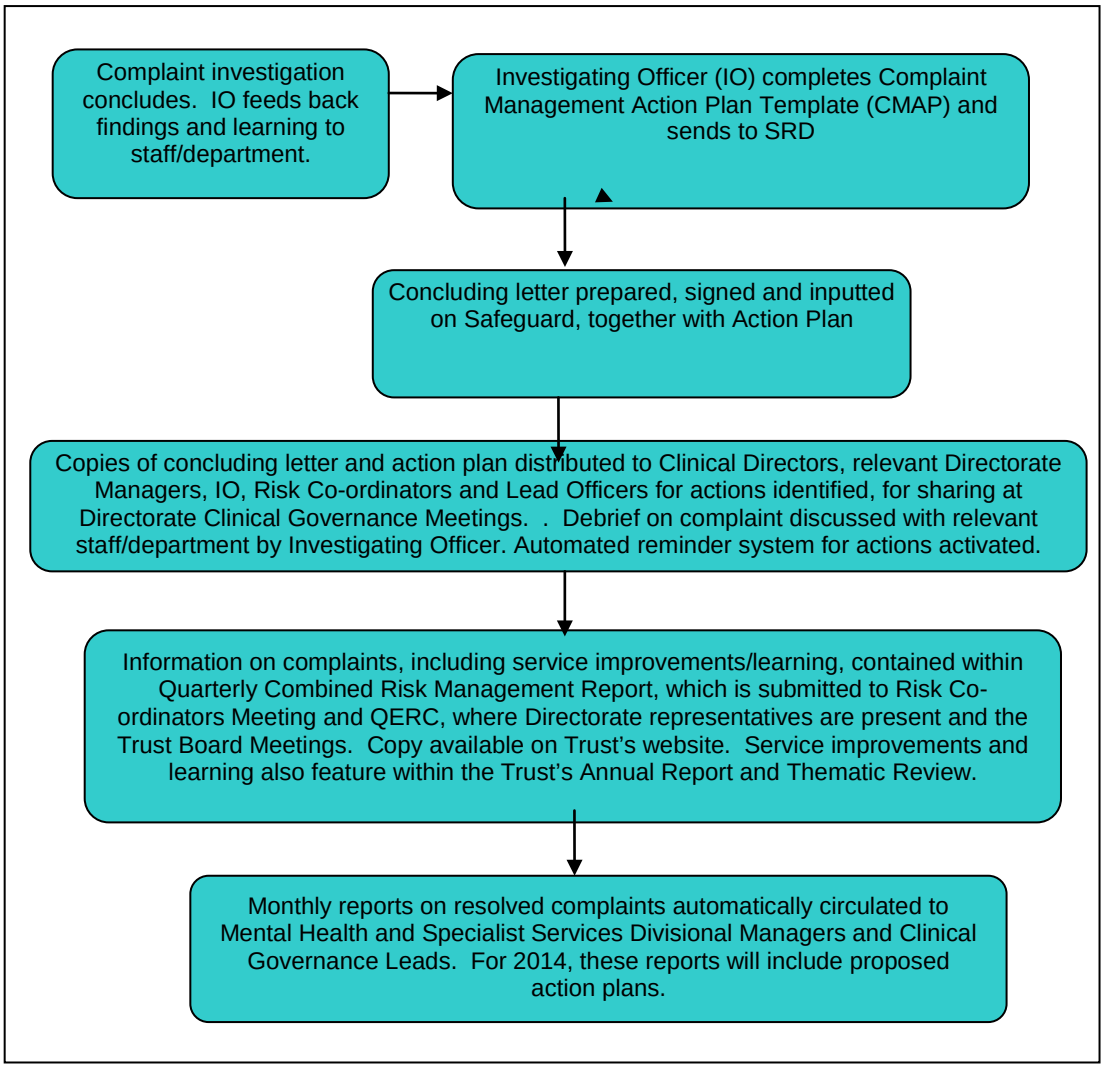
As a learning organisation, we are committed to seeking the views of service users and the public on what we do and recognise the importance of using this feedback to learn and develop/improve our services. The following are examples of some of the practical actions taken to improve the quality of service delivery, as a result of complaints received this year:

- Inclusion of an overview of the referral system for diagnostic testing as part of the local induction for locum doctors.
- Delays in the allocation of a Community Mental Health Nurse have been referred to the Acute Care Forum for a pathway to be agreed.
- Review of process to ensure use of alerts on the Electronic Patient Information System to ensure restricted information is not given out to service users or relatives/carers.
- Monthly Carer Engagement meetings where relatives and carers can attend and talk to the staff and other carers have been implemented; the meeting is facilitated by Carers Association South Staffordshire (C.A.S.S.).
- Named nurse 1:1 sessions are now monitored through the health records audit process.
- Review of signage and information provided to ward visitors.

The Service Relations Department continues to use the automated outstanding action reminder system, which is a feature of the Safeguard Risk Management System. This enables a more robust monitoring mechanism to ensure that actions highlighted, as part of the complaint investigation process are completed.

8. Learning from Complaints

The following is a pathway demonstrating how, as a Trust, we learn from complaints:



Whilst all complaints and particularly those that are upheld are subject to review in terms of the lessons learned, the need for an apology and a clear action plan to implement changes as a consequence of any acknowledged failure, the vast majority of upheld complaints arise do not arise from the absence of a policy or process. In most cases, the complaint arises either from a failure of observation of the relevant policy or process or from a failure to change cultural attitudes and behaviours which allows the recurrent themes and issues to continue to be the subject of many concerns and complaints received. The learning from this is that there must be continual reinforcement of key messages to staff regarding the observation of key policies, particularly around the areas of care planning, communication, engagement with relatives and carers and record keeping. We are able to demonstrate a range of ways in which we actively pursue understanding of why gaps in quality occur when they do and support the cultural changes required to address the recurrent themes which arise and remain confident that most of our staff deliver excellent, high quality services most of the time.

However, to address these challenges facing the Trust and to achieve sustainable cultural change, the Board of Directors has resolved that as a Trust we must deliver health care in a very different way in order that we can improve the services we provide as well as increase productivity and efficiency. It has been agreed that this will be done through he introduction of a "Lean" approach (the Virginia Mason Production System, which creates added value for users and carers of health services. By adopting this approach the aim will be to enhance productivity, improve the quality of care we provide and eliminate many of the behaviours and outcomes which result in many of

our complaints and PALS issues. The approach requires a huge cultural change which cannot be underestimated and will require senior and middle managers to really understand the business and its processes, thereby supporting and helping staff truly put people who use our services at the centre of all we do by driving out waste and improving value, in ways which are observable and measurable.

9. Reporting

The Service Relations Department and PALS contribute to the Combined Risk Management Quarterly Reports, which are presented to the Quality, Effectiveness and Risk Subcommittee of the Trust Board and to the Trust Board of Directors.

Regular automated monthly reports are also made available to Divisions and Directorates, in order that they respond in a timely manner to emerging issues and trends. In particular, the quarterly reports now include a section on where apologies have been made arising from complaints in order to raise awareness of areas where there is a need for regular reminders to staff about adherence to policy and process.

In addition, regular statistical information is prepared and submitted, on a quarterly basis, to the commissioning organisations.

The Service Relations Manager also attends, on a quarterly basis, the Mental Health Directorate's Quality, Effectiveness and Risk Group which formally reviews any emerging trends and learning from all concluded complaints.

In February 2013, the Board agreed a process to receive patient stories at Board of Directors meetings, with particular focus on stories which trigger and support learning and improvements in patient care and service delivery. The initiative was commenced in recognition that whilst the Board has acted on feedback from service users and carers on many occasions over recent years, only occasionally has this been from direct accounts of personal experience which have far more personal impact on Board members than second or third hand reports, indirect sources of feedback or statistics. It was agreed that this would include stories from a range of sources, both good and bad and from which service improvements and changes in or improved adherence to policy and practice could be highlighted. Complaints was clearly identified as potential source of such stories and an example was received at the Board which related to a complex complaint from a service user which included issues relating to unsafe practice, communication, consent, policy compliance and the role of primary care. All aspects of the complaint were fully or partially upheld and the Board heard of the learning and extensive action plan which resulted from the investigation. There were eleven key learning points from this case including revisions to Trust policy which would be applied across the Trust. It was noted that the "story" had also been presented to the Quality, Effectiveness and Risk Committee to support the dissemination of learning to all Divisions and Directorates.

10. Quarterly Meetings with Non-Executive Director

In line with one of the recommendations of the Francis Report, the Service Relations Manager continues to meet, on a quarterly basis, with the Chair of the Quality, Effectiveness and Risk Committee to review complaints handling.

As part of this review process, the NED scrutinises a selection of completed cases, specifically concentrating on the process to ensure that it has been complainant centred, appropriate and that learning has taken or scheduled to take place.

The quarterly meetings also consider the more complex cases and discuss the methodology of resolution. The opportunity is taken to brief the NED on the Complaints/PALS sections of the quarterly Combined Risk Management Report, along with any new national guidance/annual reports etc.

11. PATIENT ADVICE AND LIAISON SERVICE

11.1 Annual Statistics: Type of Enquiry

A year on year comparison of the type of enquiry received by the Trust is shown in the table below:

Type of Enquiry	2009/2010	2010/2011	2011/2012	2012/13
Compliment	253	304	360	241
Concern	506	544	576	488
Information Request	102	192	114	108
Suggestion	51	55	100	57
Interpretation Request	*	*	208	388
TOTAL	**912**	**1097**	**1358**	**1282**

* Not collected as a separate category. Interpretation requests were previously captured under either the heading of "information request" or "communication/information to patients".

During 2012/13, the Patient Advice and Liaison Service (PALS) saw a 5.6% decrease in the number of contacts received.

Requests for interpreters have continued to increase year on year reflecting the diversity of the populations served.

Any identified trends in concerns have been highlighted in the Quarterly Combined Risk Management Reports.

11.2 Number of Issues Raised by Main Category Type

The table below lists the number of issues raised under each category, during 2012/13, with comparison to previous years:

Category Type	2009/ 2010	% of Total	2010/ 2011	% of Total	2011/ 2012	% of Total	2012/ 2013	% of Total
Admission, Discharge and Transfer	27	5.3	33	6.1	54	9.4	31	6.4
Aids, Equipment and Premises	11	2.2	41	7.5	17	3.0	12	2.5
Appointments	25	4.9	37	6.8	34	5.9	26	5.3
Staffing Levels	8	1.6	20	3.7	19	3.3	7	1.4
Attitude Of Staff	79	15.6	49	9.0	57	9.9	52	10.7
Clinical Treatment	148	29.2	137	25.2	142	24.7	187	38.3
Communication and Information for Patients	20	4.0	39	7.2	38	6.6	43	8.8
Consent To Treatment	1	0.2	1	0.2	2	0.3	1	0.2
Complaints Handling	1	0.2	0	0.0	0	0.0	0	0.0

Category Type	2009/ 2010	% of Total	2010/ 2011	% of Total	2011/ 2012	% of Total	2012/ 2013	% of Total
Privacy & Dignity	24	4.7	31	5.7	33	5.7	27	5.5
Patients Property and Expenses	16	3.2	8	1.5	21	3.6	13	2.7
Environment	46	9.1	29	5.3	80	13.9	43	8.8
Personal Records	6	1.2	7	1.3	5	0.9	2	0.4
Failure to follow Procedure	2	0.4	6	1.1	4	0.7	1	0.2
Equality and Diversity	0	0.0	0	0.0	0	0.0	1	0.2
Transport	7	1.4	1	0.2	3	0.5	1	0.2
Hotel Services including Food	46	9.1	70	12.9	30	5.2	22	4.5
Mental Health Act	5	1.0	2	0.4	4	0.7	3	0.6
Other	28	5.5	10	1.8	11	1.9	6	1.2
Commissioning	2	0.4	23	4.2	20	3.5	10	2.0
Assault	4	0.8	0	0.0	2	0.3	0	0.0
Total	**506**		**544**		**576**		**488**	

The above figures include 43 concerns which started as PALS concerns but were ultimately transferred to Service Relations as formal complaints and have therefore been legitimately double counted in producing this thematic review.

There have been reductions in the numbers of PALS concerns across the majority of categories, with exceptions in the categories of 'clinical treatment' and 'communication and Information for patients'. The following observations are provided with respect to the increases and decreases in PALS concerns observed during 2012/13

11.2.1 Environment (decrease by 46.3%)

A number of these concerns related to snagging issues and problems with the acoustics following the opening of The Redwoods Centre, which were subsequently resolved. There were also a number of concerns relating to the move to introduce more stringent smoking restrictions.

11.2.2 Hotel Services (decrease by 26.7%)

Concerns relating to food reduced from 30 to 22. They related to issues of choice, portion size, availability of snacks and special diets. There is evidence that prompt action was taken to address the concerns raised to meet the needs of service users.

11.2.3 Admission, Discharge and Transfer (decrease by 42.6%)

The Trust received 31 concerns compared to 54 in 2011/12. The majority related to service users admitted to beds outside their area of residence and the distance relatives and carers had to travel when this happened.

11.2.4 Attitude of Staff (decrease by 8.8%)

52 PALS concerns were raised compared with 57 in 2011/12. Of these 10 were subsequently transferred to Service Relations as formal complaints and therefore are it

should be noted that they are therefore double counted. Of the 52 concerns, all but 11 related to in-patient services with the remainder emanating from community teams. Of the 42 concerns which did not become formal complaints only one person remained dissatisfied with the outcome of having raised the concern.

11.2.5 Clinical Treatment (increase by 31.7%)

There were 187 concerns relating to clinical treatment, compared with 142 for 2011/12. The sub categories of these concerns were:

Sub Category	Number of Concerns
Activities	3
Care Plan	17
Carers Rights	3
Consultants – dissatisfied/request for change	21
CPN – dissatisfied/request for change	7
Diagnosis Problems	3
Extra Support Needed	42
Medication	40
Unhappy With Service	50
Privacy/security	1

Of the 187 concerns, 153 were satisfied with the outcome of having raised the concern, 17 were transferred to Service Relations as formal complaints and 12 remained dissatisfied.

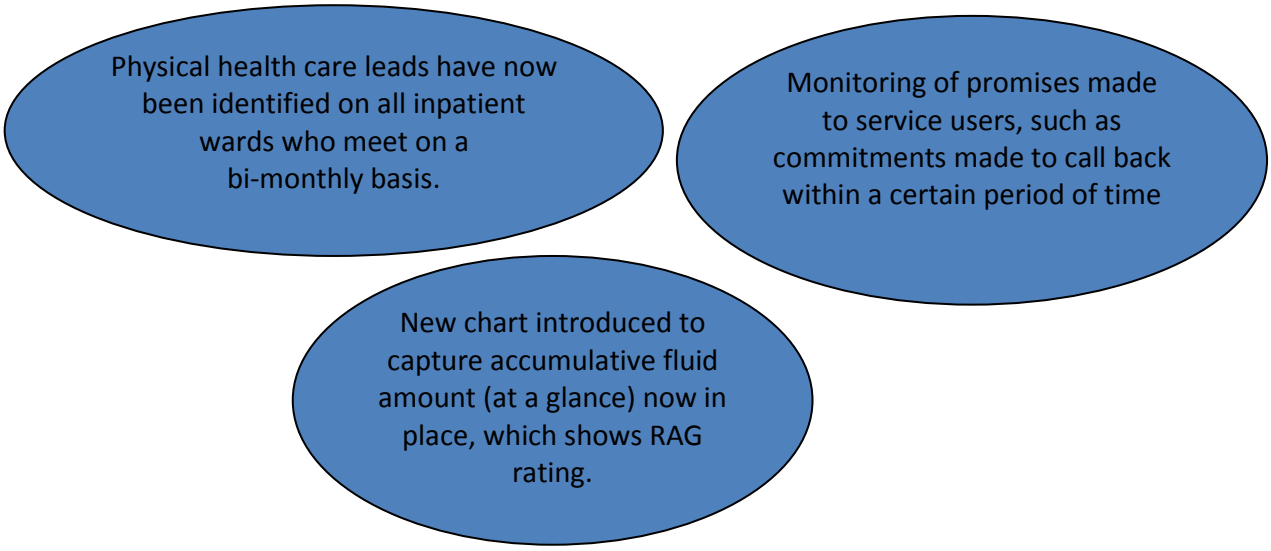
11.3 Number of PALS Issues raised by Directorate

The table below highlights the number of issues raised, by individual directorates, during 2012/2013:

Directorate	2011/2012					2012/2013				
	Compliment	Concern	Information Request	Suggestion	Interpretation Request	Compliment	Concern	Information Request	Suggestion	Interpretation Request
Chief Operating Officer	1	1	72	3	2	6	19	71	6	0
Children's	19	28	1	0	43	27	14	1	0	78
Facilities & Estates	36	81	3	41	0	3	23	1	20	0
Forensic	1	47	1	5	47	3	97	2	7	38
Developmental Neurosciences and Learning Disabilities	22	59	0	0	0	43	9	2	0	24
Mental Health: Shropshire	98	68	9	7	32	31	69	8	6	101
Mental Health: Staffordshire	142	274	26	40	79	119	242	22	15	110
Specialist Services	40	16	1	4	5	9	14	0	3	37
Other	1	2	1	0	0	0	1	1	0	0
TOTAL	360	576	114	100	208	241	488	107	57	388

It is noted that, as in previous years, Mental Health (Staffordshire Division) has received the majority of concerns but equally the majority of compliments. Further analysis suggests that more work is required in Shropshire/Telford and Wrekin to translate service user and carer feedback received in a range of different ways into PALS issues in order to gain a complete picture of the service user and carer experience of services for reporting purposes. However, it should be noted that through the mechanisms of service user and carer involvement and the Meridian system capturing patient experience, there is no shortage of opportunity for service users and carers to provide feedback.

12. Examples of changes that have been made to services following PALS intervention



13. Compliments

The PALS service has also received 241 compliments on behalf of the organisation, compared with 360 in the previous year (a reduction of 33.1%). Although the importance of inputting compliments on to the Safeguard database is emphasised at all training sessions and a regular reminder is sent to teams to report compliments received, compliments are believed to be under-reported. This is based on the probability that teams who are recorded as having few or no compliments are more likely not to be communicating them to the PALS team rather than not receiving any.

Compliments received, include:

- “Thanks and gratitude to all the staff on Baswich ward for the respect and dignity provided. The staff were always thoughtful when dealing with me and helped me to understand how to manage mum’s state of mind. I consider my mum and myself very fortunate that such care was available to her and would like to convey my heartfelt thanks to all staff.”
- A gentleman contacted PALS to compliment his named nurse following his recent inpatient stay. "She has been nothing but professional. She always comes into work early and leaves late. Although all staff are dedicated to their work she goes the extra mile. She always has time for her patients and anyone else who needs her time and never clock watches or is worried about how late she is. She gets to know each and everyone of us in detail".

- At a recent Community Meeting/PALS Surgery an inpatient reported that he would like his compliments passed onto ward staff about the excellent new facilities now provided in the Redwoods Centre; especially the provision of en suite bathrooms which were not present in Shelton. He also stated that the food is excellent and very nutritious and plentiful. He also stated that 'the staff are great'.
- A mother wrote to say that the child & adolescent mental health service has been very helpful to both her and her child. She also complimented their consultant psychiatrist.
- At an inpatient meeting, service users reported that they enjoyed the buffet that was provided instead of the cooked meal during one of the England games in Euro 2012.
- A card was received from the relative of service user, thanking staff for their help and support, and for attending his funeral.
- A doctor from a GP practice has thanked the duty team for the referral of a service user into mental health services. He said that it was done in a professional and timely fashion.

The top teams for receiving **and** submitting compliments during 2012/13 are:

Department	Total
DN&LD Shrops - Community Incl	23
Chebsey House	22
Baswich Ward	18
Brocton House	15
CAMHS - Cross Street	11
CMHT - Stafford	8
DN&LD South Staffs (East) Community	8
Memory Clinic / Service	8
Milford	7
Community Paediatrics	7
Oak Ward - Redwoods	7

14. Training and Promotional Work

PALS/Formal Complaints Awareness training has delivered 12 training sessions (156 staff) to staff across South Staffordshire and Shropshire. The success of delivering this training at individual locality team meetings has been a great success and saved considerable staff time and travelling. Training has also been delivered to Junior Doctors on their commencement with the Trust as part of their induction. To support this training, three training packs have been developed.

PALS staff attend service user and carer support groups, ward meetings and local development groups across the Trust to promote the service, receive concerns and feedback. Some examples include:

28/03/2012	Wem Service User Meeting
25/04/2012	Wombourne Fire Station
03/05/2012	SU Carer Celebration Day
06/06/2012	County Show Stafford
06/08/2012	Uttoxeter Changes
01/10/2012	Methodist Church Lichfield
02/01/1900	Changes Cannock
AGM	Redwood Centre Shropshire
13/11/2012	Uttoxeter Carers Group

15. Reporting

Apart from statistical information and trend analysis being included in the Combined Quarterly Risk Management Report, during the year, the Patient Advice and Liaison Service produces monthly reports, detailing PALS contacts received, to all Ward Managers and Locality/Area Managers. This has been undertaken using the automated reporting system, which is part of the Safeguard software.

16. Timeframe

PALS aim to resolve the majority of issues raised within 24 hours. Those falling outside of this target are monitored using the action plan module on the Safeguard system. During 2012/13, PALS dealt with 1282 contacts, of which 1099 were resolved within 24 hours representing 86%, an improvement of 3% over 2011/12. Of the issues which took over 24 hours, the longest was 109 days and related to a losses and compensation claim.

17. Interpreting and Translation Services

The Trust books interpreting and translation services in line with the national framework agreement, which has been in place since September 2012 and which is designed to provide assurance with respect to quality of service and price.

The following table details the languages requested, team and the frequency:

Language	Team	No. of requests	Total
Arabic	CDC Burton	2	5
	IAPT Shropshire	1	
	Dementia Team West	1	
	Paeds East	1	
Bengali	IAPT Shropshire	13	15
	Norton	2	
British Sign Language	CAMHS Burton	3	37
	CDC Burton	3	
	CDC Stafford	1	
	CMHT Lichfield	2	
	CMHT South Staffs	1	
	CMHT Stafford	4	
	CMHT Tamworth	2	
	Milford / Stonefield	18	
	Paeds West	3	
Cantonese	CMHT N. Shrewsbury	2	5
	CMHT Stafford	3	
Czech	Ashley	14	23
	CMHT Burton	1	
	Newport	6	
	PCT Burton	2	
Farsi	CMHT Burton	1	1
French	Brockington	5	6
	CMHT NW. Shropshire	1	
German	IAPT Shropshire	1	1
Hungarian	CAMHS Stafford	1	3
	CMHT Burton	1	

Language	Team	No. of requests	Total
	IAPT Liverpool	1	
Kurdish	CAMHS Burton	4	13
	CMHT Burton	6	
	SUSTAIN	2	
	CMHT NE. Shropshire	1	
Latvian	Brockington	1	14
	CAMHS Lichfield	1	
	CDC Burton	3	
	Child's East LD Team	5	
	CMHT E. Wrekin	2	
	CMHT Tamworth	1	
	Paeds East	1	
Lithuanian	Ashley	3	6
	IAPT Cambs	1	
	Newport	2	
Mandarin	CDC Tamworth	1	1
Polish	Brocton	7	121
	CAMHS Burton	5	
	CAMHS Tamworth	4	
	CDC Burton	20	
	CDC Tamworth	1	
	Child's East LD Team	1	
	CMHT Burton	3	
	CMHT Lichfield	9	
	CMHT OP Shrewsbury	7	
	CMHT Stafford	4	
	CMHT Tamworth	3	
	CRISIS Burton	3	
	CRISIS Shrewsbury	1	
	Early Int. Staffs	13	
	GBC, West Wing	1	
	IAPT Cambs	1	
	IAPT Shropshire	16	
	MSC, adult acute	2	
	Psychological Therapies	5	
	Services for Older People	3	
	Whittington / Pine	1	
	Paeds West	1	
	Paeds East	5	
	CMHT NE. Shropshire	5	
Portuguese	CMHT N. Shrewsbury	3	3
Potwari	CMHT W. Wrekin	1	1
Punjabi	Brocton	1	67
	CDC Burton	4	
	CMHT Burton	2	
	CMHT E. Wrekin	1	
	CMHT OP Shrewsbury	1	
	CMHT W. Wrekin	9	
	Dementia Team East	2	
	GBC, East Wing	11	
	GBC, West Wing	5	

Language	Team	No. of requests	Total
	Memory Clinic	3	
	PCT Burton	1	
	Stokesay / Birch	26	
	Paeds East	1	
Russian	Brockington	27	27
Serbian	Memory Clinic	1	1
Slovak	CMHT Burton	13	13
Spanish	CRISIS Telford	1	1
Turkish	Kinver	1	1
Twi	Newport	11	11
Urdu	CAMHS Burton	3	12
	CDC Burton	2	
	CMHT Burton	1	
	Early Int. Staffs	1	
	PCT Burton	3	
	Services for Older People	2	
Grand Total		388	

From the information provided above, the top five translation/interpreting requests compared with 2011/2 are:

2011/12	**2012/13**
Polish	Polish
Urdu	Punjabi
British Sign Language	British Sign Language
Czech	Russian
Bengali	Czech

There has been a significant increase in the demand for interpreting services relating to eastern European languages across the board.

A review of complaints and PALS concerns in the category of "communication/information to patients" has not identified any issues having been raised with respect to interpreting services or the availability of written information in different languages although one partially upheld complaint did identify issues regarding communication with the family/carers arising from difficulties with interpreting. The PALS/complaints leaflet currently advises in a range of languages that the full leaflet can be made available in a particular language, however, it may be timely to consider the routine provision of key information for service users into the future.

18. SERVICE RELATIONS DEPARTMENT AND PATIENT ADVICE AND LIAISON SERVICE ACTION PLAN 2012/13

Objective	Action Details	Outcome
To continue to promote PALS and Service Relations to staff, service users and carers.	As a minimum, deliver twelve training sessions across Staffordshire and Shropshire throughout the year	Twelve sessions have been delivered; the majority being in the Shropshire area. Rather than arranging specific training sessions, it has been found that attending staff meetings has been more successful in reaching increased staff numbers.
Promote good practice in complaint investigation	Programme of training sessions for complaint investigating officers to be provided, which will include a briefing on the expectations required to conduct a robust investigation in line with regulation.	Four training sessions for complaint investigating officers held during the financial year; 23 attended. The department has also provided 1:1 training on an ad hoc basis.
Further develop the schedule of standard reports produced for Directorates	Review the reports and circulation lists in Extractor Scheduler within the Safeguard System. Provide enhanced information in table format on resolved complaints and actions to be distributed automatically monthly to directorate representatives	The reports have been reviewed and circulation lists for the automated report system updated and implemented. Further work is required to improve the formatting and content.
To give consideration to the establishment of PALS surgeries on all inpatient wards, within the current staffing establishment	Proposal to be developed	This proposal has been developed and the recruitment process is due to commence early 2014.
To ensure that the formal complaints function is compliant with NHSLA Level II standards	Review systems to ensure that they reflect good practice.	The complaints process was informally reviewed to ensure that it complied with NHSLA Level II standards and good practice.
To ensure that the PALS function is fully compliant with NHSLA Level II standards	Review systems to ensure that they reflect good practice.	During the year, the PALS management system of handling concerns was reviewed and is in line with NHSLA Level II standards.

Explore the apparent low level of complaints and concerns from Shropshire	Volunteer PALS Liaison Officers in post and PALS surgeries commenced.	PALS representatives aim to attend ward meetings on at least a monthly basis. Offer of 1:1 meetings with service users/carers is facilitated at the end of each meeting. Volunteer PALS Liaison Officers to be appointed in the new year for South Staffordshire. Redwoods Centre has volunteers and where PALS Facilitators are unable to attend, any issues that arise are brought to the attention of PALS.

19. SERVICE RELATIONS DEPARTMENT AND PATIENT ADVICE AND LIAISON SERVICE ACTION PLAN 2013/14

Objective	**Action Details**		
Reduction of unit cost of interpretation/translation	Work with the Procurement Team to address issues with existing providers and the current framework agreement	Paula Johnson Verity Hollis	March 2014
Develop an e-learning package on complaints	Benchmark against packages developed in other organisations/commercial packages. Liaise with Learning and Development Team	Sunita Roberts	March 2014
Appointment of PALS Volunteers for South Staffordshire	Strategy and process agreed and appointments made and in post	PALS Team	December 2013
Benchmarking against PHSO priorities and actions	Priorities agreed and discussed with Divisional Directors	Paula Johnson Jane Landick	December 2013
Explore actions required to meet the cultural and language needs of individuals in identified ethnic groups to reflect the population increases in these groups.	Relevant leaflets translated into most frequently requested languages	Verity Hollis	December 2013
Establish links with the work undertaken through the Quality Improvement Framework to embed learning from complaints and PALS, achieve the behavioural and cultural changes required to improve practice and quality of services and to turn data into intelligence and act on it.	Priorities agreed and discussed with Divisional Directors	Jane Landick	December 2013

Objective	Action Details		
Implementation of opportunities for evaluating the levels of satisfaction of complainants with the complaints handling process and the outcomes.	Pilot programme of use of satisfaction surveys – paper and electronic	Paula Johnson	January 2014
Review and address outstanding actions to ensure compliance with Francis Report recommendations.	Action Plan Review	Paula Johnson	October 2013

Ongoing actions carried forward from 2012/13:

- Further development of PALS Service at the Redwoods Centre
- Future development of Complaint Management/Action Plan template
- Further training sessions for Investigating Officers to be programmed.
- Further training sessions on PALS/Complaints Awareness Training to be scheduled, to include service user/carer groups

Appendix 1
Effective Complaints Handling (Chapter 3)

Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.

Rec	Theme	Recommendation	Current Practice/Evidence	Action	Lead/ Timeframe
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	Freephone. AYS leaflets – available on all wards and departments. Trust website. Posters, appointment cards. Easy Read AYS. PALS surgeries (attending all wards. Plans to extend to community teams if capacity allows). Welcome packs. Interpreters available. Current PALS/complaint awareness training for staff – 12 sessions per year. Develop a protocol to provide post boxes for wards and departments for ease of submission for patients and also to ensure speed of delivery to PALS. Introduction of PALS volunteers.	Explore feasibility of phone app. Pager for Redwood. Free phone for PALS. Appointment of PALS reps / volunteers. Explore the possibility of increasing publicity for PALS and formal complaints in reception area.	Phone app – Sunita 30th April Post boxes – BJ 30th April Volunteers – KG 1st July Publicity – 31st May
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from	In line with regulation. In Trust's Complaints procedure.	No action required	

Rec	Theme	Recommendation	Current Practice/Evidence	Action	Lead/ Timeframe
		the considerations of litigation.			
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	See 109. Statement included in AYS? leaflet. about learning from complaints.	Review prominence of the statement about learning. Consider other means of communication, eg service user/carer forums.	
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	Each concern is triaged both by PALS and Complaints and an appropriate route taken. This could include the SI process. If complainant does not wish a formal investigation, complaint referred to Directorate for learning purposes. This is reflected in the Complaints Procedure.	Need to strengthen this process when complaint is referred to directorate to ensure feedback in cases where the client withdraws the complaint. Ensure learning is demonstrated.	
113	Complaints Handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	See recommendations below.	Assessment completed.	
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	Check Safeguard for related incident /SI invoked. Speak to divisional lead. Written in procedure (part of triage).	No further action identified.	
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;	Independent clinical opinion is utilised as appropriate. In Trust's procedure. Internal processes allow Shropshire based professionals to offer advice on Staffordshire cases and vice versa.	Complete	

Rec	Theme	Recommendation	Current Practice/Evidence	Action	Lead/ Timeframe
		• A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	Professional lead/Service Manager/HR involved should investigation reveal gross professional misconduct. Commissioners informed of any deficiencies in commissioning. Service Relations Department and PALS E-mail Liz Lockett for commissioning meetings.		
116	Support for complainants	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	Acknowledgement includes paragraph relating to ICAS in line with regulation. Complaint process leaflet. Information on ASIST and SIAS available on the wards.	No further action identified.	
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	Not an area for the Trust. Trust aware of services provided by ICAS; good links developed.	Watching brief.	
118	Learning and Information from complaints	Subject to anonymity, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	Can provide this information.	Awaiting DH guidance. Revise QERC quarterly report (on the basis that Trust Board reports are already on the website).	
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about	Quarterly Combined Risk Management Reports are	Quarterly reports will have an anonymised summary of complaints	

Rec	Theme	Recommendation	Current Practice/Evidence	Action	Lead/ Timeframe
		complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	made available. Currently do not include summary of complaints.	concluded appended. Check circulation of quarterly report and amend accordingly.	
120		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	As above	As above. Provide information in accordance with commissioner requirements.	
121		The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	Would be possible to provide this.	Await guidance. Anticipate requests for information.	
122	Handling large scale complaints	Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted; • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.		National issue? If local, consider review of major incident process and communications handling.	

Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust – Recommendations

R1	Ensure that every complainant: is clearly and specifically given a named person to liaise with is asked what their preferred method of communication is has the opportunity to discuss the issues face to face can confirm the outcome they are seeking from the complaint	Current practice, based on national good practice. Investigating Officer training. "Boundaries" letter following initial meeting with complainant. Key corporate staff trained in process. Covered by policy.	No action	
R2	Every response letter should be cross referenced against the original complaint letter and a summary of the investigative findings, to ensure that it answers all of the issues raised and does not 'miss the point'.	Current practice. See example letters.	No action	
R3	Review the process for risk assessing complaints to ensure this is conducted with clinical input and appropriate seniority	Current practice. SRD undertake an initial risk rating (CMAP). Investigating Officers are, in the main clinically trained, and as part of the investigation process, will review the initial assessment. See Complaints Management Action Plan (CMAP) template.	No action	
R4	Every investigation should have an identified lead investigator and decision maker and a clear management plan. For medium and above complaints this should be a senior member of Trust staff and where possible have two separate individuals fulfilling the two different roles. The lead investigator must not be the person who is being complained about.	Current practice. Investigating Officer training. Trust does use two Investigating Officers where complaints are particularly complex. Clinical Director and Chief Operating Officer would review.	No action	
R5	Make better use of organisational policies, NICE guidelines and	Investigating Officer training	No action	

	independent opinions when drawing together judgements to inform the decisions as to which aspects of the complaint will be upheld.	reflects national guidance. Included in CMAP template.		
R6	Introduce a standardised template for collating interview notes and statements and increase the use of interviews as part of the investigation process	A template (CMAP) was developed approximately five/six years ago for this particular purpose.	No action	
R7	Ensure those complained about are sufficiently involved in the investigation of a complaint and provision of a response	Current practice. Investigating Officer training. Responsible Consultants approve final letter prior to sending out. National good practice.	Although statements are taken from all involved staff, staff will be shown a draft copy of the concluding letter prior to sending.	Complete
R8	Clearly articulate what aspects of the complaint have been upheld, both in the evidence files and the response letter.	Based on the investigation findings, full explanation is afforded to each aspect of the complaint and the Trust will use terminology which explains whether the Trust upholds the complaint or otherwise. We do not use specific terminology such as upheld, not upheld, partially upheld.	NED monitoring	
R9	Ensure all contact with the complainant and activities of the investigation are recorded within the complaint file	Investigating Officer training. CMAP template. Use of Safeguard Contacts Section of IT system.	No action	

Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust - Standards

Standard Description		**Current Practice/Evidence**	**Action**	**Lead/Timeframe**
Standard 1:	The investigation of the complaint is impartial and fair.	Investigating Officer training Complaints Procedure. Internal audit review (two years ago).	No action	
Standard 2:	Individuals assigned to play a part in a complaint investigation have the	Investigating Officer Training. Quality assurance process via Executive Director. Buddying system	No action	

	necessary competencies.	for initial investigation.		
Standard 3:	The roles and responsibilities of the Complaints handling team are clearly defined.	Job Descriptions KSF Ongoing updates to ensure continue to review against changes to national legislation	No action	
Standard 4:	The governance arrangements regarding complaint handling are robust.	Complaints Procedure is based on statutory regulation and national best practice. Monitor process followed in a timely way, in accordance with the complainant and agreed timescales via Safeguard system. Combined Risk Management Report taken quarterly to QERC, commissioners and Trust Board.	No action	
Standard 5:	The Complainant has a single point of contact in the organisation and is placed at the centre of the process.	Current process. Complainant is informed of the name of the Investigating Officer, who will personally speak with the complainant to agree the boundaries, method of feedback and timescales.	No action	
Standard 6:	Investigations are carried out in accordance with local procedures, national guidance and within any legal frameworks.	Current practice. Trust's procedure and statutory regulation. Requirement to follow template. Template forms part of the audit trail and checked by the Complaints Team. Stored on Safeguard system.	No action	
Standard 7:	The investigator reviews, organises and evaluates the investigative findings.	Current practice. Use of CMAP template. Investigating Officer Training.	No action	
Standard 8:	The judgement reached by the decision maker is transparent and reasonable, based on the evidence available.	Current practice. Part of Quality Assurance by Chief Operating Officer.	No action	
Standard 9:	The complaint documentation is accurate and complete. The	Current practice. Use of Safeguard Risk	Audit practice in 2013/14 - complete	

	investigation is formally recorded, the level of detail appropriate to the nature and seriousness of the complaint.	Management System. Complaint file.		
Standard 10:	The Organisation responds adequately to the complainant and those complained about.	Current practice, which is based on evidence obtained by IO and documented in CMAP template. Part of the standard letter invites person to come back to the Trust if not happy with response or wants clarification. Standard format leads to all points raised by complainant being addressed.	No action	
Standard 11:	Learning lessons from complaints occurs throughout the Organisation.	Quarterly Combined Risk Management Report; Monthly Automated Safeguard Reports to Divisions on complaints received, concluded and proposed actions. Discussed at Divisional and Directorate level meetings.	No action	
Standard 12:	The Organisation records, analyses and reports complaints information throughout the organisation and to external audiences.	As above.	No action	