South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Thematic Review of Service Relations and Patient Advice and Liaison Service

June 2011

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Introduction

The aim of this second Thematic Review Report is to outline national guidance, the work that has been undertaken during 2010/11, including statistical information, and to identify priorities for future work.

This report endeavours to:

- ensure that the Board is fully aware of the ethos surrounding the legislation;
- provide an annual report on key statistical information
- produce an action plan, as outlined in the appendix, for the Board to support.

PART I: SERVICE RELATIONS DEPARTMENT

National Context

The 2006 White Paper, "Our Health, Our Care, Our Say" made a commitment to implement a single complaints procedure across health and social care. In April 2009, a new two-stage complaints process for health and social care, was published, "Listening, Responding, Improving: A Guide to Better Customer Care", and replaced the existing system. The national vision behind the new system was to transform complaints handling to become more comprehensive, accessible and patient-focussed, using local resolution to respond flexibly and quickly to individual cases.

This Trust has always adopted the ethos of being patient-focussed when resolving complaints, either formally through the Complaints Procedure or informally through our Patient Advice and Liaison Service. For this Trust, the new Regulations (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) have had little effect on the procedure that has been utilised over many years, as the new national philosophy endorses many of the principles that we have always applied.

Good complaint handling is not limited to providing an individual remedy to the complainant; indeed the Trust embraces the view that all feedback and lessons learnt contribute towards service improvement. Learning from complaints is a powerful way to improve services, enhancing the reputation of the Trust and increasing trust amongst the people who use its services.

In summary, the main principles of the Regulations are:

- all complaints have to be acknowledged within three working days following date of receipt; this can either be undertaken verbally or in writing;

- the adoption of a more flexible timescale, which is customer focussed and allows for a robust investigation, promoting a philosophy of "do it once, do it right";

- from the initial meeting with the complainant, a formal agreement should be reached and confirmed, in writing, which details the likely timescale, the issues to be investigated and how the complainant would like to be informed of the outcome;

- in almost all cases, a complaint should be made within twelve months of the incident being referred to, or the complainant becoming aware of the incident;

- although issues should be resolved as quickly as possible, allowing for thorough investigation and response, should a case continue to be unresolved for more than six months, it would be considered good practice to review the case and investigate the reasons behind the slow progress;

- if, following local resolution, a complainant remains dissatisfied, they do have recourse to request a review of their complaint by the Parliamentary and Health Service Ombudsman;

- oral complaints that can be dealt with within 24 hours need not be recorded. However, in view of the valuable learning that can be gained, these are logged and, in the main, managed by the Trust's Patient Advice and Liaison Service. PALS and the Service Relations Department have always striven to work closely together and if an oral complaint or indeed something which can be easily resolved, every effort is made to resolve the issue as quickly as possible; and

- formal adoption of a multiagency procedure for handling complex complaints. The Staffordshire/Shropshire Procedure was nationally cited in a Department of Health Advice Sheet called, "Joint Working on Complaints – an Example Protocol" as good practice.

Annual Statistics

(a) Complaints

All complaints relating to both South Staffordshire and Shropshire, have been administered centrally by the Service Relations Department, based at Trust Headquarters in Stafford. This report contains details of all complaints relating to both Shropshire and South Staffordshire received during 2010/11.

During this period 132 complaints were received by the Trust; this represents a decrease of 26% on the previous year. The Trust has always welcomed receiving complaints, as it does give the organisation opportunities to learn and improve service delivery.

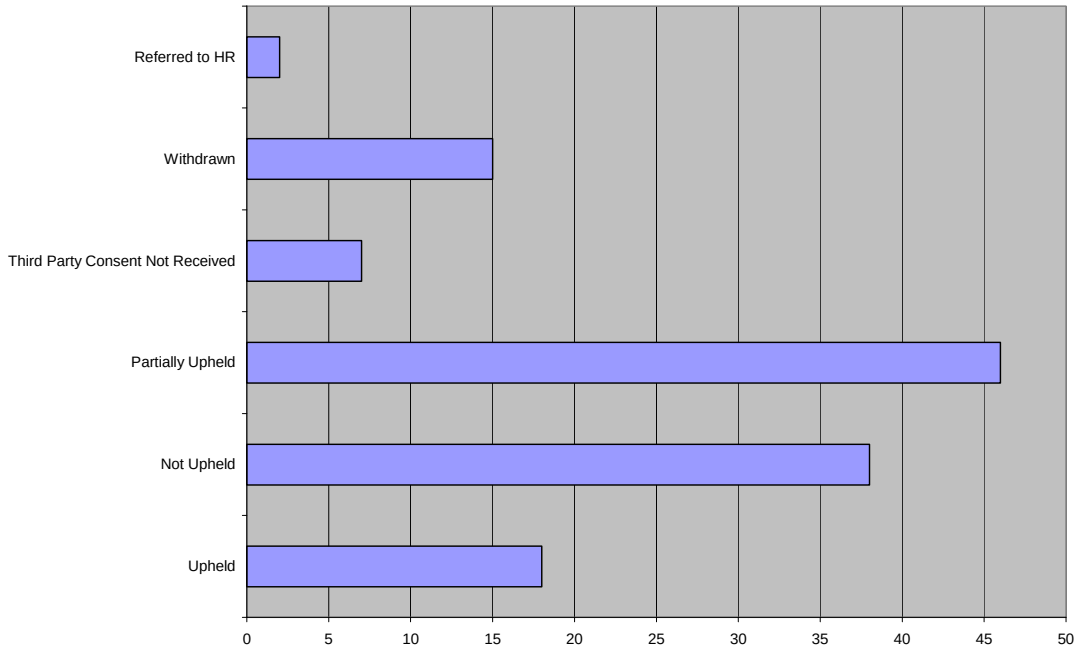
At the time of writing, the Trust had closed 126 complaint cases, with the following outcomes:

Not Upheld	Partially Upheld	Upheld	Withdrawn	No Third Party Consent Received	Referred to HR	Investigation Ongoing
38	46	18	15	7	2	6

As indicated above, the investigation in 6 cases are still on going. This is due to the following reasons; delay in service users providing signed consent to allow the Trust to share the findings with third parties where complaint is made by third party, availability of staff involved in the complaint investigation, and delay by complainant in providing confirmation of issues they would like investigated.

It is acknowledged that if a complaint is withdrawn, the official complaints procedure ends but, as a learning organisation, Directorates consider the issues raised to seek reassurance.

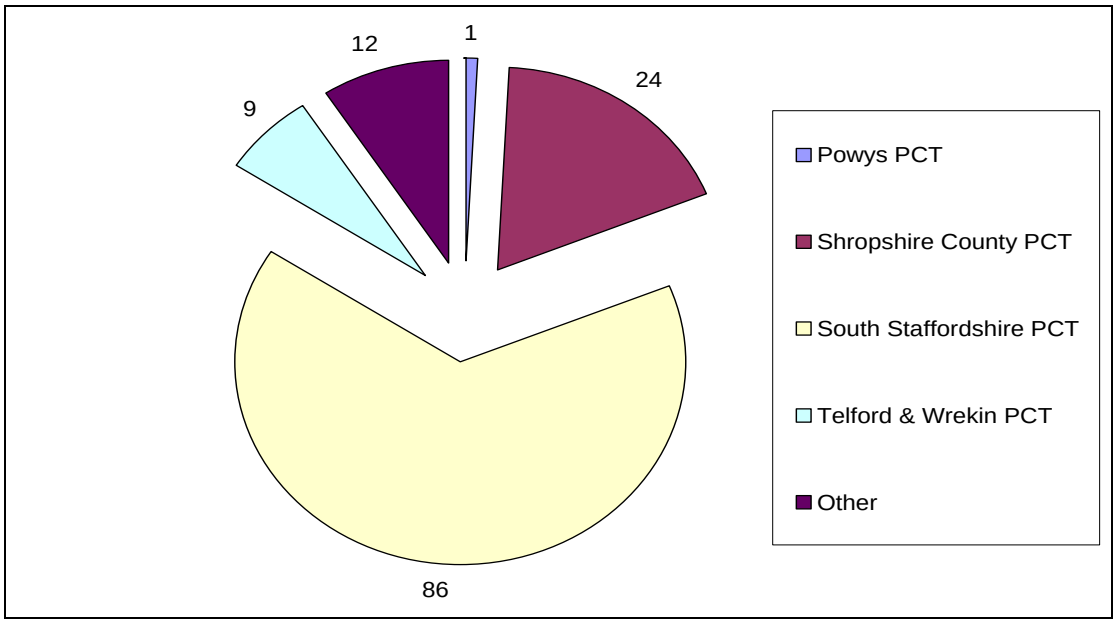
Outcome of Complaints Received



Number of Cases Received by Primary Care Trust Area

In order that Primary Care Trusts 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.



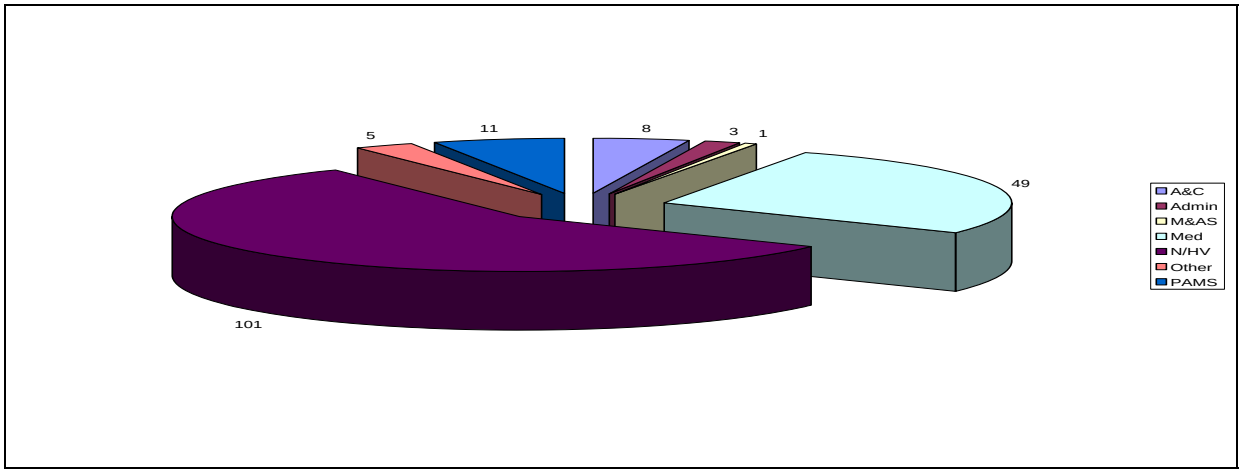
On further analysis of the commissioning bodies, it is interesting to note that South Staffordshire continues to receive proportionately more of the formal complaints made than would be expected statistically. This may be attributed to local interest in

quality of care due to the continuing publicity about care at Mid Staffordshire NHS Foundation Trust. The same information literature on our services is available throughout the Trust. There is no conclusive evidence, other than previously stated, as to why the numbers for the Shropshire County and Telford and Wrekin Primary Care Trust areas are low in comparison with South Staffordshire. However, looking at last year as a contrast, there has been no significant increase in complaints for Shropshire County and Telford and Wrekin PCTs.

Complaints by Directorate/Service

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
Chief Operating Officer	1				1
Children's Services	4	3	3	2	12
Forensic Mental Health	2		1	2	5
Developmental Neurosciences and LD	3	1	1		5
Mental Health: Shropshire	11	9	2	6	28
Mental Health: Staffordshire	19	16	7	24	66
Quality and Professional Practice			1	1	2
Specialist Services	2	3	6	2	13
TOTAL	42	32	21	37	132

Complaints by Staff Group



Main Issue of Complaint Raised by Category

Category	2008/09	% of Total	2009/10	% of Total	2010/11	% of Total
Access To Services	7	6.14	4	2.25	0	0
Admission Arrangements	0	0	4	2.25	0	0
Appointment (OP) Cancellation	1	0.88	2	1.12	1	0.75
Appointment (OP) Delay	1	0.88	9	5.05	7	5.30
Appt - Staff Failed To Arrive	1	0.88	0	0	0	0
Attitude of Staff	24	21.05	29	16.29	24	18.00
Bed Management	0	0	1	0.56	0	0
Change Of Consultant Request	1	0.88	0	0	0	0

Category	2008/09	% of Total	2009/10	% of Total	2010/11	% of Total
Clinical Treatment	26	22.81	33	18.53	29	22.96
Communication/Info to Patients	12	10.52	28	15.73	28	21.21
Confidentiality	5	4.38	7	3.90	3	2.27
Diagnosis Problems	1	0.88	4	2.25	8	6.06
Discharge Arrangements	4	3.50	8	4.49	6	4.54
Equality and Diversity	-	-	-	-	2	1.51
Failure to Follow Procedures	1	0.88	3	1.68	2	1.51
Failure To Visit Patient	1	0.88	2	1.12	0	0
PCT Commissioning, including Waiting Lists	13	11.40	13	7.30	2	1.51
Medication	2	1.75	15	8.42	10	7.57
Mental Health Act	-	-	-	-	5	3.78
Other	0	0	1	0.56	1	0.75
Patient's Privacy & Dignity	3	2.63	5	2.80	3	2.27
Patients Property	1	0.88	4	2.25	2	1.51
Personal Records (Health)	3	2.63	2	1.12	0	0
Policy & Commercial Decisions	1	0.88	0	0	0	0
Premises - General	1	0.88	0	0	0	0
Security	1	0.88	0	0	0	0
Staffing Levels	2	1.75	2	1.12	0	0
Transfer Arrangements	2	1.75	1	0.56	0	0
Visiting Arrangements	0	0	1	0.56	0	0
TOTAL	114		178		132	

The Trust has seen a reduction in the main categories of complaint in attitude of staff, clinical treatment, discharge arrangements and medication this year. However, the percentages against the number received have slightly increased in staff attitude, clinical treatment, communication/information to patients and diagnosis problems.

On analysing staff attitude and clinical treatment more closely, the following figures are based on the KO41a return, which is a report which the Trust has to send to the Department of Health, Based on the main category of complaint. From these figures, the overall outcome is detailed. Taking the individual numbers of complaints received for each of the following categories, from the number of staff attitude complaints – 12.5% were upheld last year, compared with 14% the previous year and for clinical treatment, 7% were upheld this year, compared with 6% last year.

Outcome	Staff Attitude		Clinical Treatment	
	2009/10	2010/11	2009/10	2010/11
Upheld	4	3	2	2
Partially Upheld	5	6	10	17
Not Upheld	10	6	16	7
Third Party Consent not Received	2	1	2	1
Withdrawn	7	6	2	2
Referred for SI Investigation	1	0	1	0
Referred to HR	0	1	0	0
Remains under Investigation	0	1	0	0
TOTAL	29	24	33	29

(b) Parliamentary and Health Service Ombudsman

The Trust received the outcome of an investigation undertaken by the Parliamentary and Health Service Ombudsman (PHSO). An action plan, based on the recommendations of the report, was developed and completed. This related to a complaint which was handled during 2007/08. Appendix 1 is a copy of the updated SI action plan, which includes assurances of how the individual actions have been embedded within the organisation.

As reported in last year's review, the Trust was awaiting the outcome of a further case and this was received in April 2010. The PHSO confirmed that she did not intend to invoke a formal investigation, as the complaint had been managed appropriately.

Two complaints were referred to the Parliamentary and Health Service Ombudsman during 2010/11. The Parliamentary and Health Service Ombudsman, following an initial assessment of two the cases, decided that no further action or investigation was required.

(c) Working with the Patient Advice and Liaison Service

The Service Relations Department continues to work closely with the Patient Advice and Liaison Service, in order that the most appropriate route of resolving individual complaints is agreed, taking into account the sensitivity, urgency and complexity of the concern.

(d) Publicity

During the year, a revised easy read version on how to access PALS or how to make a formal complaint was updated and distributed throughout the Trust.

(e) Investigating Officer Training

Throughout the past year, the Service Relations Department has delivered Complaint Investigating Officer Training for Band 7s (60 members of staff) and above, concentrating on the importance of thorough and robust investigations, the requirement for evidence based reporting, the importance organisational learning from complaints and statutory regulations. A further programme of training is planned for the forthcoming year.

(f) NHS Choices – www.nhs.uk

The section, "Your Thoughts" allows 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. Last year, the Trust received a total of nine entries; of which four recommended the individual hospital they had commented on to other service users. All entries have been responded to and shared with relevant staff and those that could not be fully addressed, mainly due to lack of detail, were invited to contact, in the first instance, the Patient Advice and Liaison Service.

It was interesting to note that eight of the nine comments received were from service users that had been admitted to Shelton Hospital, of which 50% were positive.

The negative comments included issues such as lack of activities in an inpatient area and communication.

(g) Patient Opinion – www.patientopinion.org.uk

This website became live during the latter part of 2009 and during the period under review, the Trust has received one submission. However, in view that the detail of the entry was incomplete, the Trust responded by asking the service user to contact the Trust with his concerns. No contact to date has occurred.

(h) Actions Taken to Improve Service Delivery

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 develop and improve our services. The following are examples of some of the actions taken to improve the quality of service delivery, as a result of complaints received this year:

- The need to explain to service users and their relatives the reasons why they may be asked questions, which could be regarded as repetitive, has been highlighted to professional staff.

- The necessity to clearly document receipt of any personal belongings/letters/documents has been reiterated to staff.

- Feedback from complaints received by the Trust contributed to the decision by the Commissioners to fund a Child and Adolescent Mental Health Service/Learning Disability Psychiatrist post.

- Staff have been informed of the importance of giving information to service users on the possible side-effects they may experience and how to obtain support if needed. Also the importance to ensure that when this information is given, it is recorded within the service user's health record.

- A system has been implemented within Adult Mental Health to ensure CMHT staff, involved in checking open referrals for potential closure, makes certain that the health record, care plan and last patient letter are all examined before closing a referral, in order that outstanding actions have been completed.

- Recommendation made that on the GP referral form to mental heath services, there should be provision to state whether the service user has a physical disability. Primary Care Trusts undertook to raise this suggestion at a Practice Managers Meeting.

- The CPA documentation has been modified to include a section which documents whether the carer has been offered an assessment.

- Ward Teams are required ensure that formal 1:1 sessions with service users are clearly documented within the health record.

- A system has been introduced whereby letters copied to service users stating that they did not attend appointments should not be sent unless it is certain that no attempt was made to attend, re-arrange or cancel the appointment.

- Ward communication book now has a prompt to inform service users, on admission, of their named nurse. Notice boards in each room are now updated on a regular basis, ensuring that the service user's key worker is identified.

- New service user information packs have now been placed in each bedroom.

- Staff have been advised to inform all service users, on admission, of the availability of the inpatient pharmacist.

- Revised documentation used for the giving of Mental Health Act rights and identifying all attempts made has been introduced.

- New CPA documentation now includes a prompt for staff to inform service users on how they can access out of hours support when they are in crisis. This information is also included on all relevant standard letters.

During the year, the Service Relations Department commenced using an automated outstanding action reminder system, which is a feature on the current Safeguard Risk Management System. This has enabled a more robust monitoring mechanism to ensure that actions highlighted, as part of the complaint investigation process are completed.

(i) Reporting

The Service Relations Department and PALS contribute to the Integrated Quarterly Reports, which are presented to the Quality, Effectiveness and Risk Subcommittee of the Trust Board and to the Trust Board of Directors, as part of the Integrated Performance Report. 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. They also submit regular statistical information on a monthly and quarterly basis to the commissioning organisations.

Service Relations is now a formal member of the Mental Health Divisions' Quality, Effectiveness and Risk Groups, which formally review the responses and learning from all complaints responded to.

(j) Meetings with Non-Executive Director

In line with one of the recommendations of the Francis Report, the Service Relations Manager is now meeting 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 meeting will also consider the more complex cases and discuss the methodology of resolution.

The Complaints/PALS sections of the Quarterly Risk Management Integrated Reports are also reviewed, along with any new national guidance/annual reports etc.

(k) Listening and Learning: The Ombudsman's Review of Complaint Handling by the NHS in England 2009-10

This report was presented the Quality, Effectiveness and Risk Committee in December 2010.

(l) Delivering Service Excellence

This training programme, which is currently being implemented throughout the Trust, focuses on attitudes and behaviours of staff and is tailored around the values of the organisation and information on complaints has been sought as part of the planning process and each programme will be tailored around the needs of each area.

(m) Internal Audit Report

During 2010, Internal Audit undertook a high level review of complaints incidents, SUIs and PALS. This review gave as assurance level of "green", but as part of the review of complaints, the following recommendation was made:

"The Trust should develop a structured approach to reviewing complaints action plans post-implementation to gauge their effectiveness in addressing the issues that led to a complaint being made. Where the actions are deemed to be ineffective, alternative actions should be introduced."

The Service Relations Department has adopted a more structured and robust approach in order to ensure that all actions highlighted as a result of a complaint are implemented (please see Action Plan 2010/11). On the rare occasion, where a similar complaint is made, a different investigating officer would be appointed who, as part of his deliberations, would look independently at the processes adopted. If there was any need to review previous actions, this would be undertaken at the time and further actions recommended if appropriate.

Trends analysis is undertaken on a monthly, quarterly and annual basis and if a trend was recognised, the attention of the relevant Directorate/Service Manager would be immediately sought. Within the quarterly report, service improvements made as a result of a complaint/PALS concern are reported on, to ensure that these are cascaded to all Trust staff members.

PART II: PATIENT ADVICE AND LIAISON SERVICE

National Context

In July 2000, the Government published the 10 year NHS Plan: A Plan for Investment - A Plan for Reform. The Plan proposed the development of a Patient Advocacy and Liaison Service which, by 2002, was to be established in every Trust.

The Core Functions of the Patient Advice and Liaison Service (PALS):

- be identifiable and accessible to patients, their carers, friends and families;
- provide immediate help in every Trust, with the power to negotiate immediate solutions or speedy resolution of problems;
- act as a gateway to appropriate independent advice and advocacy support from local and national sources;
- provide accurate information to patients, carers and families about the Trust's services and about other health related issues;
- act as a catalyst for change and improvement, by providing the Trust with information and feedback on problems arising and gaps in services;
- operate within a local network with other local PALS and work across organisational boundaries; and
- support staff at all levels within the Trust to develop a responsive culture.

PALS do not deal with:

- Complaints which require formal investigation;
- Matters relating to a breach of Trust policies; and
- Issues of breach of Law.

PALS can also support staff at all levels to develop a responsive culture. This will partly be achieved through staff being sensitive, receptive and listening to feedback from service users/carers. PALS can support staff in providing information on voluntary and statutory agencies.

(a) Training

PALS /Formal Complaints Awareness Training is delivered to all staff, including new junior doctors as part of their induction in the Trust. A schedule of twelve training sessions is programmed to take place throughout the Trust and individual team training sessions are also delivered on request.

(b) Promotional Work

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.

(c) Timeframe

In line with the new complaints reform, PALS aim to resolve all issues within 24 hours. Those falling outside of this target are monitored using the action plan module on the Safeguard system.

During 2010-11, PALS dealt with 1298 contacts, of which 1074 were resolved within 24 hours.

(d) Number of PALS Issues raised by Directorate

Table below highlights the number of issues raised, by individual directorates, during 2010/2011:

Directorate	Compliment	Concern	Information Request	Suggestion	Total
Chief Operating Officer	5	14	92	4	115
Children's	27	20	19	0	66
Facilities and Estates	15	150	2	16	183
Forensic	10	150	24	4	188
Developmental Neurosciences and Learning Disabilities	7	10	2	3	22
Human Resources & Organisational Development	1	0	0	0	1
Mental Health: Shropshire	56	87	41	13	197
Mental Health: Staffordshire	164	223	62	9	458
Specialist Services	29	30	5	4	68
TOTAL	314	684	247	53	1298

During 20010/11, the Patient Advice and Liaison Service (PALS) saw a 14.8% increase in the number of contacts received. It is felt that the rise in the number of contacts received is, in part, as a result of continued promotional work that has been undertaken by the PALS Team during the year, staff awareness training and efforts to ensure that all issues being raised by service users and carers are captured and recorded as PALS issues in a timely manner. Any trends identified have been highlighted in the Integrated Quarterly Risk Management Report and the monthly return to the PCTs, eg rationalisation of the Sexual Abuse Service, shortage of staff, food.

PALS have continued to see a significant increase in the number of requests for information. This has mainly been due to the increase in requests for interpretation and translation services, which has seen a 175% increase compared to the previous year. A revised Interpretation and Translation Policy had been developed and is due for submission for approval and ratification in July/August 2011.

It is noted that, as in previous years, Mental Health Staffordshire Division has received the majority of concerns. The table below gives a comparison from 2008/09 to 2010/11, by sub-category:

Category	2008/09	2009/10	2010/11
01 Accommodation Issues	9	2	0
01 Admission	4	1	4
01 Bed Management	4	9	6
01 Discharge	8	4	10
01 Transfer	12	13	14
02 Aids And Appliances	2	2	3
02 Car Parking	3	0	0
02 Equipment	3	3	0
03 Cancellations	3	2	4
03 Delays	4	9	13
05 Administration	0	1	0
05 Nursing Staff	3	1	0
05 Psychologists	1	1	0
03 Staff Failed To Arrive	0	0	2
05 Staffing Levels	0	1	3
06 Observation	0	3	3
06 Physically Aggressive	2	7	1
06 Rude	7	11	9
06 Unhappy With Care	19	21	16
06 Unhelpful	8	14	6
06 Verbally Threatening	0	0	1
07 Activities	0	0	3
07 Care Plan	1	10	10
07 Carers Rights	1	0	3
07 Consultants	16	6	13
07 CPN	1	6	14
07 Diagnosis Problems	11	9	7
07 Extra Support Needed	17	31	28
07 Lack of Supervision	2	1	0
07 Medication	16	30	19
07 Unhappy With Service	12	19	19
08 Availability of Leaflets	1	0	0
08 Availability Of Support Groups	0	2	3
08 Freedom of Information	0	1	0
08 Interpretation/Translation	0	0	3

Category	2008/09	2009/10	2010/11
08 Oral Communication	7	9	6
08 Patients Rights	10	31	8
08 Social Care	0	0	1
08 Written	1	3	4
09 Procedure not Followed	0	1	0
09 Rights Not Explained	1	2	0
10 Unhappy with Outcome	0	1	0
11 Availability of Same Sex Nurse	0	1	0
11 Dignity	4	7	3
11 Patients Choice	0	0	3
11 Privacy/Security	2	5	9
11 Restoring Procedures	3	1	0
11 Relationships With Other Patients	2	8	3
11 Ward Incident	2	0	0
12 Damage To Property	1	1	1
12 Missing Property	3	7	4
12 Patients Finance	1	2	2
12 Property	0	2	0
13 Health & Safety	1	13	2
13 Comfortable Furniture	0	1	0
13 Cleanliness	0	0	1
13 Air Quality/Temperature	3	0	0
13 Décor	1	1	0
13 Noise	5	3	0
13 Smoking Issues	9	2	0
13 Premises General	0	0	5
14 Personal Records - Health	3	5	3
15 Leave	1	1	0
15 Policy & Procedure	7	4	0
15 Risk Assessment	0	1	0
15 CPA	0	0	1
15 Failure To Follow Procedure	0	0	2
17 Transport General	0	0	3
17 Availability	1	3	0
17 Reimbursement	3	0	0
18 Availability of Literature	1	1	0
18 Support from Staff	0	2	0
19 Food	0	11	3
20 Terms and Conditions of Leave	0	2	0
20 Leave Cancelled	2	0	0
20 Mental Health Act	0	0	2
22 Voluntary Services	0	0	1
23 Communication between Directorates	2	1	0
23 Other PALS	1	1	0
24 Information	0	6	0
24 Other	3	5	3
25 PCT Commissioning Including Waiting	8	0	14
26 Patient to Patient	1	4	0

(e) 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
Compliment	255	314
Concern	699	756
Information Request	101	175
Suggestion	51	53
TOTAL	1106	1298

(f) Main Issue of Contact Raised by Category

The table below lists the number of issues raised under each category, during the period 1 April 2009-31 March 2010, with comparison to previous years:

Category Type	2008/09	% of Total	2009/10	% of Total	2010/11	% of Total
01 - Other PALS	36	3.579	39	3.526	0	0
01 – Admission, Discharge, Transfer	46	4.573	39	3.526	49	3.775
02 – Aids, Appliances, Equipment, Premises	26	2.584	20	1.808	54	4.16
03 – Appointments	18	1.789	25	2.26	41	3.159
05 - Staffing Levels	10	0.994	18	1.627	31	2.388
06 - Attitude Of Staff	72	7.157	97	8.77	67	5.162
07 - Clinical Treatment	192	19.085	217	19.62	214	16.487
08 – Communication/Information to Patients	69	6.859	85	7.685	228	17.565
09 - Consent To Treatment	3	0.298	3	0.271	2	0.154
11 - Patients Privacy and Dignity	34	3.38	36	3.255	44	3.39
12 - Patients Property and Expenses	12	1.193	24	2.17	15	1.156
13 – Environment	74	7.356	67	6.058	50	3.852
14 - Personal Records	11	1.093	11	0.995	18	1.387
15 - Failure To Fllw Procedure	21	2.087	7	0.633	9	0.693
17 – Transport	10	0.994	8	0.723	5	0.385
19 - Hotel Services	88	8.748	69	6.239	95	7.319
20 - Mental Health Act	2	0.199	8	0.723	3	0.231
22 - Info Given - Vol Sector/Services	3	0.298	15	1.356	6	0.462
24 – Other	20	1.988	55	4.973	25	1.926
25 - PCT Commissioning	12	1.193	3	0.271	28	2.157
26 – Assault	5	0.497	4	0.362	0	0
Complaint Handling	0	0	1	0.09	0	0
21 - Staff Compliment	242	24.056	255	23.056	314	24.191
Total	**1006**		**1106**		**1298**	

The number of issues raised under category “Other PALS” has dropped to zero, due to a change in how these issues are categorised.

There have been some marked increases in categories as follows:

- **Communication/Information to Patients**

  This principally has been as a result of the increase in the booking of Interpretation and Translation Services via the PALS team.

- **Aids, Appliances, Equipment, Premises**

This has mainly been as a result of concerns being raised about the faulty showers on Elm Ward and on Norton House, as a result of the boiler not functioning.

- **PCT Commissioning**

  This increase has, in the main, been due to the closure of a number of services which the Trust no longer provides, eg Substance Misuse Services which was based at Coton House, Sexual Abuse Services. PALS also received a number of concerns from service users indicating that they were concerned that there were plans for the Margaret Stanhope Centre to close.

- **Hotel Services**

  The majority of these issues have been around food, especially with the change in the patient food arrangements at Shelton Hospital.

- **Appointments**

  The increase in concerns about appointments was mainly due to delays in service users being offered appointments; these were not due to a particular service, indeed these were widespread throughout the Trust. There were also a number of concerns where service user appointments had been cancelled without them being informed.

(g) Following PALS intervention, changes have been made to services:

- The policies relating to the next-of-kin being informed of a service user's self-discharge and the non-prescribing of medication on self-discharge are to be reviewed.

- Hotel Services agreed to provide a menu to the wards the day before, in order that patient choice can be facilitated and requirements pre-ordered.

- Introduction of a special diet form for service users who have special dietary requirements.

- Hotel Services has reprinted menus for elderly service users in 14 font and printed on A5, which are laminated and displayed in the dining areas on each ward.

- Provision of a baby changing area in the Substance Misuse Clinic at Park House.

- Service user telephone number on Stokesay Ward now displayed next to the telephone, in order for service users can relay this information to relatives when they call.

- Paving between the bowling club and cricket club at Shelton Hospital re-laid.

- Stonefield House are now using a "traffic light signals" system, which enables service users to communicate more effectively, afford them control in different situations and improve social skills. A key ring has also been designed for service users to use in the community and at home.

(h) The PALS service has also received 314 compliments on behalf of the organisation, which was a 23% increase from the previous year. Although the importance of inputting compliments on to the Safeguard database is emphasised at all training sessions and an annual request is made in the Trust's POD for copies to be sent, there is a strong feeling that not all are forwarded to PALS.

Compliments received, include:

- Facilities and Estates Department commended for the excellent work they do, especially in the winter months in maintain the footpaths, to ensure the safety of all staff, service users and those visiting the premises.

- Compliment received for PALS from service users on Bromley Ward thanking them for responding to their concern so quickly and obtaining better quality tea bags for them.

- Service user's mum complimented the Aspen Project organised by CAMHS in Burton. "I was really glad that it was so readily available for us as a family; exactly when we needed it. The weekly meetings ran during school hours and lasted for a number of weeks. Once these regular sessions started my son's outlook on life was dramatically different. Those few weeks support have enabled him to cope much better at school but have also changed his life outside. For us I would have to say our experience is a resounding success. The support from Aspen has been immeasurable."

- Family of a service user wrote to thank the staff and the Consultant on Chestnut Ward – "We would like to say a huge thank you to all of the kindness and care you showed during the time spent with you. Familiarity and routine really helped him to settle and I know that when we look back on those days in years to come we will remember musical visits, sunshine in the conservatory and a man mostly content with an art book and a piece of cake. I am so grateful that we were able to rediscover these happy moments and for this we are indebted to you all."

- "Thank you to everyone at Spring Meadow, it has been the best thing I have ever done and it has helped me change my life for the better. I am always grateful and do not know what I would have done without this service."

- "I would like to express my thanks and gratitude for all your help. I am pleased to inform you that I am both physically and mentally well and settling in with everyone."

- Grandchildren of service user wrote a letter thanking all the excellent staff at the Margaret Stanhope Centre for helping to get their grandmother back to her happy self.

- "Thank you for your help; I have now qualified as a teaching assistant you have helped me come through so many problems."

SERVICE RELATIONS DEPARTMENT AND PATIENT ADVICE AND LIAISON SERVICE ACTION PLAN AND PROGRESS 2010/11

Objective	Action Details	Outcome	Timeframe	Progress	Lead Officer
Enhance investigation skills for investigating officers	Participate in the development of a training day for all investigating officers involved in undertaking formal investigations into complaints and SUIs	All investigating officers will be fully briefed on the expectations required to conduct a robust investigation, in line with regulation	31.10.10	A programme of Complaint Investigating Officer training sessions has been undertaken throughout the year. Further sessions are programmed.	Paula Johnson, Service Relations Manager, in conjunction with Sarah Hankey, Assistant Risk Manager
Implement automated action reminder system for complaints and PALS	Ensure that the newly installed automatic action reminder system is tested and implemented.	All lead officers with outstanding actions will be automatically E-mailed on a monthly basis, to ensure that Service Relations are informed of the current position	31.07.10	This system was implemented as from 01.09.10.	Paula Johnson, Service Relations Manager/Sean Hunter, Deputy Service Relations Manager
	In addition, as DQ 2 project work progresses, the option of exploring the uploading of any required actions onto DQ will be undertaken, in conjunction with the Performance Development Team		31.12.10	Discussion held. Safeguard System felt fit for purpose.	DQ Project Lead/ Paula Johnson, Service Relations Manager

Objective	Action Details	Outcome	Timeframe	Progress	Lead Officer
Complaints Procedure ratified	Following consultation, to be submitted to the QERC and Trust Board for ratification	The Complaints Procedure will be available on the Trust's website	31.08.10	Completed	Paula Johnson, Service Relations Manager
Produce an information leaflet explaining the full complaints process, including recourse to Parliamentary and Health Service Ombudsman, which can be appended to the formal acknowledgement letter	Develop an easy read information leaflet for complainants, based on Regulation, to ensure that complainants are fully informed of their rights in relation to the complaints process	An information leaflet will be available for inclusion with all acknowledgement letters	31.12.10	Currently in draft format. To be consulted upon and implemented by 1 October 2011.	Sean Hunter, Deputy Service Relations Manager
Ensure that a statement on Data Protection is included on the Complaints and PALS sections on the Trust's website	To research this addition further, discuss with the Trust's Information Governance Manager and produce statement.	Additional information to be included on the Trust's website.	31.12.10	Awaiting reply from Communications Manager.	Sean Hunter, Deputy Service Relations Manager
Ensure that where actions remain outstanding at the time of the conclusion of a complaint, complainants are informed when they are completed	CMAP to be modified, to ensure that a specific action is placed on Safeguard to remind SRD that a letter should be sent on completion of actions	All complainants will be informed of the outcome of any outstanding actions applicable to their complaint	30.09.10	This is now being undertaken.	Paula Johnson, Service Relations Manager
To continue to promote PALS and Service	As a minimum, deliver twelve training	A programme of 12 scheduled training	31.03.11	Completed.	Sean Hunter, Deputy Service Relations

Objective	Action Details	Outcome	Timeframe	Progress	Lead Officer
Relations to staff, service users and carers.	sessions across Staffordshire and Shropshire throughout the year	sessions to be promoted throughout the Trust.			Manager
A revised PALS Policy will be produced	PALS Policy will be reviewed, consulted upon and ratified	The PALS Policy will be ratified and available on the Trust's intranet	30.09.10	For ratification at July 2011 Trust Board Meeting.	Sean Hunter, Deputy Service Relations Manager

SERVICE RELATIONS DEPARTMENT AND PATIENT ADVICE AND LIAISON SERVICE ACTION PLAN 2011/12

Objective	Action Details	Outcome	Timeframe	Lead Officer
To ensure compliance with NHSLA standards, devise an audit tool to be used by the NED when reviewing casework on a quarterly basis.	Devise an audit tool for use from 01.10.11.	NED will audit four case files every quarter, in line with the audit tool.	01.10.11	Paula Johnson, Service Relations Manager
To produce a policy which reflects the principles of redress as outlined in the PHSO's document "Principles for Remedy"	Develop a policy document, in line with the principles of redress as outlined in the PHSO's "Principles for Remedy" document.	This policy will be ratified and available on the Trust's intranet.	31.12.11	Paula Johnson Service Relations Manager
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	A programme of 12 scheduled training sessions to be promoted throughout the Trust.	31.03.11	Sean Hunter, Deputy Service Relations Manager
Collect data on religion/belief, disability, sexual orientation from people using the service.	Explore methods whereby PALS/Service Relations can collect data.	PALS/Service Relations to commence collation of data.	31.03.12	Sean Hunter, Deputy Service Relations Manager
Monitor the uptake of PALS/Service Relations promotional material by the Teams/ Departments, in order to assist targeting areas for PALS/formal	Produce spreadsheet and target training accordingly. Schedule PALS/formal complaints awareness training, ensure that staff are fully aware of the availability of the publicity material and ensure that supplies are	All staff will be fully aware of the services provided by PALS and Service Relations, including available publicity material.	31.12.11	Sean Hunter, Deputy Service Relations Manager

Objective	Action Details	Outcome	Timeframe	Lead Officer
complaint awareness training and the provision of publicity material.	maintained.			
Enhance investigation skills for investigating officers	Programme of training sessions for complaint investigating officers to be provided.	All investigating officers will be fully briefed on the expectations required to conduct a robust investigation, in line with regulation	Ongoing	Sean Hunter, Deputy Service Relations Manager
Produce an information leaflet explaining the full complaints process, including recourse to Parliamentary and Health Service Ombudsman, which can be appended to the formal acknowledgement letter	Develop an easy read information leaflet for complainants, based on Regulation, to ensure that complainants are fully informed of their rights in relation to the complaints process	An information leaflet will be available for inclusion with all acknowledgement letters	01.10.11	Sean Hunter, Deputy Service Relations Manager

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

APPENDIX 1

ACTION PLAN FOLLOWING A SERIOUS UNTOWARD INCIDENT ON BROCTON HOUSE

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
Risk Assessment and Management					
Nursing Staff on the ward should review the handover process (also see "Communication").	The handover system should be reviewed to ensure that a full, systematic and robust handover is delivered.	November 2007 COMPLETED	JL	New protocol for handover agreed and implemented.	Handover policy has been reviewed. ***Handover book in place. Robust systems in place on wards*** Functionalisation Rapid Review Meetings on all adult acute wards, subject to audit over 2011. ***All Rapid Reviews are minuted on all wards***
Links between the care plans and the risk assessments needs to be agreed in a multidisciplinary context.	All members of the multi-disciplinary team should engage in the risk assessment/care co-ordination process Risk Assessment to be incorporated into every	November 2007 COMPLETED	JL	Process implemented.	Risk assessment and care plan form part of Rapid Review Risk Assessment information. Process audited by unannounced and announced visits by Service Manager and Matron and findings

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
	review				tabled at Locality and Ward Managers' Meetings. Audit of case notes by wards form part of weekly monitoring. ***Monitoring forms for announced and unannounced visits available on golden thread***. ***local ward audits available on wards and in golden thread ward folders on P Drive***
Care Co-ordination/risk assessment training updates should be made available to all multi-disciplinary staff.	Teams have refresher training on risk assessment and management	November 2007 COMPLETED	JL	All staff members attend risk assessment/ management training on a mandatory basis. Will be audited on an annual basis by Senior Nurses.	Clinical risk training being attended by ward staff. % captured on training report delivered monthly to Division and discussed at Ward Managers Meeting. ***Locality and Ward Managers' Meetings minuted. Clinical risk training – monthly training template is sent to wards to ensure compliance. All training attendance schedules***

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
					are available in the training department and performance drive
Documentation, Care Co-ordination and Record Keeping Regular audit of case files to check quality and legibility of the clinical notes in line with Essence of Care requirements (EOC) requirements	LA to ensure all relevant EOC requirements are incorporated into the existing programme of audits being carried out across all areas.	October 2007 COMPLETED	LA	All teams are subject to regular health records audit by the Clinical Audit Team. In relation to the single integrated notes, the ward teams have access to all health records for individual patients. The Trust has implemented a new single integrated health record, which has been rolled out.	Patient records are multi-disciplinary, integrated and subject to regular review by ward staff, Service Manager and Matron visits. Issues addressed at ward level and trends discussed at Ward Manager and Locality Manager Meeting. **Monitoring forms for announced and unannounced visits available on golden thread. Local ward audits available on wards and in golden thread ward folders on P Drive. Also minuted in Ward Managers Meetings and Locality**

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
					Meetings
All Care Co-ordinators should be encouraged to follow up their patients on admission to the ward to start to plan their discharge from the admission with the ward team	JW to ensure a check for separate records and carers' assessments is included in the audit.	November 2007 COMPLETED	JW	Confirmed that health record audit now includes this.	Care Co-ordinators attend 72 hour formulation meeting and pre-discharge meetings on wards. This will form part of an audit on the Functionalisation implementation to occur 2011. ***Minutes taken for Formulation Meetings***
		November 2007 COMPLETED	JL	New Admission and Discharge Policy in place, which ensures that robust supervision is in place.	Is currently being reviewed.
	A list of all inpatients on a Care Co-ordinator's caseload is made available to Community Team Leaders, to ensure that	November 2009 COMPLETED	JL	Robust information system already operational, which provides Team Leaders with caseload details.	This is still the current system.

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
	robust supervision is in place.				
The case files should be integrated at all stages of the care process.	Integration of all case notes already well developed is to be completed.	November 2009 COMPLETED	LA	See above comment in relation to new integrated record.	Service user records are multidisciplinary and integrated, subject to regular review by Ward Manager, Service Manager and Matron visits. Issues addressed at ward level and trends discussed at Ward Manager and Locality Manager Meeting.
Reflective practice and supervision should be strengthened to continue to highlight the process of recording therapeutic activity and/or observations in a meaningful way.	Review findings of the clinical supervision audit that has recently been conducted and act on findings	September 2007 COMPLETED	PW	Audit reviewed and work in progress.	Activity and 1:1s subject to audit undertaken by Ward Manager as part of case note review. **See page 2 for evidence store.**
	Once a month formal peer review/support meeting to be implemented on all wards	November 2007 COMPLETED	JL	Ward Managers receive monthly supervision form line manager. Ward Manager to ensure that clinical team have regular peer support and supervision on a group basis through ward	Ward Managers receive supervision from Matron and/or lead nurse. Supervision tracker being used in all areas to check supervision. ***Notes available via supervisor***

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
				meetings and on an individual basis as appropriate. This will be audited by HCC annual review.	
Communication					
The Ward Manager to review handover information given to staff and its purpose as a set standard	The Ward Manager to review handover information given to staff and its purpose and a set standard, taking account professional best practice guidance including EOC.	November 2007 COMPLETED	Ward Manager	Standard to include Healthcare Support Workers to be included in the handovers and fully briefed. Anyone who cannot attend to be fully briefed afterwards. Standard implemented through new handover protocol.	Handover policy has been reviewed. ***Handover book in place*** **Functionalisation rapid review meetings on all adult acute wards, subject to audit over 2011.** ***All rapid reviews are minuted on all wards***
Supervision systems need to be applied to ensure clear line management accountabilities are in place and opportunities for reflection and development linked to KSF.	As above actions under "Documentation, Care Co-ordination and Record Keeping".	NA	NA		Ward Managers receive supervision from matron and /or lead nurse. Supervision tracker being used in all areas to check supervision***. Notes available via supervisor***
Staff ward meeting to	The Ward Manager to	November 2007	Ward	These are now held on a	Ward Meetings in place

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
take place regularly and include practice review.	introduce regular staff ward meetings that include practice review.	COMPLETED	Manager	monthly basis and includes review of practice as a standard agenda item.	on wards. **Minutes posted on Golden Thread CQC tracker.** ***Evidence available on GT ward folder on P Drive***
Carer Assessment In line with Trust policy, carers are to be offered assessment and the main carer and their support needs are defined. This should then be audited.	Documenting carers' assessments is covered by existing policy. Audit as above under "Documentation, Care Co-ordination and Record Keeping".	November 2007 COMPLETED	JW	See above.	Carer assessment reports submitted by Local Authority and discussed at Locality Manager Meeting. ***Evidence available in locality meetings and Divisional Performance Meetings***
Engagement/ observation at night To ensure all staff are aware of the present policy and practice and are reassured they will be supported in the balance between privacy and safety if required.	The Observation Policy to be reviewed and ratified at the next Clinical Effectiveness and Risk Sub-Committee. Policy then to be deployed in all areas	October 2007 COMPLETED	JW/AW	Policy agreed and implemented.	Observation policy in situ, reviewed and ratified. Tabled at Ward Managers and Locality Meeting 2011, subject to audit 2011. ***Audit to occur and will be monitored via QERG***
The ligature assessment needs to be repeated to	The Ward Manager will	October 2007	Ward	Ligature assessments	Ligature assessments

Recommendation	Proposed Action	Target Date	Lead Officer	Comments	Assurance to QERC 2011
check if all ligature points have been addressed.	review ligature assessments.	COMPLETED	Manager	undertaken April 2007 and annual thereafter.	completed 2011. Tabled at DMT 23 May 2011. ***All audits on P Drive. Actions taken forward by Trust wide group 2011. Minutes available at Trust level***
Dual Diagnosis Adult Mental Health Services/ Substance Misuses service work together to provide integrated care	A new care pathway is currently being developed and will be deployed across all areas	December 2007 COMPLETED	MT/SP/JL	Policy agreed and implemented.	Dual Diagnosis Strategy Group in place; policy to be updated. Link worker for inpatients identified. training on DD ongoing. ***Minutes available on P drive. Strategy on Trust Intranet***
Contact with the family Prior to the Coroners Inquest the Trust to attempt to contact the family	Offer of support to family, advising that a copy of the investigation report is available to them	End of August COMPLETED	AA	Confirmed that contact made, albeit there were difficulties in this. SUI policy updated and training implemented, which highlights individuals' responsibilities.	Letter written to carers when tragedy occurs. Engagement with family at early stages of SI occurs. ***Evidence in letters from IO to family. File kept in RM office. Divisional pathway available on P Drive***