CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Report of:	Cheryl Lenney - Chief Nurse
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Date of paper:	May 2016
Subject:	Annual Complaints Report 2015/16
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Resolution • Approval ✓
Consideration of Risk against Key Priorities	Patient & Staff Experience
Recommendations	The Board of Directors is asked to note the content of this report, the work undertaken during 2015/16, and in line with statutory requirements provide the approval for the report to be published on the Trust website.
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Central Manchester University Hospitals NHS Foundation Trust

Annual Complaints Report 2015/16

1. Executive Summary

1.1 The Trust adheres to the Statutory Instruments 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public under the 2009 regulations. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the Trust, received between 1st April 2015 and 31st March 2016.

1.2 Work has continued during 2015/16 to build upon the improvements made in 2014/15. This report celebrates some of those achievements and marked improvements whilst acknowledging there are improvements still to be realised.

1.3 Following their inspection of the Trust in November 2015, the Care Quality Commission (CQC) reported a number of positive findings; including that staff were aware of how to access the Trust's complaints policy and that the Trust's staff try to resolve complaints informally in a timely manner. The CQC recognised that learning from complaints is shared, implemented and evaluated and cited good examples of system and practice changes made in response to learning from complaints.

1.4 Throughout the report the term ***complaints*** is used to describe formal complaints requiring a response from the Chief Executive and the term ***concerns*** is used to describe informal contact with Patient Advice and Liaison Service (PALS) which require a faster resolution to issues that may be resolved in real time.

2. Summary of Activity

2.1 Comparative data is provided within the report against the previous year's (2014/15) performance. Caution should applied to comparison with previous years' data as the data collection systems in previous years were not as precise as those derived using the full functionality of the Safeguard system, which was introduced from 1st April 2014.

2.2 The number of PALS concerns received in 2015/16 is 4138. This represents an increase of 564 when compared to the 3574 concerns received in 2014/15.

2.3 There has been an overall increase in the number of formal complaints in 2015/16, with a total of, 1160, which is 143 more than the number of complaints received in 2014/15 (1017).

2.4 As a measure of performance against organisational activity, the number of formal complaints must be considered in context. The following table shows the number of formal complaints in context of inpatients, out-patients and in Accident and Emergency attendances.

Table 1: Complaints received in context of activity

		2015/16
Inpatient Episodes	Formal Complaints received(FC)	446
	Finished Consultant Episodes (FCE)	281818
	Rate of FCs per 1000 FCEs	1.58
Out-patient Appointments	Formal Complaints received (FC)	481
	Number of appointments	1654713
	Rate of FCs per 1000 appointments	0.29
A&E Attendances	Formal Complaints received (FC)	109
	Number of attendances	305814
	Number of FCs per 1000 attendances	0.36

2.5 The average age of formal complaint cases at 31st March 2016 was 33 working days compared to 43 working days at 31st March 2015 and 63 working days at 1st April 2014. The number of cases resolved in 25 days has similarly improved from 11% in March 2014 and 28% in March 2015 to 30% in March 2016.

2.6 The Trust has an internal target of no more than 20% of unresolved cases being over 41 days old at any one time. At the end of March 2016, 21% of cases were over 41 days old. This compares to 48% of cases at the end of March 2015 and 71% of cases at the end of March 2014. All cases over 41 days are escalated within the division and discussed at the fortnightly Complaints KPI meeting, chaired by the Chief Nurse.

2.7 The average response rate for patients and carers raising a concern through the PALS service has improved from 11 days at the end of Quarter 4 (2014/15) to 6 days at the end of Quarter 4 (2015/16).

2.8 There has been continued improvement in relation to the acknowledgement of complaints within 3 working days, which is a statutory requirement. Throughout 2015/16 this has consistently been between 95-100% and since September 2015 compliance has been consistently between 99-100%.

2.9 The Parliamentary and Health Service Ombudsman (PHSO) represents the second and final stage of the NHS complaints process and the Trust has worked with the PHSO to satisfactorily resolve complaints during the year. The Trust continues to develop its relationship with the PHSO and this has proven to be mutually beneficial during 2015/16. Following public feedback, the PHSO changed a number of their processes enabling the organisation to work more efficiently and as a direct result nationally they have increased the number of investigations into complaints and concerns.

2.10 The PHSO closed 28 cases pertaining to the Trust between 1st April 2015 and 31st March 2016 and of these; 3 complaints were upheld, 13 were partly upheld and 12 were not upheld. The details of each PHSO case are set out in this report. This compares to 14 cases closed in 2014/15 when 3 complaints were upheld, 7 cases were partly upheld and 4 cases were not upheld. At the 31st March 2016 there were 21 complaints under investigation by the PHSO.

2.11 The Division of Surgery had the highest number of both formal complaints and PALS concerns during 2015/16. During Quarter 3 of 2015/16, the Division of Surgery attended the Quality & Performance Scrutiny Committee to present the complaints management process within the division and to present their plans for improvement.

2.12 The Division of Surgery is the first division to set local divisional trajectories for improving response times. Progress is being monitored via the Complaints KPI meeting and learning from the Division of Surgery will be shared with other Divisions. There are plans to set a performance trajectory for all divisions to meet the 25 day turnaround time in 80% of cases. The Division of Surgery continues to work to improve their complaints handling processes during 2016/17.

2.13 The most improved divisions in achieving a reduction in the number of complaints and concerns raised were the Manchester Royal Eye Hospital (MREH) and the University Dental Hospital.

2.14 The oldest case during the year was in the Division of Surgery and was open 160 days. Lessons have been learnt and shared from the management of this case regarding effective communication.

3. Complaints Scrutiny Group

3.1 The Complaints Scrutiny Group demonstrates Board level engagement and assurance regarding complaints handling through the Non-Executive Chairperson. This is complimented by other core group members which include a Trust Governor, Associate Medical Director, Deputy Director of Nursing (Quality) and Head of Patient Services. The group met 6 times throughout 2015/16 and at each meeting reviewed one complaint for each participating division, including evaluation of the effectiveness of actions taken and a progress review of any actions from the previous occasion the division attended the meeting.

4. Complaint Transformation Programme

4.1 Whilst the Complaint Transformation Programme came to an end in March 2015, the Deputy Director of Nursing (Quality) continues to work with the Head of Patient Services, the PALS and Complaints team and the Divisional Directors and Complaints Coordinators to continue making improvements to the management of PALS and Complaints within the Trust. Details of the improvement work in 2015/16 are contained within this report.

4.2 The ***'Tell us Today...'*** initiative provides a unique telephone number for inpatients to contact a senior member of staff with their concerns. This service has now been rolled out in all divisions within the Trust and whilst uptake has been low, where it has been used there is evidence that it has been effective in preventing concerns that can be dealt with quickly, escalating into more formal cases. An update of this work is contained within the report.

5. Learning

5.1 The report details examples of learning and change as a direct result of feedback received through complaints and concerns.

5.2 Examples of learning from complaints have been published in each quarter in 2015/16 and examples have now also been published on the Trust intranet and within the Patient Services newsletter, ***'Patient Experience Matters'.***

6. People

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

6.2 The Board of Directors is asked to note the content of this report and in line with statutory requirements provide approval for it to be published on the Trust's website.

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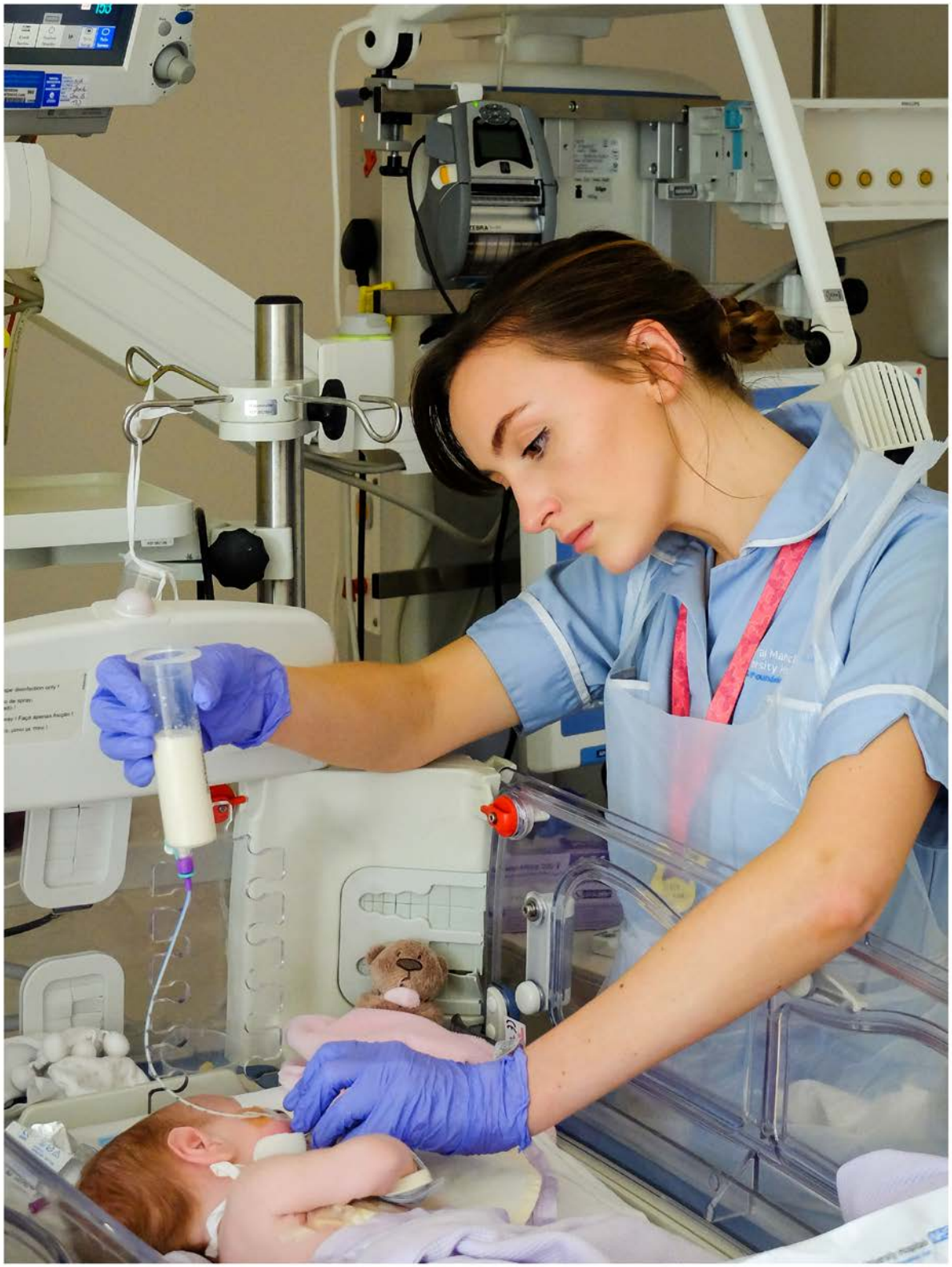


1. Statement

The Trust adheres to the Statutory Instruments 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public under the 2009 regulations. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the Trust, received between 1st April 2015 and 31st March 2016.

2. Introduction

2.1 This Annual Report demonstrates the progress made within the divisional and corporate teams during the year 2015/16. The improvement journey that started in 2014/15 has continued to develop and this has resulted in marked improvements made to the handling of complaints across the Trust.

2.2 During 2015/16 the Complaints and Patient Advice and Liaison Service (PALS) continued to build upon the Complaint Transformation Programme undertaken in 2014/15. These improvements are reflective of the contents of a paper that was jointly published by the Local Government Ombudsman, the Parliamentary and Health Service Ombudsman and Healthwatch Entitled, ***'My Expectations for Raising Concerns and Complaints'.*** This paper is aimed at improving the quality of complaints handling from a patient centred perspective.

2.3 Throughout this report the term ***complaints*** is used to describe formal complaints requiring a response from the Chief Executive and the term ***concerns*** is used to describe informal contact with PALS requiring a faster resolution to issues that may be resolved in real time.

2.4 Comparative data is provided within the report against the previous year's performance. Caution should be applied to comparison with previous years' data as the data collection systems in previous years were not as precise as those derived using full functionality of the Safeguard system, which was introduced from 1st April 2014. During 2015/16, work has been on-going to improve the quality of the complaints data and reporting. Data is now managed within the Trust data warehouse and during 2016/17 this will allow divisions to have better access to their complaints' data for reporting, management and analysis purposes.

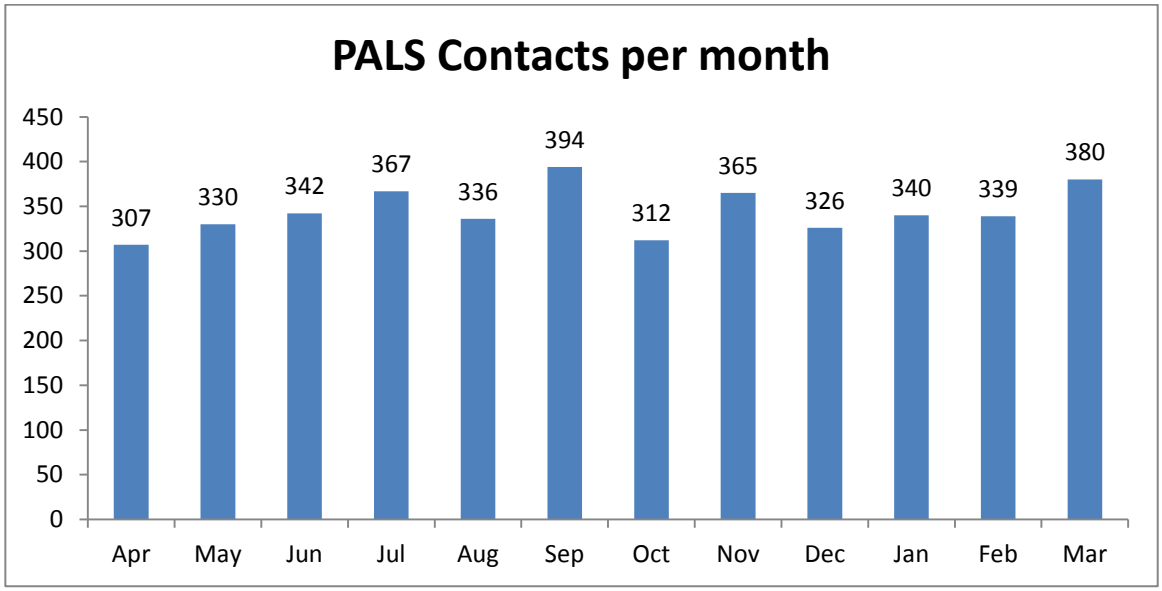
2.5 Due to the nature of complaints, the data fluctuates from day to day and this can influence the accuracy of the numbers reported within any one reporting period. For example, complaints may be withdrawn, de-escalated, deemed to be out of time or consent not received. Small variances within monthly, quarterly and annual reporting are therefore expected and accepted.

3. Overview of Activity

3.1 The number of PALS contacts received for 2015/16 is 4138, which is 564 more than the number received in 2014/15 (3574). This shows a 16% increase in the number of PALS contacts in the last year.

3.2 Graph 1 provides the number of Trust wide PALS contacts received by month for the financial year 2015/16.

Graph 1: Number of PALS contacts (by month) for 2015/2016 (Trust-wide)



3.3 The increase in PALS contacts can be attributed to a more proactive approach by the Trust to raise awareness of the PALS service and more proactive referral to PALS from within the divisions.

3.4 The introduction of the ***Tell Us Today*** telephone number for real time resolution of concerns for inpatients has also slightly increased the number of recorded PALS contacts.

Table 2: Number of PALS contacts by Division (4 year trend)

Division	2012/13	2013/14	2014/15	2015/16
Not stated/General Enquiry/Non-CMFT	57	53	37	51
Clinical Scientific Services	97	107	112	158
Corporate Services	90	173	154	179
University Dental Hospital of Manchester (UDHM)	128	156	175	130
Division of Medicine and Community Services	277	256	301	361
Division of Specialist Medical Services	328	374	468	576
Division Of Surgery	512	598	825	914
Manchester Royal Eye Hospital	349	378	355	361
Royal Manchester Children's Hospital (RMCH)	718	648	601	663
Saint Mary's Hospital	217	271	242	280
Trafford Hospitals	533	430	304	465
Trust Wide Total	**3306**	**3444**	**3574**	**4138**

3.5 The Division of Sugery received the highest number of PALS contacts in 2015/16; an increase of 11% during the year compared to 2014/15, with no specific theme identifiable with the Dental Hospital being the only division to receive less PALS contacts with a 35% reduction.

3.6 All PALS concerns are RAG rated upon receipt based on the severity of the concerns raised.

3.7 Table 3 indicates the number of contacts by risk rating grade. No contacts were graded as red (catastrophic), whilst there were increases shown in both yellow (moderate severity) and green (minor severity) categories, as is appropriate for the PALS service.

Table 3: 2015/16 PALS contacts by risk grading

Category	2012/13	2013/14	2014/15	2015/16
Not graded, escalated or enquiry	0	0	327	299
White	3	1214	N/A	N/A
Green	3018	1682	2547	2835
Yellow	2	420	666	959
Amber	283	126	33	45
Red	0	2	1	0
Total	**3306**	**3444**	**3574**	**4138**

3.8 The 2015/16 total of PALS contacts does not include those cases that were escalated for formal investigation (these are reported in the formal complaints section), were withdrawn by the complainant or were considered to be out of time according to the Complaints Regulation (2009) timescales.

3.9 The following table indicates how people access the PALS service.

Table 4: PALS Contacts by enquirer

	2014/15	2015/16
Comment Box	10	6
Email	658	768
Face To Face	527	519
Fax	1	2
From Complaints	6	1
From Family Support	9	0
From PALS	8	1
Letter	103	57
Other	10	8
Telephone	2214	2648
Tell Us Today	0	1
Website	0	1
Complainant	0	74
Family member	0	51
M.P.	28	1
Totals	**3574**	**4138**

3.10 Table 5 details the number of contacts by age; the age range relates to those of the people who were the focus of the PALS enquiry.

Table 5: PALS contact by age range

	2014/15	2015/16
0 - 18	886	1041
19 - 29	345	454
30 - 39	374	440
40 - 49	369	444
50 - 59	456	509
60 - 69	440	545
70 - 79	402	412
80 - 89	260	249
90 - 99	40	42
100+	2	2
Totals	**3574**	**4138**

3.11 Table 6 details the number of contacts by sex; again the sex relates to those of the people who were the focus of the PALS enquiry.

Table 6: PALS contacts by sex

	2014/15		2015/16	
Sex of enquirer	**Number of enquiries**	**% of enquiries**	**Number of enquiries**	**% of enquiries**
Female	1869	52.5%	2209	53%
Male	1686	47%	1836	44%
Not specified	19	0.5%	93	2%
Total	**3574**		**4138**	

3.12 Table 7 describes the ethnicity of the patients who were the focus of the PALS enquiry.

Table 7: PALS contacts by ethnicity

Ethnicity	**2013/14**	**2014/15**	**2015/16**
Any Other Ethnic Group	70	45	38
Asian Or Asian British - Bangladeshi	13	4	5
Asian Or Asian British - Indian	40	40	23
Asian Or Asian British - Other Asian	26	23	28
Asian Or Asian British - Pakistani	127	123	75
Black Or Black British - African	40	34	28
Black Or Black British - Caribbean	30	39	22
Black Or Black British - Other Black	15	13	11
Chinese Or Other Ethnic Group - Chinese	7	13	1
Mixed - Other Mixed	11	14	10
Mixed - White & Asian	4	7	3
Mixed - White & Black African	8	5	4
Mixed - White & Black Caribbean	14	16	8
Not Stated	748	1197	2260
White - British	2187	1902	1530
White - Irish	43	52	29
White - Other White	61	47	63
Total	**3444**	**3574**	**4138**

3.13 The above demographics support the data[1] that younger people are more likely to be dissatisfied with services than older people and women more likely to be dissatfied with services than others.

3.14 The Head of Patient Services is working with the Trust Equality, Divesity and Inclusion (ED&I) team to improve the number and quality of ED&I monitoring forms returned in order to be able to make this data set more representative of complainants in order to target improvements appropriately.

3.15 Graph 2 and table 8 provide a more detailed analysis of the principle PALS themes, indicating the main themes for PALS concerns relate to treatment and procedure, communication and appointment delays and cancellations.

Graph 2: Top 5 PALS Themes 2015/16

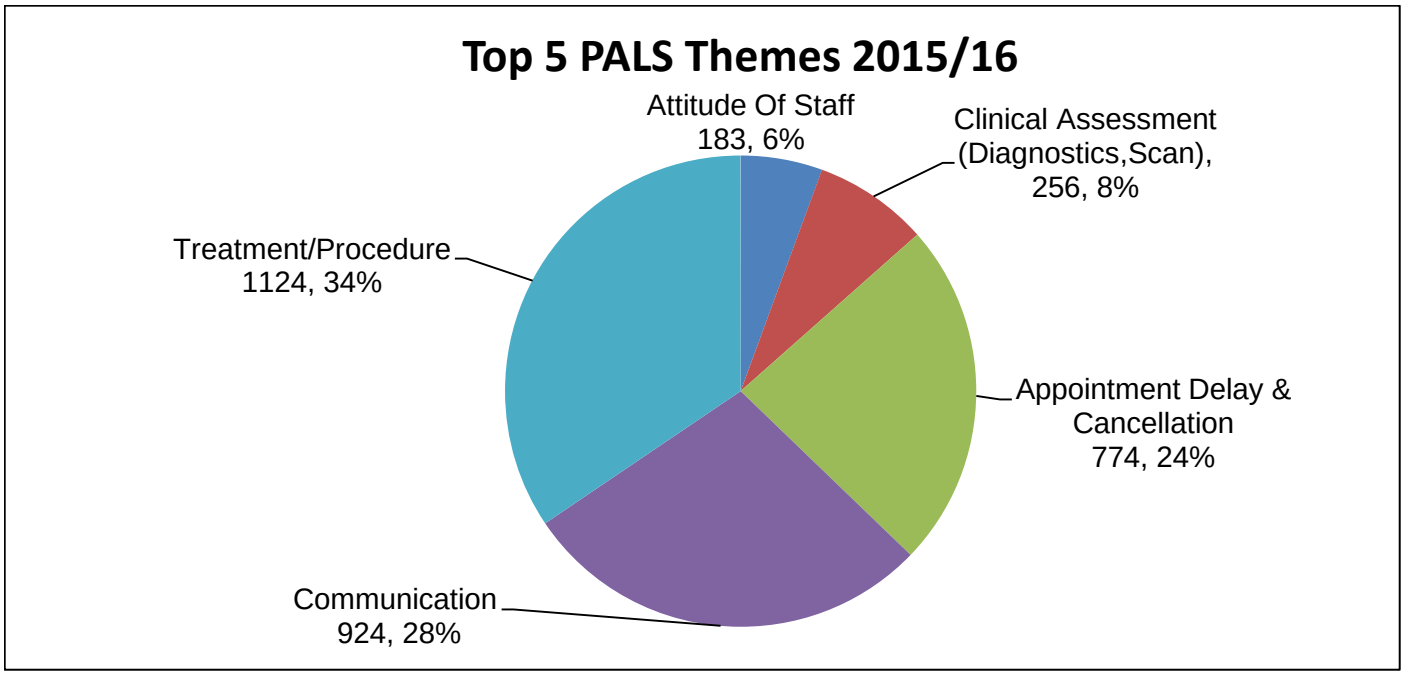


Table 8: Top 5 PALS Themes

	2013/14	2014/15	2015/16
1.	Consent, Communication, Confidentiality	Treatment/Procedure	Treatment/Procedure
2.	Treatment/Procedure	App, Delay/Cancellation (OP)	Communication
3.	Appointment Delay/ Cancellation OP	Communication	Appointment Delay/ Cancellation
4.	Positive Experience	Confidentiality	Clinical Assessment (Diagnostics, Scan)
5.	Attitude of staff	Clinical Assessment (Diagnosis, Scan)	Attitude Of Staff

3.16 The average response rate for patients and carers raising a concern through the PALS progressed from 11 days at the end of Quarter 4 2015, to 6 days at the end of Quarter 4

[1] DeCourcy, West and Barron (2012) The National Adult Inpatient Survey conducted in the English National Health Service from 2002 to 2009: how have the data been used and what do we know as a result? BMC Health Services Research series: Open, Inclusive and Trusted 2012 12:71

2016. This improvement is largely due to the ongoing work undertaken by the PALS and divisional team to provide responses in a timely manner.

3.17 The ***Tell us Today*** telephone number has now been rolled out across the Trust and provides real time responses to inpatients and their families. An update of this work is included in section 13.

3.18 Further reductions in PALS response times are expected in 2016/17.

4. Complaints Activity

4.1 There has been an overall increase in the number of formal complaints in 2015/16, with a total of 1160, which is 143 more than the number of complaints received in 2013/14 (1017).

Table 9: Number of Formal Complaints Trust wide 4 year trend

Year	2012/13	2013/14	2014/15	2015/16
Complaints Received	1084	1192	1017	1160

4.2 Table 10 details the 4 year trend for formal complaints at Divisional level. The Division of Surgery has received the most complaints at 239 compared to 203 received in 2014/15. Two Divisions have achieved a decrease in the number of complaints received namely The University Dental Hospital Manchester and the Manchester Royal Eye Hospital.

Table 10: Number of complaints by Division (4 year trend)

	2012/13	2013/14	2014/15	2015/16
Clinical Scientific Services	44	36	29	56
Corporate Services	23	34	30	52
University Dental Hospital of Manchester	30	44	47	44
Manchester Royal Eye Hospital	99	114	90	79
Medicine and Community Service	141	152	115	123
Royal Manchester Children's Hospital	177	164	126	150
Specialist Medical Services	125	123	105	137
St Mary's Hospital	134	166	149	160
Surgery (MRI)	190	183	203	239
Trafford Hospitals	101	137	116	119
Research and Innovation	0	0	2	0
External	20	39	5	0
Not Specified	0	0	0	1
Totals	**1084**	**1192**	**1017**	**1160**

4.3 There is no one single factor attributable to the increase in complaints within the Division of Surgery however the largest numbers of complaints were related to Communication closely followed by Treatment and Procedure.

4.4 The Division of Surgery had the highest number of both formal complaints and PALS concerns during 2015/16. During Quarter 3 of 2015/16, the Division of Surgery attended the Trust's Quality & Performance Scrutiny Committee to present the complaints management process within the division. During the meeting, the division presented a trajectory for improving response times. Progress was made following the development of an action plan to deliver the planned improvement trajectories with an overall reduction in the 41 day plus complaints in January and February 2016 (the number

reduced to 5). Unfortunately, the complaints coordinator and principle lead for general surgery complaints left the Trust in March 2016 which temporarily impacted on capacity, and performance has slipped back to a level of 17 cases over 41 days. In addition improvement against closure of complaints within 25 days has also been delayed. The Divisional Management Team acted swiftly to recruit a new coordinator and organise cover arrangements, supported by the corporate complaints team, that were established pending permanent recruitment to the post. A new complaints coordinator has now been recruited and the team is projecting a week on week improvement in performance.

4.5 Complaints are risk rated using a matrix closely aligned to that used by the Clinical Effectiveness teams when assessing the severity of incidents. There has been a numerical increase in complaints rated as red and an increase of 47% in the cases rated as amber. This is largely due to an improved application of the risk scoring matrix during 2015/16. Of the 12 red complaints, 5 relate to Clinical Assessment, 4 relate to Treatment or Procedure and 3 relate to Maternity or Neonatal Care.

Table 11: Complaints received 2014/15 by risk rating

Category	2012/13	2013/14	2014/2015	2015/16
Not Stated	45	0	0	1
White	10	0	0	0
Green	112	244	61	17
Yellow	547	599	559	547
Amber	359	345	395	583
Red	11	4	2	12
Totals	**1084**	**1192**	**1017**	**1160**

4.6 In accordance with the Trust Equality, Diversity and Inclusion Strategy equality monitoring data is collected in relationship to complainants protected characteristics.

4.7 Complainants are requested to provide information regarding their protected characteristics when they receive a written acknowledgement, but this process is entirely voluntary. The PALS team have sought to improve the process and improve response rates during 2015/16 by introducing a new letter explaining what how the information is used.

4.8 The Head of Patient Services will continue to work with ED & I colleagues to improve the response rate in order that the data is representative and can be used to identify improvements.

4.9 The age and sex of the patients involved in complaints during 2015/16 are highlighted in Tables 12 and 13.

Table 12: Age range of patients involved in complaints

	2014/15	2015/16
0 - 18	243	234
19 - 29	101	139
30 - 39	135	160
40 - 49	108	118
50 - 59	122	143
60 - 69	113	158
70 - 79	101	131
80 - 89	80	65
90 - 99	14	11
100+	0	1
Totals	**1017**	**1160**

Table 13: Sex of patients involved in complaints

	2014/15		2015/16	
Sex of enquirer	**Number of enquiries**	**% of enquiries**	**Number of enquiries**	**% of enquiries**
Female	567	56%	646	56%
Male	429	42%	503	43%
Not specified	21	2%	11	1%
Total	**1017**		**1160**	

4.10 Table 14 describes the ethnicity of the patients represented in complaints for the past 3 financial years.

Table 14: Ethnicity of patients represented in complaints

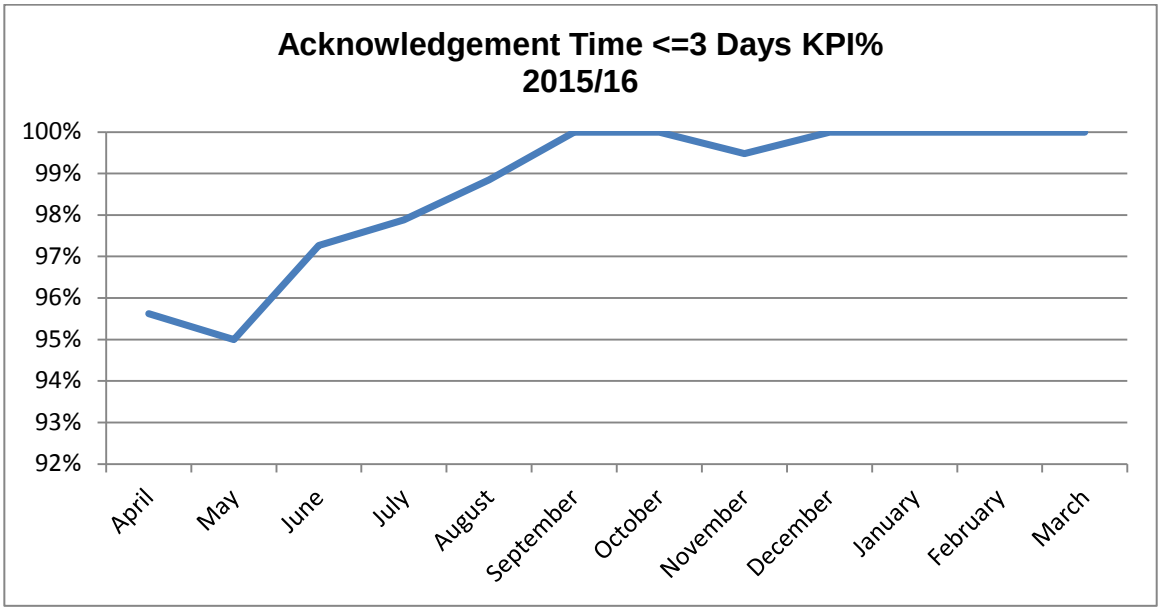
Ethnicity	**2013/14**	**2014/15**	**2015/16**
Any Other Ethnic Group	12	9	17
Asian Or Asian British - Bangladeshi	2	3	1
Asian Or Asian British - Indian	7	9	13
Asian Or Asian British - Other Asian	5	9	10
Asian Or Asian British - Pakistani	27	25	37
Black Or Black British - African	12	14	13
Black Or Black British - Caribbean	6	5	11
Black Or Black British - Other Black	5	0	3
Chinese Or Other Ethnic Group - Chinese	2	4	4
Mixed - Other Mixed	9	4	9
Mixed - White & Asian	1	1	0
Mixed - White & Black African	2	5	3
Mixed - White & Black Caribbean	5	9	3
Not Stated	537	547	496
White - British	528	359	512
White - Irish	11	8	9
White - Other White	21	6	18
Do not wish to answer	0	0	1
Total	**1192**	**1017**	**1160**

5. Acknowledging Complaints

5.1 There was continued improvement throughout 2015/16 in relation to the number of working days taken to acknowledge complaints. The statutory duty placed upon the Trust is to acknowledge 100% of complaints within 3 working days.

5.2 A dedicated case manager undertakes the role of acknowledging all complaints, providing a more personal service by contacting the complainant directly. The complaints process is explained to the complainant and an opportunity afforded to clarify the issues raised in the complaint and also to inform the complainant of the name of their dedicated Case Manager. Performance has improved from 95.6% compliance at the start of the year to 100% at the end of 2015/16.

Graph 3: Percentage of complaints acknowledged ≤ 3 working days

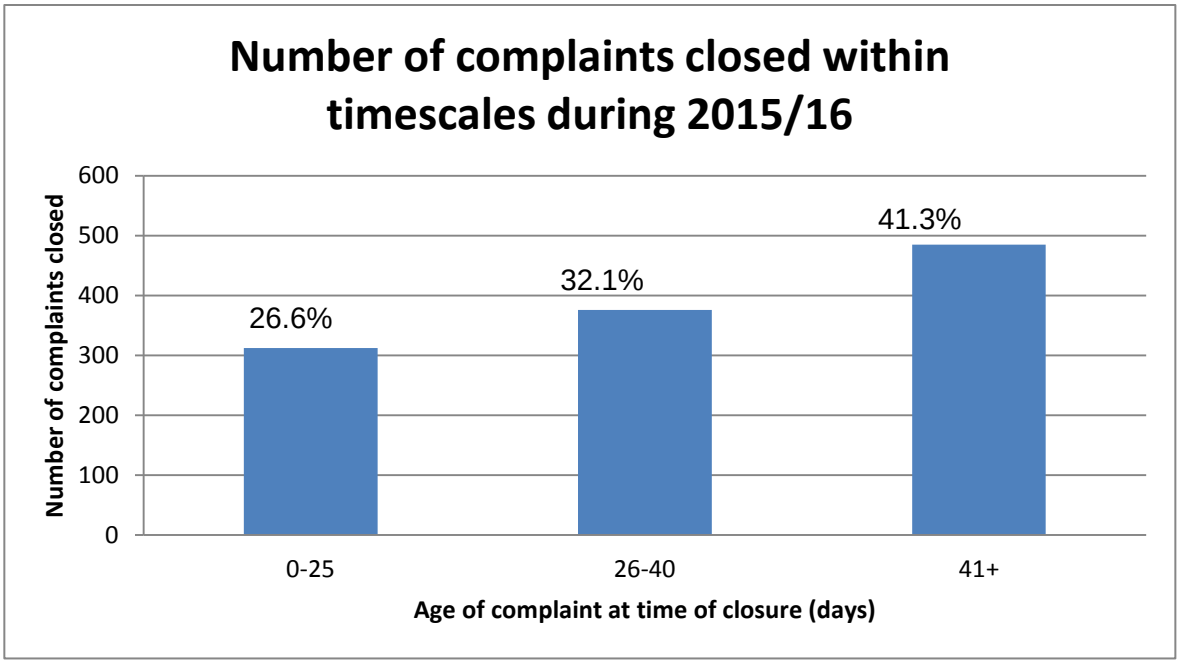


6. Response Times

6.1 The Trust target of resolving 80% of complaints within 25 working days continues to be monitored closely. Performance has improved during the year from 20% during April 2015 to 29% during March 2016, but this still remains considerably below the 80% target.

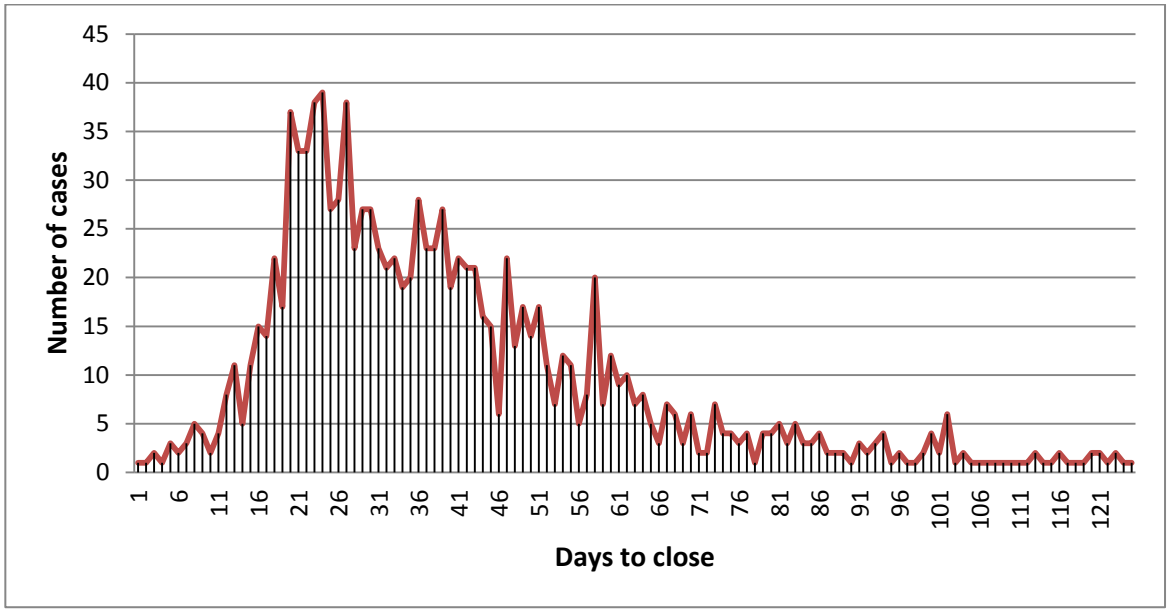
6.2 Graph 4 shows the Trust performance in relation to reponse times for complaints closed during the whole of 2015/16.

Graph 4: Complaints closed within timeframes during 2015/16



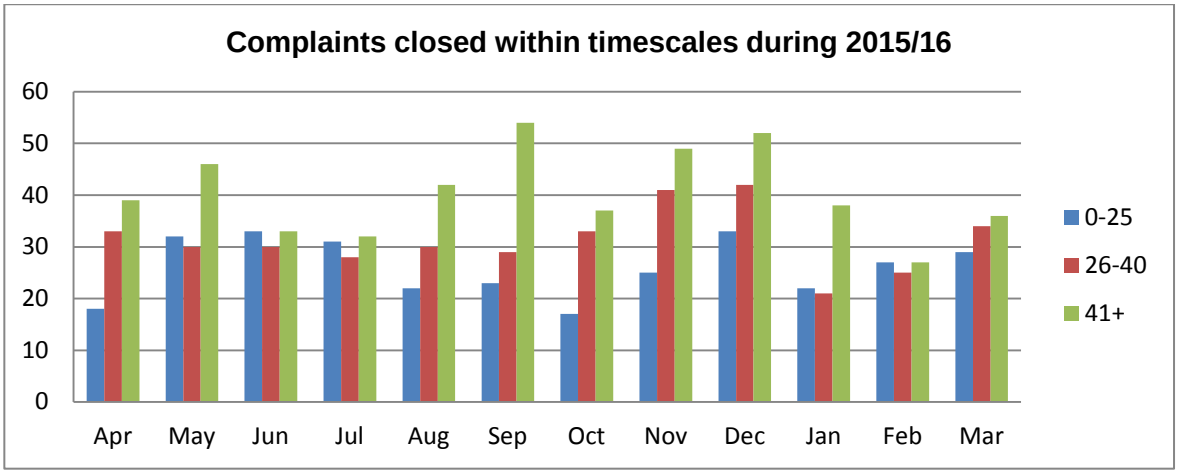
6.3 Graph 5 presents a granular level breakdown of the data shown in graph 4.

Graph 5: Number of case closed in 2015/16 within timescales



6.4 Graph 6 provises a breakdown of this performance by month during 2015/16.

Graph 6: Complaints closed within timescales during 2015/16



6.5 There was a specific focus during the year on managing the number of complaints that were over 41 days old. The Trust has set an internal target of no more than 20% of unresolved cases over 41 days at any one time. In April 2015, 48% of cases were unresolved over 41 days. This figure improved considerably to 26% of cases at the end of March 2016.

6.6 In response to the increasing number of complaints unresolved at 41 days, a Complaint KPI meeting was established in November 2015, chaired by the Chief Nurse and attended by the Divisional Directors to review all longstanding complaints. Initially all complaints over 95 then 90 days were scrutinised. During Quarter 4 this timeframe was reviewed and reduced regularly and at the end of March 2016, all cases over 41 days are being scrutinised at the meeting. The intention is to reduce the timeframe during 2016/17 to ultimately review any complaint over 25 days old.

6.7 The oldest case during the year was in the Division of Surgery and was open 160 days; this case involved two local resolution meetings as concerns remained outstanding following the initial meeting on 23rd November 2015. Delays were experienced in arranging a suitable date with the family and consultant for the meetings and the second meeting was held on 29th February 2016. The case was closed on 8th April 2016 and the lessons learnt from the management of this case related to effective communication.

6.8 The Trust continues to work toward a definitive target of closure within 25 days. Whilst this is an appropriate goal for most complaints, some will take much longer to resolve. Complaints involving High Level Investigations, complaints which are highly complex or those that involve other organisations will inevitablly take longer that 25 days to resolve. To this end, during 2016/17, the Patient Services Team will devise and implement a system for triaging complaints as they are received. A realistic time frame will be established according to defined criteria and this will be agreed with the complainant at the outset. This will support the Trust to meet its statutory duty to respond to complaints within a timeframe agreed with the complainant and enable performance reporting against this criteria to commissioners.

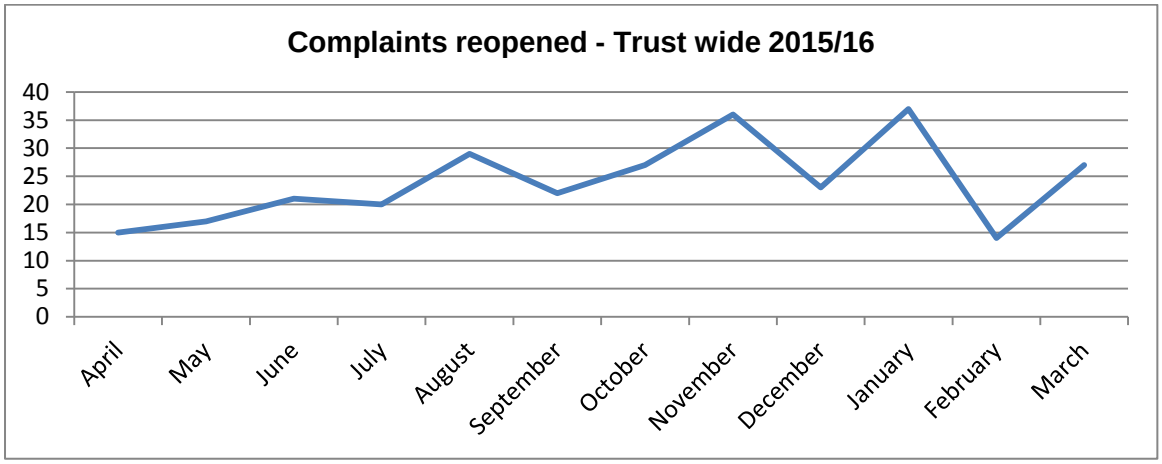
6.9 Throughout 2015/16 there was a wide variation in the number of re-opened complaints received across the Trust with a total reopened in year of 287 (24.7%). This compares to 274 (27%) reopened in 2014/15.

6.10 The Trust has an internal KPI for no more than 20% of cases to be reopened, recognising that some responses may require further information once a complaint

response has been received. In order to improve the quality of responses provided, and in an attempt to reduce the number of re-opened cases, during 2015/16 a programme of education was introduced for those staff responsible for responding to complaints. An information session was provided relating to the PHSO, a master-class was provided on using the Safeguard system and two educational sessions were provided relating to writing complaints responses and post-meeting letters.

6.11 Graph 7 details the number of re-opened complaints by month during 2015/16.

Graph 7: Number of Re-opened Complaints Trust wide by Month 2015/16



7. Themes

7.1 The themes and trends from complaints are reviewed at a number of levels. Each Division considers local complaints on a regular basis as part of their weekly complaints review meetings and monthly Quality Forums. Further analysis of complaint themes and trends is provided in quarterly complaints reports to the Board of Directors.

7.2 Table 15 demonstrates the 3 most prevalent category types raised (Trust wide) for complaints in 2015/16. The increased number, whilst representing an increase in complaints received also reflects the improved processes related to the themeing of complaints upon receipt.

Table 15: Top 3 Trust wide complaint themes (3 year trend)

Category	2012/13	2013/14	2014/15	2015/16
Clinical Assessment (Diagnosis/Scan)	461	518	444	522
Treatment/Procedure	353	440	796	1056
Consent/Communication/Confidentiality	361	475	907	1457

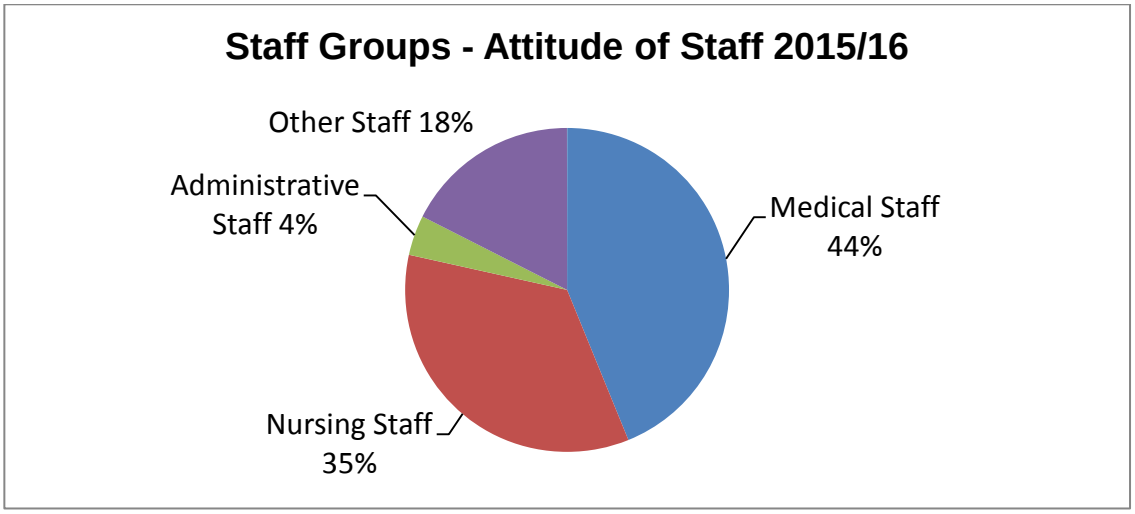
8. Our People

8.1 Table 16 provides the number of Formal Complaints and PALS that refer to staff attitude and graph 8 shows these as a percentage of all formal complaints and PALS during 2015/16.

Table 16: Number of complaints that refer to staff attitude

Attitude of Staff	2013/14	2014/15	2015/16
PALS	289	251	238
Complaint	242	294	283
Totals	**531**	**545**	**521**

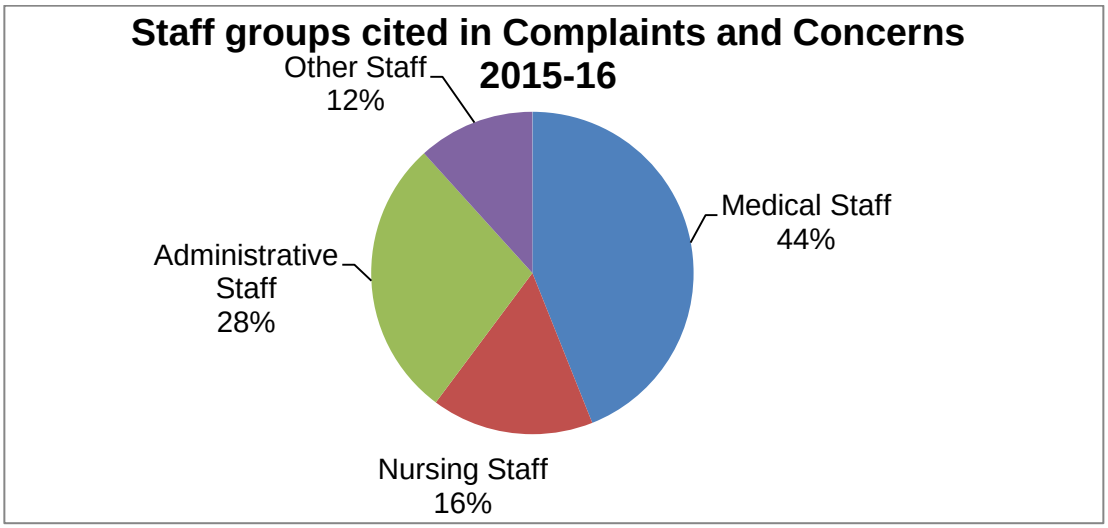
Graph 8: Percentage of complaints and concerns relating to staff attitude



8.2 During 2015/16, the number of complaints which cited staff attitude reduced to 521 from 545 during 2014/15. This represents a reduction of 4.4%.

8.3 Graph 9 highlights the top 3 professions referenced in formal complaints or concerns.

Graph 9: Top 3 most referred to professions in complaints and concerns



9. Overview and Scrutiny

9.1 The Trust Complaints Scrutiny Committee, Chaired by a Non-Executive Director, is a sub-committee of the Trust Quality Committee, with meetings held every two months.

9.2 The main purpose of the Committee is to review the Trust's complaints processes in a systematic and detailed way through the analysis of actual cases, to ascertain learning that can be applied to continuously improve the overall quality of complaints management; with the ultimate aim of improving patient experience.

9.3 The Complaints Scrutiny Committee met in total six times during 2015/16 and received ten presented cases involving all operational divisions within CMFT; due to the schedule the Trafford Divisional team attended on two occasions.

9.4 The Terms of Reference for the Complaints Scrutiny Committee were reviewed and recirculated during 2015/16.

9.5 The actions agreed at each of the Scrutiny Committee Meetings are now recorded and provided to the respective Divisions following the meeting in the form of an action log with progress being monitored at subsequent meetings.

9.6 A new Non-Executive Director (NED) was identified to chair the Committee and a new Governor was identified as a core member of the group during 2015/16.

9.7 Examples of the learning identified from some the cases presented and actions discussed and agreed at the meeting are outlined in table 17. All divisions are asked to identify and share transferable learning from the scrutiny process within and across divisions.

Table 17: Actions identified at the Trust Complaints Scrutiny Committee

Division	Learning	Actions
UDHM **(Q1)**	Key learning from the review included the importance of informing a complainant when their complaint had a direct result on delivering significant service improvements. The improvements identified will ultimately provide a better experience for future patients with complex needs.	To write to the complainant to relay the service improvement and how it will benefit future patients.
Manchester Royal Eye Hospital **(Q2)**	Key learning from the presentations was the value and importance of meeting with a complainant and listening to their ideas for service improvement and where possible to involve them in the improvement process. The case presented for the MREH involved the patient raising a number of suggestions for improvement to the service, including the need for a medication booklet for patients who are prescribed complex eye drop regimes.	The division is currently in the process of working with this patient to produce this booklet for other patients with the same and similar conditions.
RMCH **(Q3)**	A patient who was under the care of the University Dental Hospital of Manchester (UDHM) who, due to their age, required surgery at RMCH. Key	

	learning from the presentation was the value and importance of improving communication and joint working between the divisions and the benefit of introducing the play team to work regularly with children who are referred from UDHM. This arrangement was not in place at the time in question.	
Surgery **(Q4)**	No consistent communication pathway in place between medical and nursing staff and relatives	Ensure the lessons learnt from this complaint are shared across the Orthopaedic speciality, Division of Surgery, CSS and Trafford. January 2016 Consider introducing an identified communication lead for long term patients Consider the introduction of contact cards to enable patients/ relatives to contact the consultant's secretary to arrange to meet the Consultant.
Specialist Medical Services **(Q4)**	Communication issues across specialties & divisions related to patients with multiple co-morbidities and complex pathway patients No consistent process in place for identifying Lead Clinician / Team for multi-speciality patient pathway management for patients with multiple co-morbidities and complex pathway patients	Identify a lead communicator, who would be the point of contact for the patient, relative/s. January 2016 Develop process for the identification of lead clinician (as identified in this case). Consider expanding multi-speciality one-stop clinics for this patient group, learning from Vascular/ Cardiology model.
Trafford **(Q4)**	Patient perception of delay between UCC attendance and Fracture Clinical Appointment – time frame was only actually 1 week. Discussion identified that although there was not a delay in this patient's case, capacity for timely fracture clinic appointments due to general demand is an issue	On-going work includes: ▪ Adaptation of a Virtual Clinic Model ▪ Development of Clinical Pathways to ensure appropriate patients seen by orthopaedic surgeons, other patients seen by other professionals i.e. Extended Scope Physiotherapist specialising in MSK
	A number of issues were identified related to communication and explaining expected pathway and processes i.e. asking patient to repeat history of injury	Complaints are already shared as Patient Stories at team, Directorate and Divisional level. This particular complaint has been shared with UCC team and Orthopaedic Medical Staff This particular complaint will be shared at the first Joint Trauma/Elective Orthopaedic Governance Meeting.

9.8 Further to the above, complaints are also reviewed within the ward accreditation process to ensure that the ward teams are aware of complaints and actions are taken to improve services.

9.9 Complaints are also triangulated with feedback received through a number of different processes including Friends and Family Test (FFT), National Survey data, Patient Opinion website and real time Patient Experience Trackers to identify areas requiring targeted improvement.

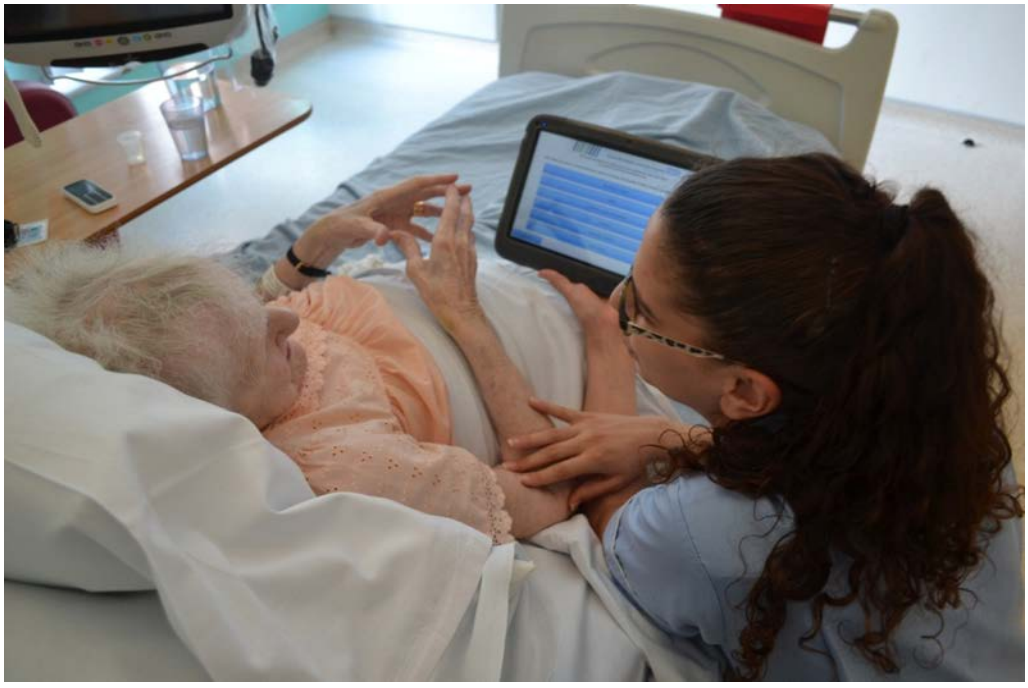
10. Care Quality Commission (CQC) feedback

10.1 The CQC conducted a full inspection of the Trust in November 2015 following which they reported a number of positive findings. The CQC noted that a formal policy is in place and reported that staff across all areas of the Trust were aware of the policy and were able to access it. Inspectors found evidence that information detailing how to raise a concern or complaint is consistently available to patients accessing the Trust's services and patients and families told inspectors that they knew how to raise a concern if necessary.

10.2 Trust staff advised the CQC inspectors that they would aim to resolve concerns in real time where ever possible and that when complaints were made they were committed to learning from this feedback. The CQC's inspection report highlighted a range of meetings, committees and discussions where complaints are reviewed and learning is identified and shared to prevent a recurrence. Examples, cited by the CQC, of system and practice improvements that have been made in response to complaints include introduction of the House Keeper role in response to concerns raised about the environment, plans for a new call bed system in a ward at Trafford Hospital and upgrades to the mortuary environment following a complaint from a family.

10.3 The CQC recognised that the Trust Quality Committee monitors formal and informal complaints on a quarterly and annual basis and noted highlighted mechanisms to share learning such as "hot topics" at Trafford Hospital and Lessons Learned Bulletins.

11. Patient Experience Feedback



11.1 **Patient Opinion**

Patient Opinion is an independent healthcare feedback platform service whose objective is to promote honest and meaningful conversations about patient experience between patients and health services. The underpinning principle is that by telling their stories patients can help make health services better. Access to Patient Opinion is either directly via a website or as a NHS Choices preferred partner, feedback can also be posted via the NHS Choices website. The CQC has partnered with Patient Opinion and NHS Choices and utilises information to help them "decide when, where and what to inspect, spot problems in care and make decisions on whether a service should continue to provide care and more" (CQC, 2015 available at: http://www.cqc.org.uk/content/share-your-reviews-us).

11.2 In Quarter 4 (2015/16) the Trust committed to the enhanced subscription package to Patient Opinion, which has increased access and support from the Patient Opinion Team for the organisation to deliver responses in a timely manner. This subscription provides the following enhanced services:

- **Engaging Staff**: 10 Logins to the response system, compared to the previous limit of 2. This will enable divisions, supported by the Patient Experience Team, to respond directly to their feedback.
- **Monitoring & Reporting**: Alerts from the Patient Opinion system can be sent directly to the most appropriate person, based upon bespoke criteria. This will allow feedback to be delivered in real-time and responded to in a timely manner. In addition, 2 Scheduled Reports per month, produced by Patient Opinion, will provide useful insights into the type and volume of feedback being received.
- **Promotion**: The Trust will have access to online and printable materials resources and support.
- **Support**: The Patient Opinion team will provide e-mail support, social media support, and a Starter Webinar session.
- **Analysis**: Comparisons of feedback on Patient Opinion will be possible with other local Trusts.
- **Evidence**: Patient Opinion will provide evidence about the quality of services delivered that can be used to support compliance with relevant Healthcare Standards and that can be submitted as evidence to the Care Quality Commission.

11.3 During 2015/16, Patient Opinion data was collected and analysed manually. The number of Patient Opinion responses by category; positive, mixed negative and positive and negative comments are recorded as detailed in table 18. The data demonstrates that the majority of comments received in 2015/16 were positive (56%), however, 36% of the 352 comments related to a negative experience of the Trust's services.

Table 18: Number of Patient Opinion postings by Division 2015/16

Number of Patient Opinion Postings received by Division 2015/16			
Division	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services	2	2	0
Corporate Services - Facilities	0	0	1
University Dental Hospital of Manchester	12	7	2
Manchester Royal Eye Hospital	8	8	1
Medicine and Community Service	29	15	6
Royal Manchester Children's Hospital	6	6	0
Specialist Medical Services	17	20	3

St Mary's Hospital	13	9	2
Surgery (MRI)	17	13	2
Trafford Hospitals	94	47	10
Total	198	127	27

11.4 Safeguard is the electronic system used to register and track complaints and compliments. Weekly reports are automatically generated to provide key performance information to identified individuals, both corporately and at divisional level. During 2015/16 the Head of Patient Services has developed an area within the Safeguard system to enable the Patient Opinion postings to be managed in exactly the same way. The information will not only enable the progress of the postings, but the timeliness of responses and provide a data set that will enable responses to be monitored at the weekly divisional complaints performance meetings. Ultimately, targets will be set for response times and the reports produced by the system will provide the same transparency for Divisional and Corporate teams to monitor compliance related to Patient Opinion responses, identify themes in a more analytical manner. The Patient Opinion Safeguard system has been operational since March 2016.

11.5 The Care Quality Commission monitors issues and concerns raised together with the Trust responses. The Trust responds to the posts however, a full response to posts is not always possible as specific patient details are not always provided. The PALS contact details are always provided in these circumstances in order that such cases can be investigated further should the person posting the feedback wish to pursue this option.

11.6 Table 19 provides three examples of the feedback received and the subsequent responses posted on Patient Opinion and NHS Choices that were published in the Quarter 4 Board report.

Table 19: Patient Opinion Postings

RMCH – Positive Comment – 14 year old with autism – Posted in February 2016	
Comment posted	(Anonymous) gave Central Manchester University Hospitals NHS Foundation Trust a rating of 5 stars for care of a 14 year old with autism. "Our 14 year old son has just completed a 5 night stay on ward 75. Despite his challenging behaviour due to severe autism and learning difficulties, the staff treated him with the upmost care and compassion. Due to the staff's patience they made a very difficult situation as positive as possible. Thank you so much".
Response from division	We appreciate the time you have taken to post comments on your experience during your son's recent stay on Ward 75 in Royal Manchester Children's Hospital. The hospital has an on-going programme of work to improve services for children and young people with autism, and it is wonderful to receive feedback which reflects the positive impact of this work on the experience of our patients and their families. Your post has been shared with the Ward 75 nursing team and staff involved in the work to make on-going improvements to services for children and young people with autism
SMS – Positive comment – Electrophysiology – Posted in February 2016	

Comment posted	"Just wanted to put a status about my recent experience with the NHS. Everyone is quick to call it and say it's not good enough, but the care I received from Manchester Royal was excellent. The porters, nurses and consultants were all lovely people and went the extra mile even though they were run off their feet. It opened my eyes as to how much pressure they are under and how busy they were but still went out of their way to do the best they could. I didn't get my pre-med as arranged and they later apologised due to being so busy and I didn't even have a bed until after the procedure but that wasn't a problem because I could see how hard they all worked and they reassured Me I was in good hands. It was easy to see the pressure they are all under I don't know how they can do that day in day out and still smile at end of their shift. I have a big appreciation to all the NHS staff and the work they do. Just wanted to put that out there! I also want to say the consultant electrophysiology is excellent and I felt so safe under their care. I had an Eps study done but no ablation was needed. Thank you" Laura from Manchester Visited in January 2016.
Response from division	Thank you for taking the time to post your positive comments and words of appreciation on the NHS Choices/Patient Opinion websites regarding the care you experienced at the Manchester Heart Centre, Manchester Royal Infirmary. We were extremely pleased to read that all the staff treated you with dignity and respect, and that they went out of their way to reassure you that you were in good hands despite the busy environment. It is always good to receive such positive feedback which reflects the hard work and dedication of our staff. We can assure you that your feedback has been shared with the Head of Nursing for the Heart Centre so that your feedback can be shared with the wider team.
MREH – Negative comment – waiting times – posted January 2016	
Comment posted	"It's been 9 months, still waiting for referral appointment. I have been referred by my new GP as I have moved from London around 10 months ago to Manchester and I had an operation for a squint in my eye in London but it do not work properly and now I have developed again and it's been 9 months that I am waiting for a first visit appointment from to this hospital every time I call, them to find out they say that I am still in the waiting list looks like a joke to me now what kind of waiting list is which never reaches to my name I feel like killing myself sometimes as this squint has changed my whole life to the worst, my London experience was much much better as I was seen every 6 weeks and the operation date was given to me fairly fast as well but, this time around it looks like it will be years before anything can be done, I don't know whom to talk to or what other way to push this matter further I really am lost in my way and my life, I can't go back to London as too as I don't have a postal address to get a referral back to that GP so that they could send me back to my old hospital. If anyone from the hospital management can help please do so".
Response from division	We were very sorry to receive your comments and concerns via the NHS Choices/Patient Opinion websites about the difficulties and the delay receiving your outpatient appointment you have experienced from Manchester Royal Eye Hospital (MREH). Unfortunately, squint services are very specialised and until recently squint clinics have had a limited number of staff to support the service. I am pleased to be able to advise you that we have recently appointed a third consultant in order to support the service with the aim of

	reducing the time patients wait for appointments. We take all issues surrounding patient experience very seriously and would very much like to hear from you directly as it is very difficult to respond to the specific concerns you have raised without being able to investigate in detail. To do this, we would need more information. If you contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@cmft.nhs.uk they will be able to discuss this with you.

11.7 Following subscription to the Patient Opinion service, in Quarter 4 the Trust was invited, as one of four pilot sites, to be involved in a project to improve the level of feedback on services from children and young people. Patient Opinion and "Monkey Wellbeing", a small independent business publishing print and online materials aimed at pre-school and primary school age children, have teamed up to create an effective and appealing invitation to children to share their feedback on Patient Opinion. Although Patient Opinion does currently accept feedback from children and young people, usage is low and it is hoped through this project, feedback from this group will now be improved.

11.8 A pilot project is currently being undertaken between Patient Services, Saint Mary's and the RMCH to allow the two clinical divisions to completely manage the whole of their Patient Opinion postings. Until now, as well as notifying the divisions regarding new postings, the Patient Services team have quality assured all responses. This responsibility has now transferred to the Divisional Directors within Saint Mary's and RMCH. If this pilot proves to be successful, this model will be rolled out to other divisions who wish to manage their posts in this way. An evaluation of the pilot will take place during Quarter 1 of 2016/17.

12. Compliments

11.1 The Trust received 595 compliments in 2015/16 of which 311 (52%) related to Trafford Division. Work is on-going to improve the capture and recording of compliments across all divisions within the Trust.

11.2 The registration of compliments received by the Chief Executive's Office is managed by the PALS team and divisions manage registration of locally received compliments on the Safeguard Complaint Management System. All responses are managed locally by the divisions and authorised by the Divisional Director.

11.3 Weekly reports are circulated to divisions detailing compliments that are registered both corporately and locally. The reports include number, detail and progress.

11.4 Table 20 below shows the numbers of compliments registered for each division. Work will continue in Quarter 1 2016/17 to improve the recording for compliments across the divisions.

Table 20: Distribution of Compliments received by Division Quarter 4 compared to Quarters 1, 2 and 3.

Number of compliments received by Division				
2015/16	**Q1**	**Q2**	**Q3**	**Q4**
Division not recorded	29	10	19	17
Clinical Scientific Services	0	3	8	1
Corporate Services	2	1	1	3
University Dental Hospital of Manchester	0	2	2	0
Manchester Royal Eye Hospital	5	5	5	10

Medicine and Community Service	17	10	34	18
Royal Manchester Children's Hospital	4	3	0	2
Specialist Medical Services	7	9	5	6
St Mary's Hospital	2	6	3	9
Surgery (MRI)	7	5	5	9
Trafford Hospitals	59	48	130	74
Total	132	102	212	149

12.5 Compliments are feedback at a local level to those staff involved and used as an opportunity to celebrate achievement and share good practice.

12. Meetings with Complainants

12.1 A total of 151 Local Resolution Meetings are recorded as taking place during the 2015/16 of which 36 were within the Division of Medicine and Community Services, 32 within the Division of Surgery and 22 within the Division of Specialist Medical Services, with the rest being spread relatively evenly across the other clinical divisions. This compares to 105 local resolution meetings held in 2014/15. This is a very positive increase as a meeting between the complainant and the staff involved in the complaint can often provide the patient and their family with a more detailed personal response to the concerns they have raised. Meetings are facilitated by the identified PALS Case Managers and summary letters provided to the complainant with an audio recording of the discussion.

13. Parliamentary and Health Service Ombudsman (PHSO)

13.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service. The PHSO are not part of government, the NHS in England, or a regulator. The PHSO are accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

13.2 The PHSO is the final stage for complaints about the NHS in England and public services delivered by the UK Government. The PHSO consider and review complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and not put things right.

13.3 The PHSO Office announced their plan to increase the number of investigations they consider and undertake in 2014/15. As a result, there was an expectation that the Trust would experience an increase in the number of investigations identified in 2015/16. As shown in table 21, whilst the number of cases has increased, the percentage within each outcome bracket has remained constant given the relatively low number of cases.

Table 21: Number of resolved PHSO cases comparison

	2014/15	2015/16
Up-held	1 (7%)	3 (11%)
Partially up-held	7 (50%)	13 (48%)
Not up-held	6 (43%)	11 (41%)

13.4 During 2015/16 the PHSO informed the Trust of their intention to allocate a Principle Investigator contact for the organisation. The newly appointed Deputy Director of Nursing (Quality) made contact with the PHSO Principle Investigator and from Quarter 2 onwards met on a regular basis. Outcomes from the meetings during 2015/16 include:

- Clarity about the PHSO compensation process and where the Trust proactively offers compensation payments to complainants, this will be fully taken into account by the PHSO during their investigations and in subsequent recommendations
- Advice from the PHSO regarding the required content for Local Resolution Meeting summary letters, which are routinely sent to complaints following a meeting, along with an audio recording of the meeting.
- The PHSO have not identified any themes from the complaints investigated from the Trust.
- An opportunity to proactively discuss some complex on-going cases and some delays in the PHSO investigating cases.
- Positive feedback from the PHSO Principle Investigator regarding the proactive nature associated with CMFT's management of PHSO cases.

13.5 The Trust had 17 cases under the review of the Parliamentary and Health Service Ombudsman at the end of Quarter 4 2015/16. Table 21 provides details of the PHSO cases resolved in 2015/16 (n=27) and shows the distribution of PHSO cases across the divisions.

13.6 In summary, 11 cases were not upheld, 13 cases were partially upheld and 3 cases were not upheld.

13.7 In total compensation was advised in 12 of the 27 cases totalling a sum of £5,350.

Table 21: PHSO cases closed between 1st April 2015 and 31st March 2016

Division	Outcome	Date original complaint received	PHSO Rationale/Decision	Recommendation
Corporate	Upheld	November 2013	The Trust caused upset anxiety and frustration due to poor communication.	£150 compensation Letter of apology for failings.
SMS	Upheld	September 2013	Service failure in the delivery of treatment.	£500 compensation Action plan to address failings.
SMS	Partially upheld	March 2012	Service failure relating to nursing care.	£750 compensation Action plan to address failings.
SMS	Not Upheld	October 2014	No failings found.	NA
SMS	Partially upheld	May 2014	Failures found in medical record keeping and in complaints response.	Letter of apology Action plan to address failings.
SMS	Not upheld	August 2011	No failings found.	NA
SMH	Not upheld	August 2014	No failings found.	NA
DMACS	Partially upheld	May 2013	Service failings related to nursing care.	£500 compensation Letter of apology.
DMACS	Partially upheld	February 2013	Service failures relating to care.	£500 compensation Letter of apology Action plan to address failings.

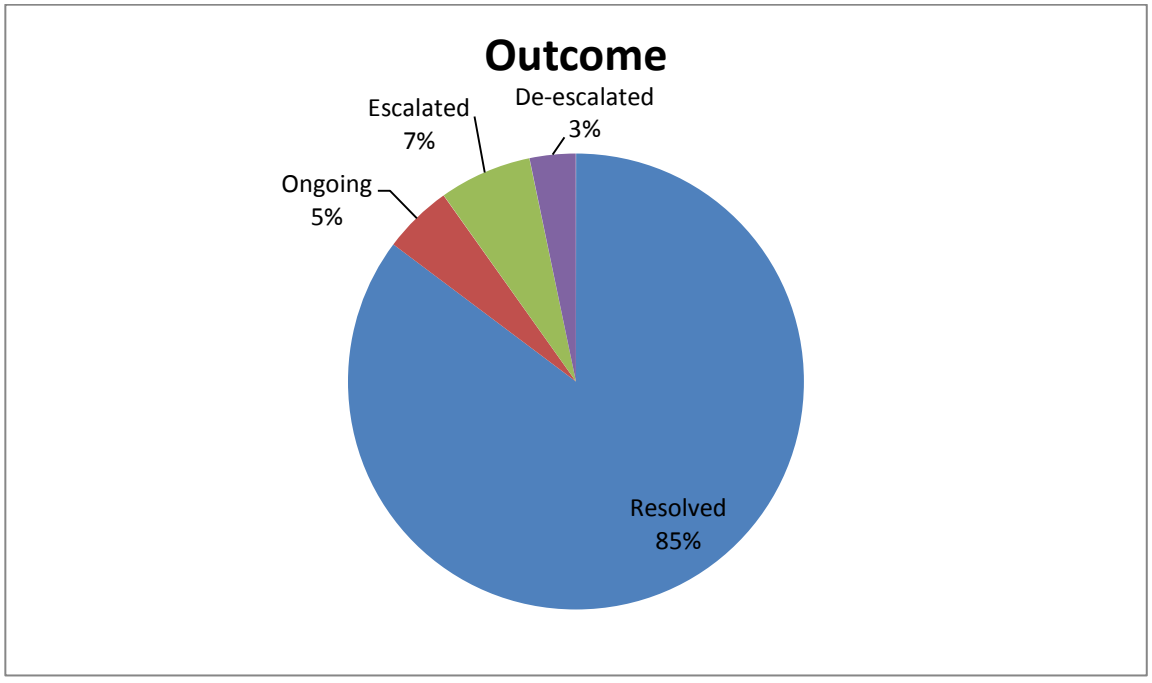
DMACS	Partially upheld	June 2013	Service failures relating to care.	Letter of apology Action plan to address failings.
DMACS	Partially upheld	October 2014	Delays in the Emergency Department led to discomfort and frustration.	Letter of apology Action plan to address failings.
DMACS	Upheld	December 2013	Service failure in the delivery of care and treatment.	£500 compensation Letter of apology and action plan.
DMACS	Partially upheld	June 2013	Poor communication during a local complaints process.	Letter of apology.
DMACS	Partially upheld	February 2014	Failings in the management of falls.	£250 compensation Letter of apology and action plan.
Surgery	Not upheld	August 2014	No failings found.	NA
Surgery	Partially upheld	September 2013	Poor complaint handling.	£200 compensation Letter of apology.
Surgery	Not upheld	October 2014	No failings found.	NA
Surgery	Not upheld	January 2014	No failings found.	NA
UDHM	Partially upheld	March 2013	Service failure in the delivery of treatment.	£500 compensation Letter of apology and action plan.
UDHM	Not upheld	September 2014	No failings found.	NA
Trafford	Partially upheld	October 2012	Service failure in the delivery of treatment.	£500 compensation Letter of apology and action plan.
Trafford	Not upheld	September 2013	No failings found.	NA
Trafford	Not upheld	July 2014	No failings found.	NA
MREH	Partially upheld	May 2013	Maladministration of appointments. Poor complaints handling.	£750 compensation Letter of apology and action plan.
MREH	Not upheld	January 2014	No failings found.	NA
CSS	Partially upheld	June 2013	Service failure in the delivery of treatment.	£250 compensation Letter of apology.
CSS	Not upheld	August 2015	No failings found.	NA

14. Complaints Review Transformation Project – "*Tell us about it*"

14.1 **'Tell us Today'** enables patients and families to escalate concerns in real time via a dedicated telephone number to a senior manager so that the issues can be resolved, the patient's experience improved and a potentially a formal complaint averted. Trafford General Hospital and the Royal Manchester Eye Hospital both went live with '***Tell us Today'*** in 2014/15. Roll out within the MRI was completed during Quarter 3 2015/16, St. Mary's Hospital went live in Quarter 4 and RMCH will go live in Quarter 1, 2016/17.

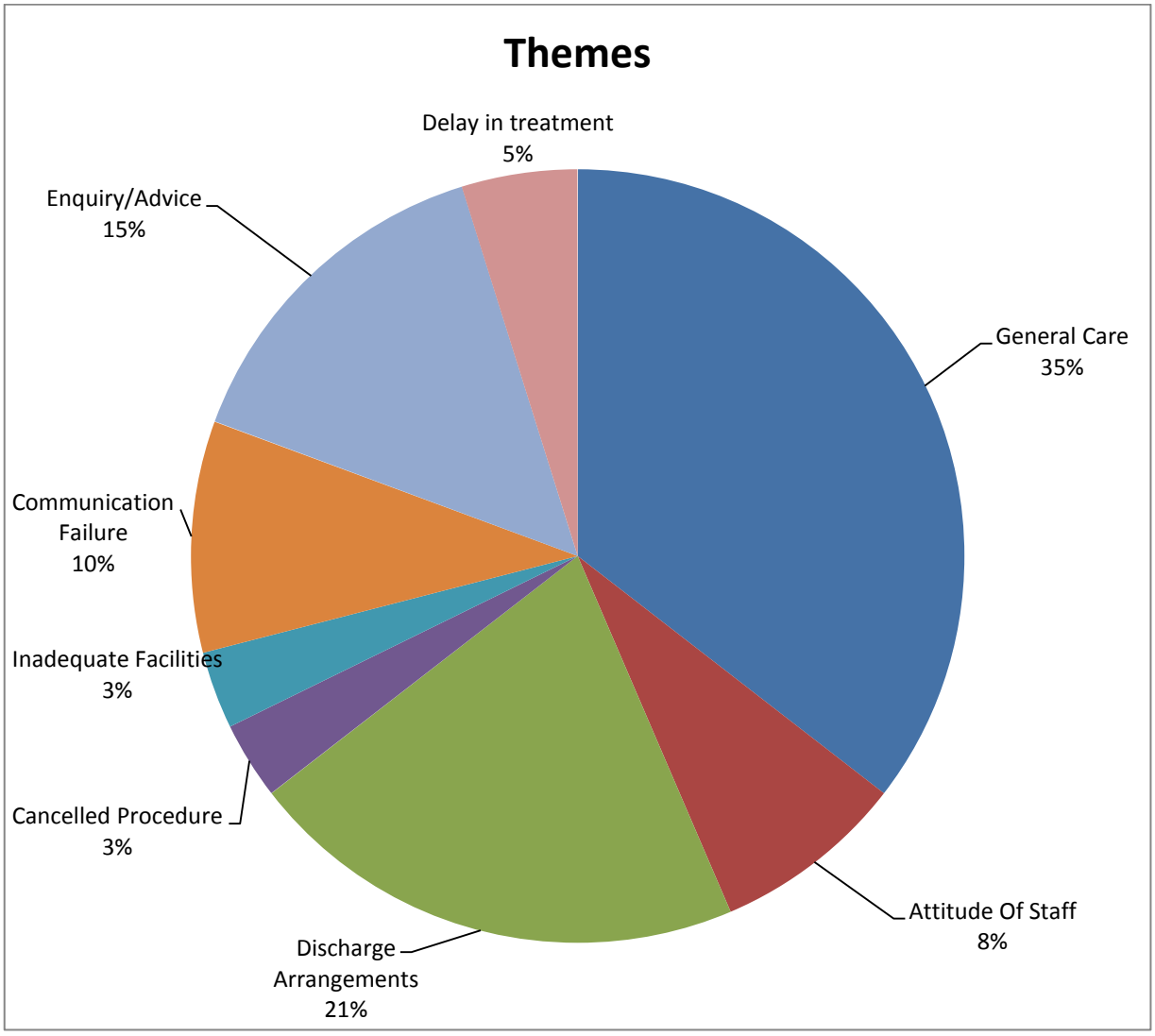
14.2 Whilst the numbers of calls received is quite low (63 calls since the service started), Graph 10 illustrates that of those calls received, only 7% were escalated to formal complaints with 85% resolved in real time.

Graph 10: Outcome of Tell us Today calls



14.3 Graph 11 illustrates the breakdown of calls to ***Tell Us Today*** by theme. This shows a variety of concerns with the most common category descriptors relating to general care (35%), discharge arrangements (21%) and Enquiry/Advice (15%).

Graph 11: Tell us Today themes



14.4 Action continues to promote this service across the Trust and uptake will continue to be monitored and reported.

15. Complaint Data Analysis and Implementing Learning to Improve Services

15.1 All Divisions regularly receive their complaint data and review the outcomes of complaint investigations at the Divisional Quality or Clinical Effectiveness Committees. The following tables identify the complaint data for each of the divisions mapped against a number of key performance indicators and a selection of complaints that demonstrate how learning from complaints has been applied in practice to contribute to continuous service improvement within the divisions during 2015/16. All of these examples have been published in the quarterly Board of Directors Complaints Reports.

15.2 An Internet page has been developed for the Trust's Website that now publishes a selection of lessons learnt and improvements made as a direct result of complaints. The page provides information about the changes that have been made as a direct result of complaints received from patients, relatives and carers. The website provides information to service users about changes in policy, protocols and other practical improvements that have been made that demonstrate that concerns have been listened and responded to and a complaint has made a difference.

Division of Surgery

Division of Surgery	2014/15	2015/16
Number of formal complaints	203	239
Number of PALS concerns	825	914
Number of reopened	55	63
Number closed in 25 days	19	39
Number closed over 41 days	177	150
Number of meetings held	13	32
Top 3 themes		
1. Treatment / procedure - 107		
2. Communication - 47		
3. Access, Admission, Transfer, Discharge - 27		

Division	Complaint and Lessons Learnt
Surgery **Q3**	**Delayed Diagnosis and Treatment** A patient had been referred via the Rapid Access Clinic but in fact had two separate ENT conditions – one relating to the balance system and one relating to the sinuses. This delayed the patient's diagnosis and treatment. A number of actions were subsequently implemented: ▪ The seniority of the doctor covering the Rapid Access Clinic was increased to improve diagnostic decision making – the clinic is now covered by a Senior Clinical Fellow. ▪ The balance service was reconfigured so that referrals can be directed straight to an audiologist without requiring a consultant-led appointment first. This has reduced the waiting time for an appointment and speeded up the diagnostic process. ▪ The job plan of one of the Rhinologists was changed to increase his effective time in theatre (extending his list from 2 to 3 sessions). ▪ Patient information leaflets were improved around management of balance

Q3	problems including insertion of self- management support strategies. **Poor Communication** A complaint was received that related to poor communication from the Urology administration team in terms of answering the telephone and passing messages to the Consultants. The team of urological secretaries have now been placed into formal pairs which mean that they do not take annual leave at the same time and provide cross cover for each other. The secretaries also work in pairs to ensure that the telephones are covered and answered in a timely way and that messages are returned in an agreed timeframe. This arrangement also allows the secretaries protected time to carry out other duties without being interrupted by telephone calls, thereby supporting a reduction in communication errors.

Division of Medicine and Community Services

Division of Medicine and Community Services	**2014/15**	**2015/16**
Number of formal complaints	115	123
Number of PALS concerns	301	361
Number of reopened	40	39
Number closed in 25 days	9	27
Number closed over 41 days	97	61
Number of meetings held	29	36
Top 3 themes		
1. Treatment / procedure - 29		
2. Communication - 25		
3. Clinical assessment - 22		

Division	**Complaint and Lessons Learnt**
DMACS **Q3**	**Communication & Awareness of the DNR Policy** The Division recently received several complaints regarding communication with families and other issues regarding the implementation of 'Do Not Resuscitate' (DNR) orders. The Division recognised that there was gap in staff awareness regarding the correct way to implement the DNR Policy. As such there was a need to ensure that the correct information was distributed to all staff to ensure that the correct processes were being followed and families adequately supported through the discussions. The DNR Policy was redistributed to all staff with a request that it was discussed at a local ward level to support staff in their understanding of the process. These discussions took place across the whole multi-disciplinary ward team. The new DNR booklets were also reordered as it was identified that some ward areas did not have them available. The booklets are now available on every ward in a visible location so that both staff and families can access them

	as required. In some areas, an old version of the 2222 advisory posters was identified. The posters have been replaced with the updated versions, which provide staff with the correct emergency information. The importance of ensuring that DNR forms are transferred with patients upon discharge has also been reflected in the Fit and Safe for Discharge Checklist and highlighted to all staff groups. **Children's Community**
Q4	A complaint was received regarding several aspects of communication with families, specifically: ▪ When potential language barriers exist and ▪ The need for families to have a clear understanding of the professional safeguarding role and responsibilities of staff The Children's Community team recognised a gap in staff awareness and understanding of parent's level of English, where English is spoken by them but if it is not their first language the impact of potential misunderstandings. The needs for a robust appraisal of parental levels of understanding of English was required to ensure either interpreters or the telephone interpretation system are accessed, to support families adequately through sensitive discussions. The process of deciding when there is a need to access interpretation services has been updated to include this additional requirement and is being recirculated to staff together with the distribution of a Lessons Learned information sheet to highlight the need to assess the level of understanding of parents. Heads of Service have been asked to highlight this Lessons Learned at all team meetings to support staff in their awareness of this issue. In addition, the Directorate Team also recognised a need to ensure all families have a clear understanding of the role and responsibilities of staff when staff assess and identify safeguarding issues and there is a need to refer to Social Care services. As such all Heads of Service have been asked to discuss this issue at team level with all staff and to raise this during staff Safeguarding supervision, to support staff to help them provide clear information and a sensitive approach for the families with whom they are working. This issue was also included in the Lessons Learned information sheet circulated to all staff working in Children's Community Services.

Division of Specialist Medical Services

Division of Specialist Medical Services	2014/15	2015/16
Number of formal complaints	105	137
Number of PALS concerns	468	576
Number of reopened	44	32
Number closed in 25 days	39	15
Number closed over 41 days	60	67
Number of meetings held	24	22
Top 3 themes		
1. Treatment / procedure - 42		
2. Communication - 31		
3. Access, Admission, Transfer, Discharge - 18		

Division	Complaint and Lessons Learnt
SMS **Q4**	**Availability of specialist services, environmental conditions and nutrition and hydration.** A patient was concerned with the resources of specialist services and that funding would be cut to the Endocrine Service that would prevent her receiving the treatment she required. The patient also raised concerns that the unit was cold and this meant her daughter had to bring in blankets for her, and that she was not offered any food or drinks during her lengthy treatment visits. Funding has been secured and the patient has now commenced her treatment. Although the department had not previously stored blankets routinely, as a direct result of the concerns raised the Matron has arranged for a regular stock of blankets, bed sheets and patient gowns. A process has also been implemented to ensure that the thermostats in the building are adjusted according to patient feedback during each treatment session. Bread, milk and biscuits are kept as stock for all patients and the staff have been reminded of the importance of offering snacks and hot drinks to patients and ordering Snack-Boxes for those patients attending for longer treatment sessions.
Q4	**Communication and Test Results** A patient raised concerns about the lack of communication from the Renal Transplant Team and Renal wards regarding his suitability for a kidney transplant. In addition, he had twice submitted stool samples, received no feedback and then asked to provide a further sample. The Renal Transplant Team has apologised for the lack of communication experienced by the patient and have confirmed with the patient that he is on the Transplant waiting list. The clinic co-ordinator personally met the patient to apologise for not providing him with an update. The Renal Matron has also confirmed that both samples were tested and the results were negative for infective organisms and has apologised that the Renal Team did not inform the patient of the outcome of the tests. To prevent the recurrence of this type of issue the team on the Renal Unit have devised a process whereby sampling and the need to follow up test results is recorded in the patient's dialysis documentation. This will ensure that the member of staff responsible for the patient's care at the next dialysis session will be aware of the need to follow up results.

Royal Manchester Children's Hospital

Royal Manchester Children's Hospital	2014/15	2015/16
Number of formal complaints	126	150
Number of PALS concerns	601	663
Number of reopened	33	19
Number closed in 25 days	22	29
Number closed over 41 days	91	71
Number of meetings held	4	16
Top 3 themes		
1. Treatment / procedure - 44		
2. Communication - 29		
3. Clinical assessment - 30		

Division	Complaint and Lessons Learnt
RMCH	**Communication**
Q3	A parent whose child was admitted for surgery onto Ward 76 was not advised that the ward is closed at weekends and bank holidays. The child was discharged home. The parent telephoned the ward directly for advice on day the ward was closed. As a direct result Ward 76 is developing a business card detailing the hours of operation and contact numbers both when the ward is open and closed.
	Staff Attitude
Q4	Following a number of complaints regarding the attitude of the administrative staff in the Paediatric Emergency Department (PED), bespoke Customer Service training has been arranged with the support of colleagues in Organisational Development and Training.

Trafford Hospitals

Trafford Hospitals	2014/15	2015/16
Number of formal complaints	116	119
Number of PALS concerns	304	465
Number of reopened	27	32
Number closed in 25 days	34	43
Number closed over 41 days	59	28
Number of meetings held	6	7
Top 3 themes		
1. Treatment / procedure - 40		
2. Communication - 22		
3. Clinical assessment - 21		

Division	Complaint and Lessons Learnt
Trafford	**Altrincham Phlebotomy**
Q3	There was an increase in the number of complaints received regarding Phlebotomy appointment arrangements and specific concerns raised regarding staff attitude at Altrincham Hospital. A review of the Altrincham Phlebotomy Service identified the need for improved signage to support patient way-finding when accessing Phlebotomy appointments. Customer Service Training was also organised for the Altrincham Phlebotomy Team to address the poor customer service delivery issues. The review of the service also led to a reconfiguration of the team with a further Phlebotomist post being identified. Senior Nursing input has also been secured to offer supplementary support to the Altrincham Phlebotomy team.
	Cardiology/Acute Medical Unit (AMU/Urgent Care Centre (UCC): Communication delay issues regarding referral for pacemaker.
Q4	A complaint was received from a patient regarding the delay they experienced following an urgent referral for a pacemaker insertion. The patient received the pacemaker 14 days following a report which stated the procedure needed to be undertaken urgently. The patient also raised concerns that they were unaware of which doctor was responsible for their care and they were concerned about various aspects of patient experience on AMU, in particular the infection control risk of visitors using patient toilets. An investigation into the concerns raised identified the need for Urgent Action Flags to be added to the Cardio-Respiratory Monitor Reports. The flag will ensure that reports for urgent attention are available for review by medical staff on the same day, so that timely referrals can be made and any delays in patient treatment and care can be avoided. A review will be undertaken of how the Physician (doctor) of the Week responsible for patients on AMU is communicated to patients, their families and carers to ensure they are aware which physician is responsible for their care and treatment. Patient Information Leaflets available on AMU are also being reviewed to ensure that they contain information with regards to visitor facilities and general infection control information.

Saint Mary's Hospital

Saint Mary's Hospital	2014/15	2015/16
Number of formal complaints	149	160
Number of PALS concerns	242	280
Number of reopened	25	35
Number closed in 25 days	59	60
Number closed over 41 days	56	48
Number of meetings held	11	11
Top 3 themes		
1. Treatment / procedure - 49		
2. Communication - 29		
3. Access, Admission, Transfer, Discharge - 28		

Division	Complaint and Lessons Learnt
SMH	**Communication**
Q4	Concerns were raised regarding the communication and awareness of a number of patients about the fertility services/process and the number of NHS-funded fertility cycles a patient is entitled to. Each couple's individual entitlement to treatment varies as the criteria are set by the CCG associated with their General Practitioner. The entitlement varies between CCGs. The team have developed a proforma that can be completed by staff and sent to the couple at the start of their treatment pathway, which will include details of which CCG they belong to, their current entitlement and where they can access more information about their CCG's funding and treatment criteria.
Q4	St Mary's have received a number of complaints regarding a lack of continuity of care, poor staff attitude and inconsistent advice. Midwifery Supervision has been utilised to raise awareness of complaints and to promote reflection and learning by individual members of staff and teams; Additionally: ▪ The importance of comprehensive history taking to ensure adequate prioritisation of care at Triage has been discussed. ▪ The need for Team Leads to review complaints regarding the lack of continuity of care within the antenatal period has been identified; specifically care provided by different members of staff. ▪ Feedback has been provided to the specific midwife regarding provision of advice regarding Breastfeeding. ▪ The Infant feeding Coordinator provided snapshot training to improve the detection of tongue tie in the new-born infant.

Division of Clinical and Scientific Services

Division of Clinical and Scientific Services	2014/15	2015/16
Number of formal complaints	29	56
Number of PALS concerns	112	158
Number of reopened	9	16
Number closed in 25 days	8	11
Number closed over 41 days	15	19
Number of meetings held	2	10
Top 3 themes		
1. Clinical assessment - 13		
2. Communication - 13		
3. Treatment - 12		

Division	Complaint and Lessons Learnt
CSS **Q3**	**Improved Core Huddles on Critical Care – End of life care/communication** Following a number of complaints regarding communication during end of life care, the critical care team has updated their core huddle agenda to include a prompt for the Nurse in Charge and the Consultant of the day to ensure they have introduced themselves personally to family members. The Nurse in charge and Consultant will also ask the family if they have any questions or concerns. **Changes to Ultrasound Scan** Within the ultrasound room usual practice was for the screen to be switched on and in full view of the patient whilst the sonographer is checking for any problems. A patient who was suffering a miscarriage told us that she knew straight away that something was wrong from looking at the screen and found this very distressing. Sonographers now leave the screen switched off until they initially view the image and only after confirming that there are no issues do they ask the patient if they wish to see the screen.
Q3	

University Dental Hospital of Manchester

University Dental Hospital of Manchester	2014/15	2015/16
Number of formal complaints	47	44
Number of PALS concerns	175	130
Number of reopened	12	21
Number closed in 25 days	20	17
Number closed over 41 days	21	19
Number of meetings held	4	6
Top 3 themes		
1. Treatment / procedure - 21		
2. App Delay/cancelled - 9		
3. Communication - 6		

Division	Complaint and Lessons Learnt
UDHM **Q2**	**Redesign of appointment booking system** A complaint was made regarding the failure to book a post-surgery follow-up appointment. Improvements to the process for making appointments were subsequently developed. The follow-up appointment booking process was redesigned to an email based referral system to a specific email address. The new system ensures all appointments are booked. The Matron monitors communication standards within the administrative team during her monthly Matron's Quality Care Rounds to ensure this new system remains in place and works effectively. **Communication** A patient identified that when she attended appointments at the University Dental Hospital of Manchester (UDHM) it was not clear from the appointment letter who would be responsible for her consultation and treatment, nor did it identify their role or area of specialism. The complainant also raised a concern about the lack of clarity in the appointment letters that the hospital is a teaching facility and that care may be provided by students. In response to this complaint, and others regarding the information provided in patient letters, a project has been initiated to review the content of appointment letters by a team of clinicians from all departments within the UDHM. A revised appointment letter has been devised by the team and shared with a group of 12 patients at a Patient Listening Event in March 2016, where patients were invited to comment on the content. A final draft appointment letter is now available and as part of the Trust-wide project to reduce the number of letter templates available, this letter will be the standard appointment letter for all patients attending UDHM.

Manchester Royal Eye Hospital

Manchester Royal Eye Hospital	2014/15	2015/16
Number of formal complaints	90	79
Number of PALS concerns	355	361
Number of reopened	20	22
Number closed in 25 days	58	59
Number closed over 41 days	21	10
Number of meetings held	9	10
Top 3 themes		
1. Communication - 21		
2. App Delay/ Cancellation - 15		
3. Treatment - 14		

Division	Complaint and Lessons Learnt
MREH	**Waiting Times**
Q1	Patient pagers were introduced into the Division based on comments and complaints about waiting times in clinics. The Division looked at ways we could improve communication through the waiting times on the CMFT-TV's and the pager initiative. Patients can now leave the department e.g. for refreshments if there is a significant wait for the doctor. A survey carried out provided overwhelming positive feedback from the patients indicated the need to introduce the pagers with a robust support system for patients and carers alike. A procedure specific consent form is being created following the identification of an issue with a botulinum injection. This will be a good initiative as it will detail all the specific indications and complications of that particular procedure involves.
	Implementation of Standard Operating Procedure/ New DNA Stamp
Q4	A number of concerns were raised that patients had not received appointments for on-going follow-up. A number of examples related to patients not attending an appointment but another appointment was not arranged. The MREH team identified that a more robust process was required to identify and record patient non-attendance and is in the process of formulating a Standard Operating Procedure for checking/monitoring clinic outcomes, including areas such as patient DNA's, diagnostics required, and patients placed onto the relevant follow-up waiting lists. An area has been identified to pilot the new process for 3 months, reviewing results, carry out the necessary modifications to process, prior to full implementation.

Corporate Services

Corporate Services	2014/15	2015/16
Number of formal complaints	30	52
Number of PALS concerns	154	179
Number of reopened	10	9
Number closed in 25 days	4	15
Number closed over 41 days	10	14
Number of meetings held	1	1
Top 3 themes		
1. Documentation/Records - 19		
2. Infrastructure - 13		
3. Communications - 12		

Division	Complaint and Lessons Learnt
Corporate: Estates and Facilities **Q4**	**Patient and Visitor Car Parking** In response to several complaints the policy and documentation for the reduction and exemption of car parking charges has been reviewed and revised to include several other patient groups for example those patients at the end of life. In addition improvements have been made to the process for the authorisation and collection of the 'complimentary permits' issued to ensure no delays are experienced.

Research and Innovation

Research and Innovation	2014/15	2015/16
Number of formal complaints	2	0
Number of PALS concerns	0	1
Number of reopened	0	0
Number closed in 25 days	0	0
Number closed over 41 days	2	0
Number of meetings held	2	0

Non – CMFT

Non – CMFT	2014/15	2015/16
Number of formal complaints	5	0
Number of PALS concerns	37	35
Number of reopened	5	0
Number closed in 25 days	3	N/A
Number closed over 41 days	0	N/A
Number of meetings held	N/A	N/A

16. Work Programme 2015/16: Achievements

16.1 The Transformation Project ***'Tell us about it'*** programme delivered a wide range of improvements to the complaints handling systems and processes and concluded at the end of March 2015. Whilst the programme delivered some significant achievements, it also enabled the teams to recognise those areas that still need to be addressed and improved. The following sections of the report detail the improvements made in 2015/16.

16.2 **Complaints Policy:** A new complaints policy entitled ***'Complaints, Concerns and Compliments Policy'*** was ratified by the Trust's Quality Committee and published in January 2016. The Policy was updated to reflect any changes that have been made to national policy and best practice and is written in line with 'My Expectations for Raising Concerns and Complaints'[2].The Policy has been published on the Trust's external website.

16.3 **Education for Complaints Handling:** Successive national reviews have highlighted that people tasked with responding to complaints can lack the necessary skills to deal with the range of issues which arise most frequently. To improve the skills of staff at the Trust who are involved in investigating concerns and preparing complaint responses, a series of educational sessions has been delivered to assist both Corporate and Divisional teams to improve the quality of complaints responses. These include sessions on how to write succinct letters following meeting with complainants, a Safeguard master class, a session about the function and process of the PHSO and an externally facilitated course on developing effective written responses to complaints. Further educational sessions are planned and will continue during 2016/17 to ensure that staff with responsibility for complaints have the necessary knowledge and skills to produce the high quality Reponses we expect.

16.4 **Newsletter:** A new Patient Services newsletter entitled, ***'Patient Experience Matters'*** was published at the end of Quarter 4, and further editions will be published during 2016/17. The Newsletter is for all staff within the Trust and the first addition provided stories and interesting articles about:

- Complaints – highlights from Quarter 3
- ***Tell us Today*** update
- Friends and Family Test – overview, performance and future plans
- An updated on the ***My Expectations review***
- Educational opportunities
- Staffing changes
- The planned move for the PALS office to the new location at the MRI 2 Entrance
- Compliments – the process and how compliments can be registered
- A personal reflection from a Specialist Nurse about an experience she had been privileged to encounter with a patient and her feelings about the experience.

16.5 **Shelford Group Complaints Process Review:** During Quarter 4, the Patient Services Team undertook a review of the complaints processes within the Shelford Group of NHS Trusts. This valuable piece of work has provided great insights into the similarities and differences between complaints processes. The findings of the review will be analysed by the Head of Patient Services, to determine the benefit of adopting any of the identified practices from other Shelford Group Trusts that are not currently within the CMFT Complaints process.

16.6 **Internal Audit:** During Quarters 3 & 4 of 2015/16, The Mersey Internal Audit Agency undertook an internal audit of on behalf of CMFT of the complaints management system. This audit was conducted as part of the internal audit schedule and will report during Quarter 1 2016/17.

[2] My Expectations for Raising Concerns and Complaints (2015) Local Government Ombudsman and Parliamentary and Health Service Ombudsman and Local Government Ombudsman.

16.7 **Complainant's Satisfaction Survey:** During Quarter 3 a new complainant satisfaction survey was developed. The survey is based upon the ***'My Expectations'*** vision, developed jointly by the PHSO, Local Government Ombudsman and Healthwatch. The survey was implemented at the beginning of Quarter 4.

Although, the response rate is currently low (response rate for Quarter 4 is 5.5% of all complainants), this is in line with other Trusts within the Shelford Group who have undertaken similar surveys.

The key results for Quarter 4 indicate:

- 100% of respondents knew they had the right to complain
- 81% thought the response letter was clearly written and easy to understand
- 73% felt their concerns were being taken seriously
- 69% received a resolution in a time period that was relevant to their case
- 67% felt that the response received was specific and personal
- 56% knew for certain that their care would not be compromised by making a complaint
- 56% felt their complaint was handled fairly
- 44% reported that they always knew what was happening with their complaints

17. Work Programme 2016/17

17.1 The Work Plan has been established to build on the improvements realised in 2015/16 and to deliver improvements in areas that have further potential for improvement.

17.2 **'My Expectations' review:** Following publication of the revised Complaints, Concerns and Compliments Policy, a self-assessment tool has been developed based upon:

- 'My Expectations' vision, developed jointly by the PHSO, Local Government Ombudsman and Healthwatch.
- 'Assurance of Good Complaints Handling for Acute and Community Care (CQC, 2015); A road map for managing complaints for Commissioners' [3] NHS England.
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The self-assessment tool will be completed by staff at different levels within Complaints/PALS and Corporate Services in order obtain a fully representative assessment of the service in relation to the above standards. The outcome of the assessments will then be used in conjunction with patient feedback to inform improvements to the service during 2016/17.

A process mapping exercise will also be undertaken to inform further improvements for 2016/17.

17.3 **Triaging of Complaints:** Currently all complaints are allocated an internal deadline of 25 working days unless an extension is requested within the Division. The Patient Services team will devise and implement a robust system for triaging complaints at the acknowledgement stage, that will continue to identify the majority of complaints are responded to in 25 days, but if due to complexity this is identified as unachievable a realistic time frame for response will be set according to defined criteria. The timeframe will be agreed with the complainant at the outset and this will help the Trust to meet its statutory duty to respond to complaints within a timeframe agreed with the complainant.

[3] Assurance of Good Complaints **Handling** for Acute and Community Care (CQC, 2015); A road map for managing complaints for Commissioners. Available from: https://www.england.nhs.uk/wp-content/uploads/2015/11/ccc-toolkit-acute.pdf [Accessed 02 December 2015].

Further to this, where appropriate the use of extensions will be mandated and monitored via the Trust Complaint KPI Meeting in terms of frequency and reasons.

17.4 **Development of Safeguard System:** The Patient Services Team will investigate improvement options to the Safeguard system that will provide a more meaningful and detailed descriptor of the themes contained within complaints that can be entered into Safeguard, at the point of receipt of the complaint. This will provide a richer source of data to identify areas of concern and inform targeted improvements to services.

17.5 **Improving use of Safeguard System:** During 2016/17, the Patient Services Team will continue to work with the divisions in order to promote more widespread use of the Safeguard system. The continuation of the educational programme for Complaints Handling will be key to the delivery of this objective. All records relating to complaints management should be recorded on Safeguard in order to provide a robust audit trail. During 2016/17 the Patient Services team will continue to monitor progress.

17.6 **Improving Data Reporting Systems:** Throughout 2015/16 the quality of the complaints data has improved. During 2016/17 the Head of Patient Services will continue to work with the Informatics Team and the Improving Quality Information Manager to continue to progress this improvement work. This will help ensure reporting mechanisms are robust, in place and provide the Divisions with a reliable source of data that both facilitates improved management of complaints and informs service improvements.

18. Conclusion

The Board of Directors is asked to note the content of this report, the work undertaken by the corporate and divisional teams to improve the patient's experience of raising complaints and concerns and in line with statutory requirements provide approval for the report to be published on the Trust's website.