

TRUST BOARD MEETING – 28 January 2010

Title of the Paper:	Complaints		
Agenda item:	18/10		
Author:	Colin Johnston, Medical Director and Director of Patient Safety		
Trust Objective:	Objective – Quality and Patient Satisfaction – Deliver safe, high quality care that patients feel meets their needs.		
<b>Key issues</b> The Trust needs to be able to demonstrate that it has in place a process for ensuring that it learns from the issues raised in complaints.			
<b>Purpose</b> Reports on current arrangements			
<b>Risk Implications for the Trust</b> (including any clinical and financial		<b>Mitigating Actions (Controls):</b>	
Failure to demonstrate effectiveness of a process will lead to a lack of assurance to the Board that lessons have been learnt from complaints made		Processes in place within the Divisions and Corporate Groups to agree, monitor and review actions and ensure that, where appropriate, changes are made to service delivery	
<b>Level of Assurance that can be given to the Trust Board from the report</b> [significant, sufficient, limited, none]:  Significant			
<b>Links to Key Line of Enquiry (KLOE 1 - 5)</b> N/A but relates to C14 of Standards for Better Health and evidence of implementation of the Trust Complaints Policy is required for NHSLA.			
<b>Legal Implications:</b>  None identified.			
<b>Recommendation to the Trust Board:</b> The Trust Board is asked to: <ul style="list-style-type: none"><li>note the process that has been introduced in order to more accurately provide the assurance needed that lessons learnt from complaints are being taken forward.</li></ul>			



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**Public Board Meeting - 28 January 2010**

**Complaints**

**Presented by: Colin Johnston, Medical Director/Director of Patient Safety**

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**Background**

This paper updates the Board on recent changes that have been introduced within the complaints process to provide greater assurance that the lessons learnt from complaints received by the Trust are being taken forward and where appropriate, changes made to the way in which services are delivered.

From April 2009 the national framework for the handling of complaints changed. The Trust put in place the new arrangements to accommodate these changes and deliver a much more patient focussed complaints process. There is now much more of an emphasis on making direct contact with complainants to try and resolve issues on an informal basis through face to face meetings or telephone contact. Part of the process has also been to look at ways in which we can ensure that lessons are learnt from the complaints that have been made and to reduce the incidents of formal complaints.

**Current Position**

Following the investigation of every complaint Divisions are now completing an action plan indicating the specific actions that need to be taken arising from the complaint, who will lead on those actions and the date that it is signed off by the Divisional Boards. Progress against the delivery of the completed action plans and Divisional Board sign off will be monitored by the Complaints Department. The action plans will then be summarised and reviewed at the regular Divisional Integrated Standards Executive meetings chaired by the Medical Director. Subsequently, a high level summary of all the Divisional action plans will be prepared by the Complaints Department for review by the Business Integrated Standards Executive and the Clinical Quality Committee (CQuaC) in order to ensure that any Trust wide learning is identified and taken forward. Where appropriate, the Nursing and Midwifery Strategy Group and the Clinical Policy and Practice Group will address key nursing and medical issues that arise from the action plan summaries. The high level summary and appropriate commentary will form part of the Complaints, Litigation, Investigations and PALs (CLIP) report that is submitted to the Board on a regular basis.

## **Action Required**

The Board is asked to note the process that has been introduced in order to more accurately provide the assurance needed that lessons learnt from complaints are being taken forward.

**Colin Johnston**  
**Medical Director / Director of Patient Safety**  
**January 2010**