West Hertfordshire Hospitals NHS
NHS Trust

TRUST BOARD MEETING – 24 November 2011

Title of the Paper:	**Review of Formal Complaints – August 2011**
Agenda item:	**179/11**
Author:	**Chris Green, Non Executive Director**
Trust Objective:	**Provide safe patient care** **Improve Outcomes and Quality of Care**

Purpose
The September Board agreed an independent review of public complaints by a non-executive director (rotating). This paper reviews the written complaints received by the Trust in August 2011 against our new criteria.

Risk Implications for the Trust (*including any clinical and financial)*	**Mitigating Actions** *(Controls):*
Not applicable	Not applicable

Level of Assurance that can be given to the Trust Board from the report [significant, sufficient, limited, none]:

Not applicable

Links to CQC, BAF
Not applicable

Legal Implications:
Not applicable

Recommendation to the Trust Board:

The board is asked to receive and note the report.

West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item 179/11

Public Board Meeting 24 November 2011

Review of Formal Complaints – August 2011

Presented by: **Chris Green, Non-Executive Director**

1. Purpose

The September Board agreed a comprehensive patient experience strategy which included an independent review of public complaints by a non-executive director (rotating). This paper reviews the written complaints received by the Trust in August 2011 against our new criteria.

2. Summary

The Trust received 67 written complaints in August (65 in August 2010) against a total of 80,000 patients/visitors in an average month. Each one of these complaints offers us an opportunity to improve our patient experience. It is important that Board Members get a regular feel for the issues which are being raised.

Having reviewed the 40 complaints which were available for reading they have been identified, below, against the three headings of our Board strategy for better patient experience and are fairly evenly distributed:

Professional Clinical Care	= 12
Robust Processes	= 13
Supportive Behaviours	= 9

A further 6 letters (10% of letters) were actually commendations for an excellent patient experience, in addition to the hundreds of “thank you” letters that are sent straight to the wards.

3. What Patients Are Telling Us

3.1 Professional Clinical Care

These start with two avoidable deaths and are a stark reminder of the responsibility that every doctor and nurse faces every time they interact with a patient. There is also a chain of complex relationships between GP, urgent care centre, A&E, acute admissions unit and the specialist wards and clinics. The responses show doctors being impressively open in admitting mistakes, sending personal apologies to complainants and offering to meet dissatisfied patients. It is inevitably less obvious from the replies to be certain that the lessons are being learnt across the Trust.

3.2. Robust Processes

There were a range of mix-ups over appointments, operation dates and other clinical issues. In almost every case a clear process was already in place to avoid the incident and most track back to better training and self-discipline. In many cases, better communications with the patient at the time could have avoided both the frustration and the complaint.

3.3. Supportive Behaviours

These are nine classic examples of how *not* to interact with our patients and relatives. The public have a core expectation that health staff are caring people and feel shocked when they are not treated with respect. The responses are, however, impressive with individuals not only being challenged, but being named in the replies – often with a personal apology. This reinforces the importance of the Board's new patient experience strategy, together with a zero tolerance for staff who cannot offer respect, care and empathy to ill patients in their trust.

4. The Quality Of Our Replies

The WHHT responses are excellent. They reflect a caring management team that is determined to get to the bottom of the issues. They are effectively mini-investigations and can be up to 9 pages long. They give chapter and verse on each issue raised by the complainant and impressively name every individual involved in the chain of events and often include their apologies or explanations of a misunderstanding. The responses are invariably signed by the Chief Executive, the Director of Nursing or a Divisional Manager and offer further contacts.

5. Are Our Processes Robust?

The WHHT processes are undoubtedly fit for purpose. The Trust has a dedicated team of a manager and three assistants under the inspired leadership of Mark Jarvis. They register the correspondence, send an acknowledgement letter within two days, allocate the letters to a lead Divisional Manager and then track progress weekly through a spread-sheet.

For the majority of complaints the full investigation and drafting of the initial response takes place within the divisions and is then sent to the complaints team for review. In two specific areas the divisions produce investigation reports from which the complaints team draft the letter. This is a trial that may be extended to cover all complaints in the future. We should, however challenge the team on aiming towards a 95% response for the 40 day target. We are currently achieving about 75% and a streamlining of some of the processes could help achieve a 95% delivery.

The process for reviewing the action plans arising from complaints and checking that the lessons have been learnt lies with the Claims, Litigation Incidents and PALs (CLIP) group. Where specific issues need to be picked up individually this is done through the Integrated Standards Executive meetings that take place each quarter and chaired by Colin Johnson. Additionally Natalie Forrest picks up specific issues as part of the patient experience strategy implementation.

Mark Jarvis's own role has been broadened from public complaints (and the other areas he covers) to the broader patient experience agenda. This now ensures that patient feedback is locked into future training and delivery about complaints. It would be uplifting if his 'public complaints' team could be re-titled the 'patient experience' team.

6. Can We Learn From Other Organisations?

We are probably already better than most other service industries. Virgin Trains had broadly the same organisation and processes with a faster response rate. However, NHS complaints are of a different order of magnitude involving complex clinical issues in a complex industry. This makes for a longer complaints process and we should be proud of our delivery.

7. Conclusions And Recommendations

We clearly have a robust and caring process for handling public complaints and the process now lies at the heart of the new patient experience strategy.

The Trust Board is asked to endorse the outcome of the review and consider the additional improvements that could be made:

- Seek to answer 95% of complaints within the 40 Day target
- Demonstrate more robustly that Trust-wide lessons are being learnt from individual incidents
- Continue to implement the patient experience strategy to generate continuous improvement in staff attitudes and behaviours across the Trust
- Re-title the public complaints team to a more positive name: eg patient experience team