

Item 8.4

Committee Paper

Subject: Q3 Complaints Activity Report 2015/16
Date of meeting: 1ST March 2016
Prepared & Presented by: Lisa Gurrell, Patient & Family Support Manager
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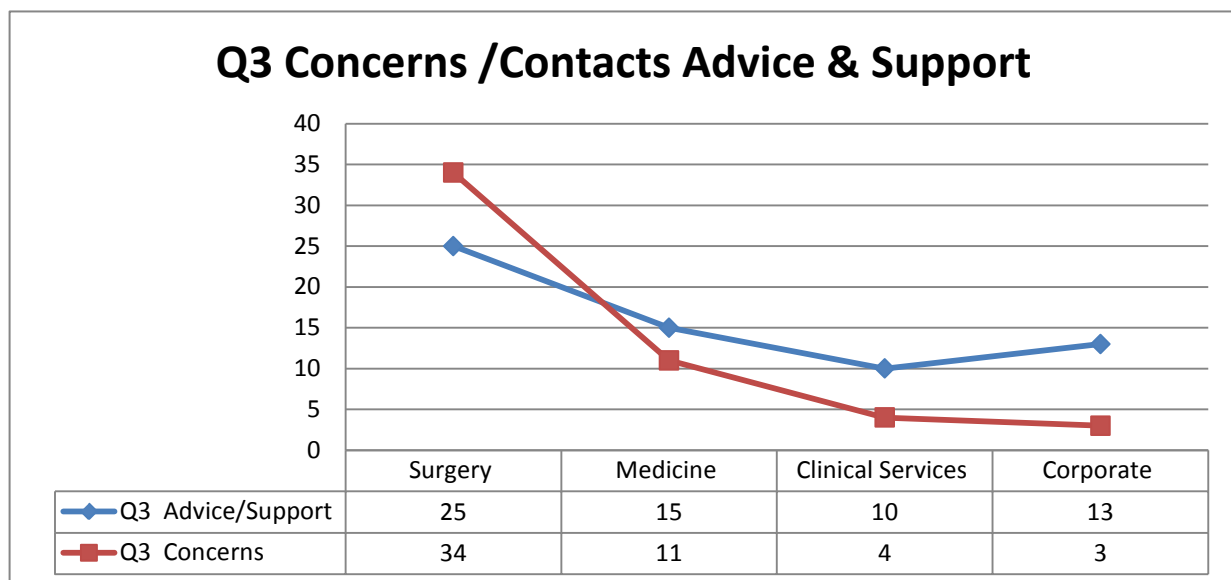
Assurance Report	Data Quality Rating	CQC Outcome	Level of concern? Y/N (If yes: Major / Moderate / Minor)
Internally Assured	Bronze	N/a	N

1. Introduction

This report outlines concerns and complaints captured in Q3. It includes the numbers of complaints received per division, trends, and severity of complaint, outcomes and summary of learning.

2. Contacts - Concerns – Advice & Support

Total contacts: 115 – 63 requests for advice/information/support and 52 concerns raised.



Trends:

Surgery:– Cancelled Surgery /Waiting time for surgery

Clinical Services – Concerns relating to MRI scanner out of service

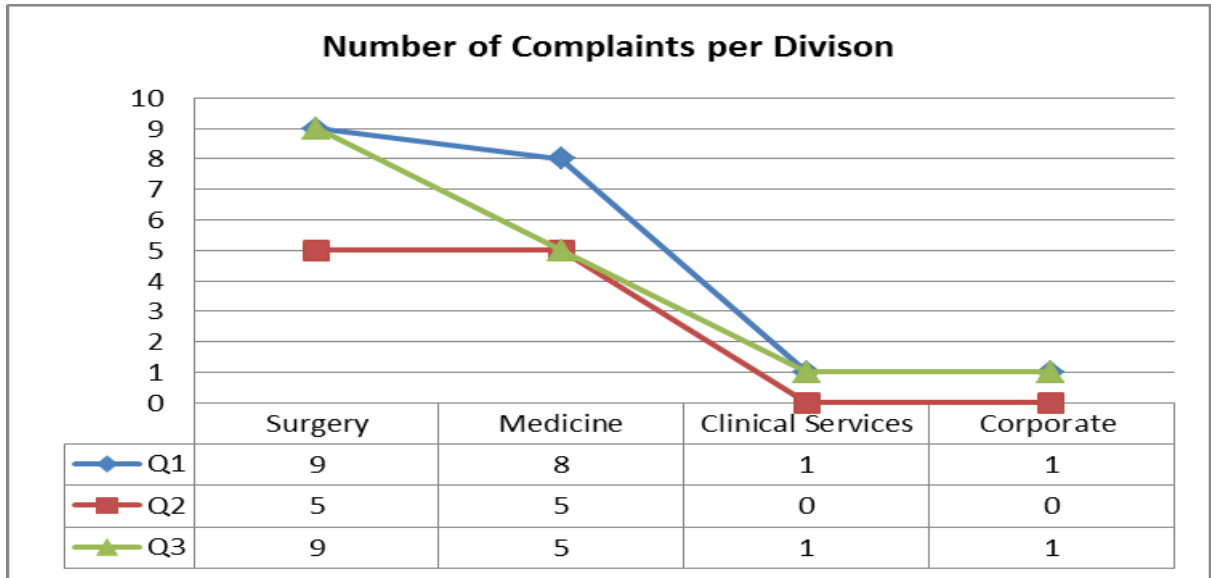
Medicine - No trends

Corporate – No trends

All concerns raised were investigated and were resolved before escalating to a formal complaint.

3. Complaints

The graph outlines the number of complaints per quarter per division with a total of 16 received in Q3.



The table below demonstrates the complaints received in Q3 via division, including details, trends for 2015/16. Action plans produced following a complaint are presented to the relevant monthly governance meetings as and when produced, following the complaint.

Division	Number of Complaints	Themes/categories
Surgery	9	Clinical Care/Nursing (2) Clinical care & Communication (2) Clinical care/post op cardiac arrest (1) Nursing/Therapies communication (1) Discharge process & follow up (1) Waiting time for surgery (1) Waiting time for procedure following admission (1)
Medicine	5	Nursing care/discharge process for patient who required additional support (1) Patient lost to follow up pacemaker clinic (1) Complication following procedure (1) Cancelled appointment(1) Not reviewed by consultant in OPD (1)
Clinical Services	1	Post op complications on ITU following surgery (1)
Corporate	1	Car parking charges (1)

It is important to note that some complaints required input from other divisions and complaints relating to administration services/service lines may be included in the divisions.

At time of producing this report :

- All complaints from all divisions were acknowledged within 3 working days
- There were a number of complaints that required re-negotiating because investigation took longer than anticipated.
- All complaints were graded medium or low, no complaints in Q3 were graded High/Extreme.

3.1 Learning from Complaints

Division	Brief summary of Learning for Q3
Surgery	<ul style="list-style-type: none">• Improved documentation for communication with relatives• Nursing staff to adhere to values and behaviour and introduce themselves• Policy to be reviewed regarding the frequency of redressing a pressure dressing for guidance for staff• Staff instructed on correct disposal of equipment waste
Medicine	<ul style="list-style-type: none">• Review of discharge process and discharge case conferences to be arranged with family members for complex cases• Improved communication with family members• Appropriate cardiac rehabilitation programme to be offered to all patients who require this on discharge
Cross Organisational	<ul style="list-style-type: none">• New OPD documentation in EPR to improve documentation and record outcomes to prevent patients being lost to follow up.

All complaint responses either verbal or written were honest and open in-line with the statutory Duty of Candour.

Other Learning:

One complainant from Q2 (surgery) met with the CEO and relevant senior staff in Q3. They have agreed to provide a family story via video to share the experience they had as a family. The complaint related to cancelled surgery, communications relating to the cancellation and their experience whilst the patient was in ITU.

4.0 Parliamentary Health Service Ombudsman (PHSO)

In Q3 one request was made by the PSHO from a complaint initially raised in October 2014 for the Medicine Division.

Summary: This related to a patient who was a visitor to Liverpool and was transferred from the RLUBH with a diagnosis of biventricular heart failure and previous septal MI. He was known to be under follow-up for this in his home town of Sheffield for heart failure. The patient was transferred across and had an ICD inserted. Patient arrested 48 hours following procedure and died.

Complainant (wife) has alleged:

- Care was not well planned
- May have been a delay initiating CPR
- Not being contacted when health deteriorated and discouraged to have a post mortem

Status: PHSO have accepted complaint for investigation.

4. Recommendations

The Council of Governor's are asked to receive the report and take assurance that the complaints and learning have been discussed at each Divisional Governance meeting in January 2016 and take assurance that complaints management is proactive and robust across the divisions and organisation.