

# PAPER

BOD 57/2013

(Agenda Item: 9)

# Report to the Meeting of the Oxford Health NHS Foundation Trust

# Board of Directors

**Quality Report: Patient Experience**

**29 May 2013**

**For: Information**

**Report**

This report summarises the activities carried out in the Trust to monitor the patient experience and act on their feedback. It covers the following areas:

* General updates including: changes to catering as a result of feedback; Friends and Family pilot; 15 step challenge; Trust initiatives to improve and monitor patient experience.
* Summaries of Divisional feedback from patients and actions taken to improve services as a result.
* Complaints 2012 – 2013 including quarter 4
* Accolades

The general Quality and Safety Section provides an update on

* Infection Control status report

**Recommendation**

The Board is asked to note this report.

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**Lead Executive Director:** Ros Alstead, Director of Nursing and Clinical Standards

A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.

This paper provides assurance and evidence against the Care Quality Commission Outcomes: 1 Respecting and involving people who use services and 16 Assessing and monitoring the quality of service provision

**Quality Report: Patient Experience**

1. **General Menu Review**

**1.1** **Catering**: The quality choice, and nutritional value of food served to patients has been reviewed, during the months of October 12 – February 2013, results both positive and negative were used to make improvements to the menu whilst also ensuring all dietetic and cultural needs continue to be met. The new menus were implemented on 3rd April alongside a full dietetic coding book available for all to use in the event of a late admission or information required for diet plans etc.

Menu’s have also now been updated and highlighted in red to show foods that contain tomatoes following a serious incident involving a tomato allergy. Menus are coded (see below) to enable patients to make an informal choice for their meal choice. The menus are designed in line with the BDA (British Diabetic Association) guidelines to ensure that they meet the needs of all client groups.

|  |
| --- |
| HY = Healthier Eating, HE = Higher Energy, LF = Low Fat, NAS = No Added Salt, LS = Low Sodium, LK = Low Potassium, RF = Restricted Fibre, |
| Vgt = Vegetarian, Vgn = Vegan, S = Soft,  FF = Fish Free, NGCI = No Gluten Containing Ingredients, WF = Wheat Free, MF = Milk Free, EF = Egg Free, |  |  |  |  |  |  |  |  |  |  |  |
| SF = Soya Free, ZF = Sesame Free, NF = Nut Free, CF = Celery Free, BF = Mustard Free, AF = Alcohol Free, SO² = (See dietetic coding book for details), MAOI = Suitable for those on MAOI diets |  |  |  |  |

**Nutrition Audit**

**1.2** During the month of December 2012 a nutrition audit was completed, it highlighted there is an issue with Obesity amongst patients in mental health inpatient wards in Oxfordshire. A new standard to screen patients on admission has been introduced to identify who is at risk so that patients can be supported by peers and staff to become healthier whilst in our care. Care plans will be implemented to ensure that patients’ needs are met so that excessive weight gain or loss does not occur, and diet plans are now in place and are reviewed monthly by ward managers, comments from patient council meetings are communicated and meetings arranged with suppliers so that services offered continue to meet the needs of individual groups whilst also staying healthy offering a fully balanced diet.

With  the information collated over the past year it has shown in some client groups there are complex issues with weight gain, the Safer Care Programme aims to help the Trust develop organisational plans for patient safety improvements and to build teams responsible for driving improvements across their organisation. Kingfisher Ward Safer Care focus is healthy eating amongst women vulnerable to weight gain.

**1.3** In the month of March the Mental Health Division completed real time surveys which showed that there were some changes in patients views of meal services supplied.

|  |  |  |
| --- | --- | --- |
| **Q.14** | The food is good and varied (38) | **All Responses** |
|  |  |  |  |  | strongly disagree |   |   |   |   | 13.2% | 5 |
|  |  |  |  |  | disagree |   |   |   |   |   |   | 34.2% | 13 |
|  |  |  |  |  | neither disagree or agree |   | 13.2% | 5 |
|  |  |  |  |  | agree |   |   |   |   |   |   |   | 23.7% | 9 |
|  |  |  |  |  | strongly agree |   |   |   |   |   | 15.8% | 6 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
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As part of an action plan the catering manager will fully investigate the issues raised with the supply of food with users and Anglia Crown  so that improvements can be made. Early indications show that changes need to be made to the salads and sandwiches that are offered, one ward is currently sampling sandwiches from another supplier, this may lead to a change in service if this indicates that the quality is superior to current goods supplied, findings will be communicated to the team and users  as part of the plan.

**2. Friends and Family test pilot:** In the Febraury the Board of Directors were informed about the requirement to implement the F&F test in the Community Hospitals and Minor Injuries Units (MIU) from April 2013. During quarter 4 we undertook a pilot testing 4 methods of surveying to see which may be the most productive. The Community Hospitals and Abingdon and Witney MIUs patients were given on discharge or departure a postcard with the test question and four follow up questions which could be returned via freepost or completed on site and placed in a comments box. The postcard also contains information about how the patient could either complete the survey online or phone a free phone number and have the questions asked of them. Henley MIU had an electronic kiosk in the area outside the treatment room where a patient could complete it on site but with privacy.

The pilot was run from 14th Jan to 20th March 2013 there were 198 responses in total from the following sources;

* on-line survey – 5
* postcards – 157
* kiosk – 36
* telephone - 0

The Department of Health expects a response rate of 15%; the Trust during the pilot achieved a 4% response rate which poses a real challenge to prepare for the F&F test being a mandatory requirement by April 2014. In the meantime the Trust is expected to publish its net promoter score for Community Hospitals and MIUs and submit the score to the Local Area Team.

The net promoter score is calculated using the proportion of patients who would strongly recommend the service minus those who would not recommend it, or who are indifferent. Those respondents who answer the question as don’t know or blank are excluded from the calculation in line with national reporting guidance. During the pilot the Trusts NPS (net promoter score) was 65.

% of respondents who said extremely likely to recommend (133 divide 191 x 100 = **69.63**)

% of respondents who would not recommend (neither likely or unlikely, unlikely and extremely unlikely) (9 divide 191 x 100 = **4.71**)

**Net promoter score = 65** (out of a possible 100)

Minus

**3. 15 step challenge** - The 15 Steps Challenge gives a structured opportunity to look at various health care settings through the eyes of a patient or a visitor, helping to hear “what good looks and feels like.” Provides a way of capturing patients’ or visitors' first impressions and what can be changed to enhance the patient experience. It is an opportunity for the public, ward staff and senior team to work together on quality improvements. The unannounced visit will give confidence that high quality care is given at all times.

Two 15 Steps Challenge visits to two Community Hospital wards have taken place at the end of last year. Verbal feedback was given on the day followed up by written feedback. An action plan has been devised with some actions having already been achieved. Outcomes from the two site visits were, improvements to signage, points  on improving privacy and dignity , recommendations regarding reception area and storage , focus on improving the clarity and usefulness of information regarding ward  displayed in public areas. The full feedback and associated actions are in Appendix 1.

**4. Initiatives**: The Complaints & PALS Department has a scheme called “The PALS Exchange” where the team collects donations from a wide range of sources. The team seeks donations via announcements on the Trust’s Intranet and in the Insight magazine and requesting donations from local companies, Tesco’s in Aylesbury have been particularly supportive of the Trust in this respect. The items collected, books, DVD’s, CD’s, magazines, board games, puzzles and toiletries are given to wards for patients. Articles such as DVD are provided on an exchange/rotation basis to ensure variety on wards. PALS have been working closely with the Community Champion from the large Tesco’s store in Aylesbury and together have run a number of themed events on the wards within Aylesbury. These have included an Olympic event, a pamper session, flower arranging and most recently an Easter themed event. The team runs with Helen to run a different themed event every month.

**4.1** The Complaints & PALS Department has also recently started to recruit volunteers to assist in running PALS surgeries across the Trust. There are currently three volunteers due to start participating in PALS surgeries from May. Each are experts by experience and it is anticipated that on occasions this may assist in patients feeling more confident ion giving feedback and suggestions for improvement.

Mystery Shoppers – see Harm Minimization services

**5. Real Time Feedback (RTF) report :** From September 2012 to March 2013, there have been two surveys in use, the Mental Health Inpatient Questionnaire, and a Children’s Survey, specifically used in CAMHS. The graph below shows the responses to the key question “Overall, how would you rate the care you have received from Oxford Health”, since the surveys were implemented in April 2011. The average for this question is 80% since the RTF devices were put into circulation in April 2011. During April 2012 and May 2012 the machines were not in circulation, these months were omitted from the graph to reduce the data being skewed by these outliers.

The Trust updated the hardware disseminated to Divisions at the end of March and Divisions have taken this opportunity to review the questions in surveys, as a consequence there has been some delay with getting devices back out to teams to be used. Additionally teething problems with uploading data where services do not have wireless connection has arisen. Response rates for April will therefore be lower but will be refreshed in the coming months when manual uploading is completed. The response to this high level question during April 2013 has therefore been omitted from the report. More detailed reporting from these surveys is covered in the Divisional updates.

**6. Mental Health Division**

**6.1 In-patient Services -** Real Time Feedback (RFT) devices have been rolled out to all in-patient services (with the exception of Ashurst ward). The results of the feedback is presented to each clinical area on a monthly basis and action planning undertaken at ward/clinical area and discussed in clinical meetings. The main areas for improvement identified in the most recent feedback was in relation to:

* The amount of time Care Co-ordinators spend with patients when they are in hospital
* Level of involvement patients have in their discharge planning
* The standard and variation of food
* The rationale for nursing observations being clearly explained to patients
* The number of nurses available on duty to care for patients

**6.2** In support of existing arrangement ‘Have Your Say’ meetings are in place to obtain patient feedback including (community meetings, RFT devices, essential standards audit and PALs surgeries), the wards have implemented **‘**Have Your Say’ meetings. The key rationale for the meeting is to provide a space for service users to discuss issues that are important to them and have their experience heard, validated and responded to by each other and the staff team. The other aim is to create a direct line of service user feedback for developing and improving the experience of individuals on the wards.

It is based on recommendations in 'NICE quality standard on service user experience in adult mental health in the NHS in England' (specifically Standard 2 and 5). The meetings (initially piloted on Phoenix ward), have been introduced to other in-patient areas. The whole staff team are involved in the meeting (including OT, modern matron and ward manager) and feedback the minutes to the wider team in business meeting. This is to ensure service users feel their comments are important and gain feedback/information/actions for the next meeting. We are there to respond to patients immediate issues and these meetings are patient led.

Outcomes:

* PALs have fed back that Phoenix had no new complaints about the ward experience following the inception of the meeting.
* We are pulling out the key themes from each quarter to publicise on the ward with an action plan on how we intend to make improvements based. These will be in an area of the ward used by staff, service users and carers.

Development:

* The meetings have now been rolled out to all the inpatient wards.
* Quarterly meeting with service user representatives from each ward who look at the key themes from each ward, compare these and discuss potential service wide changes.

**6.3 Community Mental Health -** A Patient Satisfaction Survey based on areas for improvement in the National Patient survey, was conducted March 2013, and we are presently awaiting results which are being collated by patient perspectives. We are also planning to send out questionnaires to community patients and are in the process of agreeing timescales and agreeing questions.

**7. Community Services Oxford**

**7.1 Surveys**

During 2012-13 surveys were undertaken by 22 services across Oxon Community Division. When patient survey feedback is received, services develop action plans to address any negative feedback and support the cycle of continuous improvement. The action plans are monitored by the divisional Patient Experience Group.

|  |  |
| --- | --- |
| **Actions taken to improve** | **What patients say now** |
| **Community Hospitals** |  |
| East Kent Outcome System (EKOS) care planning is being implemented. This method improves patient involvement in goal setting.Clinical notes to be completed by the bedside and in patients’ bays and rooms, to aid in improving communication and discussion with individual patients.A system of named nurse communication after weekly Multi-Disciplinary Team (MDT) meeting to be trialed.A document to be given to the patient, detailing on-going care and contact details for advice on discharge.To raise the issue at staff meetings and MDT meetings to alert staff in improving communication with patients regarding care planning, treatment provision and discharge planning. | In 2011 39% of patients said they definitely thought their views were taken into account when deciding what was in their care plan; results for 2012 show a small increase to 41%.In 2011 46% of patients said they understood what was in their care plan; results for 2012 show an increase to 57%.In 2011 28% of patients who were aware that they had a care plan; in 2012 55% of patients said they were confident that their plan for care and treatment had been discussed with them.**Further improvements**The most recent results are currently being reviewed in order to develop action plans. Work related to EKOS continues so further improvement are expected when this is fully implemented. |
| **Actions to improve** | **What patients say now** |
| **District Nursing** |  |
| Following the last survey there has been agreement from the commissioners to extend the DN service from 8am to 6.30pm including weekends from 1st November 2013 which will provide a more consistent cover for patients.Named nursing to be put in place. | In 2011 62% of patients said they knew they had a care plan; results for 2012 show a slight increase to 63%.94% said that the main reason for the visit by the District Nurse was dealt with to their satisfaction |
| **Nutrition & Dietetics** |  |
| To reduce the number of DNAs for first appointments by attending GP Clinical Team meetings to clarify criteria and appropriateness of referrals to the team. | 94% said that they were seen at a convenient place and 91% said they were seen at a convenient time. |
| **OCCMET** |  |
| To reduce waiting times by introducing a triaging system was introduced.Joint education classes for Chronic Fatigue Syndrome (CFS) and Myalgic Encephalomyelitis (ME) | 100% said that they were seen at a suitable place and 92% said they were seen at a convenient time.“Everyone was very knowledgeable and understanding - a first in my experience of having CFS”“The entire experience. The staff, the OT, the Dr. The information shared. The techniques taught. The patient, gentle and accommodating approach of the clinician, occupational therapist, and Dr”. |
| **Continuing Care** |  |
| Lack of understanding of why an application for Continuing Care was required so the Decision Support Tool will be used to document explanation and provide opportunity for clients or their carers to record their views and comments.  | 100% said that they were given the right amount of information about the full assessment. |
| **Urgent Care - MIU** |  |
| White boards to be used to display current waiting times.Pain scores to be introduced at triage and re-measured post administration of analgesia | 94% stated that if they had any worries or fears about their condition or treatment a nurse did discuss them.95% stated that they did have enough time to discuss their health or medical problems with the nurse. |
| **Urgent Care - OOH** |  |
| Reduce waiting times for home visits by introducing new Omnilocation Vehicle Tracking system which will support improved allocation of visits.Customer Care training will be provided for all administrative staff | 100% said they were satisfied with the attitude of the receptionist92% stated that the main reason they contacted out of hours was dealt with to their satisfaction. |

**8. Specialist Services**

**8.1 Forensic Mental Health Services**

A Patient Satisfaction Survey was conducted in September 2012 across all Forensic Inpatient Wards. Results were collated and a summary was presented at the Low and Medium Secure Clinical Governance Committee (24 January 2013). Local action plans have been developed but getting these agreed and taken forward has been hampered by a lack of attendance at the medium and low secure clinical governance meeting.

Posters for the wards have been produced that summarise the results for patients, comparing scores to last year. It is also intended to submit an article for publishing around the use of the survey and developing service user involvement ion forensic services.

There is some concern that the service user forums on some wards are finding it difficult to attract representatives, though others continue to do well. The Lead OT is leading a discussion on reviewing the model of user involvement.

**8.2 Prison Service**

Amended Patient Satisfaction Surveys were disseminated by Patient Perspective in HMP Bullingdon and HMP Huntercombe the week beginning 28 January 2013.

As a result of the findings of these surveys, the healthcare departments at Huntercombe and Bullingdon prisons are improving the information provided to patients at their consultations. This is being done by ensuring information is given to patients about their condition, the results of tests and side effects of prescribed medications. Records of consultations are being reviewed in staff supervision and matrons are regularly observing consultations and feeding back to individual clinicians. Additional leaflet and poster information on common conditions and medications is being provided. Work is also being taken forward at Huntercombe to provide guidance on recording consent and addressing the diversity of the prison’s population now that it houses foreign national prisoners. Other areas for improvement at Bullingdon prison have been handed over to Virgin Care who now have the responsibility for the health centre at that prison.

**8.3 Specialised Community Services**

**8.31** *Salaried Dental*

Patient Perspective was commissioned to run another Dental 2012/13 survey during January 2013 with a sample size of 200 patients across 10 clinical sites. We have been chasing the results but they haven’t yet been received.

*Luther Street Medical Centre*

The results of this survey have been reported through the Specialist Community Clinical Governance Committee. The action plan is being implemented.

***8.32*** *Harm Minimisation – Mystery shoppers*

Following the recent re modeling of the adult drug treatment services within Oxfordshire and its involvement within the payment by results framework. The Harm Minimisation service, recognising the need to incorporate service user’s involvement at the heart of its service provisions developed a mystery shopper approach to reviewing services, to achieve the following aims:

* Establish, increase and maintain effective user involvement within adult drug treatment services within Oxfordshire
* Establish, increase and maintain effective user involvement in strategic planning, delivery and evaluation of service provisions
* Improve health and social care for users
* Promote harm reduction to service users
* Educate the wider community around areas of concern associated with Substance misuse thus reducing the stigma attached to user

Mystery Shopping is where individuals are trained to observe, experience and evaluate the customer service process of an organisation; they do this by posing as a customer and undertaking a series of agreed tasks, which monitor the service delivery and the effectiveness of staff training and development. Each shop is followed by an evaluation, usually in the form of a questionnaire, through the questionnaire, they report on their experiences in a detailed and objective way.

The shoppers are given various scenarios to test out in practice with services which cover the following areas:

* Accessibility,
* Advocacy and Complaints,
* Harm Reduction advice/Drug Awareness,
* Family and Carers,
* PIEDs (performance and image enhancing drugs)
* Customer service and Confidentiality,
* Signposting.

The first series of mystery shopper exercises were carried out in quarter two with a view to establishing a baseline position of its service delivery and the second series in quarter four. The full report is available from Roy Walsh (Harm Minimisation Service) but the graphs below show high level feedback on accessibility, family/carers and customer care. This is a new service model so feedback enables staff to adjust and improve what they do.

### Accessibility section

### Family and Carers section

### Customer service and Confidentiality section

Comments made by shoppers include:

*"staff were ultra-responsive to my needs."*

*"Experience with staff was fantastic."*

*"A very warm welcome by staff."*

*"staff were knowledgeable, professional and caring."*

*"staff were very good at quelling my nerves."*

*"It would have been 5 out of 5 if it wasn't for the dirty room. The drop-in room needs a lick of paint."*

*"The whole set up inspired confidence, a relaxed atmosphere."*

*"The approach of the worker made me feel relaxed and comfortable.*

*"[It's a] shame drop-in at Banbury is only once a week. Staff are a valuable resource."*

*"There is nothing to identify the site as a drug and alcohol drop-in."*

*"Clear guidance given regarding pathways for prescribing."*

*"staff were very approachable and made me feel at ease very quickly."*

*"the worker was a very skilled helper."*

*"Clear explanation of OST was given."*

An example of actions taken on the basis of feedback is:

**Question: In the instance of advocacy were you supplied with the following information for: OUT, PALS and ICAS**

In Q2 sign posting to OUT for advocacy was 100%, in Q4 the 100% was maintained. In Q2 sign posting to PALS was 40%. In Q2 sign posting to ICAS was 0%.

In Q4 sign posting to OUT for support around making complaints was 80%, in Q4 it was 100%. In Q2 sign posting to PALS for support around making complaints was at 20%, in Q4 it was 100%. In Q2 sign posting to ICAS for support around making complaints was at 0%, in Q4 it was 60%.

In terms of further actions it was recommended that all staff be issued with the downloadable PDF leaflets and that the Harm Minimisation Service organises a visit by ICAS and PALS to attend team meetings and to present the services to team members and for team leaders to check sporadically if leaflets are visible at drop-ins.

**9. Child and Family services**

**9.1  *Health Visiting:***

Health visitors have had a focus on Service users feedback and as a result have developed a new leaflet giving information to families. They are currently asking for comments on the new leaflet to continue to ensure that it gives information that families say they need.

Service users have created a video giving feedback on the Family Nurse Partnership service and Service user comments are published in the HV newsletter to ensure staff get the benefit of the feedback. Some of which is shown below. An action plan has been created around including giving evidenced based advice at all times and ensuring staff have contact details of the family and where possible inform the client if the visit will be over 15 minutes early or late.

*“The service is fantastic – even during the busy baby drop-in clinic, the health visitors make time to answer specific or personal questions”*  *“Some advice I was given seems outdated, especially on weaning”*  *“As this is my second baby, I felt that my experience was taken into account and I was listened to when any advice was given, which was excellent”*

* *Were you* ***involved*** *as much as you wanted to be in decisions about your care?* - **Achieved 96%**
* Timing of visits: 10% either too early or too late
* *Did the health visitor* ***listen carefully*** *to what you had to say? -* **Achieved 93%**

***9.2 Children’s Integrated Therapies:***

Service user engagement in creation of Care pathways is under way with parents attending the Downs syndrome and cerebral palsy pathway meetings. A new smiley face survey has been developed for young people who have communication difficulty as a result of poor response rate from the annual postal surveys.

**9.3 *Community CAMHS***

Young people have been involved in recruitment of Consultants for 2 community bases and the CAMHS Parent & Carer Involvement network have developed a service questionnaire (SQ) aimed at parents of Young People accessing CAMHS following feedback that parents can find it difficult to give their views on services. A separate SQ has also been developed from the CAMHS Outreach and Crisis team (OSCA) following feedback from Young people using the service to ensure the question are relevant for that group. Article 12 & the parent & carer involvement network are also giving their “experiences” using MH services to share with other service users as they felt this helps to reduce anxiety and stigma attached to mental health.

Some feedback from the SQ’s this quarter included below and all teams have created action plans around the information and Article 12 are doing some work about signposting young people for Advocacy services.

*“The service is very friendly, and you never feel ashamed of needing therapy”. “They are making me better and supporting me.” “Let more children know that this is here”.*

* *“Do you know who will have* ***access to information*** *about your care?” 83*% said no or not sure
* *“Have you been given information about advocacy services?”22* % said yes, 41% could not remember
* *“****Overall*** *how would you rate the care you are receiving form mental health services?” 92*% answered positively

**9.4 *Highfield Unit, Oxford***

Inpatients at the Unit evaluated the new building in a workshop or via face to face interviews to feedback on how the building works for them. Views they gave said –

*“(we) like having our own bathrooms” “the temperature is good” “Noisy at night” “doors bang” “the Music room is great! We use it all the time” “building doesn’t feel ‘clinic-y’, (it) feels much more homely”*

Things that were liked included: Bedrooms, colour scheme and windows – “because you can open them more (than in the old unit)”

Things that were disliked: Hard floors, no sensory room, Doors banging.

Inpatients agreed they would like to receive a copy of the report once written and were very pleased to be asked their views.

**10. Complaints; 2012- 2013**

**10.1 Number of complaints**

278 complaints have been received in 2012/13. The number of complaints includes those complaints jointly coordinated and responded to with other NHS or Health and Social Care Providers as required. The number of complaints received by quarter was Quarter 1 (April-June 2012): 42, Quarter 2 (July-September 2012): 68, Quarter 3 (October-December 2012): 87 and Quarter 4 (January-March 2013): 81. The graph in figure 1 shows the number received by month; the average number received for the last two years is 20 per month. This increases to 23 per month if the average is taken just for the last year; 2012/13. There is an upward trend in the number of complaints which have been received and this trend is also reflected in the number of calls made to the Complaints & PALS Service free phone number to discuss and log either a formal complaint or informal concern, see figure 2.

Out of the 278 complaints received, 46 were received via an MP with peaks in July 2012 (9 = 35% of all complaints received), November 2012 (10 = 31% of all complaints received) and March 2013 (7 = 24% of all complaints received).

The majority of complaints which have been received are from or about the care and treatment of different patients/service users; out of the 278 complaints received 258 were from different patients, and nine patients made two or three complaints (seven made two complaints and two made three complaints).

In 2012/13, 24 concerns initially raised as a formal complaint have since been withdrawn by the complainant and resolution has been reached informally, there is no particular trend of which Division or team/ ward the concerns are being withdrawn from.



Figure 1: Total number of complaints received by month



Figure 2: Number of Calls to the Free Phone Complaints and PALS Service



Figure 3: Number of Complaints by Division

**10.2** The Parliamentary Health Service Ombudsman (PHSO) have reported that NHS Trusts are receiving an increasing number of complaints and that in 2011/12 there was a rise by 13% in complaints received from 2010/11. The Trust has seen these same increases with 154 complaints received in 2010/11, 203 in 2011/12 (32% increase on 2010/11) and 278 in 2012/13 (37% increase on 2011/12). However it is important to note the size of the Trust and number of services now provided has changed over the last three financial years.

The largest group of complaints came from service users (79 = 28%) with an additional 35 complaints from parents of children, giving a total of 41% of complaints received from service users or parents of children.

From the 278 complaints received 148 (53%) have been graded as green, 96 (35%) have been graded as yellow, 33 (12%) have been graded orange and one complaint was graded as red using the NPSA risk matrix based on likelihood of reoccurrence and impact to patient(s). The red incident was reported in full to the Board of Directors in the quarter when it occurred.

**10.3** Acknowledgement times - 94% of the 278 complaints were acknowledged within the NHS Complaints Regulations (2009) of three working days. 18 cases were not acknowledged in time of which six concerns were sent via an MP and the process for acknowledging these cases is slightly different. The majority of the cases not acknowledged within three days were for complaints received in October, November and January (11 out of 18) when a high number of complaints were received. The range for the acknowledgements outside three working days is from four to 13 working days.

**10.4** Response Times - 225 cases have been received and closed, 53 cases are still open. On average complaints were responded to in 38 calendar days, from the date when the complaint letter was received to the date on the letter of response or meeting held to feedback the findings.

82% of the 225 closed cases (184) have been responded to within an agreed timescale with the complainant; this includes extensions agreed with the complainant as per the NHS Complaints Regulations (2009). The average timescale set to respond to the complainant was 24 working days. The range for the responses outside an agreed timescale is from one to 28 working days with an average delay of 5 working days. The majority (25 of 41) of the delayed responses were for complaints received in September, October, November and January when an exceptionally high number of complaints were received.

**10.5 Improvements arising from complaints**

The following are examples of actions taken following complaints:

* A second EpiPen was placed in the emergency bag for the healthcare team in one service.
* A prisoners notes were updated to clearly note his severe allergy to ensure all professionals regardless of Prison are informed.
* Four separate HR processes were initiated for four members of staff following complaints.
* The Crisis Team was reminded of the importance of good communication with other relevant parties e.g. GP around the management of a patients crisis.
* The out of hours doctor has reflected with their supervisor on how they could have improved their communication with a family during a very challenging situation when a patient was at the end of their life.
* Clarification provided to the CAMHS team to place an alert on a patients notes if there is a safeguarding concern about sharing information.
* Reviewed the way help with assisting patients to the toilet is carried out in the evenings within a Community Hospital.
* Out of hours doctor to reflect with supervisor on how he communicated the decision made and the reason to the family and how he followed up an action to pass an urgent message to the relevant day time staff.
* A complaint has been used as a learning case within one of the education evenings and clinical newsletters around palliative care for the out of hours service.
* The district nurses are reviewing how they access their messages during the day time if they are out on visits to improve responsiveness to calls.
* Nursing staff within the Community Hospital were reminded of the importance of documenting fluid and dietary intake (as well as refusals) and the ward manager is now regularly checking this.
* Learning was fed back to the Community Hospital nursing staff about palliative care and the importance of regularly updating care plans when a person’s health is deteriorating.
* Staff on the forensic ward reminded to take time to explain and involve a patient about a decision and the reasons to transfer from one ward to another, checking the patient understands.

**10.6** **PHSO** - 14 complaint cases have been referred to the PHSO since 1st April 2012 10 of these cases have been closed, of the cases closed one has resulted in formal action being recommended by the PHSO, details of which the Board of Directors have previously been advised of.

**11. Compliments/Accolades**

In addition to the monitoring of complaints Oxford Health FT monitors the number of compliments received and is pleased to report an increase in the number of compliments during 2012/2013 in comparison to 2011/2012. The increase is partially due to promotion to encourage clinical services to share and report when they receive a compliment.

The number of compliments received can be seen in the table below, work continues to ensure all teams share the compliments they receive as there seems to be under-reporting.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Ward/Team | April 2012 | May | June | July | Aug | Sep 2012 | Oct 2012 | Nov 2012 | Dec 2012 | Jan 2013 | Feb 2013 | March 2013 |
| 2012 | 2012 | 2012 | 2012 |
| Specialised Division | 12 | 4 | 14 | 17 | 22 | 20 | 46 | 46 | 30 | 39 | 37 | 27 |
| Children and Families Division | 41 | 16 | 21 | 32 | 41 | 54 | 34 | 41 | 91 | 71 | 50 | 31 |
| Oxfordshire Community Services Division | 115 | 90 | 215 | 265 | 258 | 70 | 243 | 257 | 185 | 281 | 60 | 289 |
| Mental Health Division | 9 | 16 | 16 | 30 | 26 | 45 | 45 | 63 | 93 | 36 | 45 | 48 |
| Trust wide | 177 | 126 | 266 | 344 | 347 | 189 | 268 | 407 | 399 | 427 | 192 | 395 |

An example of an exceptional accolade sent in during the year is shown below:

*Dear Dr x,*

*Just about a year ago you suggested that I would benefit from an investigation by a specialist from the Tissue Viability team based in Abingdon.*

*I would like to thank you for setting that up as it has led to tremendous improvements in my condition and my day-to-day life.*

*Back in 2005 the vascular surgery team under the excellent Linda Hands had confirmed that nothing more could be done to correct the deficient peripheral blood flow in my legs, and that the only remaining choices were amputation or care & maintenance of a chronic condition.*

*Having decided against amputation, I entered an enforced early retirement with drastically reduced mobility and settled into a time-consuming care regime to deal with large open wounds with their consequent regular pain and mess. I made the best of it as there was no prospect  of any alternative in view (indeed I remember one of the Practice nurses around at that time looking at my wounds and exclaiming “That’s not so bad. With some of our old dears you can actually see exposed bone!”)*

*It became clear from the very first meeting with the Tissue Viability service’s Sarah Gardner that “be thankful for small mercies” has no part at all in her, or the team’s, philosophy. After an extensive initial examination Sarah identified a number of areas which might repay some attention; instead of jumping in, though, she led a discussion (involving your own Sarah Gordon) to ensure that I understood the issues, to establish what I wanted to happen and then to agree an action plan. The very clear philosophy embodied by Sarah Gardner and her colleagues is to identify – for each individual patient – what is possible and what is desirable, to agree on a course of action and its expected outcomes and then to put in place – and protect – a treatment plan.*

*There have been a number of setbacks to the plan where progress has stopped and reversed, often producing considerable additional pain. Sarah Gardner was always ready to recommend an alternative approach, or even to identify promising innovations in the market place and set up trials. With Sarah Gordon’s weekly support we’ve achieved dramatic improvements in my condition that would have seemed impossible a year ago. My ulcers are now down to around 25% (Left leg) and 30% (Right leg) of their original size, and the consistent pain levels are considerably reduced. Improvements to my right leg mean that I’m now able to bear contact at the back of the calf for the first time since 2005 and, consequently, can sleep with my leg in bed instead of propped up on a chair. I’m getting a decent night’s sleep for the first time in around ten years.*

*The point I’d like to emphasize is that the knowledge that the Tissue Viability team have is profound. Add to that their ability to keep abreast of developments in products, techniques and research findings and one must conclude that they represent an expert resource that is way beyond what any Practice-based nursing team can achieve, particularly with the modern emphasis on patient throughput measured in 10-minute slots.*

*I don’t know if the latest rganizational upheaval to move to Clinical Commissioning Groups is likely to impact on specialist services such as the Tissue Viability team, but as a direct beneficiary of their support I would argue strongly for their continued well-being and even enhanced usage by GP teams. I don’t know what communication routes exist within the Healthcare community between specialist units and front-line Practices such as your team but I do know that the Tissue Viability team have the ability to widen horizons for more generalist nurse practitioners and to recommend possibilities that are positively life-enhancing for patients with long-term problems.*

*Thanks again for setting up this contact; I’ve found it enormously beneficial.*

*Best wishes…..*

**12. Infection Prevention and Control**

**12.1 Community health services -** There were 2 cases of *Clostridium difficile* infection (CDI) in community hospitals in April. 1 was at Didcot (3.4.13) and 1 case Wallingford (29.4.13).

There have been no cases so far in May. Full RCA’s were completed into both patients and action plans developed.

This equates to 2 cases YTD. The threshold for 2013/14 is yet to be agreed.

**Outbreaks -** There has been a suspected norovirus outbreak on St.Leonard’s ward, Wallingford hospital reported on 14th May. It is currently affecting 3 patients and 5 staff and all precautions have been implemented. The 3 affected bays have been close to admissions but the remaining bays can be admitted to and the ward remains open at this time.

**12.2 Mental health services -** There have been no CDI cases in March 2013.

**Outbreaks -** There has been a confirmed outbreak of norovirus on Phoenix ward at Littlemore hospital from 3rd- 10th May 2013. It affected 14 patients and 4 staff. The ward was closed by infection control although one admission did occur due to patient need.

The ward was managed using infection prevention and control precautions and was reopened following a full terminal clean.

There was a second invasive Group A *Streptococcal* (GAS)infection patient identified in blood cultures on admission to Stoke Mandeville hospital from Cromwell ward. This patient was identified on 1st May 2013. There had been another invasive GAS patient identified on 24th March 2013. Although the time between the two cases was more than the 30 days in the Public Health England (PHE) guideline, the decision was taken to treat the cases as possibly linked and manage the situation as an outbreak.

Management included environmental swabbing and daily monitoring of staff and patients for possible signs of GAS infection. No patients were symptomatic and were all well. 3 staff were off sick with possible signs of GAS and were managed via occupational health. 2 of the 3 staff swabbed were negative and the remaining staff member will be swabbed this week. All environmental; swabs were negative to GAS and 4 patients who had breaks in skin due to grazes, friction from falls were screened and found negative as well. A full terminal clean of the wards was undertaken and following a review with PHE, commissioners and Oxford Heath the ward was reopened on 10th May. The ward will continue to be monitored closely and a separate report will be prepared.

There have been no MRSA or MSSA bacteraemias in either community or mental health services.

**13. CQC Inspections**

There have been no CQC inspections.

Appendix 1 - **15 Steps Challenge/ Townlands Hospital action plan**

Ward area: Peppard Ward; Townlands Hospital Date: 17 January 2013

Welcoming

|  |  |
| --- | --- |
| Recommendations | Agreed actions |
| Staff may like to consider notices and instructions at the entry to the ward –as they were unclear and gave ambiguous instructions for visitors. | * Some of the misleading information at the entry to the ward has already been removed. There are 2 call bell systems present; the call bell procedure is now clearer.
* Other general notices in the foyer of the ward (prior to entering the ward) are currently being reviewed.
* LG will arrange for a clear notice to be made, that can sit on the Reception Hatch when the receptionist is not in attendance. This will give alternative instructions to visitors.
 |
| A commode was placed in each empty patient room. Staff may like to consider what message this could give to a new patient and arrange to store this equipment elsewhere. | * Storage is limited at the Hospital. FM feels that the ward has no alternative but to store commodes in this way. On the acceptance of a new patient referral, staff assess whether a commode is likely to be required; the equipment will be removed if not needed. No further action required; it is hoped that adequate storage has been planned in the new build.
 |

Safe

|  |  |
| --- | --- |
| Recommendations | Agreed actions |
| Internal doors to administration / meeting rooms / storage areas appear to be left open; staff may like to consider if this presents a hazard to the rehabilitating or wandering patient. | * FM has advised staff of this issue and efforts are being made to ensure doors remain closed.
 |
| Boards appeared cluttered and were not always easy to follow; staff may consider reviewing this along with the font size used on notices. | * Hospital staff to review information on notice boards, its usefulness and clarity. FM has already started this process along with her staff.
 |
| Patient specific details on the “Patient Status at A Glance” board could be seen from the general corridor (ward office). Staff should think about obscuring the glass panel next to this board to maintain confidentiality. | * LG will contact the Estates Department to request window film be fitted to the glass panel in the ward office, this will maintain confidentiality of patient information.
 |
| Visitor chairs observed outside each bedroom and floor fans in use in corridor. These could be a hazard to rehabilitating patients; staff may like to consider reviewing storage capabilities on the ward. | * Staff report that they have very few patients who are independently mobile; they risk assess hazards continuously. However cleaning would be easier if chairs were stacked or stored elsewhere. FM to discuss this issue with Support Services Manager to see if a storage solution can be found. It is hoped that adequate storage has been planned in the new build.
 |

Caring and involving

|  |  |
| --- | --- |
| Recommendations | Agreed actions |
| Staff had made considerable efforts to provide useful information for visitors to the ward but some information was out of date and many leaflets were missing. Ward routine was not immediately clear to a visitor; ward rounds, mealtimes, drink rounds. Staff may like to consider how to share information with patients / visitors in a clear and user friendly format. | * Hospital staff led by FM to review and prioritise what information is placed on notice boards and to ensure it is kept current.
 |
| Staff report that it is difficult to find a quiet area to speak to relatives in confidence. Staff may like to look at room availability within the Hospital to see if suitable space can be identified. | * FM and LG feel there could be a possibility of creating a quiet, confidential area to meet with relatives by merging two staff rooms. Suggestion to be discussed with Support Services Manager.
 |
| Staff also report that the patient shower area is not fit for purpose as it leaks.Hopefully these concerns will be addressed during the rebuild. | * No action required. Working shower rooms will be available in the new build.
 |