Liverpool Women's
NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

Complaints Annual Report: 2023-24

Contents

Summary

This annual report provides an overview of complaints and feedback that Liverpool Women's NHS Foundation Trust (LWH) has received from patients, relatives, and users from 01 April 2023 to 31 March 2024. The report is written in accordance with the NHS Regulations and is made available on the LWH website.

Complaints are a valuable source of information on the quality of service the Trust is providing. This report looks at complaints to understand the factors that may lead to them, what can be done to address these factors, and whether the Trust's response to complaints can be deemed to be both appropriate and sufficient.

Making a complaint is never easy and it is important that there is an effective and sympathetic process for dealing with complaints. Those who complain should feel that they have been listened to and that learning has taken place. The Trust continues to work hard to ensure that its complaint process is personal and responds to the needs of the individual to ensure that their experience is listened to and put right simply and quickly. This philosophy aligns with the Health Service Ombudsman's Principles of Good Complaints Handling which promotes a customer focused complaints system.
The report provides: -

- A summary of complaints received between April 2023 and March 2024
- Details of the areas of the Trust the complaints focus on
- The primary causes of complaints
- Future Plans
- Lesson Learnt

The key findings in 2023-24 are: -

- There were 64 complaints received which shows a decrease from the 77 the previous year.
- The primary issue in the majority of complaints related to communication. Individual instances of these were noted a total of 121 times in the 64 complaints received.
- 77 complaints were resolved in the last year which includes complaints received in 2022-23. This is an increase from 66 the previous year.

- Of the 77 complaints closed, 7 complaints have been upheld, 15 complaints have not been upheld and 47 complaints have been partially upheld. 8 complaints were withdrawn.

The primary conclusions of the report are: -

- There are well established mechanisms to capture the experience of patients and their families to drive continuous improvement. These include the “Friends and Family” patient feedback programme, use of information gathered through complaints and PALS, information gathered from Care Opinion, listening to patient stories at the start of the Trust Board meeting and National and Local Patient Surveys. There has also been a lot more involvement and engagement with the communities that we serve and listening events have been held with both local and city-wide groups, these include the hard-to-reach groups with protected characteristics. All patient experience is used to motivate and drive service improvement.
- Complaints received during 2023-24 have continued to see a wide-ranging number of HOC per complaint.
- There continues to be a need to focus on evidencing and promoting the changes that occur in practice from the Trust learning lessons from complaints. New processes around action plan monitoring have been introduced which show positive improvements, and in 2023-24 a Trust level KPI continues to monitor this.

Complaint Levels

The Trust received 64 complaints in 2023-24, which is decrease from the previous year figure of 77.

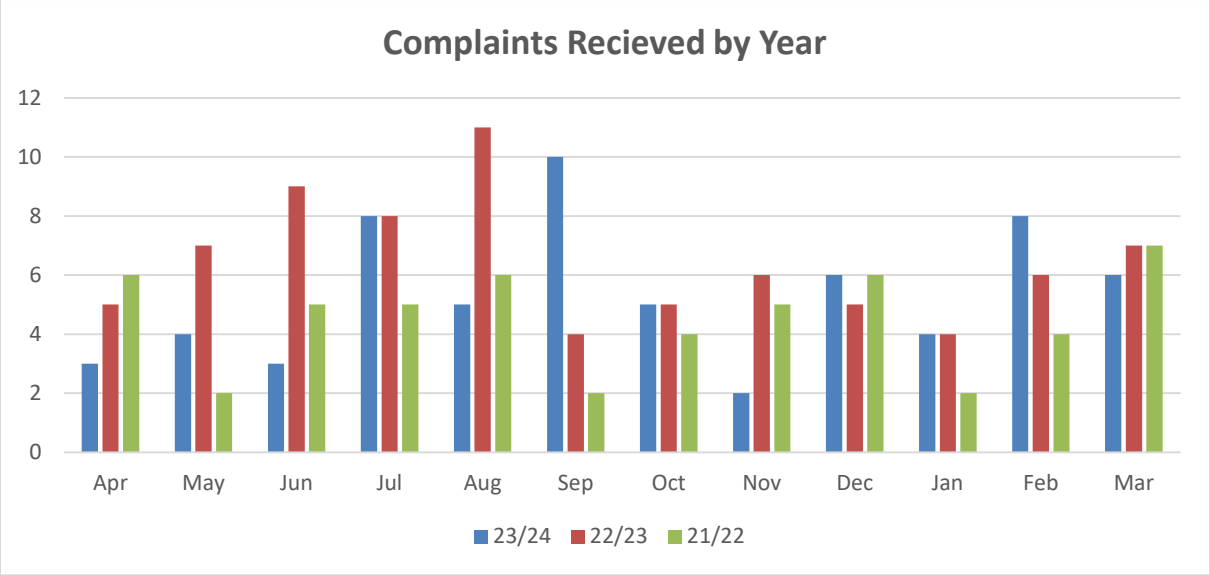


Figure 1: LWHFT Complaints comparison by month

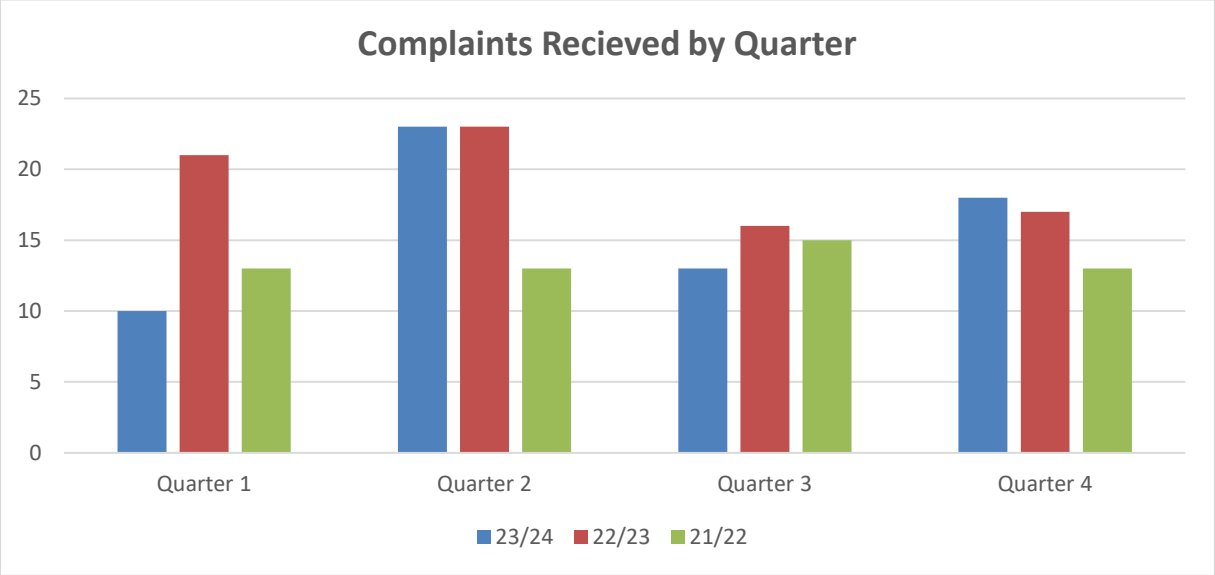
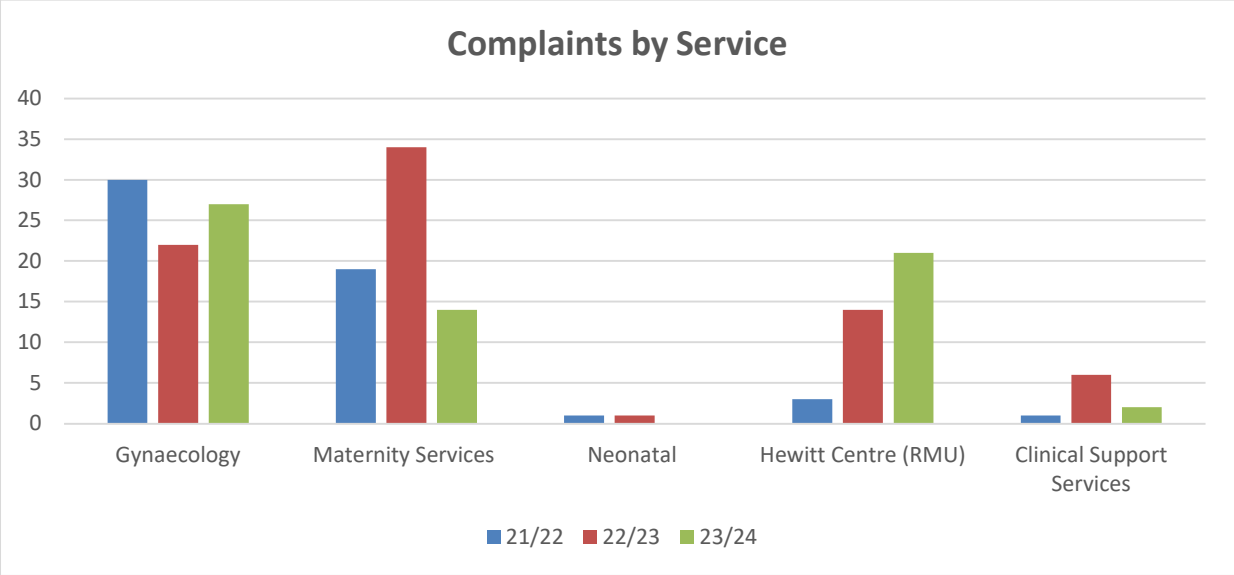


Figure 2: LWHFT Complaints by Quarter, yearly comparison

The Trust is committed to widening the number of channels through which patients can access the complaints arena. It continues to receive feedback via Care Opinion websites and its Twitter and Facebook accounts which can in turn be registered formally. There has also been a Help Hub introduced at the main entrance to the Hospital. This is an open desk with Happy to Help in many languages displayed, there is also an Interpreter on Wheels that can support non English speaking people to be able to raise concerns. Nevertheless, the specifics of all complaints are continually analysed to ensure problem areas are identified with appropriate actions drawn up and implemented to effect change.

Figure 3: Complaints Breakdown by Service



**Clinical Support Services include Genetics, Imaging, Theatres and Pharmacy*

Figure 3 gives a full breakdown of complaints with comparisons against the figures for the previous two 12-month periods. Most complaints (75%) were attributed to Gynaecology and this also includes the Hewitt Centre, this is an increase from the previous year. Hewitt Centre are increasing year on year with Complaints and this year has seen another rise. Although the main area of complaint is recorded in the table above, a complaint may have elements attributed to other services. These are recorded as Heads of Complaint and recorded against those services to enable full review of the feedback concerned.

Maternity Services

There has been a decrease in the number of complaints in 2023-24 by 20 as compared to 2022-23. There was a total of 14 formal complaints with the following themes:

- Clinical treatment
- Communication
- Patient care
- Access to treatment/drugs.

Complaints received related to postoperative concerns following caesarean section, commencing medication treatment on time, alleged failure to treat infection in a timely manner, misdiagnosis of a cleft palate, lack of patient information leaflets for women undergoing induction of labour (IOL) and communication with patients and their families. Themes identified align to feedback from the CQC National Patient Survey (February 2023) which gives LWH the opportunity to benchmark against other organisations. In response to this Quality Improvement Projects have been started which are clinically led and supported by the operational team and consist of representatives from the multidisciplinary team, with engagement and collaboration of service users, through the Maternity Neonatal Voices Partnership (MNVP).

QI projects include:

- Induction of Labour
- Maternity Base improvement group focusing on medicines management, achieving full and sustained compliance with completion of MEWS observations, with appropriate escalation, handover SBAR and checking of pressure ulcers assimilated to intentional rounding.
- Thermoregulation of the newborn, to avoid term admissions to the Neonatal unit.

Actions and improvements implemented:

- Development of a scheduled wound review clinic in the Maternity Assessment Unit, to provide women with consistent, evidence based wound care and management.
- Development of an Induction of Labour (IOL) patient information leaflet and video.
- Creation of a designated IOL clinical area, consisting of 5 single ensuite rooms, which is scheduled to open from 1.5.24. Additional IOL capacity will release labour and birthing rooms on Delivery Suite for women who are waiting for surgical IOL. There should be a reduced number of delays in IOL and improved patient experience, by allocating women to single rooms.

- In addition to formal complaints, Maternity services received and addressed 441 PALS queries. Meetings were arranged with a designated staff member/ lead with the aim of supporting the service user to resolve their concern. All learning is shared with maternity staff at the Maternity Risk and Clinical monthly meeting.
- Education and updates for midwives who complete NIPE (Newborn and Infant Physical Examination).
- 4hrly medication rounds (during the day) on Maternity Base.

Gynaecology Services

There has been an increase of 5 complaints in 2023-24 compared to 2022-23. There was a total of 27 formal complaints The highest department groups for the receipt of the formal complaints during this period was related to Outpatient services and Gynaecology Medical. Themes within the complaints highlight the following:

- Appointments
- Communication

Actions taken to improve upon complaint themes:

Upon completion of a complaint investigation actions are assigned on Ulysses to address any areas whereby learning and improvement can be implemented. At present current Divisional performance is good for actions completed with only one action currently outstanding in relation to discharge checklists from Gynaecology ward.

Appointments / Communication

- Waiting list management continues to be a challenge regionally for Gynaecology. A daily review of all waiting times is a core component of activity management within the Division. Increased demand for Rapid Access Clinic (RAC) appointments due to referral volume has led to cancellations on occasion of general Gynaecology. In addition, lost days due to industrial action has seen a loss of 620 patient appointments. This continues to be a focus for Gynaecology Division.

- A recent quality improvement project has been launched with the aim of text message validation of appointments for patients, this project was presented at the recent Quality Strategy event and has already demonstrated improvements in terms of supporting patient advancing and being managed through waiting lists correctly.

- Furthermore, when a patient attends and there has been a clinic cancellation or appointment scheduling error the Divisional Operational team and Admissions Team manager are immediately made aware so that an understanding of the cause can be identified.

- Introduction of medinet services to support appointment and scheduling.

- Admissions attendance at twice daily safety huddle to ensure To Come In (TCI) and appointment activity is efficient, issues picked up and rectified immediately as to not inconvenience the patient.

In addition to formal complaints, Gynaecology services received and addressed 30 pals plus and 1018 pals queries. Meetings were arranged with a designated staff member/ lead with the aim of supporting the service user to resolve concerns. All learning is shared with Gynaecology staff at Divisional Governance as well as local safety and governance huddles as a 'you said' 'we did' approach.

As a result, the following quality improvement work is either completed or ongoing:

- Three phases to improving and optimising the Gynaecology Emergency Department Telephone Triage line. The key aim of doing so is to increase the quality of the service as well as ensure patients are directed to the most efficient route of receiving safe and timely care.
- Continue to build upon provision of care for under 18-year-old patients against KSF standards.
- Stakeholder engagement in Ultrasound improvement group
- Lead in Menopause special interest group. - women's Hub working with GPS
- Second Trimester Miscarriage project role out
- Tea and teach sessions on Gynaecology ward – re wound care and discharge advice.
- Colposcopy systems interface project
- Outpatient Locssip QI

Hewitt Fertility Centre (HFC)

There was a substantial increase of 7 complaints over this period, this is a significant increase over the last 2 years by an extra 18 complaints compared to 21/22 which was 3 Complaints. There was a total of 21 formal complaints.

The main theme of the Heads of Complaint continues to be 'communication'. In an attempt to address this complaint theme, HFC has introduced safety huddles and feedback to staff from complaints themes, this has also been disseminated through the clinical break sessions/staff meetings and within the training day agendas. HFC is currently implementing a range of tools which will help to improve communication with patients (examples ; the HFC patient portal, e-leaflet library and the use of QR codes) and continues to attempt to further improve patient and staff learning tools via the Fertility Consent package.

A further three members of the senior team have been trained as investigating officers this year although, on occasion, it has been difficult to assign an investigating officer within the specified time frame. Regular meetings continue to take place between the Quality manager and the Patient Experience Team to help with complaints and PALS issues, to ensure patients have a timely and satisfactory resolution.

In June 2023, the HFC Complaint Refund Policy was updated and ratified. In line with SFI and following a request from the Director of Finance, all refund or reimbursement of funds to patients requires a formal investigation prior to any reimbursement being awarded. Whilst the number of formal complaints was increasing prior to this date, the change in policy has seen

a continuation of increased complaint numbers as patients are required to submit a formal complaint before any request for reimbursement of payment can be considered.

HFC has implemented an increase in patient de-briefs to allow patients to discuss their concerns and possible reduce the number of formal complaints. These are attended by a Consultant, Senior Nurse and HFC Quality manager and Lead Embryologist if required. A representative of PALS may also be in attendance. HFC will continue to monitor the number of debriefs that take place and review any possible impact on complaint numbers.

HFC has an extremely busy Nurse triage telephone system which is now embedded within the patient pathway processes. However, HFC still faces issues with regards to this, as nurse staffing levels can impact on the accessibility/call waiting time/return call times for patients. This is often a theme within the patient complaints. A capital funds request has been submitted for the next financial year with the aim of further roll-out of the 'Netcall' system to aid patients access to the service. The 'patient portal' will have a positive impact on accessibility to patient information, removing (on some occasions) the need to speak to a clinician.

Review of complaints and complaint responses shows that the majority of complaints concerning care at HFC are from Private patients. It is also important to note that the majority of 'Heads of Complaints' are not upheld therefore no reimbursement or refund is awarded.

Further work continues with pathway reviews for NHS and private patients for the clinical transformation group. The gamete donation and recipient pathways are also being reviewed. These will be recorded as Quality Improvement projects as all aspects of HFC are reviewed and evaluated as required.

There is also an improved 'contact us' page on the HFC website, increased use of social media channels, Patient Engagement Group / Patient Representatives and Patient surveys and interaction for feedback and insight.

Neonatal Services

Neonatal have received 0 complaints during 2023-24, this is consistent with the numbers being very low in the previous years. This is due to the continuing proactive measures taken by staff within Neonatal. Staff are always with families within the clinical areas, and this helps build relationships and promotes trust. The relationships formed with all staff allows families to raise concerns/ issues which the staff respond to promptly. The staff continue to provide timely feedback, updating parents before a solution has been reached, this promotes reassurance that the staff are still investigating and taking all concerns seriously. The promotion and maintenance of family integrated care enhances relationships with families. Parents are involved in ward rounds with the multi-disciplinary teams and feel involved in decision making with their baby's care. The Neonatal team continue with '*You said we did'* board but also plan to start bi-weekly questionnaires to capture any suggestions for improvement in a more timely manner. The Neonatal team also promote family engagement through celebrating special

occasions through the calendar year. The most recent was a family board game and pizza evening which proved to be the most successful evening to date.

Clinical Support Services (CSS)

Clinical Support Services have received 2 complaints during 2023-24, this is a decrease from 6 in 2022-23, these numbers have returned to the low levels that have been seen in previous year. Clinical Support Services (CSS) encompasses various departments in the Trust and includes theatres, anaesthetics, genomics, physiotherapy, imaging, pathology, resus, transfusion and dietetics. Both complaints were recorded in Anaesthetics only. Due to the nature of the services under CSS, there were several elements of other complaints that CSS assisted with during the year. Concerns raised during the year centred on the process and procedures being undertaken in relation to the provision of a variety of appointments. The Division is keen to improve the feedback that is received from patients and have implemented bespoke solutions in all departments to generate additional feedback. It is very pleasing to hear about the advantages that the new Patient Experience Portal will bring as well. As CSS provide critical functions to other Divisions, they continue to work hard to improve the experience for patients, in ways such as developing improved patient information, providing improved patient facilities, as well as sharing leaflets and reviewing digital solutions that could possibly be implemented to make services more efficient.

PALS +

The PALS+ model continues to be utilised for dealing with complaints and concerns and is having a positive impact for both patients and the Trust. By implementing the PALS+ model it has given LWH the opportunity to address patients concerns in a proactive and dynamic way. The patient is put in contact with senior medical, nursing, midwifery, and operational staff to discuss the concerns raised, answer questions they have and find a rapid solution to assist with the concern raised. The national complaint standards framework supports this proactive method of addressing concerns raised.

It is not for the member of staff to go immediately and speak to the patient, but for PALS to arrange a suitable method of contact with the patient for these conversations to take place. It would not be the member of staff whom the issue was about who would make this contact. These conversations would usually occur after some initial fact-finding reviews had taken place to understand the full circumstances around the issues. This contact may be face to face, by phone, email, or letter, whichever is most suitable for the person's needs.

Causes of Complaints

Each complaint received is often multi-faceted with concerns expressed about several aspects of the patient's experience of LWH. This is particularly true of inpatient concerns which may cover the multi-disciplinary teams and relate to events over a short or extended period of time. With this in mind a great deal of thought goes into how complaints are categorised to ensure it is appropriate to the concerns raised.

Fig 4. Main Complaint Category 2023/24

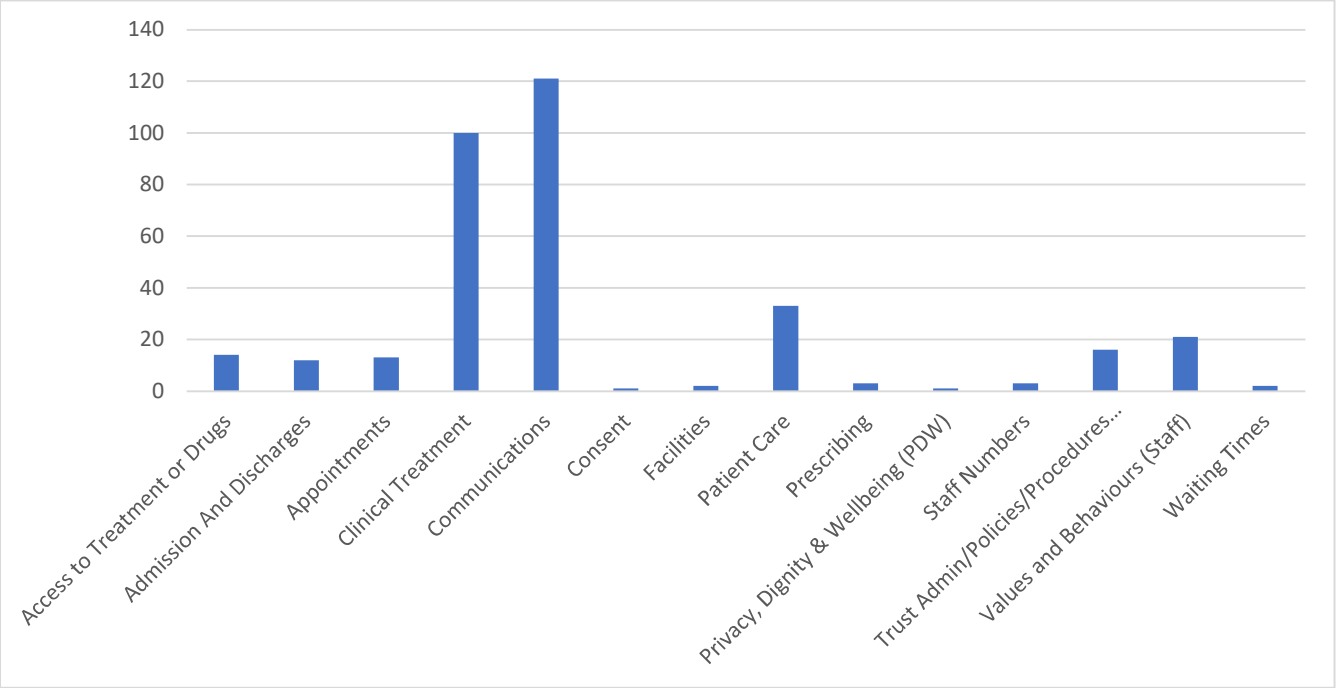
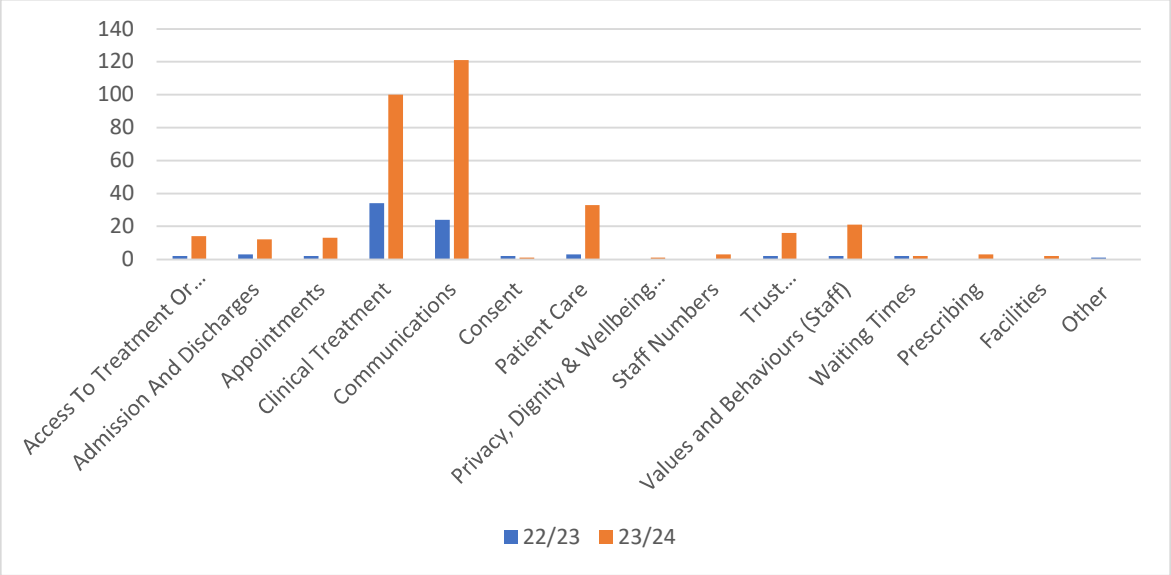


Fig. 5 Main category of complaints between 2022-23 and 2023-24



For the ease of reporting in this report the categories in Figures 4 and 5 are assigned based on the main issue only. Reporting in the Trust does cover all issues raised in the complaint and the departments these concerns are raised against, allowing for more in depth analysis.

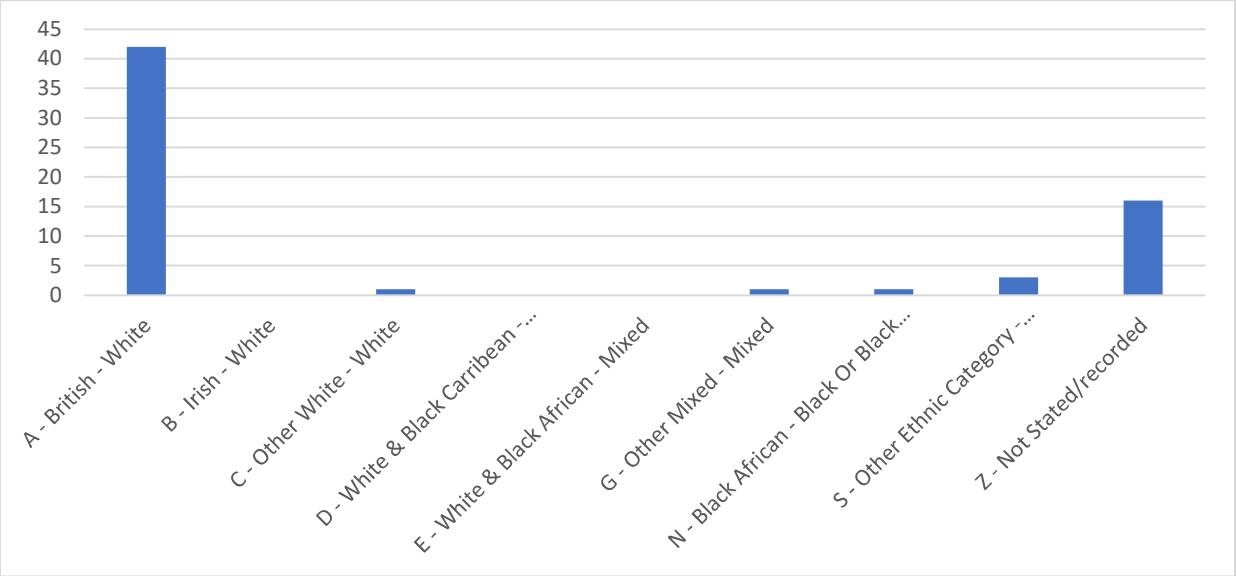
The main recorded issue relates to Communication, accounting for 33%. The top main category in this area is Communication with the patient. All issues identified after investigation have been addressed with an appropriate action plan to facilitate improvement.

The second main recorded issue relates to Clinical Treatment, accounting for 29%. The top main category is Failure to Follow Up. All issues identified after investigation have been addressed with an appropriate action plan to facilitate improvement.

Each quarter the Patient Involvement and Experience Subcommittee receives a report detailing the themes from Complaints and PALS concerns. The Chairs report from Patient Involvement and Experience Subcommittee was received at the Quality Committee.

Patient Involvement and Experience Subcommittee will make recommendations to address any themes or trends that reoccur and progress on these will be reported to Patient Involvement and Experience Subcommittee at agreed intervals until completion.

Ethnicity of complainants in 2023-24



The percentage of complainants recorded as “British – White” in 2023/24 has increased from 62% in 2022-23 to 66% this year. In 2023-24, complainants from global majority groups (Previously referred to as BME/BAME) made up 9% of the complainants recorded this year and this is a decrease from 12% recorded in 2022-23.

LWH would expect to see the percentage of people from various recorded ethnicities who complain, to largely mirror the overall patient population treated that year. For example, if you saw a significantly higher or lower percentage of complaints from a particular ethnic group, then that may point to issues such as service provision/design or barriers being placed in the way of raising concerns. However, what LWH have seen in the data from 2023-24 is a significant rise in complainants’ ethnicity not being stated/recorded. This rose from 22% in 2022-23, to 25% in this reporting year. The complaint ethnicity data is obtained from the central patient record held by LWH. This issue is being addressed on a wider Trust level to improve the overall ethnicity recording for all patients and as such should produce more comprehensive patient monitoring data.

Assessing the cause of Complaints

Following changes made to the reporting systems more accurate reporting of the total concerns that are raised in a whole complaint can be identified. The total number of causes of a complaint usually exceeds the overall total number of complaints received. This is because all complaints are multifaceted and identify various areas of concern that need review and investigation. For example, a patient may raise 4 allegations in their complaint of

communication issues. Under the new reporting regime each instance will be noted and recorded as 4 separate causes of the complaint.
Improved reporting has also enabled identification of the outcome of each of the individual HOC reviewed during the complaint investigation. This is particularly useful in partially upheld complaints where LWH can clearly see the areas for improvement.

Timeliness of Complaints Response

LWH Policy for Managing Complaints & Concerns states that all complaints should be acknowledged within 3 working days. The complaints policy, which was developed in 2017, and reviewed and updated in 2023, has removed the previously specified rigid timescale to ensure a more patient centric personalised response target for the Trust to adhere to. The Trust commits to providing a written response within a timeframe agreed with the patient. Should an investigation take longer than expected or become more complex during the investigation process, this timescale is discussed with the patient and a revised timescale is agreed upon.

There was work undertaken 2023-24 to address the challenges in the previous year regarding adherence to complaint timescales, in Q1 2023/24 the average compliance was 40%, since the review was undertaken and actions put into place the compliance has been 100% in the remaining 3 Quarters of the year. There are weekly Complaint meetings that each Division attend and is chaired by the Head of Involvement and Experience.

Responding quickly is a key factor in the Trust ensuring its complaints process remains personal and responsive to the needs of the individual. Ensuring the experiences of those contacting the Trust are listened to and put right is central to the Health Service Ombudsman's Principles of Good Complaints Handling which promotes a customer focused complaints system. A response to all complaints that is speedy, simple and details clear findings, conclusions and recommendations is a key aim of every complaint investigation.

Lessons Learnt

Repairing relationships is the primary focus of complaint handling. An investigation is concerned with establishing the facts to reach a judgment in the matter of complaint and organisational learning is a by-product of the activity. The trust is committed to implementing the learning and recommendations from every complaint where improvements have been identified and recommended.
During 2023-24 some examples of the lessons learnt, and the actions taken are:

Lesson Learnt	Summary of Action Taken
Poor care of the patients' belongings after transfer had been identified.	Process introduced for recording patient belongings to prevent recurrence
Sepsis assessment tool not completed on admission	Audit the use of the sepsis tool is undertaken monthly. To assist with compliance a recent modification of the training has been introduced to include completion of the sepsis assessment and sepsis six wizards. There have also been more computers on wheels purchased so the sepsis tools can be opened simultaneously to show the CTG for women who are in labour. Completion of the tool has been highlighted and been a recent 'lesson of the week'.
Screening information currently given to patient regarding pre/ post egg collection is unclear	Patient Information Leaflet updated so patients are aware of screening required and the risks/benefits of delayed genetic screening. SOP also updated.
The interpretation of NHS fertility funding found to be unclear.	Agreed that further clinical information will now be included in the IFR request letter to funding to provide clarity.
Visitors being asked multiple times if they were allowed to be on the ward.	Partners to stay on the ward 24/7 within Maternity which should reduce this issue
Post-mortem protocols were not clear to staff	Training for staff to consent post-mortem. Alder Hey Childrens Hospital pathology department to make sure all gender reports are forwarded to the Honeysuckle Team as soon as known.
Lack of specific information leaflet for women who present with Pre-labour Pre-term Rupture of Membranes	Patient Information Leaflet created.
Regular communication and updates were not being undertaken for all women who are undergoing Induction of Labour.	Multidisciplinary (MDT) ward rounds on Delivery Suite will now discuss with patients' plans for ongoing or delayed Induction of Labour.
Delay in prescription completion resulting in delay to patient	Review of process undertaken. Amendments made to process. In addition to daily prescription completion, all patients due imminent treatment will have their prescription completed in clinic by the Consultant / Medical staff / Nurse prescribers that have seen the patient. This should prevent delays.

Delay in prescription completion resulting in delay to patient	Changes made to prescription process surrounding invoices. This will have a positive turnaround time for prescription arriving in finance office and being sent to patients in a timely manner. Invoices being sent via email rather than relying on the mail service for delivery.
Documentation on the digital platform needs to be more thorough	Digital midwives continue to educate and share updates/comms related to all aspects of K2 on an ongoing basis, particularly in response to incidents. Monthly K2 training sessions for new starters and existing staff are available.
New starters do not receive training for the maternity electronic paper record at induction	Managers now advised how to request training once induction date has been confirmed.
Delays identified for complex joint surgeries that require LUHFT colleagues	Meetings with LUHFT already instigated and in place to ensure cases are actively monitored
Failure to maintain accurate and contemporaneous records	Audit of notes with Preceptorship Midwife and reflective discussion undertaken to assist and support staff member.
Conflicting information regarding catheter care identified.	All intrapartum staff informed of correct information. Lesson of the week circulated to ward staff and discussed at ward huddles
No Gelatine free alternative Vitamin K supplied as stock to wards	Stock of Neokay supplied to Delivery suite. All intrapartum staff informed via email of stock/supply/location
Gamete and embryo donation SOP's needed updating, specifically outline that restrictions on donations that conflict with the Equality Act will not be accepted. Initial donor checklists and Patient Information Leaflets need updating to clearly reflect this also.	SOP's updated along with changes made to initial donor checklist and patient information leaflets.

No support with visiting Neonatal Unit and storing of breast milk	Neonatal feeding meet regularly with infant feeding lead for maternity to support and trouble shoot. Maternal resources regarding breast milk are included with the expressing packs provided. Regular staff updates and education for infant feeding occurs on Neonatal, with neonatal nursing staff also supporting in-patient Mothers when expressing and storing milk etc.
No explanation or demonstration on how to administer blood thinning injections	Discharge checklist changed to include discussion and demonstration of injections if required.
Pressure ulcer risk recorded retrospectively	K2 maternity pressure ulcer risk assessment template adjusted to show the individual risks and scores to reflect the Trust guideline when assessed and prompt action to be taken.
No recorded documentation of pressure area checks	Addition to K2 documentation now includes pressure ulcer prevention changes of position template for documentation of evidence of position and change of position.
Conversations with patient allowed the patient to feel that they lack integrity or misinformed.	Named staff members to reflect on conversations discussed.
Practitioner performing egg collection in this case was not aware that laparoscopic egg collection had been discussed with patient as possible procedure	Introduced a template for MDT to include type and route of egg collection to ensure consistency of information
Pain assessment documentation is duplicated whereby it has the potential for staff to be able to record information in an incorrect place therefore creating the risk of duplication or recordings being missed.	A full review of the pain assessment documentation was undertaken. Updated documentation now on DigiCare EPR system
Lack of assurance that comfort rounds are being utilised correctly	Communicated with ward managers to allocate senior staff to ensure comfort rounds are done. Teach new starters to ensure it is completed
Not all staff appear to be familiar with the Pain assessment document	Formal training has taken place for all staff
Patient unclear of clinical management plan	Clinical Director to discuss with clinicians at consultant meetings and share through lesson of the week.
Patient not listened to and reason for conducting own investigations was not explained.	Clinician conducted a reflective piece in writing and discussed with Clinical Director

Patient struggled to contact GED following procedure	Reviewed information regarding pain and post-procedure contact details on Hysteroscopy leaflet. The leaflet now states where a patient can seek further advise following Hysteroscopy if they need it.
Patient found procedure painful and felt ill informed regarding this.	Reviewed LWH hysteroscopy leaflet and adapted for ambulatory patients.
Patient did not receive adequate information regarding wound care.	Lunch and learn sessions have been commenced on the ward, wound care will be one of the topics covered.
Patient left to wait in Gynaecology Outpatients in pain with no alternative option offered.	Notification for patients now displayed in the waiting area for patients to request assistance from the nursing team via the receptionist if in pain or uncomfortable
Conflicting information regarding catheter care identified.	Ward managers now perform monthly audit of SBAR completion for every shift change and transfer between clinical areas.
Patient personal information not updated to show changes	Training for administration staff and nursing staff around updating patient information to be undertaken.
Lack of understanding from complainant re discharge process	Poster created to put in each room to explain the discharge process and why there can be delays
Patient was not provided with additional information leaflets following diagnosis of ectopic pregnancy	Learning to be shared with GED team to ensure staff are aware of the importance of information leaflets being provided at the correct point of care.
Issue regarding SBAR completion between clinical areas.	Audit of SBAR completion by midwifery managers on a monthly basis and results discussed at Maternity Risk meeting on a quarterly basis.
Wrong information given regarding attending appointment as a single person.	Ensure all staff are made aware that having a partner in attendance is not a prerequisite for a fertility screening appointment/access to the service
Midwife on MAU did not review notes sufficiently to be able to identify place of birth.	LOTW reminding all staff of importance of checking the risk status of every patient attending via triage on MAU
Documentation not sent to GP in a timely manner regarding anti-depressant medication	Clinical Break Session regarding the process to be followed when patients require counselling referral
Error made with date of embryo transfer – incorrect date initially given to patient	Training session regarding frozen embryo transfers completed on Clinical Break Day.
NICE guidance to be reflected in the Antenatal Care policy regarding not sending urine samples at the booking appointment	Antenatal care policy amended and agreed, to be ratified at Maternity Clinical meeting 2024

Patient missed antenatal appointment whilst named midwife on leave	SOP has been created for management of caseloads of staff who have unexpected leave.
Patient required side room for postnatal stay which was not clearly communicated.	Email sent to midwifery and medical staff regarding clear communication to patients.

Access for Complainants

The Trust is committed to allowing access to its complaints system to all patients. The Trust and the Patient Experience Team aim to increase confidence of patients by having a flexible approach to resolving concerns. There is extensive work with staff on the wards and in departments to help prevent complaints by listening to and being responsive when issues need to be put right.

When further support is needed the Trust aims to ensure that the complaints process is signposted locally so that patients know how or where to complain. LWH are constantly continuing to improve access to information for patients on a range of patient experience initiatives, including complaints, this a key focus for the Trust following the Francis Report.

The predominant method for making a complaint remains by letter, email, or by telephone, but by signposting other options such as the Trust's website, social media, Healthwatch and Care Opinion websites, LWH ensure that patients are given a choice.

Where contact is initially made in person or by telephone, the Patient Experience Team supports the complainant in registering their concerns formally with the Trust.

PALS

The Trust is continuing to promote the PALS and PALS+ service which continues to see a robust number of contacts

2023-2024 has seen 2674 PALS and PALS+ cases raised with the Patient Experience Team. This is an increase of 409 cases from the previous year.

Compliments

The Trust continues to report on the number of compliments that the Trust receives which are collected from several sources. The Patient Experience Team oversees the triangulation of compliments to feed into one report. The compliments are shared with the relevant teams at the Trust. In 2023-2024 there were 108 compliments formally registered through the Patient Experience Team, this is a decrease from 127 in the previous year.

Progress on priorities reported for 2022- 23

The focus and the additional steps that were put in place in the complaints process in Q1 2023-24 to support Trust wide has made extensive improvements and the agreed response timeframes continue to be 100%.

The Patient Experience Team now have weekly meeting with the access team to support the issues of the clinical and administration telephone lines. This continues to be a challenge so intelligence from the complaints will be able to help shape and improve the performance in this area.

Weekly meetings were put in place between HFC and the Patient Experience Team to address any concerns raised but there continues to be an upward trend with complaints for HFC. There was a change in policy with refunds and also with sibling funding and this has generated more concerns being raised by service users.

Work to address Health Inequalities and improvements Trust wide continues and a new Help Hub was introduced in January 24. This helps support non English speaking people to be able to raise concerns, there is also an Interpreter on Wheels that has been procured specifically for this area.

Priorities for 2023-24

To ensure Divisions have the correct access to information pertaining to Complaints without having to ask the Patient Experience Team for information, Power BI is going to be utilised to ensure the information is easily and readily available.

Divisions to ensure Complaints and Concerns raised are discussed at Divisional Level and Lessons Learnt reported on.

A process to be put in place to resolve concerns raised within the Hewitt Centre before they become a formal complaint.

Poster that allow people to access how to complain in different languages to be displayed Trust wide and to encourage use of the Help Hub and Interpreter on Wheels for Non English Speaking Families.

Patient Experience Team to work with the Digital Team on the new Patient Information Portal to help address the many concerns raised with regards to Communication.