Norfolk County Council
at your service

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 29 May 2014**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership (subject to amendment by County Council on 27 May 2014)

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr J Bracey	Mr P Balcombe	Broadland District Council
Mr D Bradford	Mr P Manning	Norwich City Council
Mr M Carttiss	Mrs A Thomas / Miss J Virgo / Mr J Ward	Norfolk County Council
Mrs J Chamberlin	Mrs A Thomas / Miss J Virgo / Mr J Ward	Norfolk County Council
Michael Chenery of Horsbrugh	Mrs A Thomas / Miss J Virgo / Mr J Ward	Norfolk County Council
Mrs A Claussen-Reynolds	Mr B Jarvis	North Norfolk District Council
Mrs M Fairhead	*Vacancy*	Great Yarmouth Borough Council
Mr E Seward	*To be advised*	Norfolk County Council
Mr T Jermy	Ms D Gihawi	Norfolk County Council
Vacancy	Ms D Gihawi	Norfolk County Council
Mr R Kybird	Mrs M Chapman-Allen	Breckland District Council
Dr N Legg	Mr T Blowfield	South Norfolk District Council
Mr A Wright	Mrs S Young	King's Lynn and West Norfolk Borough Council
Mrs M Somerville	Mrs A Thomas / Miss J Virgo / Mr J Ward	Norfolk County Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:

Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

1. Election of Chairman and Vice Chairman

The Chairman to be elected from the County Council Members on the Committee.
The Vice Chairman to be elected from the other Members on the Committee.

2. To receive apologies and details of any substitute members attending

3. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 17 April 2014. (Page 5)

4. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter.

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

5. To receive any items of business which the Chairman decides should be considered as a matter of urgency

6. Chairman's announcements

7.	**10:10 – 11:10**	**Hospital complaints processing and reporting**	
		A report on how the Boards and Governors of acute hospitals in Norfolk receive information about complaints and how the hospitals learn from and act upon trends in complaints.	(Page 11)
8.	**11.10 - 11.50**	**End of life care in Norfolk's acute hospitals**	
		An update on new end of life care practices in hospitals to replace use of the Liverpool Care Pathway.	(Page 114)
9.	**11:50 – 11:55**	**Terms of reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee**	
		The Committee is asked to agree new terms of reference with Suffolk Health Scrutiny Committee.	(Page 129)
10.	**11.55 – 12.00**	**Forward work programme**	
		To consider and agree the forward work programme.	(Page 132)
		Glossary of Terms and Abbreviations	(Page 135)

Chris Walton
Head of Democratic Services

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 20 May 2014

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Norfolk County Council
at your service

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 17 April 2014

Present:

Mr C Aldred	Norfolk County Council
Mr D Bradford	Norwich City Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs M Fairhead	Great Yarmouth Borough Council
Dr N Legg	South Norfolk District Council
Mr E Seward	Norfolk County Council
Mrs M Somerville	Norfolk County Council

Substitute Members Present:

Mr P Balcombe for Mr J Bracey, Broadland District Council

Also Present:

Christopher Cobb	Director of Medicine & Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
James Elliott	Deputy Chief Executive Officer, NHS Norwich CCG
Matt Broad	General Manager for Norfolk, East of England Ambulance Service NHS Trust Norfolk Area Locality Director, East of England Ambulance Service NHS Trust
Jane Webster	Head of Commissioning, NHS West Norfolk Clinical Commissioning Group
Steve Sheldrake	Team Leader for the Wheelchair Service, Queen Elizabeth Hospital, King's Lynn
Jocelyn Pike	Chief Operating Officer, NHS South Norfolk Clinical Commissioning Group
Sally Child	Head of Child Health Commissioning Support, NHS Anglia Commissioning Support Unit
Carolyn Young	Programme of Care Manager – Trauma, NHS England (specialised wheelchair commissioner)
Tanya Clarke	Operational Manager for Wheelchair Services, Norfolk Community Health and Care
Nina Melville	Service Manager for Specialist Rehabilitation, Norfolk Community Health and Care
Dr Trevor Wang	Family Voice
Maureen Orr	Scrutiny Support Manager (Health)
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr J Bracey and Mr T Jermy.

2. Minutes

The minutes of the previous meeting held on 27 February 2014 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's Announcements.

6. Ambulance turnaround times at the Norfolk and Norwich Hospital

6.1 The Committee received a suggested approach from the Scrutiny Support Manager (Health) to an update from the Norfolk and Norwich University Hospital NHS Foundation Trust, the East of England Ambulance Service NHS Trust and NHS Norwich Clinical Commissioning Group (CCG) about action underway to improve ambulance turnaround times at the Norfolk and Norwich hospital.

6.2 The Committee received evidence from James Elliott**,** Deputy Chief Executive Officer, NHS Norwich CCG, Christopher Cobb, Director of Medicine & Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust and Matt Broad, General Manager for Norfolk, East of England Ambulance Service NHS Trust. The Committee also heard from David Russell a Member of the public whom had asked to speak on the matter.

6.3 In the course of discussion, the following key points were made:

- Project Domino (a scheme to improve the urgent care network in central Norfolk) had been successful in reducing delays in ambulance turnaround times at the Norfolk and Norwich hospital and in meeting the increasing demand for Accident and Emergency Services (A&E).

- An urgent care network group of senior managers met on a monthly basis to deal with strategic issues across the urgent care network.

- There was also a capacity planning group which met regularly (usually on a weekly or fortnightly basis) to deal with operational issues.

- The number of patients entering A&E at the Norfolk and Norwich hospital had increased to approximately 100,000 a year from approximately 50,000 patients at the time when the hospital had opened to the public.

- Today, the work of an A&E Department included that of "emergency care"

which had not been the case at the time when the Norfolk and Norwich hospital opened to the public.

- Only by all partners working together was it possible to improve ambulance turnaround times at the Norfolk and Norwich hospital and meet the challenges going forward.

- On an average week between 800 and 850 patients were admitted to the A&E Department at the Norfolk and Norwich hospital. This was the highest total number of patients of any A&E Department in the Eastern region. The next nearest hospital had approximately 300 less patients a week.

- A number of marginal efficiency gains across the whole system had meant that the overall position with regard to ambulance turnaround times at the Norfolk and Norwich hospital had improved significantly since this matter had previously been considered by the Committee.

- The anticipated difficulties in recruiting nurses and consultants to work in the A&E Department at the Norfolk and Norwich hospital had not occurred. Since April 2013, the recruitment of 39 additional nurses and the creation of a 24/7 hospital ambulance liaison officer (Halo) had helped reduce average patient handover times.

- NHS partners had indicated that they would continue to support “Halo” roles, through the work of the CCGs and the urgent care pilot at the Norfolk and Norwich, with support from GPs and community health staff.

- Mr Russell speaking as a member of the public said that it was important for the “halo” system to continue to be funded through the health service commissioning route.

- Mrs Chamberlin praised the work of the ambulance crews operating in Norfolk; she said that she had visited the emergency call centre and joined with an ambulance crew in Diss on a Sunday which had been very worthwhile experiences.

- The witnesses pointed out that guidance was expected to be received from NHS England that the allocation of winter pressure funding which had been first introduced in December 2013 would continue for winter 2014/15.

- The introduction of the seven days a week immediate assessment unit (IAU) had been a success.

- For 2014/15 a 2.6% growth in attendance at the Norfolk and Norwich hospital was predicted. National predictions were that after 2014/15 there would be an expectation of a 15% reduction in attendances at hospital A&E Departments as efforts to refocus on moving people away from using hospital front of house services continued to gain momentum.

6.4 The Committee welcomed the improvement in ambulance turnaround times at the N&N and noted the continuation of Project Domino phase 2.

7 Wheelchair provision by the NHS Central and West Norfolk

7.1 The Committee received a suggested approach from the Scrutiny Support Manager (Health) to an update on the commissioning arrangements for NHS wheelchair services and the performance of the services in central and west Norfolk.

7.2 The Committee received evidence from Jane Webster, Head of Commissioning, NHS West Norfolk Clinical Commissioning Group, Steve Sheldrake, Team Leader for the Wheelchair Service, Queen Elizabeth Hospital, King's Lynn, Jocelyn Pike, Chief Operating Officer, NHS South Norfolk Clinical Commissioning Group, Sally Child, Head of Child Health Commissioning Support, NHS Anglia Commissioning Support Unit, Carolyn Young, Programme of Care Manager – Trauma, NHS England (specialised wheelchair commissioner), Tanya Clarke, Operational Manager for Wheelchair Services, Norfolk Community Health and Care and Nina Melville, Service Manager for Specialist Rehabilitation, Norfolk Community Health and Care. The Committee also heard from Dr Trevor Wang (not a medical doctor) of Family Voice who spoke on behalf of service users.

7.3 In the course of discussion, the following key points were made:

- The witnesses pointed out that responsibility for the commissioning of highly complex specialist wheelchair provision currently rested with NHS England. From 1st April 2015 the CCGs would be responsible for the commissioning of all NHS wheelchair services. NHS England was working with the CCGs to ensure a seamless handover of the service.

- There was no reason why the public should be concerned about the changes in the commissioning arrangements.

- There were currently no issues concerning waiting times for NHS wheelchairs in central and west Norfolk. The service was operating within the requirements set out in the commissioning arrangements.

- The average waiting times at the Norfolk and Norwich hospital for a NHS wheelchair were between six and eight weeks.

- There were clear policies in place for the repair of wheelchairs, the return of wheelchairs of the deceased and for the recycling of wheelchair parts.

- Dr Wang commented that the wheelchair services had not made sufficient progress on the issues that Family Voice had raised when they had previously given evidence to the Committee, particularly concerning the need for user engagement groups to identify problems, test ideas and communicate effectively about customers needs. Where user groups had been set up Family Voice had not been sent the details and invited to take part.

- The Committee considered that this was particularly important for the voice of the child to be heard when it came to highly complex specialist wheelchair provision for children. It was suggested that this could be done by setting up an email user group for the use of those who were unable to attend user group meetings.

- It was considered particularly important for the NHS to address the

specialist wheelchair needs of those children who had been placed in the care of the County Council.

- The witnesses' spoke of mixed success in the setting up of user engagement groups since this matter was discussed by the Committee in October 2013.

- It was pointed out that on 6 March 2014 Norfolk Community Health and Care had held their first service user group. Details about the meeting had been sent to three hundred service users and their carers over a period of one month and five adult service users had attended the meeting. The next user group meeting was due to be held in May 2014.

- The NHS South Norfolk Clinical Commissioning Group encouraged service user participation through its website.

- No service user group had been set up in the west of the county. It was pointed out that the possibility of setting up two user groups in the west of the county including one for children who required specialist wheelchair provision would be examined.

7.4 The Committee agreed that it was imperative that the voice of children, young people and their families should be heard in the planning and provision of wheelchair services. The commissioners and service providers were asked to report back to the Committee in six months time on what more would be done to hear the views of the children, young people and families who used the wheelchair service, in keeping with the spirit of The Children and Families Act 2014.

8 Appointment of a link member with North Norfolk Clinical Commissioning Group

8.1 The Committee agreed to appoint Mr J Bracey as the NHOSC formal link member with the North Norfolk Clinical Commissioning Group.

9 Forward work programme

9.1 The Committee agreed the list of items on the current Forward Work Programme subject to the following changes:

'Changes to Mental Health Services in West Norfolk – consultation by the CCG and Norfolk and Suffolk NHS Foundation Trust on potential *(permanent)* closure of inpatient facilities' – postponed to a later meeting (after May 2014), when the CCG and NSFT will be ready to consult.

'Delayed Discharge from Hospital in Norfolk' – postponed to 10 July 2014.

'Use of the Liverpool Care Pathway in Norfolk's hospitals' – brought forward from 10 July to 29 May 2014 meeting, subject to the hospitals being able to report in May.

'Hospital complaints processing and reporting' – 29 May 2014 – alert all County

Councillors that this subject will be on the NHOSC agenda and that they are welcome to attend.

'Availability in the local NHS of NICE recommended treatments and drugs' – for a future NHOSC meeting (item suggested by Cllr P Balcombe).

9.2 In response to a request from Mr Richard Bearman (who was not in attendance at the meeting) the Committee agreed that the Scrutiny Support Manager (Health) should remain in contact with NHS England about developments concerning the possibility of the Walk-in Health Centre moving from its current location in the Castle Mall, Norwich. At the moment it was unclear what might be proposed regarding the future of the walk in centre.

The meeting concluded at 11.45 am

Chairman

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Norfolk Health Overview and Scrutiny Committee
29 May 2014
Item no 7

Hospitals complaints processing and reporting

Suggested approach from Maureen Orr, Scrutiny Support Manager

This report sets out how the Boards and Governors of acute hospitals in Norfolk receive information about complaints and how the hospitals learn from and act upon trends in complaints.

1. Introduction

1.1 In February 2014 Norfolk Health Overview and Scrutiny Committee (NHOSC) agreed to put the subject of hospital complaint processing and reporting on its forward work programme for scrutiny. NHOSC was particularly interested in how the acute hospital Boards and Councils of Governors receive information about complaints and issues raised with Patient Advisory and Liaison Services (PALS) and how they learn from and act upon trends in complaints.

2. Background

2.1 In 2013 Ann Clwyd MP and Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust were asked to co-chair a review of the NHS Complaints Process as part of the follow-up to the Francis report on mid Staffordshire NHS Foundation Trust. The report, published in October 2013, can be viewed on-line at:-

https://www.gov.uk/government/publications/nhs-hospitals-complaints-system-review

The report made recommendations about:-

- improving the quality of care
- improving the way complaints are handled
- ensuring independence in the complaints procedures
- whistleblowing

The review looked right across the NHS complaints process but one of the recommendations especially relevant to the subject on NHOSC's agenda today was:-

'There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These

reports should be available to the Chief Inspector of Hospitals'.

2.2 In 2013 the Parliamentary Public Accounts Committee (PAC) looked at the related subject of whistle-blowing and the use of 'gagging orders', or compromise agreements, in relation to severance payments to NHS staff. One of the PAC's concerns was about the potential for preventing departing NHS staff from speaking out about patient safety. In March 2014 Health Secretary Jeremy Hunt said that the use of 'gagging clauses' in the NHS must stop.

2.3 Healthwatch England and YouGov conducted a survey of 2076 UK adults in 2013 and found that less than half those who had had a bad experience of the NHS between 2010 and 2013 actually did anything to report it. This was because they did not know how to complaint or lacked confidence that their complaint would be dealt with effectively or make any real difference. Of those who did pursue a complaint only 13% entered a formal complaints process, which could mean that the NHS is taking no formal learning from almost 9 out of 10 experiences of poor care.

3. Purpose of today's meeting

3.1 Each of the three acute hospitals in Norfolk has been asked to provide the following information for today's meeting:-

- The latest complaints report taken to their Boards or Council of Governors
- The number of issues raised with PALS and the number of those that progress to formal complaint
- The number of formal complaints received each quarter over the past two years
- Details of how the hospitals compare with national benchmarking in terms of complaints received
- Examples of changes in practice in response to complaints
- Their whistle-blowing policies
- The number of whistle-blowers in the past 2 years
- Information about any use of gagging clauses in staff contracts or severance agreements in the past 2 years
- Information on where members of the public can get information on the level and nature of complaints about the hospital.

3.2 Reports from each of the hospitals are attached and representatives will attend today's meeting to answer Members' questions:-

Appendix A – Norfolk and Norwich University Hospital NHS Foundation Trust. (The report includes links to Board papers on the NNUH's website)

Appendix B – The Queen Elizabeth Hospital NHS Foundation Trust
(The last report to the QEH Board on 25 March 2014 is available on their website via the link **http://www.qehkl.nhs.uk/boardMeeting0325.asp** Item 10, page 21)

Appendix C – James Paget University Hospitals NHS Foundation Trust (The report includes links to Board papers on the JPUH website)

3.3 Appendix D is a report from Healthwatch Norfolk.

Healthwatch Norfolk has been looking at how complaints about health care are handled in Norfolk. It has spoken with the NHS commissioner and provider organisations (including the hospitals) and has received feedback from complainants.

The work is ongoing and Healthwatch Norfolk has offered to bring a full report to NHOSC later in the year but for today's meeting it has provided an interim paper setting out some of its initial findings and recommendations (Appendix D). These include a recommendation about publication of the outcome of complaints to show the changes that have been made. Healthwatch recommends a 'you said, we did' approach to publishing this information to make it easily accessible to all members of the public.

A representative of Healthwatch Norfolk will attend today's meeting to introduce the paper and answer any questions that Members may have about the work.

Information on how to raise concerns and complaints about health and social care in Norfolk is available on Healthwatch Norfolk's website:- **http://www.healthwatchnorfolk.co.uk/sites/default/files/complaintsinfographic3_2.pdf**

4. Suggested approach

4.1 After the representatives from the hospitals and Healthwatch Norfolk have presented their reports, members may wish to discuss the following areas with them:-

(a) Will all the hospital Boards of Directors now receive monthly reports on complaints as recommended by the Clwyd / Hart review?

(b) The N&N's report mentions that the Parliamentary Ombudsman says that over 75% of complainants from this area are approaching her office prematurely, sometimes 'appealing' before even submitting a complaint. Can the hospital representatives comment on what might be the reasons for this?

(c) Do the hospitals recognise the need for consistency in complaints processing across different organisations to help promote public understanding of the system? Do they share best practice across Norfolk?

(d) Within each hospital, is there a consistent approach towards recording and learning from complaints across all clinical areas?

(e) Is the learning from the concerns raised with PALS captured and shared across all clinical areas?

(f) There are differences in how the hospitals define the subject of complaints in their reports. Is 'interpersonal conflict' at the N&N the same thing as 'staff attitude' at the QEH?

(g) Are the Directors and Governors aware of the number of concerns raised with PALS that do not progress to formal complaints and the subjects of those concerns?

(h) The N&N and QEH complaints reports include benchmarking information which shows how they compare with national averages or with other hospital trusts. The JPUH's report does not include any such information. Is complaints benchmarking information available to the Board and Governors of the JPUH?

(i) How are patients and the public made aware of service improvements that have taken place as a result of making complaints?

(j) Do all of the hospitals survey both complainants and staff to get feedback on how complaints have been handled?

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Our Vision
To provide every patient with the care we want for those we love the most

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Ms Maureen Orr
Scrutiny Support Manager (Health)
Norfolk County Council
4th Floor, County Hall
Martineau Lane
Norwich NR1 2DW

Our Ref: JPG/vr/MI.14.002

22 April 2014

Dear Maureen

I am replying to your request for information in preparation for the HOSC meeting in May.

There are three mattes raised:
1 PALS (Patient Advice and Liaison Service);
2 Complaints;
3 Whistleblowing.

1 PALS

- *the number of issues raised with PALS and the number of those that progress to formal complaint.*

I have made enquiries and understand that our Patient Advice and Liaison Service (PALS) registers around 2,000 to 2,500 matters per annum. Some of these are expressions of gratitude, others are suggestions or requests for information, whilst others are expressions of concern.

Over the last 2 years, 346 people were referred from PALS to the Complaints Department. We do not however differentiate between cases in which people have been signposted by PALS to the complaints process and those in which the matter has 'progressed' to a complaint.

2 Patient Experience Feedback

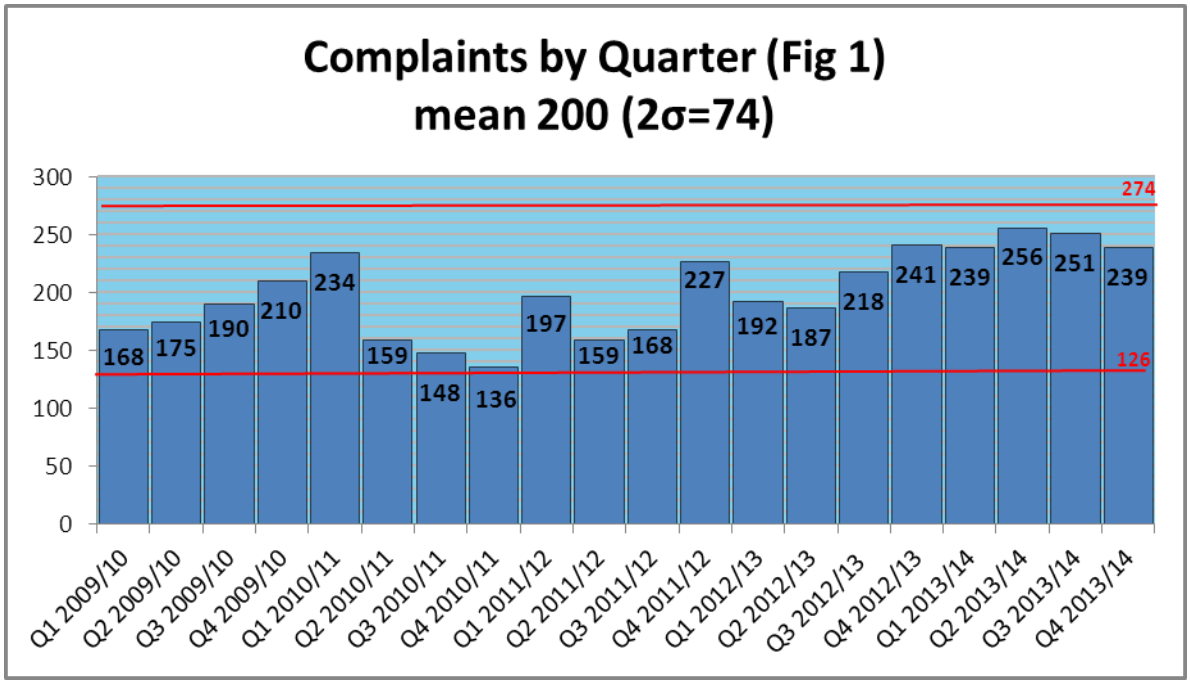
- *the number of formal complaints received each quarter over the past two years*
- *details of how the hospitals compares with national benchmarking in terms of complaints received*
- *examples of changes in practice in response to complaints*
- *information on where members of the public can get information on the level and nature of complaints about the hospital.*

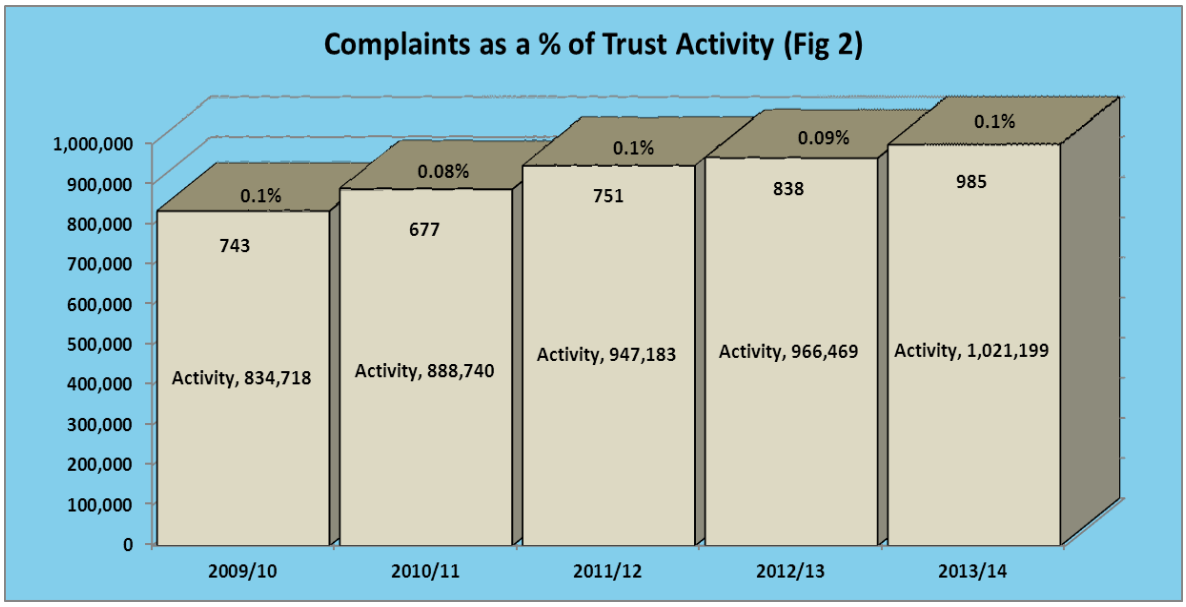
We have a system in place to proactively gather feedback from patients so that we can identify where we are doing well and areas in which we can take action to improve. In this way we have obtained the views of tens of thousands of patients, both in-patients and outpatients. Although it can be hazardous to reduce qualitative issues to a single numerical value, in March the Trust's inpatient 'Friends and Family Test' result, of those patients who would recommend the Trust to their friends or family, is '84' – the highest yet recorded and significantly higher than the national NHS rate of 72.

In addition to this source of feedback, we collate data derived from the formal complaints process and the graphs below provide quarterly and annual figures of numbers of complaints received. We also calculate the numbers of complaints as a percentage of overall trust activity and this is set out in Fig 2.

As requested, I enclose copies of reports to the Trust Board from May 2013 and November 2013 and a presentation to the Board from November 2013. These provide relevant benchmarking data and examples of changes in practice in response to complaints. All of this information is routinely published on the Trust website, with summary information included in our Annual Report.

You will see that, whilst there has been a rise in the number of complaints this year, this was predicted in light of the publication of the Francis Report into Mid-Staffordshire Hospital. Activity at this Trust has grown considerably over recent years and the number of complaints as a percentage of activity is consistent with that in previous years.





I also enclose a copy of a spreadsheet report that was provided to our Board in November 2013 and which sets out our position against the recommendations of the Clwyd/Hart review of the NHS Complaints Process (October 2013).

3 **Whistleblowing**

- *whistle-blowing policy*
- *the number of whistle-blowers in the past 2 years*
- *information about any use of gagging clauses in staff contracts or severance agreements in the past 2 years*

In line with best practice, our policy of encouraging staff to raise concerns is known as our Speak-Up Policy. I attach a copy.

The process for staff to raise concerns is summarised at page 5 of the Policy. In short, staff are expected to raise concerns with their line manager in the first instance, or if that is inappropriate or unsatisfactory, to escalate the matter to the next level within the Trust, and on upwards as necessary.

Our Speak-Up Policy contains a 'safety-valve', whereby a member of staff who feels that they cannot raise a concern within the structure headed by the Chief Executive or Chairman can approach the Senior Independent Director (a Non-Executive Director on our Board) (see 6.2 and page 9). There have been no occasions in the last two years on which staff have felt this to be necessary.

We have recently joined the national 'Speak Out Safely' campaign and it is hoped that this will encourage Trust staff to report issues internally, to maximise opportunity for learning and improvement. There is daily dialogue with our staff about ways in which we can improve the Trust and its services for patients and we are constantly revising and reforming to make things better. We view this as part of a healthy culture, open to learning and to suggestions for getting better. We are not aware of any occasions on which staff have felt it necessary to 'whistle-blow' i.e. raise a concern externally under protection of the Public Interest Disclosure Act.

With regard to 'gagging clauses' it appears that there is some misunderstanding generally about this subject. It has been common practice for severance agreements on the termination of employment to contain confidentiality clauses. Typically these clauses have been requested by the member of staff who did not wish for there to be any public comment on the reasons for their departure. For our part, and to avoid any doubt about the nature or purpose of those confidentiality clauses, paragraph 10 of our Speak-Up Policy requires that all 'compromise agreements' shall state:

> *"For the avoidance of doubt, nothing in this Agreement shall prejudice any rights that the Employee has or may have under the Public Interest Disclosure Act 1998 and/or any obligations that the Employee has or may have to raise concerns about patient safety and care with regulatory or other appropriate statutory bodies pursuant to his or her professional and ethical obligations including those obligations set out in guidance issued by regulatory or other appropriate statutory bodies from time to time."*

I hope that it will be clear that severance agreements involving this Trust cannot be viewed as 'gagging' agreements.

Please do let me know if you need any further information or if it would be helpful to discuss.

Yours sincerely

John Paul Garside
Board Secretary and Head of Legal Services

Encs
Reports to Board of Directors on complaints received (May 2013 & November 2013)
Report concerning Clwyd/Hart Review – November 2013
Presentation to Board of Directors on Learning from Experience – November 2013
Speak-Up Policy

Norfolk and Norwich University Hospital NHS Foundation Trust

Enclosures to letter of 22 April 2014 - weblinks and attachments:-

Report to Board of Directors on complaints received May 2013 – attached

Report to Board of Directors on complaints received November 2013 - http://www.nnuh.nhs.uk/publication.asp?id=415 (page 77)

Report concerning Clwyd/Hart Review – November 2013 - http://www.nnuh.nhs.uk/publication.asp?id=415 (page 83)

Presentation to Board of Directors on Learning from Experience – attached

Speak up policy - attached

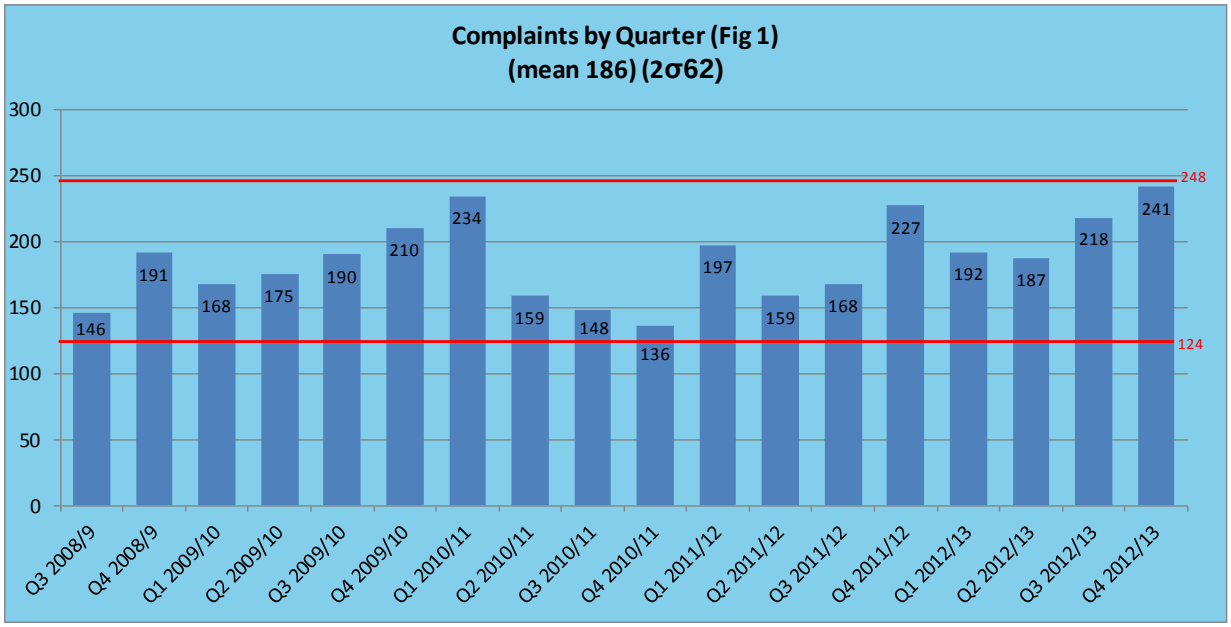
REPORT ON COMPLAINTS – MAY 2013
(1 January 2013 to 31 March 2013)

Background

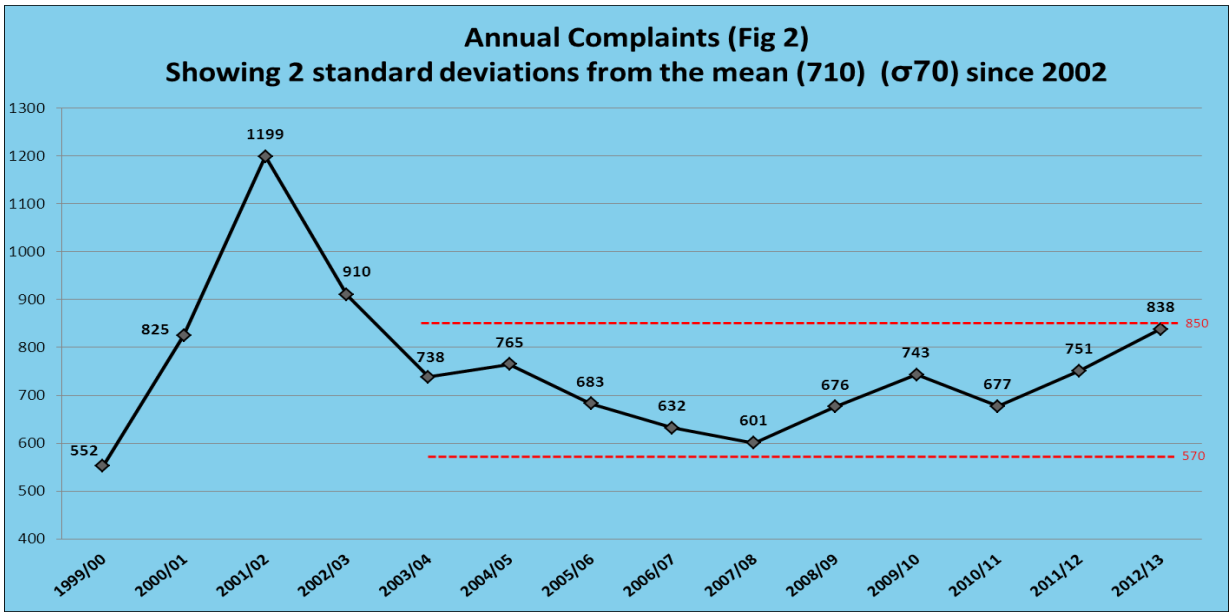
The Trust's Complaints Policy requires that the Trust Board be provided with regular reports on complaints received. This report focuses on the period 1 January 2013 to 31 March 2013 but also provides an overview of the year 2012/13.

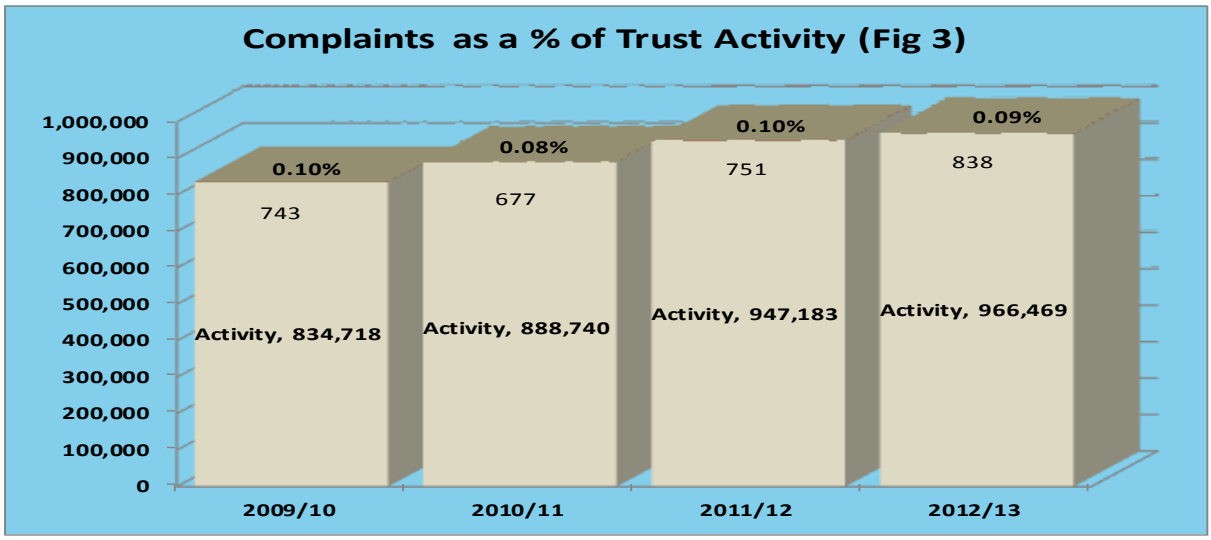
Complaints Profile

As anticipated in the report to the Board in February, the number of complaints has risen in Q4 (see Fig 1). This is consistent with previous times at which the NHS has been the subject of increased media attention and a rise was anticipated in association with critical media coverage of the NHS in association with the Francis Report into Mid Staffordshire NHS Foundation Trust.



The increased number of complaints received in Q4 may also reflect the operational pressures previously discussed by the Board. These are reflected in complaints in relation to cancelled admissions, transfers between wards and general 'stresses' in the patient pathway due to high demand resulting, for example, in the use of temporary escalation areas. As shown in Fig 1 and Fig 2, the number of complaints both by quarter and year is within the range of two standard deviations from the mean and as shown in Fig 3, the number of complaints as a percentage of overall Trust activity has fallen.





The Subject of and Learning from Complaints

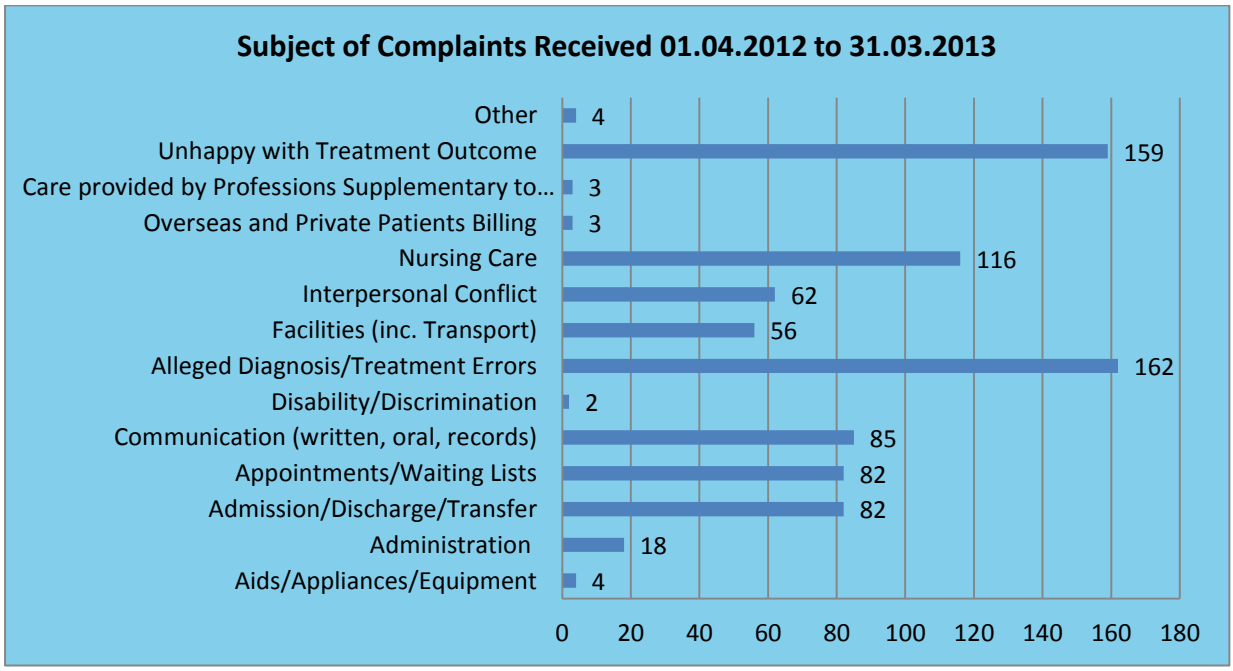
It is important not to lose sight of the significance and value of complaints in pure numerical analysis and in order to ensure that complaints are used to learn lessons, leading to service improvements for patients, every complaint is reported to the relevant divisional/departmental manager and clinical director. Each file remains open until confirmation has been received that it has been reviewed to identify any necessary action. Composite reports detailing the subject of complaints are then sent to the Divisions for review.

Examples of actions or changes in practice resulting from complaints in Q4 are show in the table below:

Ref	Summary	Outcome
DT.13.0192	Patient distressed during procedure.	Review of communication process to enable patients to express wishes when unable to speak during procedure.
DT.13.0089	Complaint about support provided to patient with learning disabilities following their unexpected stay after a day procedure.	Ongoing work to simplify process for a patient's long term carers to continue providing support for them whilst they are in hospital.
DT.13.0060	Unsuccessful gynaecology procedure.	Review of specialist ultrasound training for medical staff.

DT.13.0029	Difficulties with feeding regime for patient with long term nasogastric feeding.	Review of policy to facilitate involvement of carers of adult inpatients to promote continuity of care during hospital admission.

Fig 4 below shows the subjects of complaints received between 1 April 2012 and 31 March 2013. This profile is essentially consistent with that of previous years in that most issues relate to the most significant activity in the hospital namely the provision of clinical care.



Disability & Discrimination Issues
No complaints received this quarter raised Disability and Discrimination issues.

Coronial Inquests
Two Coronial Rule 43 letters have been received this Quarter:

- IQ: Review of policy relating to communication of end of life decisions.
- IQ: Review of policy for management of patients with suspected head injury.

Formal responses to both letters have been sent.

The total of Rule 43 letters received in 2012/13 is two and none are outstanding.

Appeals from the outcome of complaints investigations
In Q4, the Trust was informed that 4 complainants had contacted the Health Service Ombudsman with respect to their complaints. Such cases are reviewed by the Ombudsman to assess, for example, whether everything reasonable has been done at the local level to resolve the complaint, in which case no intervention is warranted. The Trust has been informed of the outcome of two such reviews this quarter:

- **DT.12.0355** – PHSO declined to investigate, all reasonable steps having been taken by the Trust.
- **DT.10.0786** – PHSO declined to investigate, all reasonable steps having been taken by the Trust.

Complaints Handling
In the aftermath of the Francis Report the NHS Complaints Procedure is again under formal review. Whilst there is always room to improve, below are some examples of positive feedback received by the Trust this quarter relating to its response to complaints:

- *"Thank you for your long, clear letter and apology"*
  Ms S (January 2013) DT.12.0784

- "*My family and I are happy with your explanation and thank you for providing this to us*"
  Mr R (April 2013) DT.13.0043

- "*We are grateful for your apology and assurances… that measures put into action will prevent any kind of reoccurrence. Thanks again for your letter and best wishes to all concerned with the care of Norfolk patients*".
  Mr S (March 2013) Q.13.0014

- "*Thank you so very, very much. Your help has been very much appreciated, and I am sincerely grateful. You are a credit to the hospital" "I would like to thank you for bringing my concerns to a satisfactory conclusion. It now enables me to be free from worry"*
  Ms S (March 2013) DT.12.0808

- *How to make a complaint "clear instructions and advice on your website"*
  Ms S (March 2013) DT.12.0784

- *"I am fully satisfied with how my complaint was dealt with"*
  Ms D (March 2013) DT.13.0052

Learning from experience

Report to Board of Directors (29.11.13)

John Paul Garside
Board Secretary and Head of Legal Services

Gathering patient experience feedback

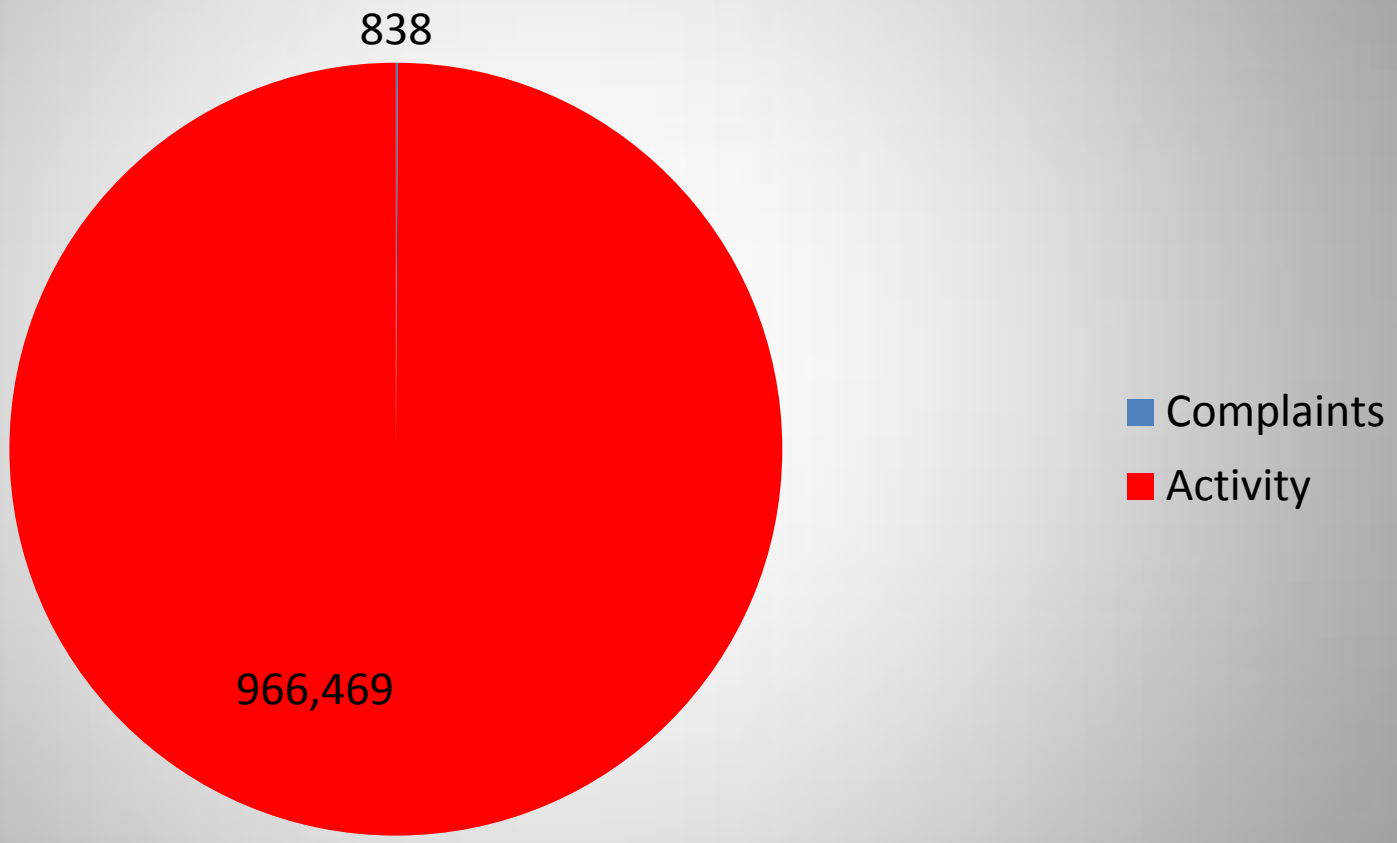
- The Trust systematically and proactively seeks feedback from patients about their experience of the Trust.
- Thousands of patients are surveyed every year
- Hundreds of ward and department quality assurance audits are carried out
- So we can learn and improve

Sometimes things go wrong

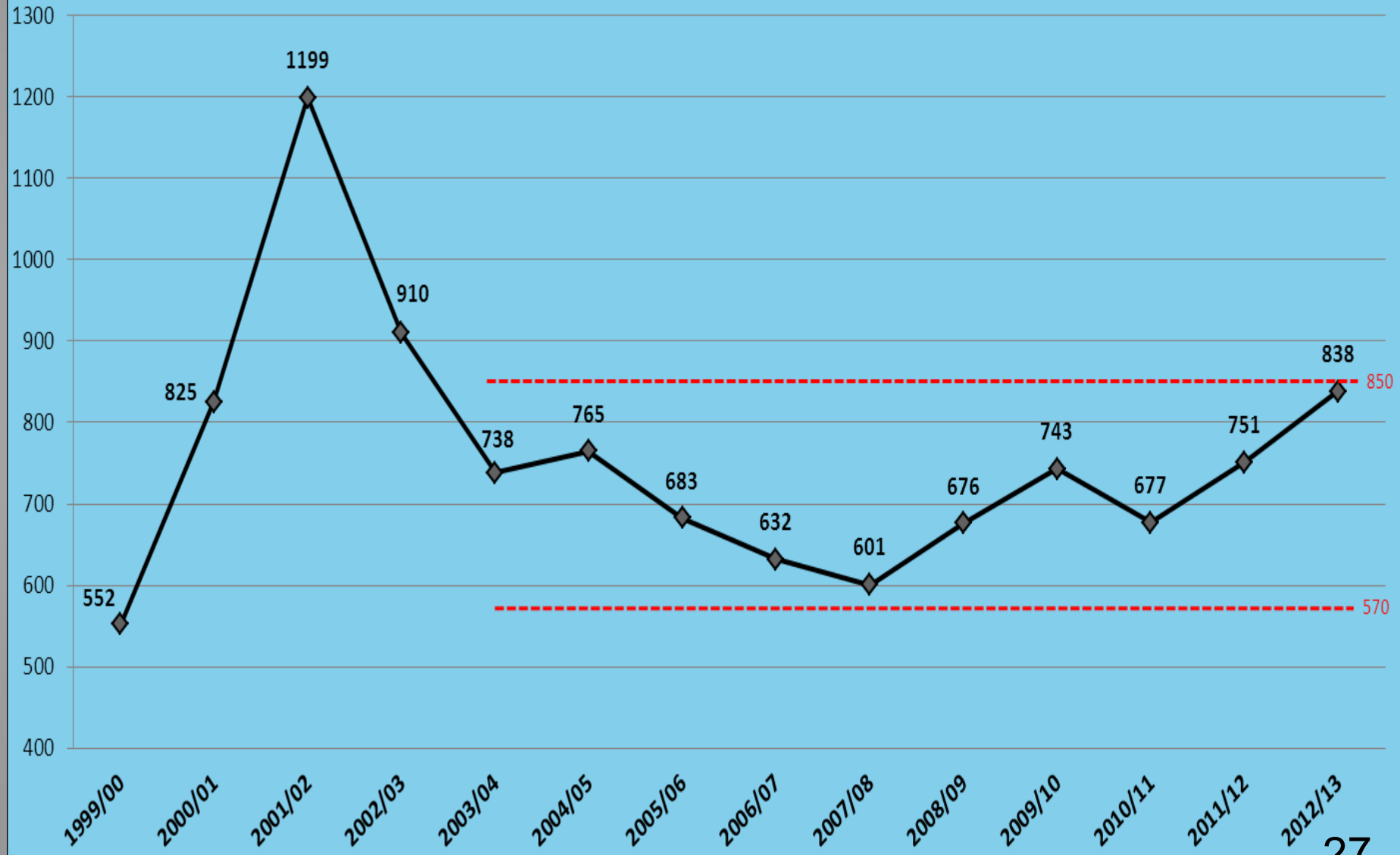
- Then we need to:
  - investigate
  - explain why
  - apologise
  - learn and improve

- The NHS complaints procedure was established in 1996. Reformed - 2004, 2006, 2009 and 2012.
- Now reviewed again by Ann Clwyd MP & Prof Tricia Hart

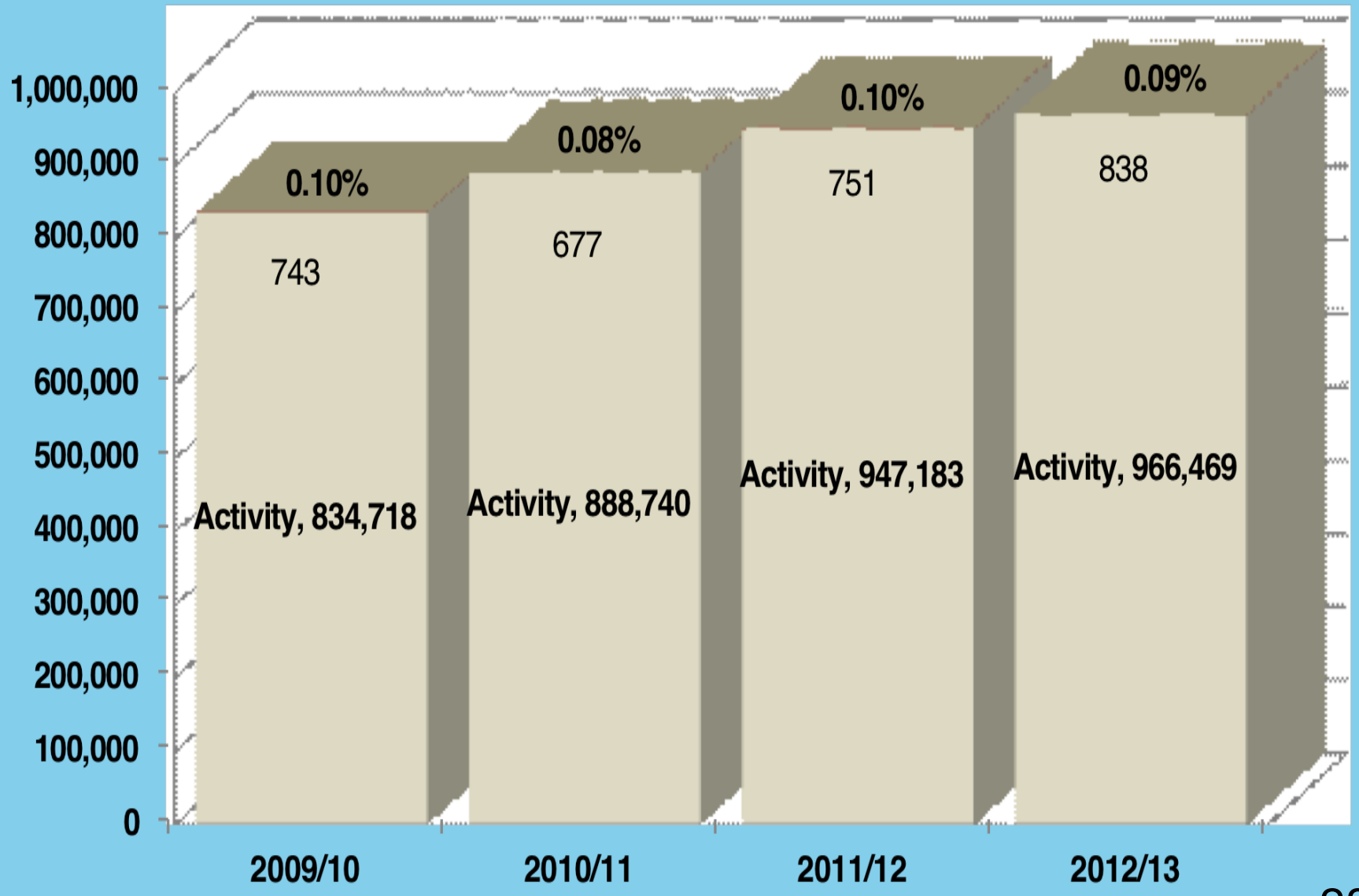
Number of Complaints relative to overall Trust activity (2012/13)



Annual Complaints (Fig 2)
Showing 2 standard deviations from the mean (710) (σ70) since 2002



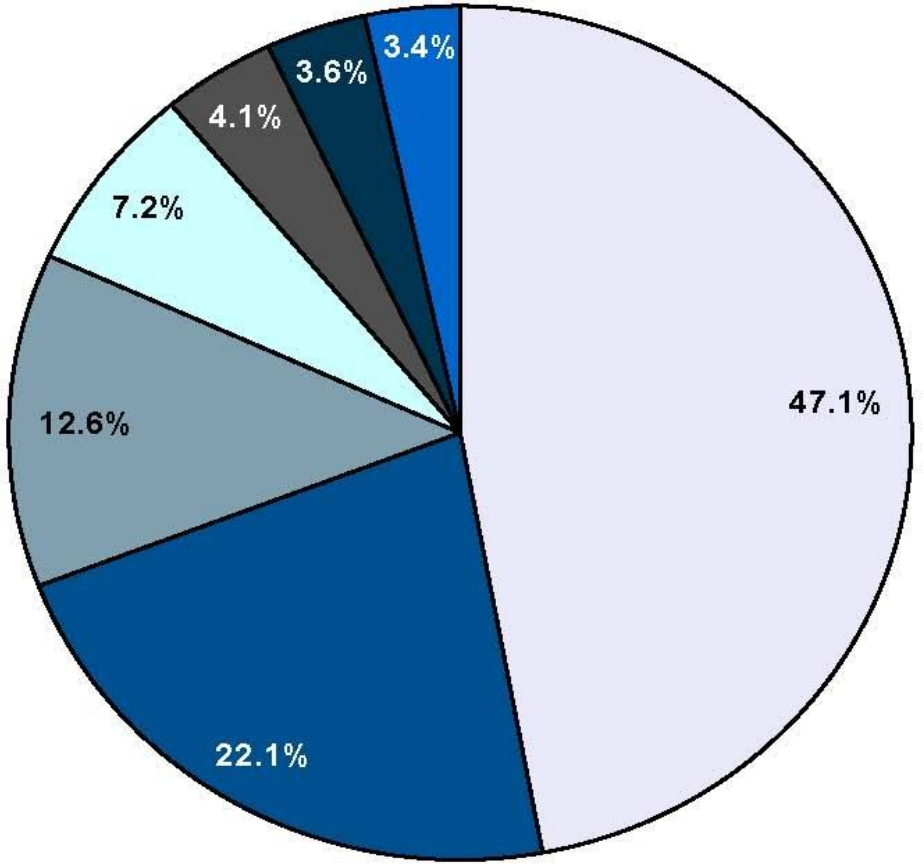
Complaints as a % of Trust Activity (Fig 3)



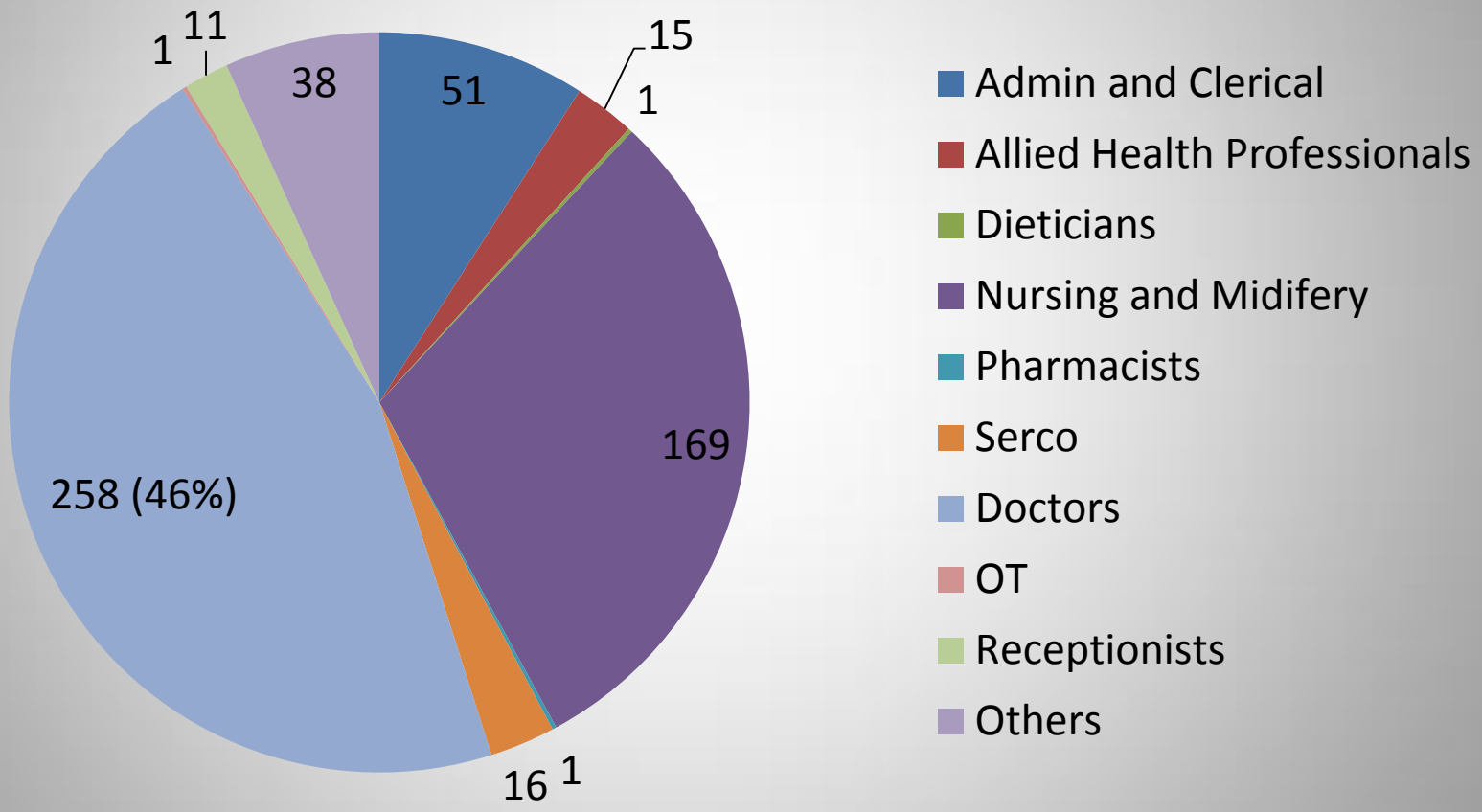
HCHS by Profession

Figure 2: 2012-13 Hospital and Community Health Services (HCHS): Written Complaints by Profession, England

	2012-13
Medical (including surgical)	51,462
Nursing, Midwifery and Health Visiting	24,146
Other	13,812
Trust Administrative staff / members	7,818
Ambulance crews (including paramedics)	4,438
Professions supplementary to medicine	3,926
Professions with < 2%	3,714
PCT Administrative staff / members (exc GP admin)	1,077
Scientific, Technical and Professional	1,051
Dental (including surgical)	918
Maintenance and Ancillary staff	668
Total	**109,316**



Complaints by Profession (13/14 YTD)

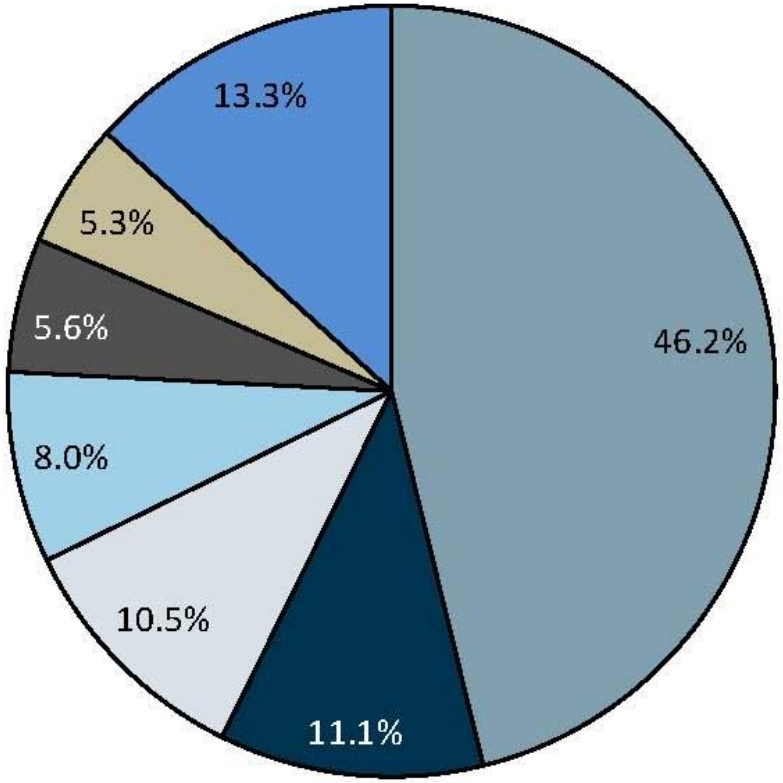


Complaints by Clinical Specialty 01.04.13 to 27.11.13

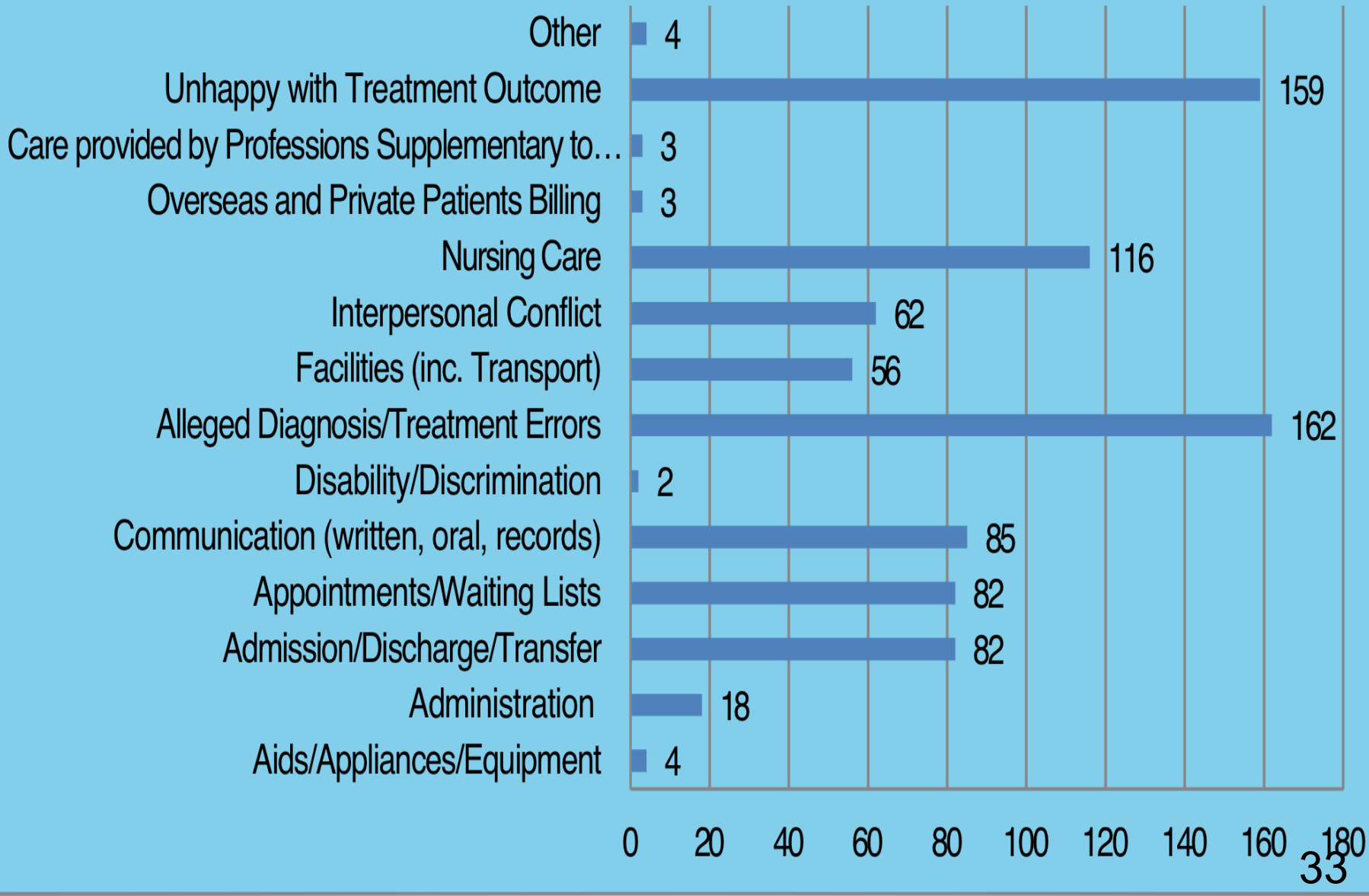
HCHS by Subject

Figure 3: 2012-13 Hospital and Community Health Services (HCHS): Written Complaints by Subject [2], England

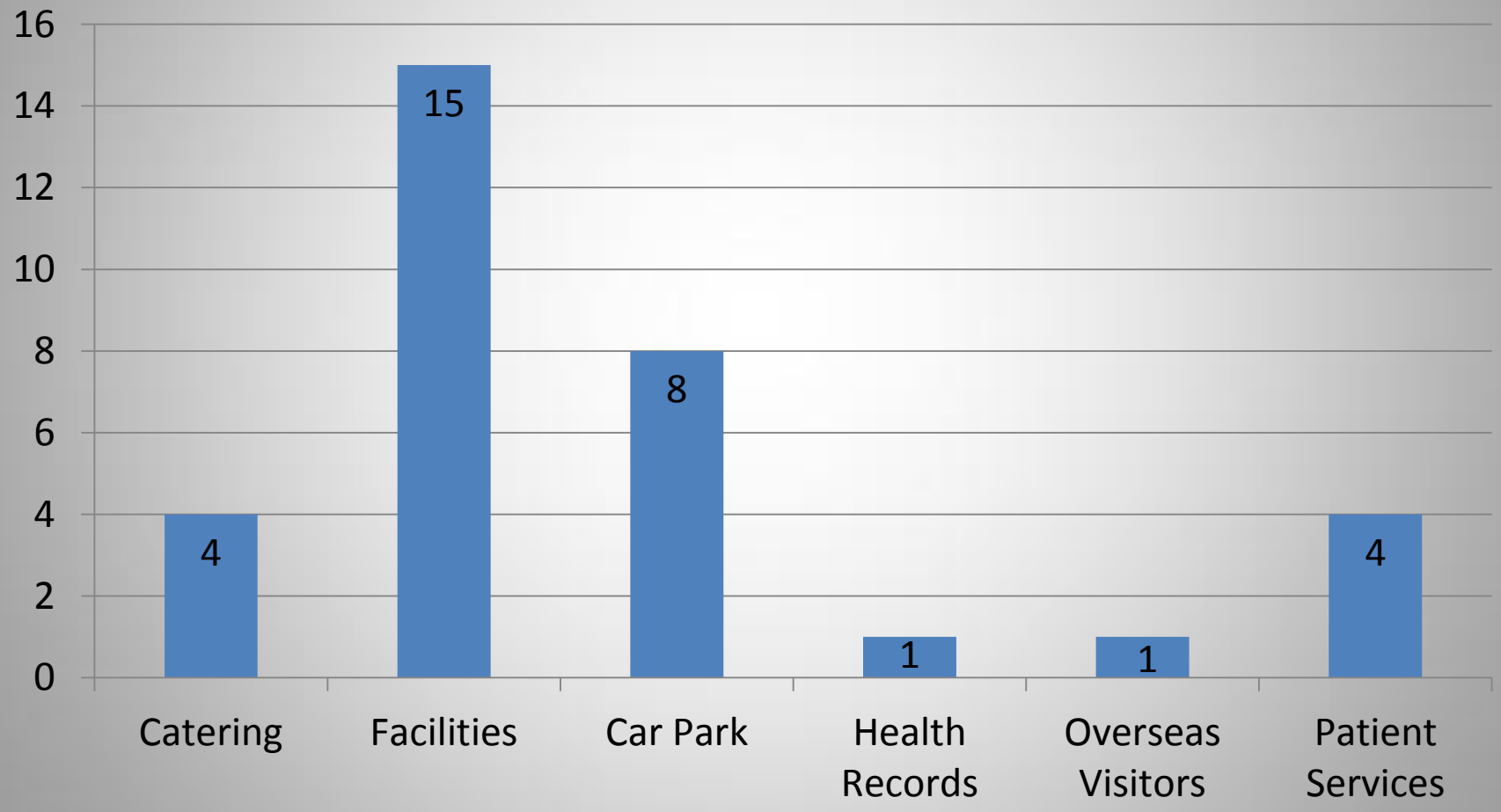
	2012-13
All aspects of clinical treatment	51,071
Attitude of staff	12,303
Communication / information to patients (written and oral)	11,606
Appointments, delay / cancellation (outpatient)	8,886
Admissions, discharge and transfer arrangements	6,227
Other	5,809
Subjects with < 5%	14,737
Total	110,639



Subject of Complaints Received 01.04.2012 to 31.03.2013



Complaints by Non-Clinical Specialty



There is a lot of criticism of NHS complaints handling

The Ombudsman's submission to the Clwyd/Hart review said:

"…there is a toxic cocktail that prevents concerns and complaints being heard and addressed".

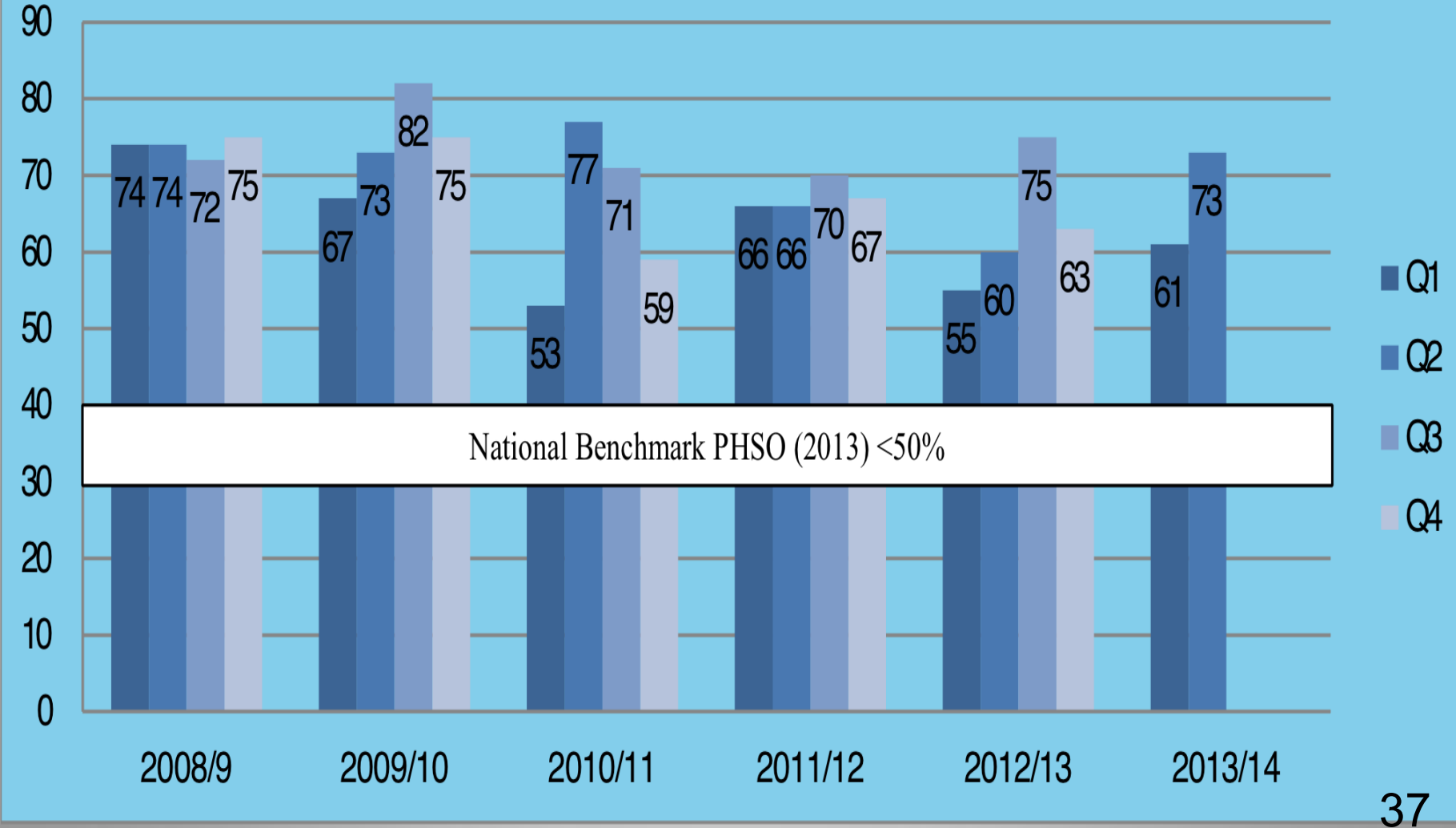
i) reluctance on the part of patients, families and carers to express concerns or complaints
ii) defensiveness on the part of hospitals and their staff to hear and address concerns.
iii) as a result opportunities to learn and improve care are lost.

Our process is designed to address these concerns.

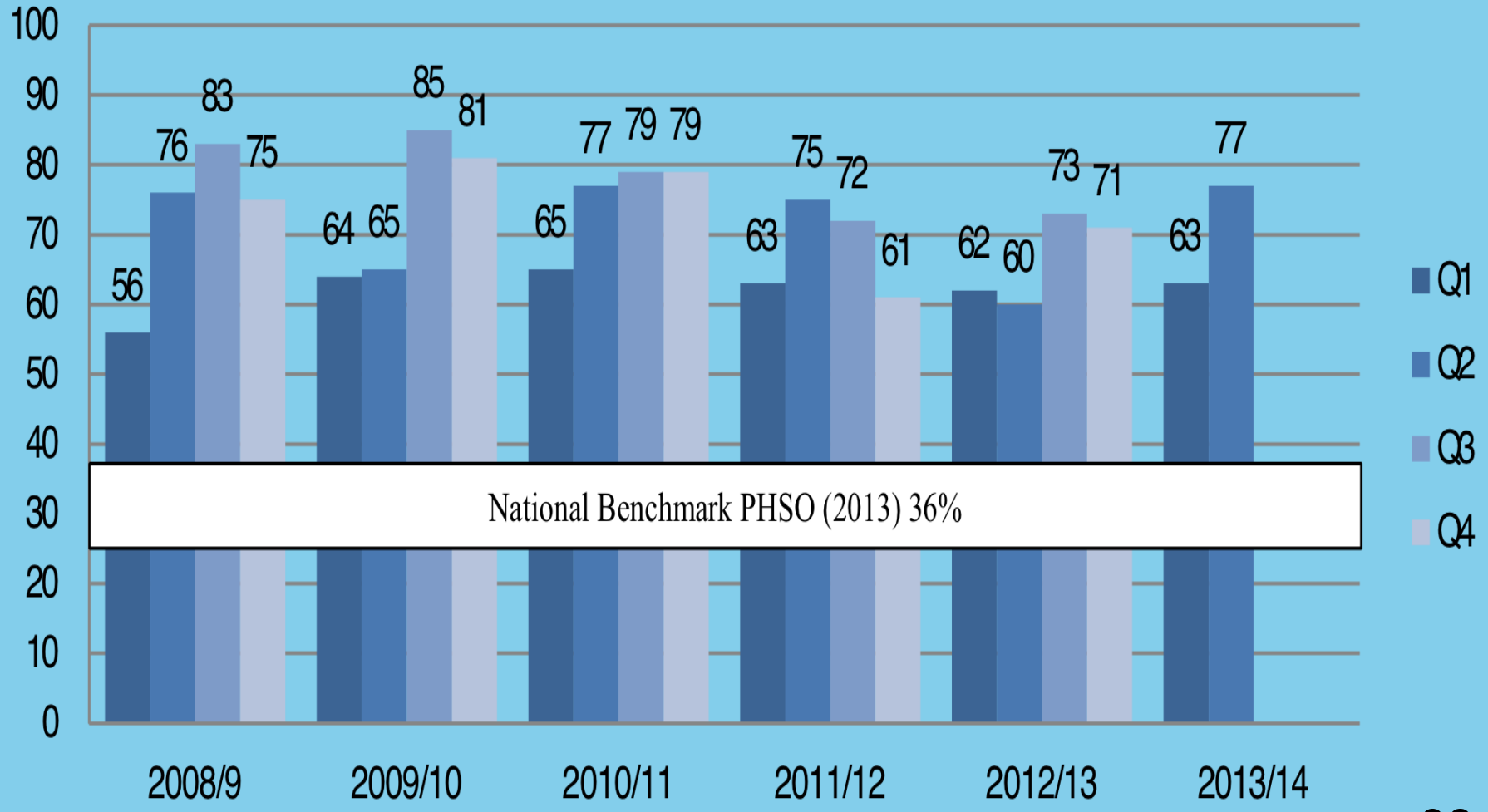
- We survey every complainant. 6,500 questionnaires since 2004

- Did they find the procedure easy to access?
- Did the process address their concerns?
- Are they satisfied?
- Was complaining worthwhile or a waste of time?

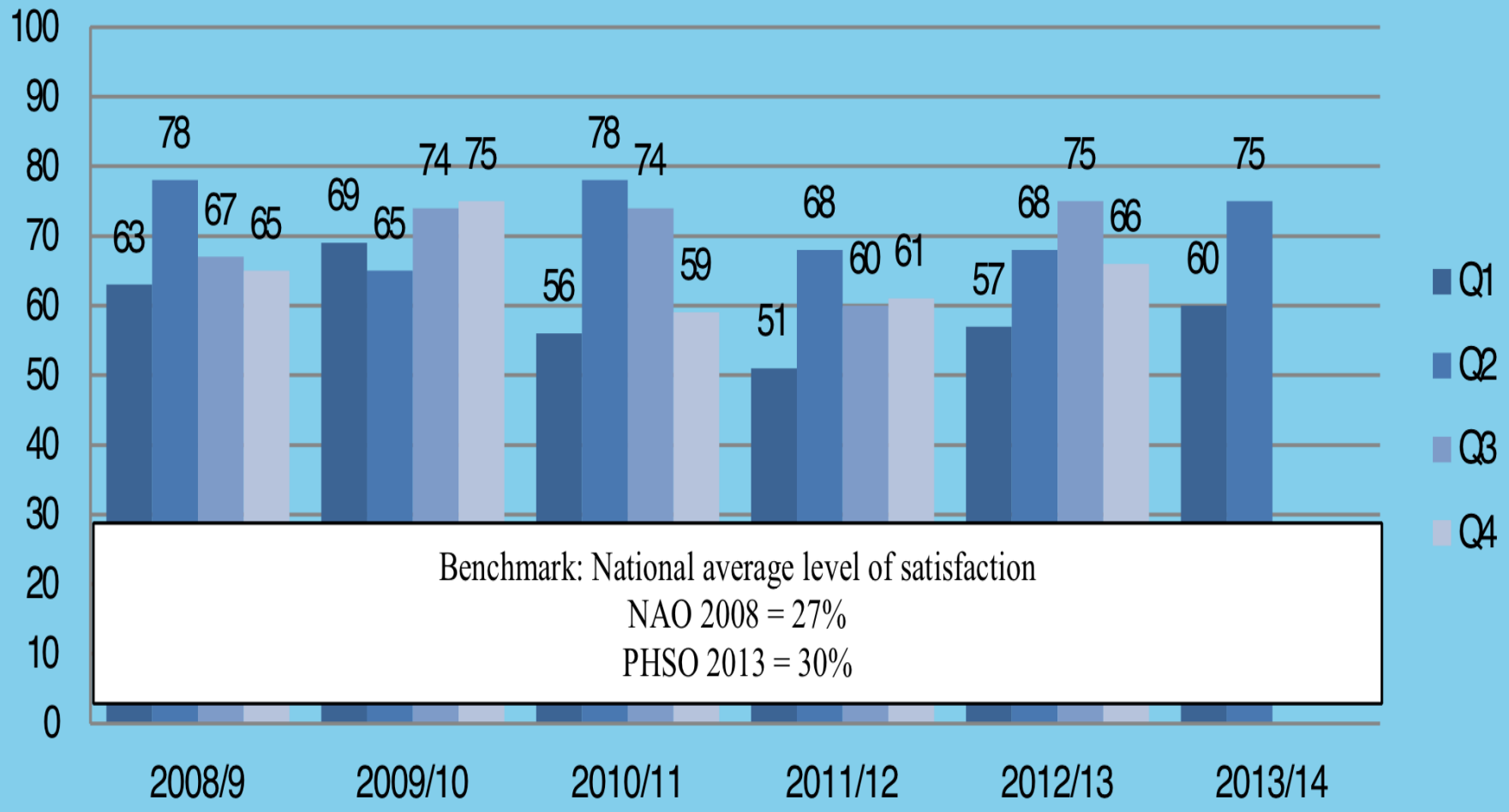
2008/9 to 2012/13 - % of complainants who felt their concerns were properly listened to (Fig 3)



2008/9 to 2013/14 - % of respondents who felt the process was useful or worthwhile



2008/9 to 2013/14 - % of complainants who indicated they were satisfied (Fig 2)

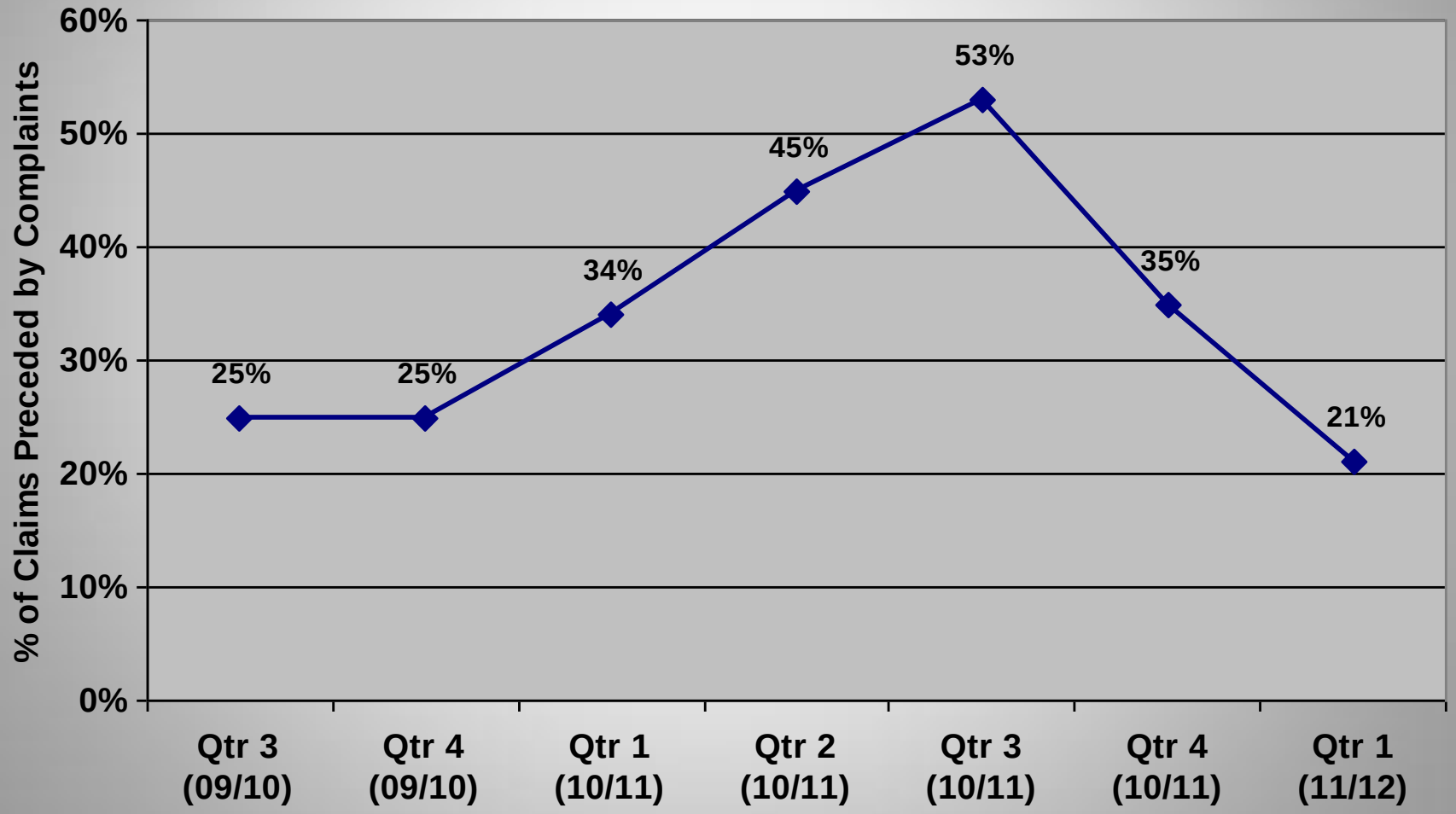


Some people we can't satisfy

- Q. What would you like to achieve through the complaints process*? A. "Mr A's head on a plate."*

- Sometimes there are at least two sides to the story and all we can do is try to explain and apologise

Use of the Complaints Procedure as a Prelude to Pursuing a Claim



We also survey staff

- Its easy to say '*treat complaints as a jewel not a threat*' – if you are not the one complained about
- Our challenge is to support staff to learn from mistakes – not to humiliate
- 1,500 responses – 95% consider the process was fair to staff and complainants alike
- Fairness should be the objective for all parts of the process

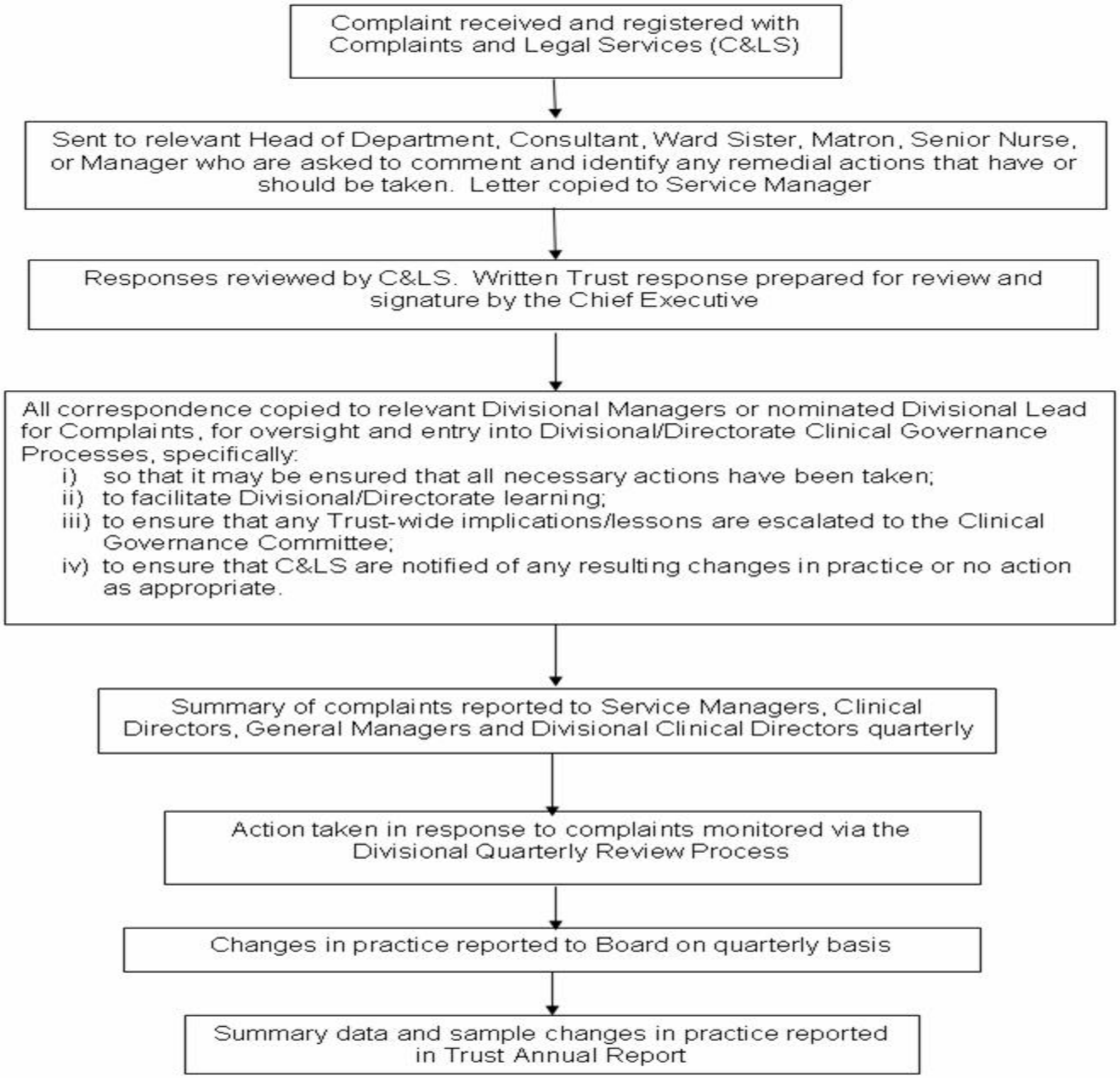
Before it gets anywhere near a formal complaint

- Deal with the issue on the “front line”
- Stop and listen to what the patient/family want … talk to them

- Is it a concern or a complaint?
- Refer to PALS
- Involve a colleague to review situation

Appendix Two

Process to Identify, Implement and Share 'Lessons Learnt' From Complaints



Gathering patient experience feedback

- The Trust systematically and proactively seeks feedback from patients about their experience of the Trust.
- Complaints form a part of that jigsaw
- So we can learn and improve

Speak Up Policy (formerly the Whistleblowing Policy) EP3

Post Holder Responsible for Policy:	Director of Human Resources
Directorate Responsible for Policy:	Human Resources
Author of Policy:	HR Manager: Policy, Law and Projects
Contact Details:	HR Department
Date First Written:	June 2000
Date Revised:	June 2013
Approved By:	Trust Board of Directors
Date Approved:	28 June 2013
Next Due for Review:	2015
For use in:	Trustwide
For use by:	All staff
Key words:	Whistleblowing

As detailed in the Trust's Scheme of Delegation, this Policy is not to be revised without approval of the Trust Board of Directors.

Version Information

Version No.	Updated By	Date of Update	Description of changes to this version
1		June 2000	Policy first issued
2	HR Dept.	July 2004	Policy updated
3	HR Dept.	January 2008	Policy updated
4	HR Dept.	October 2010	Policy updated
5	HR Dept.	March 2011	Update following LCFS recommendations
6	Legal Services	June 2013	New Section 10 re confidentiality agreements

CONTENTS

Related Policies and Guidance:

1. Trust Grievance Policy and Procedure
2. Trust Code of Business Conduct
3. NHS Social Partnership Forum Guidance (2010) - “Speak up for a healthy NHS”
4. NHS Employers (2013) “Speaking up charter”
5. Trust Anti Fraud Policy
6. Trust Anti Bribery Policy

1.0 Introduction.

1.1 All of us, at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved. However, when they are about unlawful conduct, financial malpractice, fraudulent activity, breaches of codes of conduct, ill-treatment of patients/ clients, disregard of health and safety rules, matters relating to gifts, hospitality or conflicts of interest, dangers to the public or the environment or any other similar matter it can be difficult to know what to do.

1.2 You may be worried about raising such issues or may want to keep the concerns to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or to the organisation. You may decide to say something but find that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. You may also be afraid of recriminations or have concerns about your personal safety, should your identity be disclosed to the subject(s) of your concern.

1.3 The Trust promotes a climate of openness and dialogue in which staff are encouraged to feel able to raise concerns without fear of reprisals or victimisation reflecting the Public Interest Disclosure Act 1998 which offers a framework of protection against victimisation, disciplinary action or dismissal for staff who raise genuine concerns. Appendix 1 provides further details of the Public Interest Disclosure Act 1998.

1.4 The Trust is committed to achieving the highest possible standards of service and the highest ethical standards in public life and in all of its practices. The Trust has therefore introduced this procedure to encourage freedom of speech and to enable you to raise your concerns about such malpractice at an early stage and in the right way. We would rather that you raised the matter when it is just a concern rather than wait for proof. Appendix 2 details the Trust's contacts for raising such complaints under this policy.

1.5 In addition to permanent and fixed-term employees this Policy also applies to those on secondment, trainees, agency staff, contractors, suppliers, external bodies and volunteers.

1.6 If something is troubling you which you think we should know about or look into, please use this procedure. If, however, you are aggrieved about your personal position, please use the Trust Grievance Policy which you can get from your manager, the Human Resources Department or is available on the Trust intranet and internet sites. This Speak-Out policy (formally known as the Whistleblowing Policy) is primarily for concerns where the interests of others or of the organisation itself are at risk.

If in doubt – raise it!

2.0 Our Assurances to You.

Your Safety

2.1 The Trust is committed to this policy. If you raise a genuine concern under this policy you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, we do not extend this assurance to someone who maliciously raises a matter they know is untrue – the Trust may choose to discipline or take other formal action regarding such individuals under these circumstances.

Statutory protection

2.2 The Public Interest Disclosure Act 1998 encourages people to raise concerns about malpractice in the workplace and in doing so requires employers to respond by addressing the message rather than acting against the messenger. It does this by preventing an employer taking disciplinary action against, or victimising a member of staff who genuinely raises a concern.

Your confidence

2.3 The Trust will not tolerate the harassment or victimisation of anyone raising a concern. However, we recognise that you may nonetheless want to raise a concern confidentially under this Policy. If you ask us to protect your identity by keeping your confidence, we will not disclose it without your consent. The exception is when we may be obliged to reveal your identity, on legal advice, where investigation of serious allegations leads to the establishment of an external enquiry, police action against individuals, or potential dismissal of employees. If it becomes clear that any of these may apply, we will discuss with you how we can proceed.

Anonymous Allegations

2.4 Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. While we will consider anonymous reports, this Policy does not apply to concerns raised anonymously.

3.0 How We Will Handle the Matter

3.1 Once you have told us of your concern, we will look into it to assess initially what action should be taken. This action will be taken using a risk based process to determine what action is required. This may involve an internal inquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her and whether your further assistance may be needed. In this way you can be sure that your concern will not be forgotten or ignored. If you request it, we will write to you summarising your concern and setting out how we propose to handle it. We will also keep you informed of timescales relating to any investigation.

3.2 When you raise your concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

3.3 The purpose of this Policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it and we will give you as much feedback as we properly can.

3.4 If requested, we will confirm our response to you in writing. Please note, however, that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

4.0 Duties of Staff and Professionals

4.1 In addition to the general duty of staff to disclose malpractice to their employer, most professional NHS staff are also under obligation to their statutory body within the Codes of Conduct to take positive steps to disclose any concerns about colleagues which may affect the care provided. Details can be obtained from the relevant professional body.

4.2 Members of staff can seek support and guidance from their Trade Union or professional organisation when raising a concern. Staff may be represented at any stage of the procedure by a trade union representative or a friend not acting in a legal capacity.

5.0 How to Raise a Concern

Appendix 2 details all the relevant contact details and designated officers with whom staf may wish to raise a concern..

Option 1; Speak to your line manager

5.1 If you have a concern about malpractice, we hope you will feel able to raise it first with your manager. This may be done verbally or in writing.

5.2 Line managers will need to advise the member of staff as soon as possible of any action taken in relation to their concern.

Option 2; Speak to the appropriate designated officer

5.3 If you feel unable to raise the matter with your manager, for whatever reason, please raise the matter with one of the following designated officers. The Trust's designated officers are detailed in Appendix 2.

5.4 Please say if you want to raise the matter in confidence so that they can make appropriate arrangements.

Option 3; Write directly to the Chairman or Chief Executive

5.5 If the channels above have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above you may also write directly to the Chairman or Chief Executive. For contact details please refer to Appendix 2.

5.6 The Chief Executive will arrange for a senior member of staff to meet with you on their behalf and to report back on the outcome.

6.0 Concerns about very senior personnel at the Trust

6.1 If your concern is about a very senior person in the Trust, you should raise this on a confidential basis with either the Chairman or the Chief Executive of the Trust Board who will decide on how the matter shall be taken forward.

6.2 If for any reason you do not feel able to refer the matter to the Chairman or Chief Executive you may approach the Senior Independent Director who is one of the Non-Executive Directors on the Trust Board. Refer to Appendix 2 for contacts details.

7.0 Independent Advice

7.1 If you are unsure whether to use this procedure or you want independent advice at any stage, you may contact: -

- your Union, or Professional Body
- the independent charity Public Concern at Work (PCaW) on 020 7404 6609. Their lawyers can give you free confidential advice at any stage about how to raise a concern about serious malpractice at work. More information can also be found at www.pcaw.org.uk
- Appendix 3 details how you can raise a concern with Mental Act Commissioner and Health Service Commissioner

8.0 External Contacts including the Media

8.1 While we hope this Policy gives you the reassurance you need to raise such matters internally, we would rather you raised a matter with the appropriate regulator or, where appropriate, with the police, than not at all. Public Concern at Work will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely. **However, we would expect you to contact the Trust's Chief Executive before taking any matter to the Press, to give an opportunity for the organisation to resolve the issue through the use of this Policy**.

9.0 If you are Dissatisfied

9.1 If you are unhappy with our response, remember you can go to the other levels and bodies detailed in this Policy. Whilst we cannot guarantee that we will respond to all matters in the way that you might wish, we will try to handle the matter fairly and properly. By using this Policy, you will help us to achieve this. Section 7 of this policy details how to get further independent advice.

10.0 Confidentiality Agreements

10.1 Concern has been raised nationally that in some circumstances, staff wishing to raise concerns about patient safety or clinical quality have been inhibited from doing so by confidentiality clauses within the context of what are called compromise agreements on the termination of employment. It is this Trust's policy that no member of staff should be inhibited from raising such legitimate concerns through proper channels in the public interest.

10.2 The following clause, or one of equivalent effect, shall therefore be included in all compromise agreements agreed by the Trust:

"For the avoidance of doubt, nothing in this Agreement shall prejudice any rights that the Employee has or may have under the Public Interest Disclosure Act 1998 and/or any obligations that the Employee has or may have to raise concerns about patient safety and care with regulatory or other appropriate statutory bodies pursuant to his or her professional and ethical obligations including those obligations set out in guidance issued by regulatory or other appropriate statutory bodies from time to time."

11.0 Monitoring

11.1 The number and type of referrals made under this Policy will be reported to the Trust Board by the Director of Human Resources.

12.0 Communication of this Policy

12.1 This Policy will regularly be communicated to our staff via our internal communications bulletin and other internal communication media.

12.2 This policy will be included in the Trust's Corporate Induction.

Appendix 1

Public Interest Disclosure Act 1998

The Public Interest Disclosure Act 1998 (PIDA) encourages employees to raise concerns about malpractice in the workplace. The Act applies to genuine concerns about crime, civil offences (including negligence, breach of contract, breach of administrative law), danger to health and safety or the environment and the cover up of any of them. It applies whether or not the information is confidential.

In addition to employees, it covers trainees, agency staff, contractors, home workers and every professional in the NHS.

The Act confirms that workers may safely seek legal advice on any advice on any concerns they have about malpractice. This includes seeking advice from Public Concern at Work (see page 9).

A disclosure in good faith to a manager or employer will be protected if the whistleblower has a reasonable suspicion that the malpractice has occurred, is occurring or is likely to occur.

The Act protects disclosures made in good faith to 'prescribed bodies' where the whistleblower reasonably believes that the information or any allegation is substantially true.

Prescribed bodies relevant to NHS employees include: -

1. The Audit Commission for England and Wales
   1 Vincent Square
   London SW1P 2PN
   (☎ 0845 052 2646)

2. Health and Safety Executive
   Caerphilly Business Park
   Caerphilly
   CF83 3GG

   (☎0845 345 0055)
   www.hse.gov.uk/contact

3. Information Commissioner
   Wycliffe House
   Water Lane
   SK9 5AP
   Cheshire
   (☎-0303 1231113)

Wider disclosures (e.g. to the Police, media, MPs and non prescribed regulators) are protected if, in addition to the tests for regulatory disclosures, they are reasonable in all circumstances and they meet one of three conditions. These are: -

- the whistleblower believed s/he would be victimised if s/he raised the matter internally or with the prescribed regulator;
- reasonably believed a cover-up would be likely and there was no prescribed regulator, or
- had already raised the matter internally or with a prescribed regulator.

The whistleblower should also have not made the disclosure for personal gain.

Appendix 2

Contact details

Option 1; Speak to your line manager

Option 2; Speak to the appropriate designated officer

If you feel unable to raise the matter with your manager, for whatever reason, please raise the matter with one of the following designated officers: -

1. For Clinical Staff (not including Medical Staff) – Director of Nursing and Education, (telephone 01603 287605).

2. For Medical Staff – Medical Director, (telephone 01603 287605).

3. For all other staff – one of the other listed Executive Directors:

   Director of Resources, (telephone 01603 287199)
   Director of Human Resources, (telephone 01603 287194)

4. If your concern is about fraud and corruption, you can also contact the Local Counter Fraud Specialist (Sarah Catterall) on 01908 577450 or on 07881 811 902 or the National Fraud Reporting Line on 0800 028 4060.

Option 3; Write directly to the Chairman or Chief Executive

Chief Executive, Anna Dugdale
Chairman, John Fry

The contact details are as follows:

Norfolk and Norwich University Hospital NHS Trust
West Block: Level 4
Colney Lane
Norwich
Norfolk
NR4 7UY

(☎ 01603 287420)

Concerns about very senior personnel at the Trust

If your concern is about a very senior person in the Trust, you should raise this on a confidential basis with either the Chairman or the Chief Executive of the Trust Board who will decide on how the matter shall be taken forward. The Chair of the Trust Board and the nominated Senior Independent Director may be contacted via the Trust Management Office (on 01603 287420).

Appendix 3

The Mental Health Act Commissioner and The Health Service Commissioner

The Mental Health Act Commissioner *(the Ombudsman)*

Where a member of Staff has a concern about the care of a patient or client detained under the Mental Health Act 1983, he or she may be able to refer the matter to the Mental Health Act Commission, if the concern remains unresolved after pursuing it through local procedures.

The Health Service Commissioner *(the Ombudsman)*

If a member of staff wishes to raise a concern on behalf of a patient, the Ombudsman may look into the issue, providing that they are satisfied that there is no-one more appropriate such as an immediate family member/carer. The Ombudsman's process requires that in normal circumstances initial efforts to resolve a concern locally should be made before her office can investigate.

Appendix 4

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Document Name: **Speak Up Policy** **Policy Reference:** **EP3**
Document Owner: **Human Resources Department** **NHSLA Standard:** **Standard 5, Criterion 10 – Being Open**

Element to be monitored	***Lead responsible for monitoring***	***Monitoring Tool / Method of monitoring***	***Frequency of monitoring***	***Lead responsible for developing action plan & acting on recommendations***	***Reporting arrangements***	***Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document***
All concerns raised through the Speak Up policy are reviewed to ensure that they have been acted upon appropriately.	Director of Human Resources	Review of the number and type of referrals made through this policy.	Annual	Director of Human Resources	The monitoring results and action plan progress will be reported to the Trust Board.	The Lead responsible for developing the action plans will disseminate lessons learned via the most appropriate committee.

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

The Queen Elizabeth Hospital
Gayton Road
Kings Lynn
Norfolk
PE30 4ET

www.qehkl.nhs.uk

Complaints Department
Tel: 01553 613890/613359
Fax: 01553 613628
Minicom: 01553 613888

15 May 2014

Ms Maureen Orr
Scrutiny Support Manager (Health)
Norfolk County Council
4th Floor, County Hall
Martineau Lane
Norwich
NR21 2DW

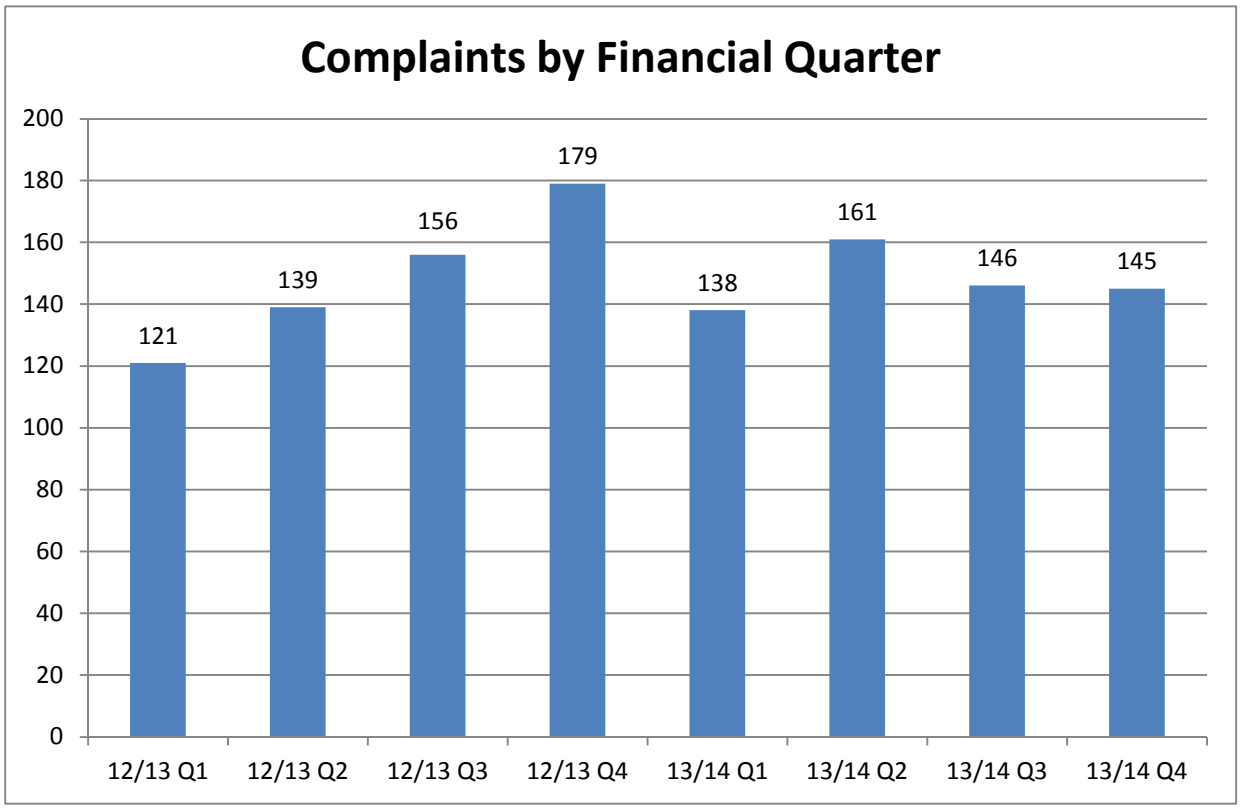
Dear Maureen

I am writing in response to your request for information in advance of the meeting on 29 May 2014. I will list these below in turn:

- ***The number of issues raised with PALS and the number of those that progress to formal complaint***

During the financial year 2013/14 the trust received 5495 PALS contacts, or these 241 related to concerns and 60 of which progressed to a formal complaint.

- ***The number of formal complaints received each quarter over the past two years***



- ***Details of how the hospital compares with national benchmarking in terms of complaints received***

This information is captured in the Trust's 1st Quarter CLIP (Complaints, Litigation, incidents and PALS) report, which is attached with this report. The Trust provides information in relation to the number of complaints to the Department of Health and this is publicised annually in the Health and Social Information Centre – Data on written complaints in the NHS (2012/13 copy attached). The Trust uses this document as a source to benchmark complaints.

- ***Examples of changes to practice in response to complaints***

Enclosed is a copy of the complaints section of the Trust's Board Report in which provides examples of changes made as outcome of complaints.

- **Whistleblowing information**

- 1) Whistleblowing Policy – previously sent attached

- (2) Whistleblowing cases in past two years – 17 cases (these include all received via the Whistleblowing Helpline, the majority of which were 'mainstreamed' via application of standard Trust policies; Mutual Respect, Capability, Disciplinary, etc.

- (3) There were no cases of settlement agreements in the last two years containing gagging clauses preventing subjects from raising issues of public interest under the Public Interest Disclosure Act 1998 (the whistleblowing legislation).

- ***Information on where members of the public can get information on the level and nature of complaints about the hospital.***

The Trust's website; www.qehkl.nhs.uk promotes Freedom of Information, and this is included on the complaints page. The Trust Board reports which include complaints performance are also published on the Trust's website.

Yours sincerely

Manjit Obhrai
Chief Executive

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

Complaints, Litigation Incidents & PALS (CLIP) REPORT

1st Quarter 2013/2014

(1st April to 30th June

2013)

Report Title	Complaints, Litigation, Incident and PALS Report 1st Quarter 2013 / 2014
Author	Shirley Munday, Corporate Risk Manager
Department	Patient Safety Directorate
Submitted to	Quality Committee
Submission Date	October 2013
Owner	Director of Patient Safety and Medical Director

EXECUTIVE SUMMARY

The aim of this report is to provide an overview of the information that is collated through the risk managements systems in place to manage complaints, incidents, claims and the PALS service, whilst capturing the learning, and changes to practice. In addition, to report on bench marking of the Trust's performance against other small acute Trusts or Hospitals in this Region that has been udertaken.

BENCH MARKING

National bench marking data has been released in September for Incidents, complaints and claims.

Y Incidents

The National Reporting and learning System (NRLS) gathers information on incidents from all hospitals and then produces reports on a bi annual basis. When bench marking the Trust's performance (Q3 and Q4 2012/13) it has demonstrated that the incident reporting culture has greatly improved and the timing of the submissions of incident reports to the NRLS from the date of the incident has reduced to an average of 34 days. The introduction of the DATIX electronic reporting system has been key to this improvement. However, what has been highlighted is that our proportion of incident reports regarding staffing (25.2%) is significantly higher than the average (7.5%), and communication -7.2% compared to 3.7% as an average of other small Trusts.

Y Complaints

The NHS Information Centre for National Statistics has produced the following Complaints data comparing the QEH with other hospitals in the region. This identifies that the QEH has had an increase in the number of complaints financial year 2012/13 compared to 2011/12 however these are placed in the centre of the group and does not exceed the average.

Y Claims

The NHSLA are now providing a dashboard of data and we are able to compare this Trust with other small acute Trusts with regards to claims data from 2009. Claims for the last year sit very close to the national average. Recent claims have been from Orthopaedics and obstetrics followed by General Medicine and Surgery.

SUMMARY OF INCIDENTS, COMPLAINTS AND CLAIMS Q1 2013/14

During Q1 2013/14 the number of incidents and complaints were reduced slightly compared to the previous quarter, however key themes are clearly identified as risks to patient experience, improvement of quality of care and safety. The main issues identified have been around, staffing, communication.

Trauma and Orthopaedics have the largest increase in number of incidents reported compared to last quarter (mainly around staffing) but the highest reporters are A&E and MAU. When compared to the complaints data these three specialties have received the most complaints and these have been related to staff attitude and communication. However, it should be noted that the *PALS service has recorded an*

increase of compliments received, demonstrating patient satisfaction.

With regards to claims it would not yet be apparent if there are any claims related to incidents or complaints from this quarter however there has been an increase in the number of claims received (29) compared to that last quarter (19). The largest number of claims received are around failure or delay in diagnosis followed by loss or damage to personal belongings.

ACTION TAKEN / LESSONS LEARNED

There has been a considerable amount of action as a result of complaints and incidents during this quarter. The key pointers are:-

- There has been an extensive recruitment drive (both national and international)
- Review of the static mattresses provision to assist in the relief of pressure ulcers
- Introduction of a nationally recognised training programme for chest drain insertion
- Reviews of systems and process and protocols
- Improved communication for patients in A&E by the installation of an electronic information board
- Extra wheelchairs have been purchased to assist patients that are unable to walk along the long corridors

1.5 Conclusions

This has been a challenging period in which staff shortages have been very problematic. However there has been a considerable effort to maintain services, and improve patient experience by all staff as demonstrated by the increase in the number of compliments.

The enclosed report gives further detail on the types of incidents, complaints and claims that have occurred and the numerous changes to practice, as part of the lessons learned.

1.6 Recommendations

It is recommended that the Quality Committee note the contents of this report, acknowledging the benchmarking data on performance compared to other Trusts at a time preceding this quarter, and takes into account the problems highlighted and the lessons learned during this challenging time.

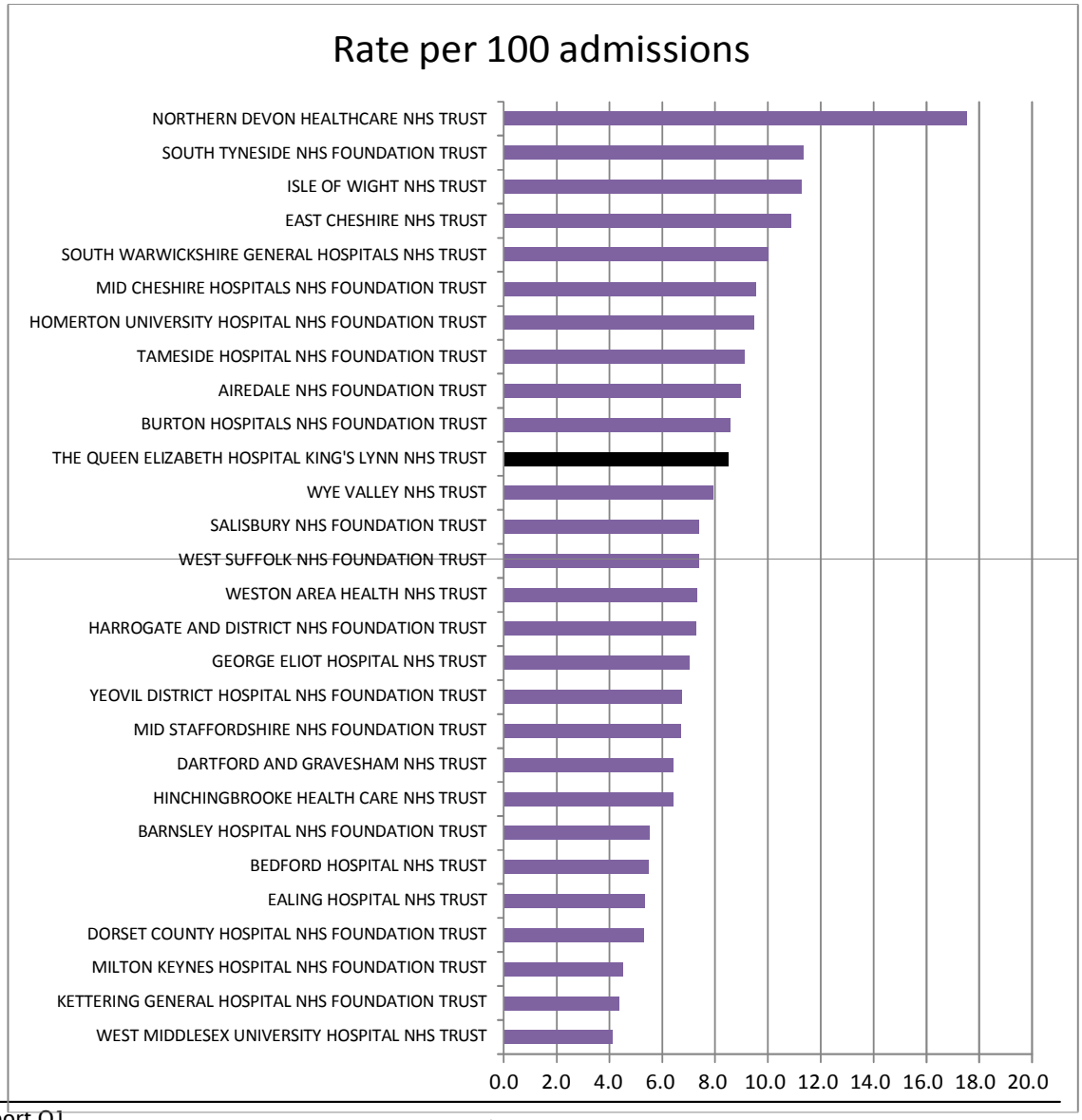
1.0 INTRODUCTION

It is important for the Trust to have a process for the analysis of incidents, complaints and claims to enable learning and improvement. It is acknowledged that aggregated analysis of this data can provide an opportunity for learning and implementing controls to prevent recurrence. Comparing the performance against other similar Trusts assists in the identification of any issues / risks that are emerging.

2 BENCHMARKING

2.1 Incidents

National bench marking data for Q1 2013/14 is not available at this time however to provide the most up to date bench marking data the following information was published in September 2013 and covers the period 1st October 2012 to 31st March 2013. All incidents are reported to the National Reporting and Learning System (NRLS) on a regular basis and this data is analysed every six months. The data compares our Trust against other Small Acute Trusts.



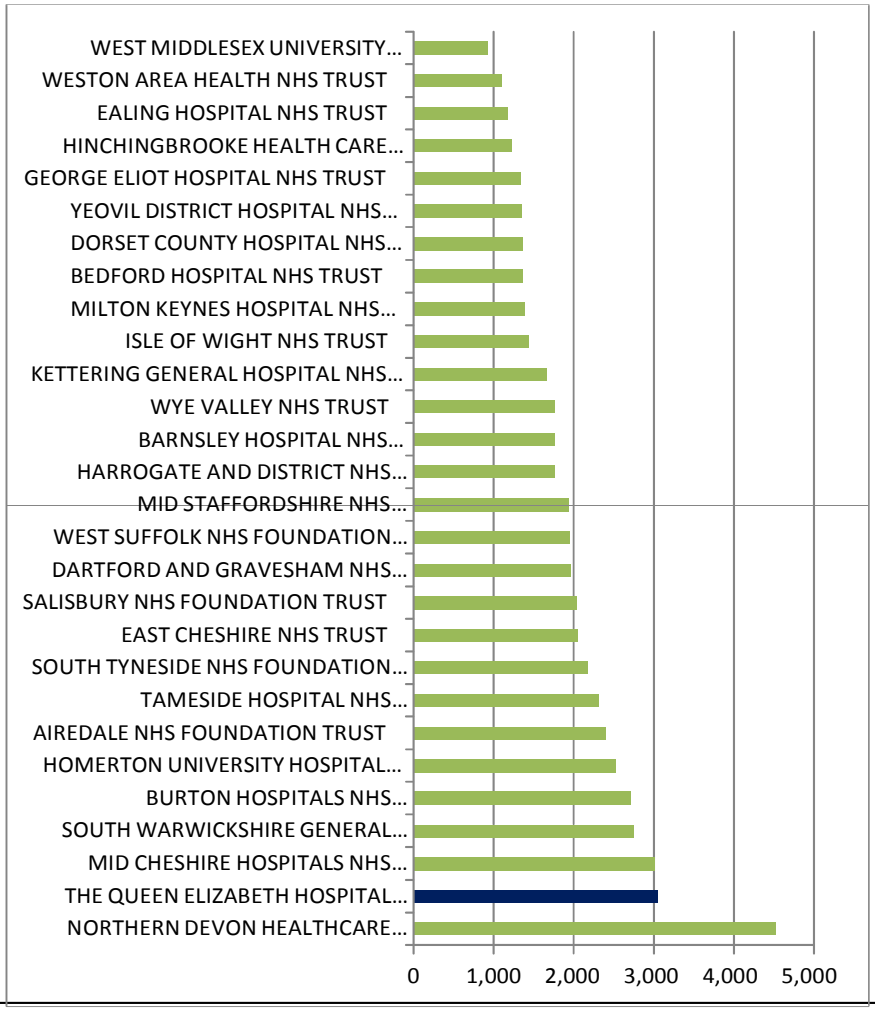
QEH = 8.5% against an average of 7.9%

The following table shows the levels of patient activity within the Trust and how the number of formal complaints, and incidents received compares in percentage terms against 100 admissions. There has been a steady increase on both complaints and incidents over the last year.

	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	Q1 2013/14
Complaints	**113**	**128**	**150**	**168**	**168**
% Complaints per 100 Admissions	0.65%	0.74%	0.86%	0.96%	0.99%
Patient Safety Incidents	1309	1344	1396	1988	1853
% Incidents per 100 Admissions (provided by Trust)	7.58%	7.72%	7.98%	11.37%	10.88%
National Average for incidents per 100 admissions provided by NRLS	6.5		7.9		Data not available

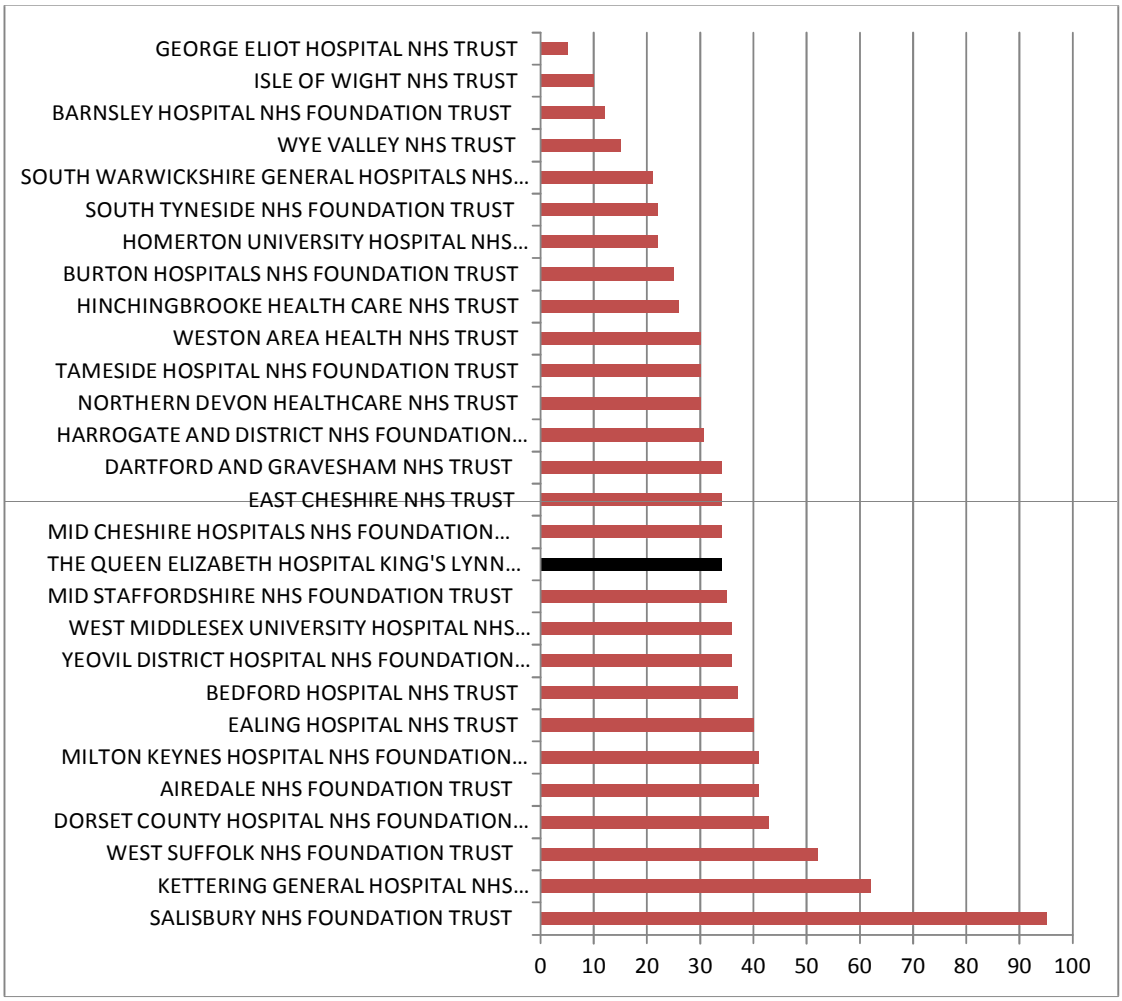
2.1.2 Number of Incidents Reported Q3 and Q4 2012/13

The QEH has moved from the middle quartile on the previous bench marking report to second from the top for the number of incidents reported. This demonstrates an improvement in reporting culture of the organisation.



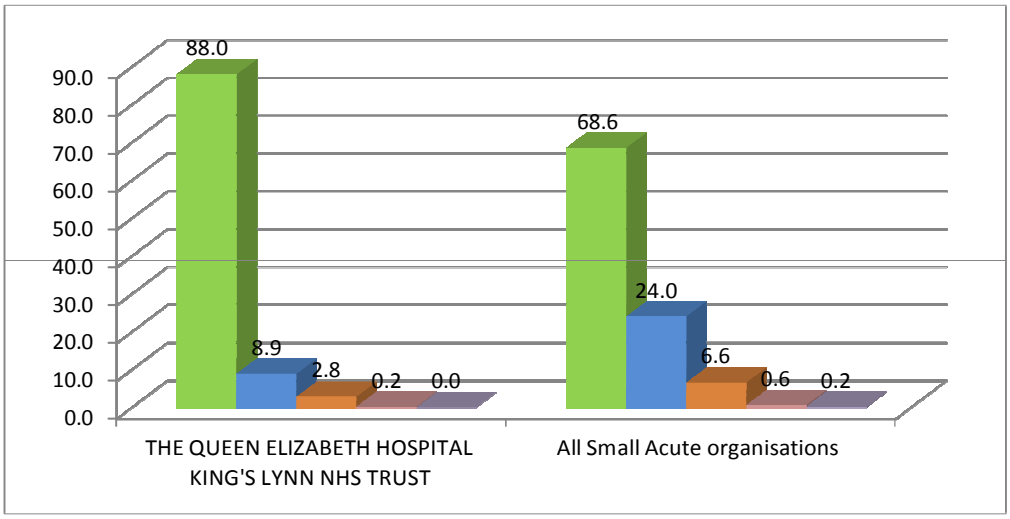
2.1.3 Number of Days from incident to Reporting to NRLS

There has been an average of 34 days between incident occurring and being reported to the NRLS. This is a marked improvement since Datix web was introduced. The table below demonstrates that our performance is in the middle of performance rates against other small acute Trusts



2.1.4 Incidents by degree of harm x average of other small acute Trusts

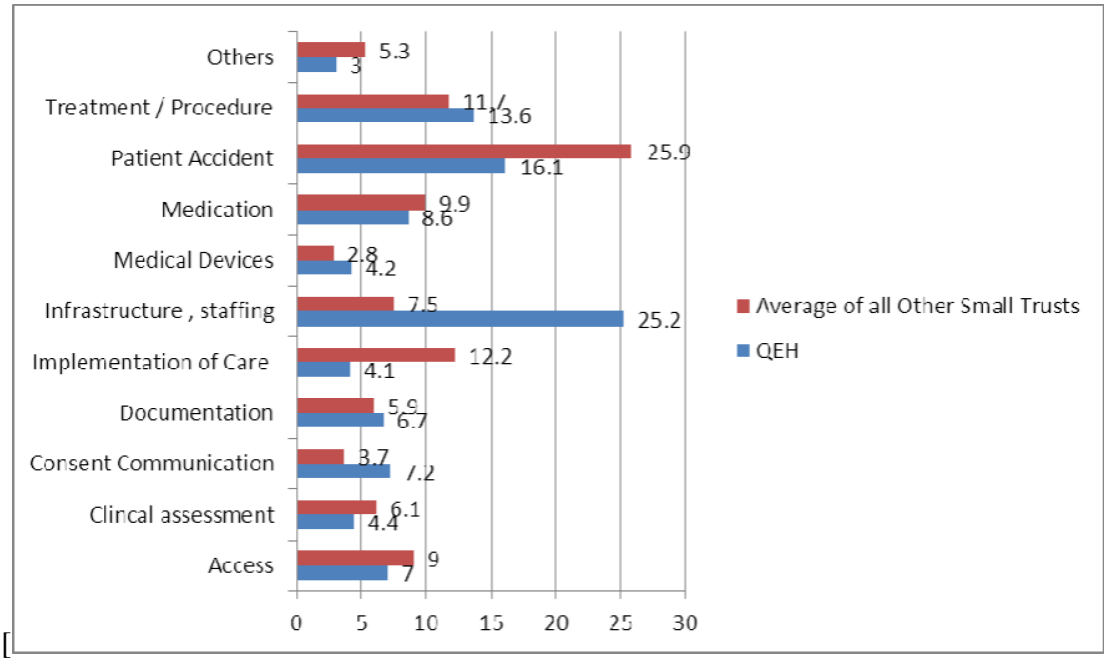
It is recognised that organisations that are high reporters have fewer Major or Catastrophic incidents. (NPSA). For this period the Trust was the second highest reporter and 88% of those incidents were graded as negligible (no harm).



QEH

2682 Harm, 271 Minor, 86 Moderate, 7 Severe and 1Death

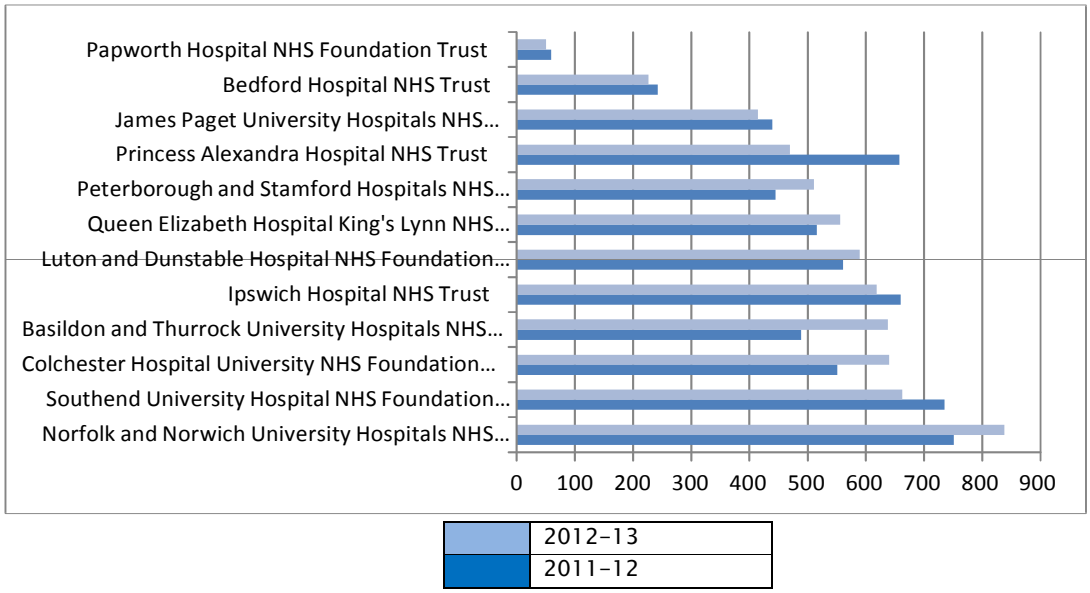
2.1.5 % of Incident Reports by Categories Compared to Average of all other Trusts



Staffing (25.2%) is predominately the highest percentage of incidents that have been reported and during this period compared to an average of (7/5%). followed by communication documentation, medical devices, and treatment and procedure.

2.2 Complaints Bench Marking

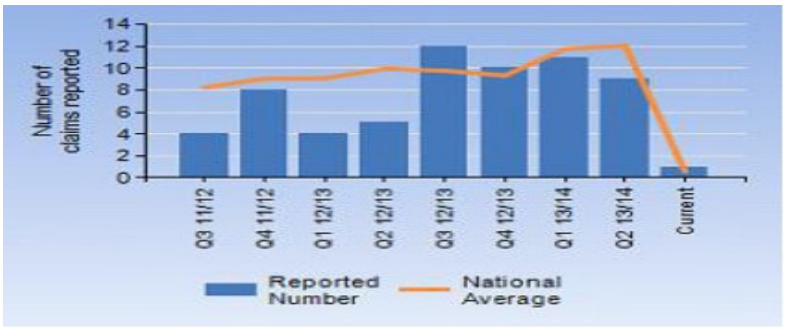
The NHS information Centre for National Statistics produces an annual report entitled "Data on written complaints in the NHS". The following chart identifies the hospitals in this region and the number of complaints 2011 -12 compared to 2012-13. The QEH has had an increase in the number of complaints 2012-13 compared to 2011-2 however these are in the centre of the group.



2.3 Claims Bench Marking

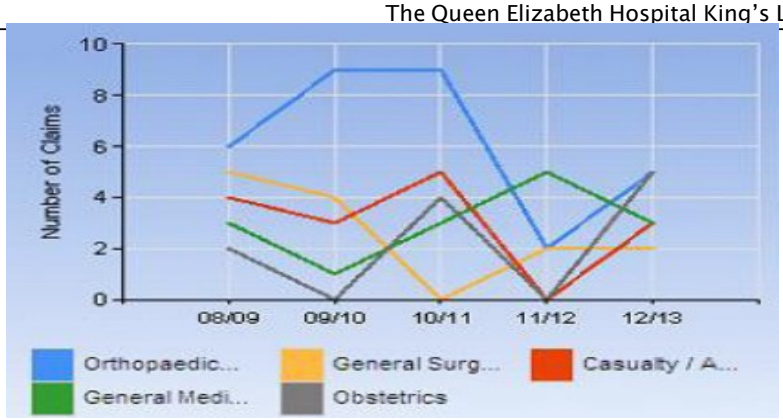
2.3.1 Claims x National Average of all Small Trusts

The NHSLA have redesigned their statistical reports on Claims management and a dashboard of comparable data is available. The chart below represents the number of reported claims by the QEH with a comparison of the average of other small acute Trusts. There was a rise above the average in the number of claims Q3 12/13 but the numbers are very small therefore no worrying trends have been identified.



2.3.2 Claims By Specialty over the last 5 years

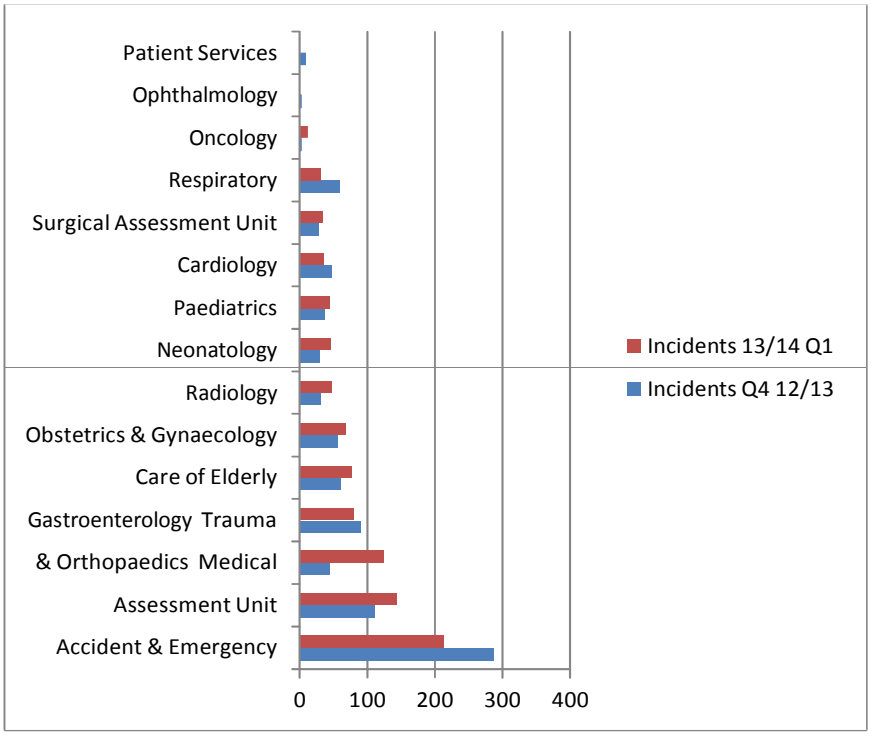
Recent claims have been predominantly from Orthopaedics and Obstetrics followed by General Medicine and General Surgery.


Number of Claims
10
8
6
4
2
0
08/09
09/10
10/11
11/12
12/13
Orthopaedic...
General Surg...
Casualty / A...
General Medi...
Obstetrics

3 AGGREGATED DATA FROM COMPLAINTS AND INCIDENTS (Risk Profile)

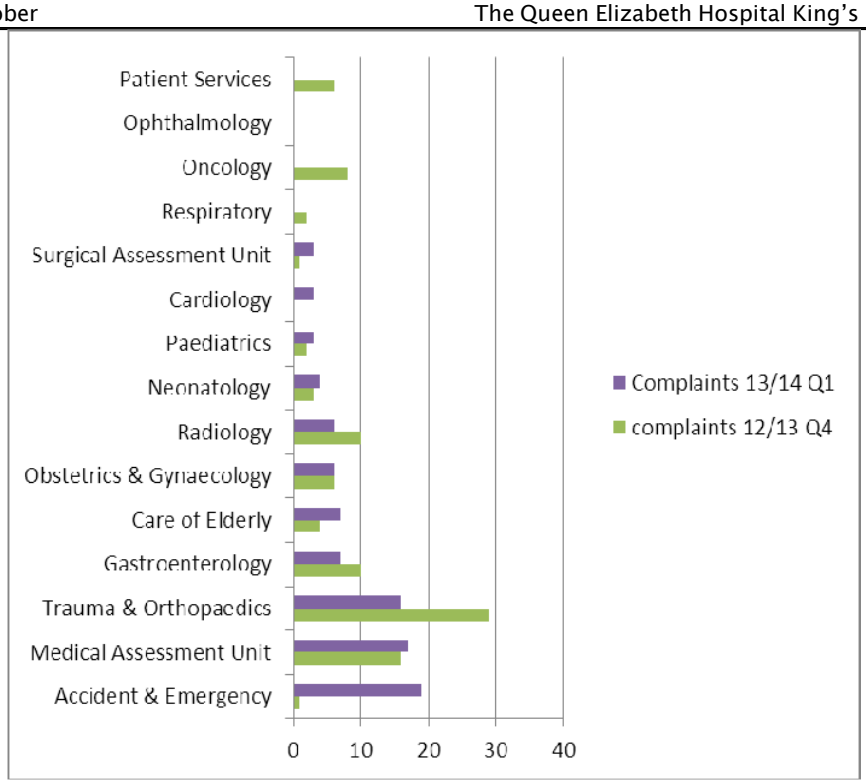
3.1.1 Incidents by Specialty Compared to Last Quarter

Incidents by specialty, provides a clearer picture of where issues have been raised. The largest increase comes from Trauma and Orthopaedics with the highest number of incidents being reported by A&E and MAU, the main themes of these incidents were staffing and lack of beds.



3.1.2 Complaints by Specialty / Department Compared to Last Quarter

The highest number of complaints is for A&E, MAU and Trauma and Orthopaedics however there is a reduction this quarter for Trauma and orthopaedics.

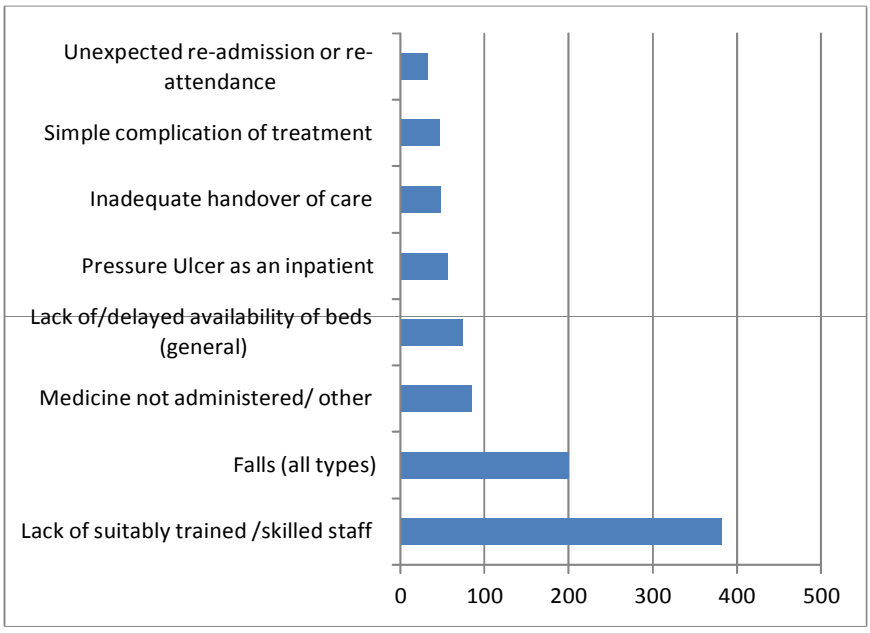


3.2 Top Reported Subjects

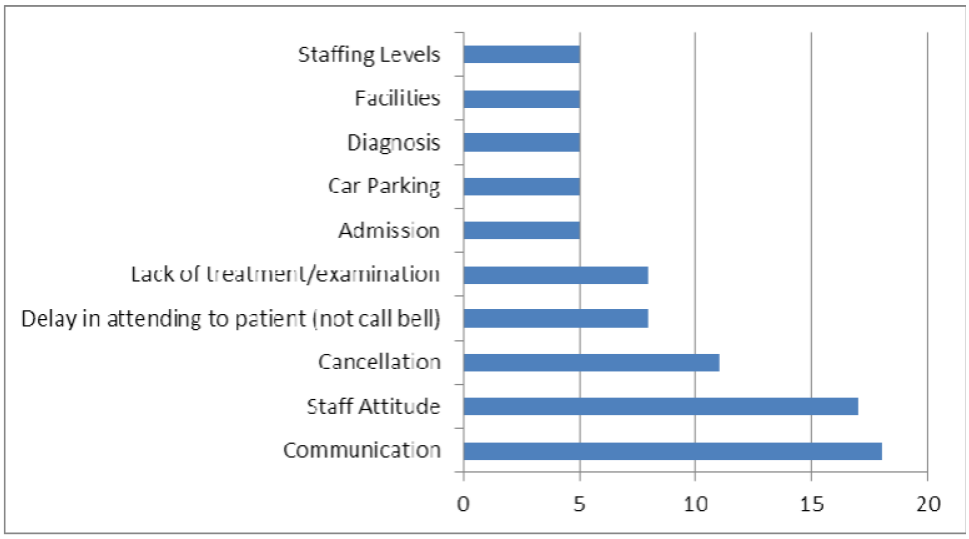
Due to the difference in reporting descriptors and codes required to log internally and report externally, it is not possible to code 'like for like'. However, the tables below indicate the highest type of incident, complaint, and claims received.

It would appear that there is some coloration between Incident reports regarding lack of staff with complaints regarding staff attitude and lack of communications and not answering the call bell.

3.2.2 Incidents



~~2.2.3 Complaints Top Ten Issues~~



~~2.2.4~~ Claims

Of the new claims received this quarter the highest number of claims are relating to delay in diagnosis (8) and loss of personal belongings (6)

3. COMPLAINTS OVERVIEW

3.1 The Trust records all expressions of concern that have been raised, this includes formal complaints that require investigation in addition to informal complaints that are resolved by the department concerned and require no further action.

During Quarter 1, the Trust received 134 formal complaints and 6 informal complaints compared to 168 formal and 11 informal reported in Quarter 4 2012/13. This demonstrates a decrease of 20.2% on formal complaints and a 45% decrease on informal complaints. Of the formal complaints received, 128 were for clinical and 6 were for non-clinical reasons.

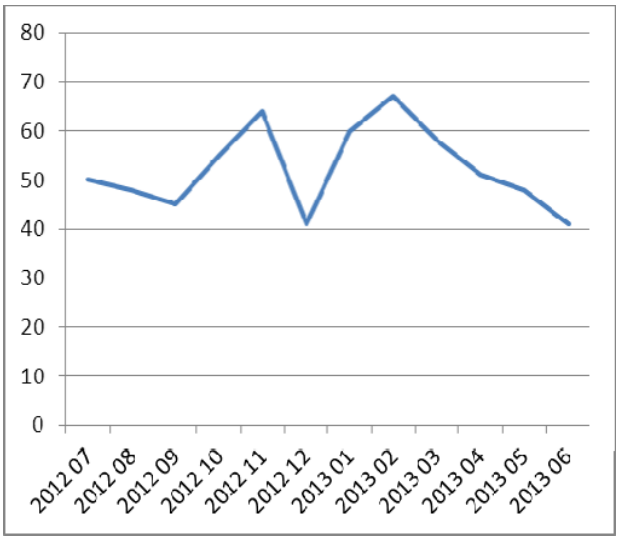
- 80.5% of formal complaints were responded to within the 30-working days. This is an increase of 10.5% compared to the last quarter
- 4 complaints included more than one division
- 2 complaints were multi-agency
- 117 (87.3%) of complaints were resolved following the first response from the Trust.
- 17 (12.6%) complainants requested a second investigation
- 22 conciliation meetings were offered for complaints received during this quarter; to date 16 have taken place
- 97 complaints were recorded as upheld

3.1.2 Actions taken

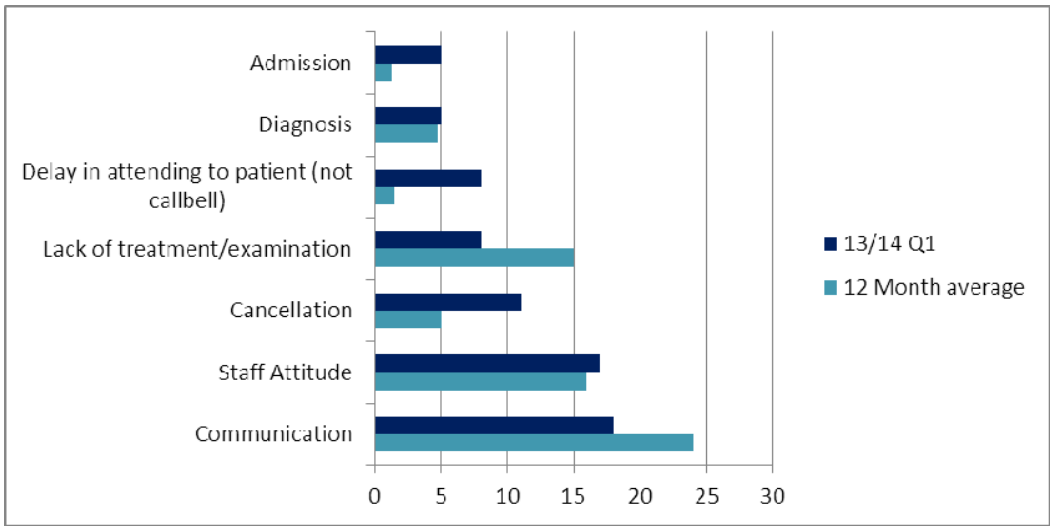
There has been a significant increase in the number of complaints closed within 30-working days. The department has worked hard to raise the importance of compiling the response within the turnaround time.

A new report is now compiled and distributed each month, incorporating information from the Friends and Family Test. This report is broken down by Service Line, sharing how many complaints and PALS enquiries have been received, if they are upheld and if they were responded to within 30 working days.

3.2 Number of Complaints received over the last 12 months

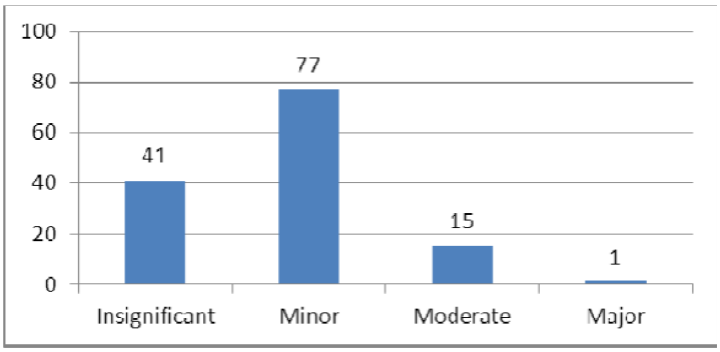


3.3 Type of Complaints Received this Quarter Compared with a 12 Month Average.



There has been a reduction in the number of general complaints in total however increases on staff attitude from nursing staff in A&E) has risen, and delays of attending the call bell has been highlighted as problem in addition to the number of complaints regarding cancellations / admission process

3.4~~Complaints by Severity of Outcome~~



All complaints are graded by severity. During Quarter 1 2013/14:-

- 15 complaints were graded as moderate, of which the subjects included communication, lack of treatment/examination, pain/discomfort, infection control, lack of observations.

- 1 complaint was recorded as major.

  This incident related to a patient who was confirmed as having Diverticulitis and not cancer following an endoscopy, but after the patient had some concerns with her deteriorating health, her GP re-referred her to the hospital, where it was confirmed that the patient did have cancer. This was investigated but concluded that this misdiagnosis reflected the national picture as described in a number of published studies in which cancer in this location can be missed.
  No complaints were recorded as catastrophic

3.5 Independent Review

During the 1st Quarter 13/14 the Trust received one request for an independent review by the Parliamentary and Health Service Ombudsman (PHSO). The complaint file, recording of the conciliation meeting and the patients records were supplied to the PHSO for review and they provided the Trust with their response. The PHSO concluded not to conduct their own review and the complaint has been resolved to a satisfactory level to the complainant and the PHSO following input from the Legal Services Department.

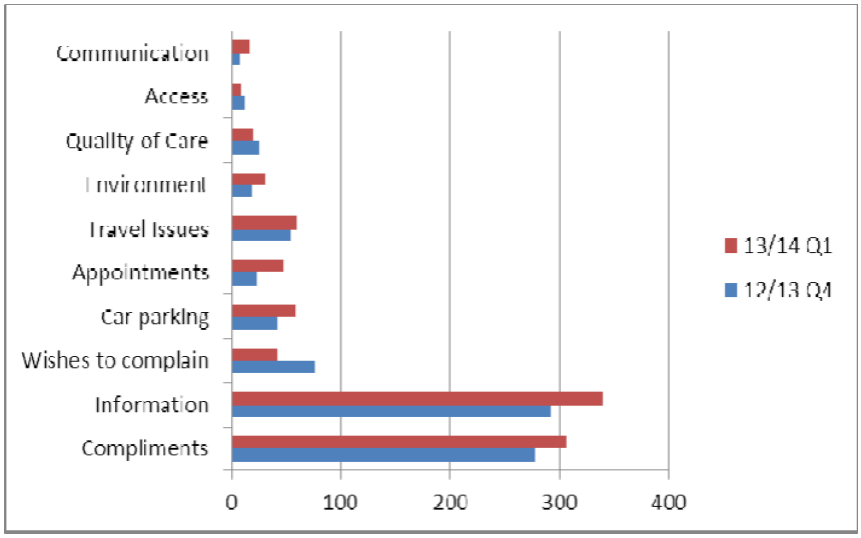
3.6 Learning / Actions from Complaints

- A review of the Acute Oncology Service pathway and bed provision has been undertaken.
- An electronic information screen in the Emergency Department
- Extra Wheel chairs have been purchased to assist patients along the long corridor from Tilney Ward
- Values and Behaviours Workshops are now mandatory for all staff
- Ambulatory Care pathway introduced
- Car park attendants to ensure they regularly check the blue bay's in front of hospital are only being used by patients

4 PATIENT ADVICE & LIAISON SERVICE (PALS)

4.1 PALS enquiries received this Quarter Compared last Quarter

The table below summarises the subject enquiries made through the PALS service for the period of Quarter 1 2013. There have been a total of 949 enquires recorded onto Datix and majority of enquiries were compliments and request for information.

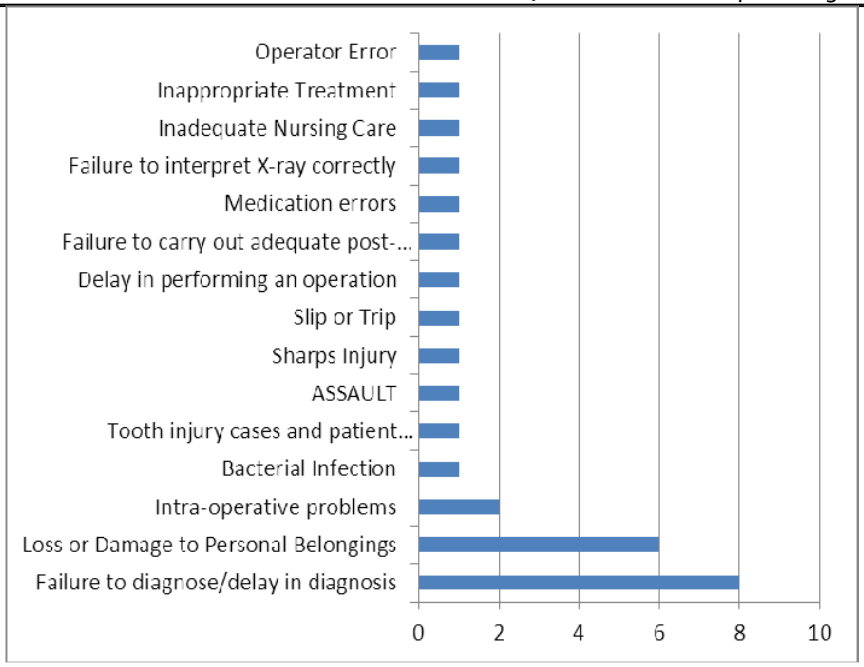


The Patient Advice and Liaison team continue to fulfil their role and provide support to patients, family members and staff members. New uniforms were ordered towards the end of the quarter, to ensure the PALS team are clearly visible and recognisable by both patients and staff members.

A monthly report is produces for all Heads of Departments and Matrons identifying the Compliments received in additions to concerns.
It is of particular note that compliments for this quarter have increased.

5 LITIGATION (CLAIMS)

There have been 29 new clinical negligence claims received. This is an increase on last quarter where 19 claims were received.
Numbers of claims are set out below. Due to the small numbers of these compared to reported incidents and complaints, and the generally late arrival of these following any incident, the statistical significance of any trends is thought to be low or not useful in risk management terms. It may be the case that a serious and gross trend occurs within claims that could have been undetected within complaints or incidents, but that has not been seen this quarter.
The largest number is with regards to failure to diagnose or a delay in diagnosis.



5.2 Details of Claims Closed

During this quarter there have been a total of 4 claims closed. The table belows identifies further details on those claims.

Type	Incident date	Directorate	Location (exact)	Description	Outcome
CNST	25/02/2011	Inpatient Services	Outpatients Department	Developed ruptured tendon whilst on Levofloxacin	Settled
Small Claims	13/03/2013	Non Clinical	Accident & Emergency	Loss of dentures while attending A & E	Settled
Small Claims	14/03/2013	Inpatient Services	Leverington Ward	Ugg Boots lost while staying on Leverington and Feltwell on 14th March 2013	Settled
Small Claims	21/05/2013	Non Clinical	Corridor, Lift, Elevator, Public Areas	Damage to glasses	Settled

6 INQUESTS

Notification of New Inquests with Trust involvement	4
Number of Inquests Held with Trust Involvement	1

One Inquest was held this quarter relating to the Trust. The verdict was:

1. Narrative: Patient died from an overdose of therapeutic drugs and the question

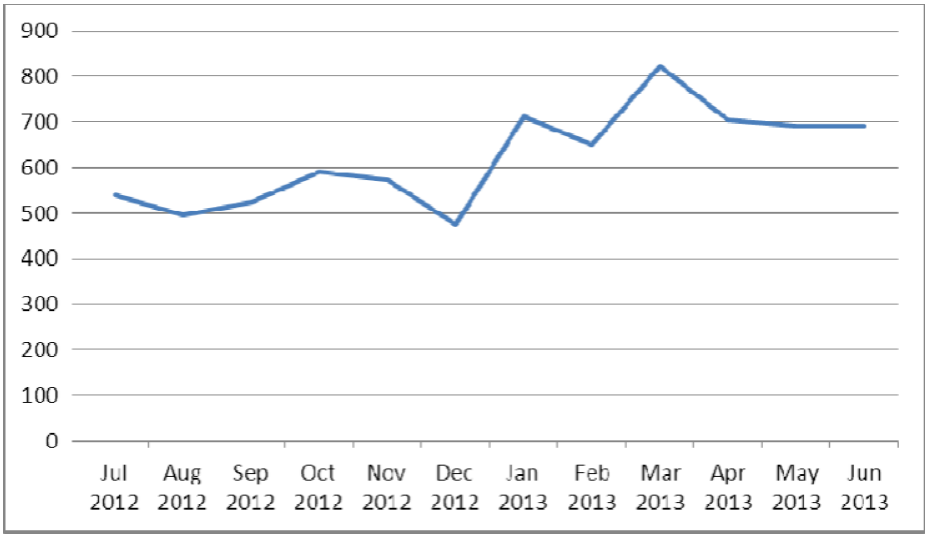
of intent remains unclear

7 INCIDENTS

7.1 There have been a total of 2088 incidents reported during the period Quarter1 2013 /14, compared to Q4 2.12/13 where 2188 incidents were recorded. Monthly reports to local governance meetings and specialist committees are produced to ensure that relevant staff have oversight of both the detailed information and the trends in a timely manner.

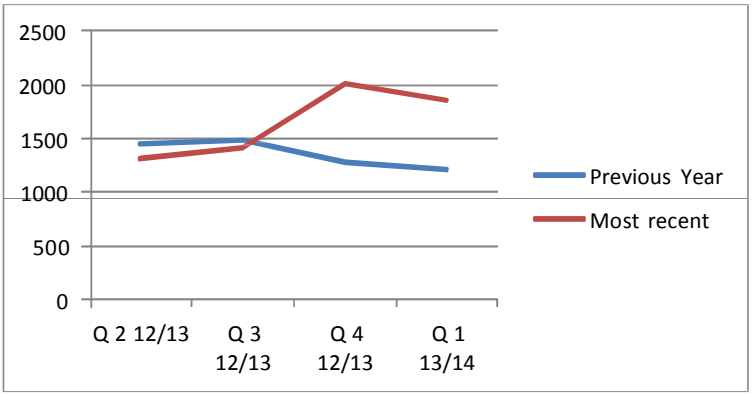
The table below demonstrates that there has been overall increase in the average number of incidents over the last year, beginning in December with the highest peak being in March 2013.

Total Number of Incidents Reports over the last 12 Months



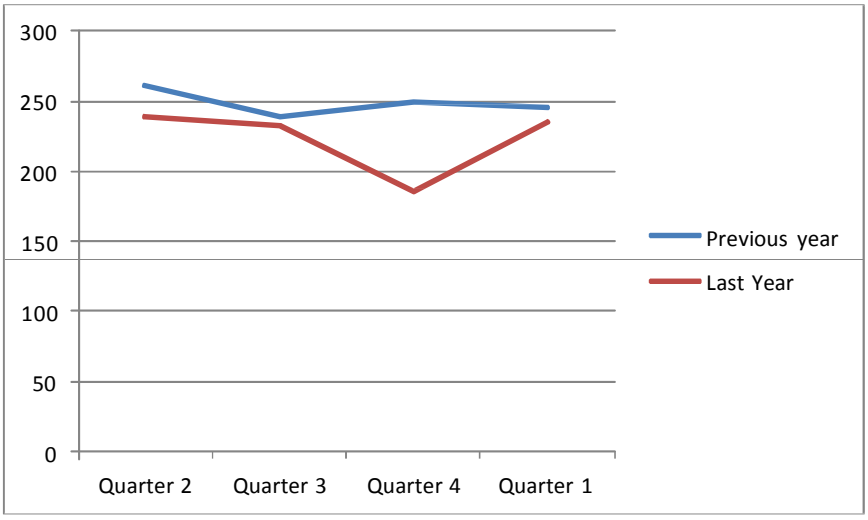
7.2 Clinical Incidents

The graph below demonstrates clinical incident reporting rates compared to same quarter last financial year. Datix electronic incident reporting was introduced in July and the rates have increased significantly.

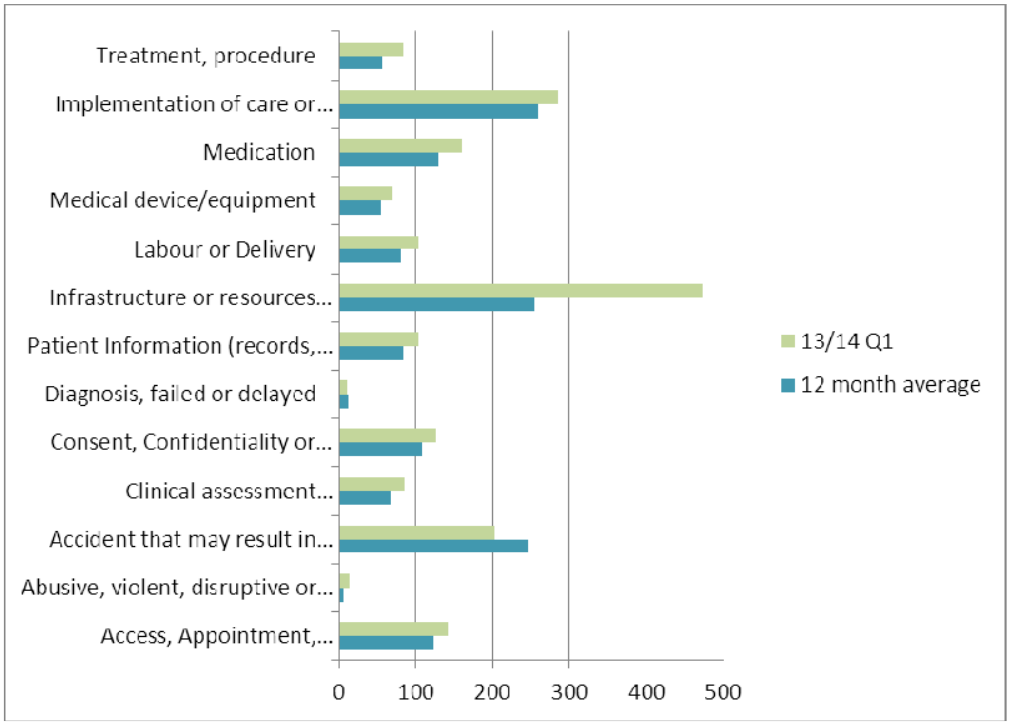


7.3 Non clinical Incidents (Including Health and Safety, fire and Security)

The graph below demonstrates non clinical incident reporting rates compared to same quarter last financial year. It was a matter of concern that the introduction of Datix web might affect the ability of ancillary staff to report an incident however as the graph below identifies there was a reduction on reporting rates Q4 last year there has been a recovery by Q1 13/14.



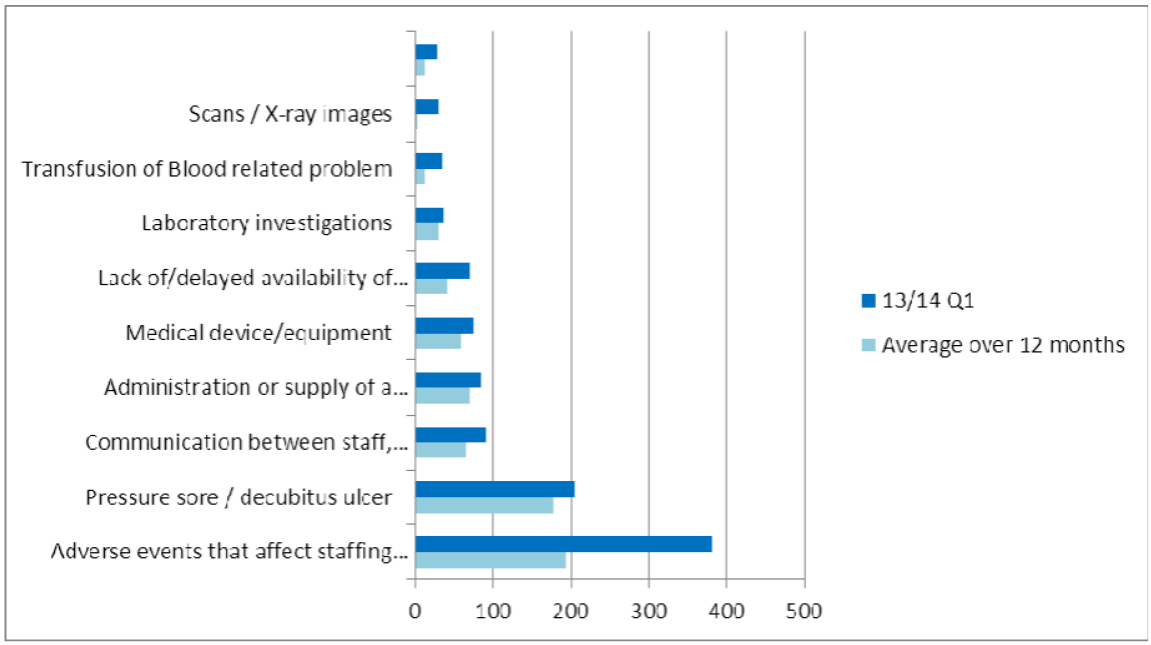
7.4 Detailed Incident Trends Compared to the Average of the previous 12 Months by Stage of Care



The most significant increase has been related to infrastructure or resources, followed by implementation of care. More detail on the adverse event is provided in the table below.

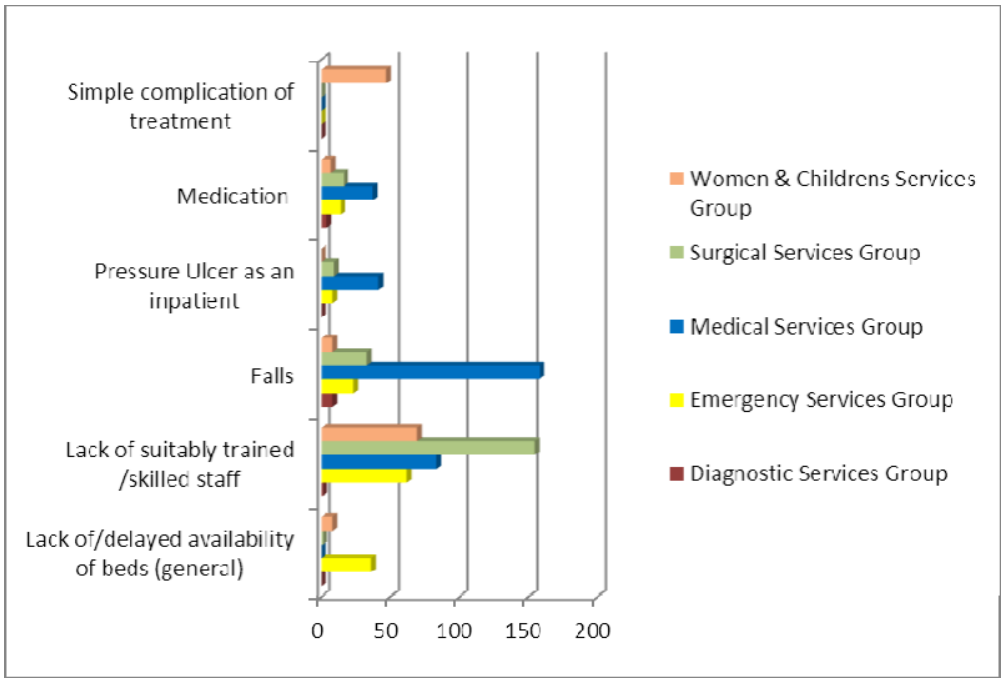
7.4.2 Adverse event

The largest increase has been on reports regarding staffing shortages followed by communication between teams.



7.4.3 Top six adverse events by Clinical Services Group

The table below details the type of incident most reported by the Service Group. Highest reporter of falls is the Medical Services Group, highest reporters of staff shortages is the Surgical Services Group.

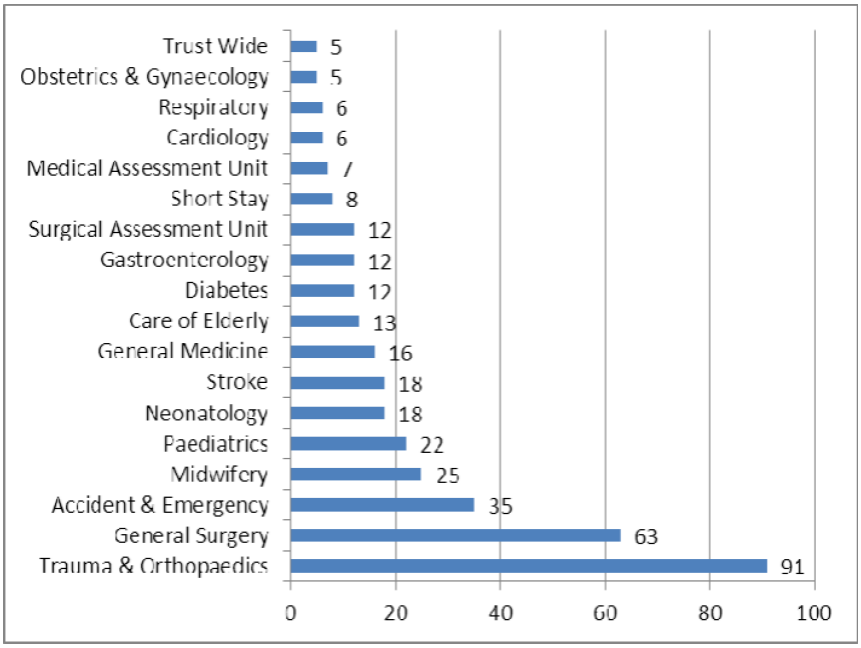


7.4.4 Further Information on Highest reported

Adverse Event Staff Shortages by Speciality

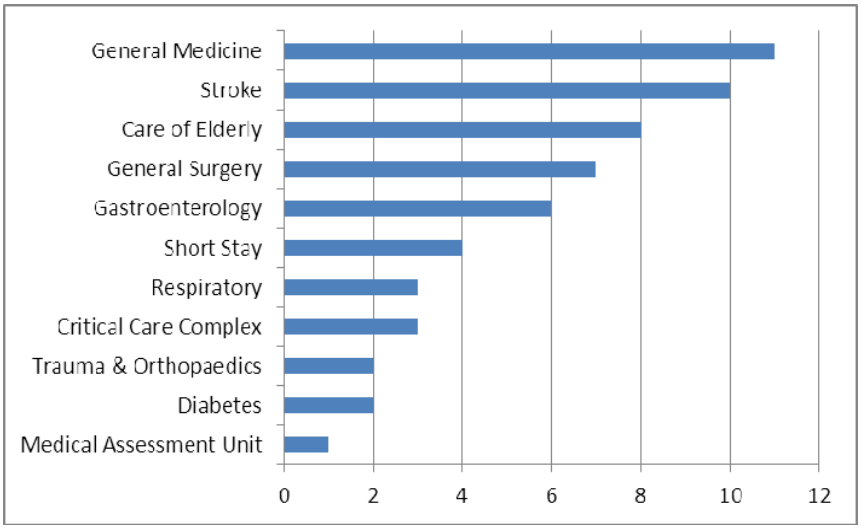
Q1.

Trauma and Orthopaedics, followed by General Surgery have reported the most incidents regarding staff shortages

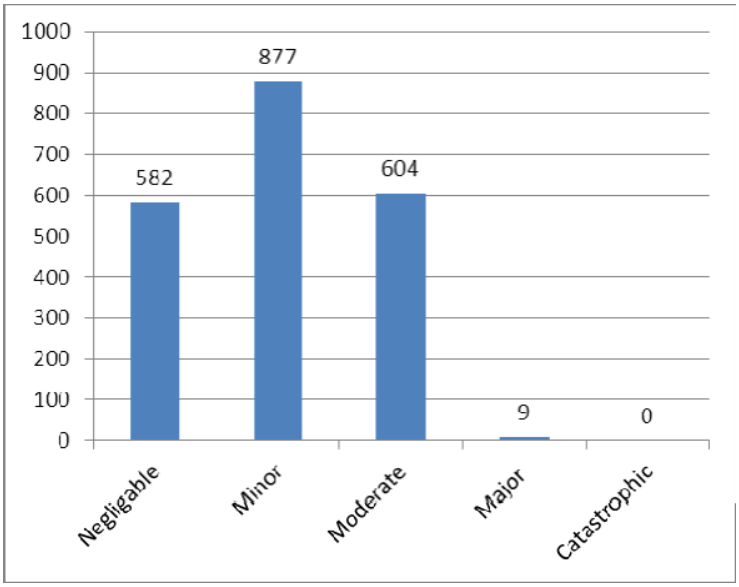


7.4.5 Breakdown of Pressures Ulcers (Hospital Acquired) by Specialty

During this quarter, General Medicine, Stroke and Care of the Elderly have recorded the most hospital acquired pressure ulcers.



7.4.6 Total number of incidents by severity of outcome



There have been no catastrophic (deaths) incidents this quarter and 8 incidents were graded as major.

Of the incidents regarded graded as major 6 have been reported as SI's.
Of the ones not reported as SI's they were regarding:-

- One incident was regarding a collapse of lighting in the BMC where medical records are stored. There were no injuries but the Major category was assigned as this interrupted access to archived patient notes for up to 4 days.
- Lack of Bipap devices, at certain times there are peaks in the demand for this equipment and there is not always enough for each patient. This has been highlighted in the Medical Devices Annual Report and entered onto the Risk Register
- Insufficient beds which is being addressed by the Iflow project and the introduction of the Ambulatory Emergency Care provision.

In addition there were 21 moderate incidents that have had been subjected to further review as they were identified as requiring monitoring.

7.5 Serious Incidents (SI's) Reported during Q1

There have been 19 SI's reported during Q1. Of these SI's:-

- 11 were grade 3 pressure ulcers,
- 5 were falls resulting in serious harm,
- a serious bleed following a chest drain procedure on a Jehovah's Witness in MAU
- a neonatal death
- a failure to act on test results at antenatal clinic resulting in the baby contracting Strep B.

RCA's have been carried out on all incidents and the Trust has received closure on all except for the Neonatal death where the Clinical Commissioning group has decided to "Stop the clock" to enable an independent review to take place.

Action plans are all on track and monitored by the Patient Safety Committee

7.6 ~~Never Events~~

There have been no Never events reported during Q1.

7.7 RIDDOR Reportable Incidents

There have been 8 staff accidents that were classified as RIDDOR reportable. All of the incidents identified below have been reported to the Health and Safety Executive

Contact with very hot or very cold surface	2
Injured while restraining patient (see also ABUSE)	1
Lifting in the course of moving a load	2
Accident of some other type or cause	1
Fall on level ground	2

All have been followed up and training provided where required.

7.8 IRMER

There have been 2 radiation incidents reported to IRMER during this quarter. Both were a request for the wrong patient.
All were followed up with the Consultant or referrer. An action plan has been completed focussing on increasing the understanding and awareness of Junior Doctors.

7.9 Lessons Learned / Action Taken following Incidents

- A comprehensive recruitment drive both nationally and in Portugal has taken place.
- Revision of static mattress with a view to submitting a business case to replace all static mattresses with Invacare pressure relieving mattresses. (actioned in August 2013)
- Junior doctors often lacked competency in insertion of chest drains. A policy , a protocol has been written and the development of a comprehensive training programme including competency assessment involving the QEH, UEA,and other Healthcare Providers in the Region. The first training session was Introduced at the Trust Saturday 14 September 2013. This is available to all Trust Dr's and has been offered externally. Investment in a teaching dummy has been made to ensure that doctors can practice in a safe environment.
- Review of the procedure for antenatal CTG analysis to align with current practice on Delivery Suite and ensure all staff are up to date with training which will include competency assessments.
- Update guidelines on the following:- Caesarean section, Fetal Blood Sampling, Fetal Monitoring
- Trust guidelines on induction of Labour reviewed in light of 2nd Term +14 fetal loss and the guidelines have now been amended to term +12
- An audit is taking place to provide assurance that protocols regarding prophylactic antibiotics required during premature labour are being followed.
- Redesign the master copy of growth charts to ensure that any printed versions can be read / interpreted.
- When staff have been moved from one area to another there is a need to

continually risk assess and monitoring of staffing resources during the 24 hour.

- Daily consultant review is required for any antenatal in-patient, this must be undertaken with documented care plans

- When the patient is a Jehovah's Witness a thoughtful and thorough management plan is required.
- The MAU consultant for the day needs to be on MAU as much as possible supporting and teaching the junior doctors.
- When Doctors asking another doctor to see a patient it should be agreed who is responsible for the follow up care and what that will entail. This needs be documented in the notes.
- It should be clear which nurse is responsible for which patient per shift.
- Protocol on treatment of Hyperkalaemia has been written and training delivered for staff
- A review of the morning and evening medical handover in MAU has taken place to ensure that the Trust is in line with standards. The handover will include the nurse in charge of the shift to ensure that she has a clear picture of what is happening across the floor.
- Laminated GBS information card developed containing all information for staff when calling women regarding their results in midwifery
- Patient Safety Culture Survey was sent out in May 2013 of which results are awaited.

8 Conclusions

This has been a challenging period in which staff shortages have been very problematic. However there has been a considerable effort to maintain services, and improve patient experience by all staff.

The content of this report provides detail on the types of incidents, complaints and claims that have occurred but also demonstrates that there have been an increase in the number of compliments received and numerous changes to practice, as part of the lessons learned.

9 Recommendations

It is recommended that the Quality Committee note the contents of this report, acknowledging the benchmarking data on the performance compared to other Trusts at a time preceding this quarter, and takes into account the problems highlighted and the lessons learned during this challenging time.

POLICY FOR STAFF WHEN EXPRESSING CONCERNS ABOUT STANDARDS OF CARE OR OTHER TRUST ACTIVITIES

'WHISTLEBLOWING'

(MAKING A DISCLOSURE IN THE PUBLIC INTEREST)

Unique Reference / Version				
Primary Intranet Location	Policy Name	Version Number	Next Review Month	Next Review Year
Human Resources	'Whistleblowing' Policy	V2.0	September	2018

Current Author	Adam Kirton
Author's Job Title	Associate Human Resources Business Partner
Department	Human Resources
Ratifying Committee	HR & Education Committee
Ratified Date	September 2013
Review Date	September 2018
Owner	David Stonehouse
Owner's Job Title	Director of Resources

It is the responsibility of the staff member accessing this document to ensure that they are always reading the most up to date version - This will always be the version on the intranet

Related Policies	Capability Policy Complaints Handling Policy and Procedure Disciplinary Policy and Procedure Grievance Policy Mutual Respect Policy Safeguarding Children Policy and Procedures The Management of Adverse Events and Serious Incidents

Stakeholders	Human Resources & Education Committee Recognised Trade Unions All members of staff Voluntary staff Students on placement at the Trust

Version	Date	Author(s)	Author's Job Title(s)	Changes
V1.0	February 2011	Ian Vince	Deputy Director of Human Resources	Initial development
V2.0	September 2013	Adam Kirton	Associate HR Business Partner	Update of existing policy into new format in line with changes in practice, national

Short Description
To advise on the procedures to be followed for staff, volunteers, and students with concerns about standards of care or other aspects of Trust activities.

Key Words
Concerns, Corruption, Fraud, Safeguarding, Whistleblowing

'WHISTLEBLOWING' POLICY

CONTENTS

APPENDICES

'WHISTLEBLOWING' POLICY

1 INTRODUCTION

1.1 The policy of this Trust is that it will strive to create a climate of honesty, transparency, accountability, and openness within the organisation. All staff are encouraged to express their concerns freely within the Trust on all aspects of Trust activities, but particularly on the delivery of care to patients. The expression of such concerns is welcome and will be viewed as a contribution towards improving the services offered to our patients. The Trust is committed to ensuring that staff concerns will be taken seriously, and be fully investigated. The Trust will ensure that staff who raise concerns responsibly and reasonably will be protected against victimisation.

1.2 Ensuring NHS staff are able to voice concerns about standards of care or other aspects of Trust activities provides an important public safeguard. This has on occasion meant NHS staff contacting the press or other media to voice their concerns; this is sometimes referred to as 'whistleblowing', or making a disclosure in the public interest.

1.3 It is acknowledged that all members of staff may find these issues difficult and sometimes sensitive, and it is important to strike the appropriate balance between the ability to raise their concerns whilst at the same time exercising their contractual duty to fidelity to their employer. These guidelines are designed to ensure that a common understanding exists of the circumstances and the manner in which staff should be able to express views about health service issues. The Trust is committed to tackling any difficult issues that arise, and staff who are unsure or unclear on an issue are encouraged to raise their concerns.

2 PURPOSE

2.1 The purpose of this policy is to set out for employees of the Trust how to raise concerns constructively within the Trust, and how to seek advice externally if ultimately they feel compelled to do so.

2.2 This policy has been prepared to take account of the Public Interest Disclosure Act 1998, the NHS guidance set out in EL (93)51 'Guidance for Staff on Relations with the Public and the Media', 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children', the guidance provided by the Public Concern at Work website, and the Principles of Whistleblowing guide from the government, and is updated to incorporate changes to related legislation.

2.3 It shall apply to all employees of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. It also applies to voluntary workers, and students on placement with the Trust. The generic term 'staff' has therefore been used throughout this policy to cover all of these groups.

2.4 In many cases, concerns can be dealt with very effectively through more traditional channels, including, but not limited to, the Capability, Disciplinary, Complaints, Grievance, and Mutual Respect Policies. However, it is accepted that in some cases members of staff may have sound reason for coming forward under the terms of this policy and procedure.

3 DEFINITIONS

3.1 Whistleblowing

The 'Public Concern at Work' charity defines whistleblowing as:

(a) Bringing an activity to a sharp conclusion as if by the blast of a whistle *(OED)*
(b) Raising concerns about misconduct within an organisation or within an independent structure associated with it *(Nolan Committee)*
(c) Giving information (usually to the authorities) about illegal or underhand practices *(Chambers)*
(d) Exposing to the press a malpractice or cover-up in a business or government office *(US, Brewers)*

4 RESPONSIBILITIES

4.1 Director of Resources

The Director of Resources is chiefly responsible for reviewing any concerns that are raised formally under this policy, and has overall responsibility for the Whistleblowing Helpline.

4.2 Deputy Director of Human Resources and Organisational Development

The Whistleblowing Helpline is managed by the Deputy Director of Human Resources and Organisational Development and this individual is responsible for checking any messages left on a daily basis. The Deputy Director will maintain a manual register of issues and subsequent actions taken for all instances of whistleblowing. A summary status report will be provided to the Trust Board when new cases are reported, or when the status of cases changes. The Deputy Director is responsible for appointing a deputy to oversee the Whistleblowing Helpline when absent from the Trust.

4.3 Line Managers

Managers must ensure that all staff are easily able to contribute suggestions about care and delivery of services, and that all concerns raised are dealt with thoroughly and fairly. In the first instance, staff wishing to discuss concerns should approach their immediate line manager, or the most immediate manager available to them. This manager is then responsible for taking action to resolve the issue, and contacting the member of staff raising the initial concern with the outcome of the intervention. If they are unable to resolve the issue directly, they can contact the Whistleblowing Helpline for assistance.

4.4 Local Counter Fraud Specialist

In circumstances where fraud and/or corruption are suspected, staff 'blowing the whistle' may consider discussing their concerns with the Trust's Local Counter Fraud Specialist (LCFS). The LCFS can investigate instances of fraud or corruption without needing to implement the formal procedure detailed in Section 6.2.

4.5 Trade Union Representatives

The Trust recognises the right of accredited trade union representatives to raise issues both within, and outside, the Trust on behalf of their trade union in the legitimate

interests of their members. This may involve local representatives contacting the media or other external bodies to express a view on behalf of the trade union. Nothing in this policy should be seen as affecting this right. In the spirit of good employee relations, the Trust expects trade union representatives to act in good faith on information they reasonably believe to be true, and to seek to have any issues addressed within the Trust in the first instance.

4.6 Divisional Directors, Clinical Directors, Associate Chief Nurse and Deputy Directors

Within the formal procedure for raising concerns at the organisation, 'stage one' meetings should be chaired by the appropriate Divisional Director of Clinical Services, Clinical Director, Associate Chief Nurse, or associated Deputy Director of a non-clinical service. This chairperson is responsible for ensuring the procedures detailed in Section 6.2 are adhered to, must determine any actions as a result of the procedure, or escalate the matter to the Chief Executive in a 'stage two' meeting.

4.7 Chief Executive

Following the 'stage one' process, the Chief Executive or a nominated Executive Director is responsible for chairing the 'stage two' meetings within the formal procedure. They are required to follow the procedures in Section 6.2, to determine the necessary actions to be taken, or to escalate the matter to the Chair in a 'stage three' meeting.

4.8 The Chair of the Trust Board

The final step in the formal procedure for whistleblowing at the Trust is a series of meetings chaired by the Chair of the Trust Board, or a nominated Non-Executive Director. They must follow all of the necessary procedures in this policy, and determine suitable actions to be taken as a result of the process.

5 GENERAL PRINCIPLES

5.1 The individual interests of the patient are paramount, and all staff have a responsibility to seek to ensure that the needs of patients are being addressed appropriately within the Trust.

5.2 Staff have a right and a duty to raise any issue which they consider to be damaging to the interests of patients, and to suggest any improvement. At the same time, staff may also have a responsibility to raise the concern with their professional body. Nothing in this policy should be seen as replacing the duty of a registered professional to raise matters of professional practice with a professional registering body where this is appropriate.

5.3 Employees will be supported by senior staff within the Trust so that they can express their views within the Trust, provided that:

- They have a reasonable belief that the disclosure is in the public interest.
- The member of staff reasonably believes that the information given and any allegations contained in it are substantially true.
- They are not made for the purposes of personal gain.
- Staff use the proper channels which are outlined in this policy.

5.4 Should a member of staff have a concern about something he or she feels ought to be addressed, effort should be directed to trying to ensure that the issue is not raised in such a way that confuses the message with the messenger. The following questions from 'Public Concern at Work' may help to create clarity around whether, or how, to raise a concern:

- Is someone (e.g. a patient) unaware that they are being exposed to a risk that you would not take, or expose your loved ones to?
- Do you believe that any of your colleagues or your team would answer the question in the same way?
- If the tables were turned and someone had a concern about your clinical practices, how would you want them to raise the issue?
- How can the risk be addressed so that the least damage is caused to the colleague involved?
- Have you talked to your colleagues or your team? If not, why not?
- Can you find a solution within your team?
- Who in the hospital will be dealing with the fallout if your concern is not raised and it proves well founded?
- If you have known of the risk for some time, why are you minded to raise the issue now?
- What do you think would be a satisfactory outcome?
- What obstacles are there to it?
- What is your motivation?

5.5 Before 'blowing the whistle' it is important to remember that a 'whistleblower' is a witness, not a complainant. The approach needs to let the facts speak for themselves and allow those responsible to take an informed decision.

6 PROCEDURE

Set out below are the steps which should be followed by members of staff if they have concerns about standards of care, or other aspects of Trust activities. It may be appropriate to omit some of the stages and staff may choose an entry point to these stages appropriate to the circumstances.

For the informal and formal procedures relating to concerns raised around child protection and child safety, please refer to the Trust's Safeguarding Children Policy and Procedures.

6.1 Informal Procedure

In the first instance, staff should discuss any concern with their immediate line manager or in an emergency with the most immediate manager available. If the concern is about their manager, then staff should contact the appropriate service manager or the Director of Resources. Out of hours, staff should contact the relevant on-call director via switchboard. In circumstances where fraud and/or corruption are suspected, staff may also consider discussing their concern initially with the Trust Local Counter Fraud Specialist (contact details in Appendix 2) or a senior member of the Trust Finance or Human Resources Departments.

If action is appropriate then this will be taken as a priority by the manager to whom the concern has been reported, and the staff that raised the concern will be notified of the

outcome. Such cases can often be 'mainstreamed' using alternative Trust policies such as the Grievance Policy, Mutual Respect Policy, Disciplinary Policy and Procedure etc.

If the member(s) of staff is/are still concerned despite the outcome of the above, they should be told how to pursue the matter further through the formal procedure set out below.

6.2 Formal Procedure

For all whistleblowing issues that do not concern child protection or child safety there are three stages through which members of staff can raise concerns, reflecting the Trust's management structure, up to and including members of the Trust Board. Non-Executive Directors, including the Chair, have a particularly important role in reviewing issues raised as concerns by members of staff.

At all stages of the formal procedure, a meeting will take place and the outcome will be recorded. Recognising the potential sensitivity of such issues, staff should have the right to be accompanied by a representative.

Setting of timescales is difficult because of the sensitive nature of the matters which are being discussed. However, in order to ensure that the issues are dealt with swiftly and responsibly, it is recommended that the response time for arranging a meeting and an outcome being notified should be no longer than two weeks at each stage. Flexibility around timescales may be necessary, particularly at stages two and three, subject to the availability of the nominated Trust officers.

The following are the persons at each stage of the process who would consider a concern raised formally under this policy, and who would chair the meeting:

Stage One: Divisional Director of Clinical Services, Clinical Director, Associate Chief Nurse, or associated Deputy Director of a non-clinical service as appropriate.
Stage Two: Chief Executive or other Executive Director. Stage
Three: Chair or other Non-Executive Director.

The person chairing the meeting may wish to call other members of staff (e.g. the line manager who first considered the member of staff's concern) or external professional advisers to the meeting. The concern may then need to be investigated and any action taken as appropriate to address it. The member of staff who raised the concern will be informed of the outcome of the investigation and any resulting action as deemed appropriate.

6.3 Whistleblowing Helpline

If staff are in doubt about what they should do, or they wish a nominated officer to progress their concern, they may leave a message on the secure, dedicated Whistleblowing Helpline on extension 3949 (for calls from outside the Trust, use the full number 01553 613949). Messages should include the caller's name, contact details, and a brief outline of the issue (for details on anonymous calls, see Section 6.4).

The Helpline will be checked daily on Monday to Friday by the Deputy Director of Human Resources and Organisational Development, and action will be taken to respond to any messages left. A manual register of the issue and subsequent action taken will be

maintained, and a summary status report provided to the Trust Board when new cases are reported, or when the status of current cases changes up to and including 'closed cases'.

6.4 Anonymous Concerns

Individuals are encourages to put their name to any disclosure they may make. This can be an issue when complaints are raised via the telephone and particularly via the Whistleblowing Helpline. It should therefore be understood and accepted that concerns expressed anonymously are more challenging to address, but may still be considered at the discretion of the Trust. In exercising this discretion, the factors to be taken into account may include:

- The seriousness of the issues raised.
- The credibility of the concern.
- The likelihood of being able to confirm the allegation from attributable sources.

Depending on the disclosure wishing to be made, anonymous concerns can also be submitted online via Datix Incident Reporting.

7 RAISING ISSUES OUTSIDE THE TRUST

7.1 A member of staff who has exhausted the formal procedure, but still remains concerned, may wish to write to the Secretary of State for Health if appropriate. If their concern is about fraud and/or corruption, they can also contact either the Trust's Local Counter Fraud Specialist on 07929 207174, or the NHS Fraud and Corruption Reporting Line on 0800 028 4060.

7.2 The various professional bodies and trade unions can also be contacted if they have not already been involved under the formal procedure set out in Section 6. See Appendix 2 for addresses and telephone numbers.

7.3 If, having gone through all established procedures set out in this document, the member of staff is still concerned, they may decide to go to the media. However, this is something which should be approached with caution, information given unjustifiably or maliciously to the media may unreasonably undermine public confidence in the health service, and therefore disciplinary action may ensue if the appropriate procedures have not been followed.

7.4 For reference, the following paragraphs set out the issues around 'confidentiality' and 'fidelity' which may need to be considered if a member of staff is contemplating contacting the media:

7.5 All staff have a duty of confidentiality to patients. Unauthorised disclosure of personal information about a patient is unacceptable and is likely to lead to disciplinary action. Only in very unusual circumstances would it be considered that the public interest, taking account of the rights and freedoms or legitimate interest of any person, outweighed the patient's right to privacy.

7.6 All employees have a duty of fidelity to the Trust as their employer. This includes acting in a way which would damage the reputation of the Trust and the services it provides. Again, it would only be in very unusual circumstances that the public interest would be considered to outweigh this duty.

7.7 Any member of staff considering disclosing information to the media or otherwise into the public arena is very strongly advised to first seek specialist advice. A list of possible sources of advice is attached at Appendix 2.

7.8 Section 5 outlines the use of accredited trade union representatives to assist staff in implementing this policy.

8 FURTHER INFORMATION

Further information regarding this policy can be obtained within the Trust from Human Resources, or for child protection and safety concerns from the Patient Flow Business Group. Sources of external information and guidance are set out in Appendix 2.

9 EQUALITY STATEMENT

A Stage 1 (Screening) – Equality Impact Assessment has been undertaken, and no negative impact on any group was indicated (see Appendix 1)

10 DISSEMINATION OF DOCUMENT

Following approval by the Joint Staff Consultative Committee, this policy will be submitted to the Human Resources and Education Committee for ratification. This policy will be uploaded onto the hospital intranet site under Human Resources. Policy notification will be through an email to all staff members within the Trust.

11 REFERENCES

11.1 Legislation

Fraud Act 2006
Public Interest Disclosure Act 1998

11.2 Guidance

EL(93)51 'Guidance for Staff on Relations with the Public and the Media'
Letter from Mike Deegan, Acting Director of Human Resources 'Freedom of Speech in the NHS' dated 25 September 1997.
Letter from Alan Milburn, Minister of State for Health 'Freedom of Speech in the NHS' dated 25 September 1998.
Principles of Whistleblowing guide.

12 MONITORING COMPLIANCE

Key Elements (Minimum Requirements)	Process for Monitoring (e.g. audit)	By Whom (individual / group / committee)	Frequency of Monitoring
Ensuring an effective Whistleblowing Helpline is maintained.	A dedicated telephone line, regularly promoted via policies and general communications is 'manned' from 08:00 – 17:00 on weekdays, with functions to leave a message, or to divert	Deputy Director of Human Resources and Organisational Development.	Ongoing.
Documenting all calls received and messages 'followed up'.	A handwritten record of all telephone calls received on the Whistleblowing Helpline is maintained, and the logs are locked away when not in use. This is used to capture	Deputy Director of Human Resources and Organisational Development.	Ongoing – for each new instance of whistleblowing.
Effective case summaries produced and disseminated.	This is a document produced for the purpose of presenting a summary update to various committees as required from time to time. Personal details are removed to preserve confidentiality. It also	Deputy Director of Human Resources and Organisational Development.	Ongoing – for each new instance of whistleblowing, and for each necessary committee
Case summaries are reviewed to determine trends and progression.	The case summaries allow for 'at a glance' reviews of emerging trends and potential problem areas, and an indication of the	Various committees; BoD, TEC, HR & Education, Audit	As and when required.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Tool

(To be completed and attached to any policy document when submitted to the appropriate committee for ratification.)

STAGE 1 - SCREENING

Name & Job Title of Assessor: Adam Kirton, Associate HR Business Partner	Date of Initial Screening: September 2013
Policy or Function to be assessed: 'Whistleblowing' Policy	

		Yes/No	Comments
1.	Does the policy, function, service or project affect one group more or less favourably than another on the basis of:		
	• Race & Ethnic background	No	
	• Gender including transgender	No	
	• Disability:- This will include consideration in terms of impact to persons with learning disabilities, autism or on individuals who may have a cognitive impairment or	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
2.	Does the public have a perception/concern regarding the potential for discrimination?	No	There is no known reason for the public to have any concerns with this policy

If the answer to any of the questions above is yes, please complete a full Stage 2 Equality Impact Assessment.

Signature of Assessor: Adam Kirton, Associate HR Business Partner Date: September 2013

Signature of Line Manager: Georgina Goodman, Assistant Director of HR Date: September 2013

APPENDIX 2 – POSSIBLE SOURCES OF ADVICE

This list is not exhaustive, but staff may wish to contact one of the following if considering raising a concern about the standard of care or any aspect of Trust activities. This is very strongly advised if a member of staff is contemplating contacting the media.

- A recognised trade union *e.g.* UNISON, UNITE, RCN, BMA *etc.*

- Professional bodies *e.g.* GMC, NMC, GPhC *etc.*
  The NMC has issued guidance in the form of a booklet entitled 'Raising and Escalating Concerns'. This covers the role of the nurse or midwife in raising concerns, how to raise a concern, and the legislation in place to protect the concerned party. Copies of the guidance and further information such as a flow chart of the stages in the process can be obtained via the NMC website.

- The charity 'Public Concern at Work'. Tel 020 7404 6609.
  This is a whistleblowing charity with a legal advice centre designated as such by the Bar Council. Through its helpline, its lawyers can provide confidential advice, free of charge, to people concerned about wrongdoing at work, but who are not sure whether, or how, to raise the concern. Information that is disclosed to it in the course of seeking advice is protected under the Public Interest Disclosure Act. It can advise on other regulatory bodies such as the Health and Safety Executive etc.

- Government-funded Whistleblowing Helpline. Tel 08000 724 725.
  This is a service for all staff and employers in the NHS and social care sector that offers legally compliant, unbiased support and guidance to ensure you can act in accordance with your values.

- NHS Executive/Department of Health for Secretary of State. Tel 0113 254 4000.

- The NHS Fraud and Corruption Reporting Line. Tel 0800 028 4060.

- The Trust's Local Counter Fraud Specialist via the Trust Switchboard.

James Paget University Hospitals NHS
NHS Foundation Trust

Report to	Norfolk Health Overview and Scrutiny Committee
Date	29 May 2014
Title	Complaints Report
Sponsoring Director	Director of Nursing, Quality and Patient Experience
Author	Anna Hills, Associate Director of Governance, Safety and Compliance

Introduction

The Trust's Chief Executive, Christine Allen, received a request from Maureen Orr, Scrutiny Support Manager (Health), to provide a report to the Norfolk Overview and Scrutiny Committee on 29 May 2014. The Trust was asked specifically to provide the following information:

- *Copies of the latest complaints report taken to your Board (if it meets in public) and to your Council of Governors;* You have been provided with links to the following reports on our website:
  - Complaints Report February 2014
    http://www.jpaget.nhs.uk/documents/About_Us/Board_of_Directors/28_February_2014/28022014_Quality_Sit_RepLL___PUBLIC.pdf (page 19)
  - Annual Complaints Report June 2013
    http://www.jpaget.nhs.uk/documents/trust_board/28_June_2013/280613_Complaints.pdf
  - Quality Report February 2014
    http://www.jpaget.nhs.uk/documents/About_Us/Board_of_Directors/28_February_2014/28022014_Complaints.pdf

There is information regarding complaints provided monthly to the Board of Directors. The latest reports for the April Board meeting are available on the Trust website.

http://www.jpaget.nhs.uk/documents/Board_of_Directors_25_April_2014_/25042014_Quality_Report___PUBLIC.pdf (page 18)

- *The number of issues raised with PALS and the number of those that progress to formal complaint;*

Month and Year	Number of PALS enquiries	Number converted to formal complaints
Apr-13	193	24
May-13	174	8
Jun-13	111	29
Jul-13	112	19
Aug-13	147	4
Sep-13	134	8
Oct-13	136	7
Nov-13	136	3
Dec-13	62	3
Jan-14	93	3
Feb-14	104	24
Mar-14	101	8
TOTAL	**1503**	**108**

- *The number of formal complaints received each quarter over the past two years;* this detailed information is available within the reports referred to above and also see table below.

Quarter	12-13 (Total = 415)	13-14 (Total = 267)
1	107	73
2	118	64
3	93	67
4	97	63

- *Details of how the hospitals compares with national benchmarking in terms of complaints received;* national benchmarking data regarding complaints is not readily available. However the Trust has been participating in the Norfolk wide review of Complaints by HealthWatch and hopes to receive some useful benchmarking information following completion of this.

- *Examples of changes in practice in response to complaints;* the reports to the Board of Directors included above contain examples of changes to practice following complaints and adverse incidents. Furthermore, there is detail contained within the Quality Account. A draft of the 2013/14 Quality Account was shared with NHOSC on 11 April 2014.

- *Your whistle-blowing policy:* The whistleblowing policy is currently subject to review and updating. We hope to be able to share a final draft with you at the meeting if required.

- *The number of whistle-blowers in the past 2 years;*

	2012/13	**2013/14**
Number of whistle-blowers	1	4

- *Information about any use of gagging clauses in staff contracts or severance agreements in the past 2 years;* The Trust does not use gagging clauses.

- *Information on where members of the public can get information on the level and nature of complaints about the hospital;* as detailed above there is monthly reporting to the Board of Directors regarding complaints, which is publicly available via the Trust's website. Furthermore, there is detailed information within the Trust's annual Quality Account which is also publicly available.

Title: **Healthwatch Norfolk – Report on NHS Complaints Handling in Norfolk**

Authors: **Alex Stewart and Christine MacDonald - Healthwatch Norfolk**

Date: **29th May 2014**

1.0 Introduction

1.1 Healthwatch Norfolk (HWN) identified a need to assess the NHS complaints handling in Norfolk. For the purposes of the report HWN has only focussed on NHS complaints handling but will be reviewing later in the year whether there is a need to carry out a similar piece of work focussing on the handling of complaints solely about social care.

1.2 The purpose of the report is to outline how the complaints handling process operates at present, identify good practice and make recommendations for improvements. The report also identifies the ongoing role for HWN in monitoring NHS complaints handling in Norfolk.

2.0 Background

2.1 Members will be aware that there have been a myriad of national reports published in the past 18 months. The complexity as to how complaints relating to the NHS are dealt with is clearly considered to be both important and topical. HWN originally commissioned POhWER (independent complaints advocacy provider for Norfolk) to research the issues. However, failure to produce a detailed report has resulted in HWN having to undertake further work with acute and community providers; completion of this work is due to be finalised by the beginning of June.

2.2 Members need to be aware that recommendations that are currently in the report may change once the research study has been completed.

2.3 The issue of complaints handling, brought to the fore as a result of the Mid-Staffordshire NHS Trust Enquiry, recognised that complaints are regarded as an issue of great concern to the public. Healthwatch England's Chairman - Anna Bradley – said:

"The system is incredibly complex and gets in the way of people making complaints about poor care".

A survey carried out by Healthwatch England (HWE) last year stated that 54% of people who experienced a problem with health or social care did not report the matter. Since April 2013, 53.5% of the enquiries received by HWN have related to the complaints process. This is one of many reports that highlights concerns about the complaints process. HWE have identified that there are more than 75 different types of organisations involved in the health and care complaints system.

Appendix 1 lists other recent reports that have included comments and recommendations about improving NHS complaint handling and which illustrates the national focus on this subject.

3.0 The Complaints Framework

In recognition of the complicated scenario, HWN has published a diagram on its website to help patients and their families through the maze of potential organisations and contacts (see Appendix 2).

http://www.healthwatchnorfolk.co.uk/sites/default/files/complaintsinfographic3_2.pdf

The diagram illustrates that some organisations (e.g the hospitals) handle the complaints themselves whereas the Clinical Commissioning Groups (CCGs) have a Service Level Agreement with the Commissioning Support Unit to handle the complaints on their behalf. The CCGs are responsible for commissioning local healthcare services.

Should a patient wish to make a complaint about primary care services (e.g., GP, dentist, optician and pharmacist), in the first instance, this is dealt with by the service provider. If this is not resolved by the individual service provider to the complainant's satisfaction, then the matter should be dealt with by NHS England (NHSE) as the commissioner of primary care services. NHSE also commission a number of specialist services including prison healthcare. This brief explanation of which organisation deals with different complaint issues illustrates the complexity of the system.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 introduced new legislation for complaints handling. The previous 3 tier system was replaced by a 2 tier system – local resolution followed by referral to the Parliamentary and Health Service Ombudsman (PHSO). The previous timescale for handling complaints (25 working days) was replaced by a more flexible, individual approach whereby organisations are expected to discuss an investigation plan, including the proposed timescale, with each complainant.

The PHSO requires that NHS complaints are handling in accordance with their 6 Principles for Remedy:

- Getting it Right
- Being Customer Focussed
- Being Open and Accountable
- Acting Fairly and Proportionately
- Putting Things Right
- Seeking Continuous Improvement

4. Methodology

4.1 Phase 1

In order to gain information from all organisations that commission and provide NHS healthcare in Norfolk, HWN has engaged with the following organisations.

- Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)
- James Paget University Hospitals NHS Foundation Trust (JPUH)
- Queen Elizabeth Kings Lynn NHS Foundation Trust (QEH)
- Norfolk and Suffolk NHS Foundation Trust (NSFT)
- East Coast Health Community Care (ECCH)
- Norfolk Community Health and Care (NCHC)
- East of England Ambulance Service NHS Trust (EEAST)
- Integrated Care 24 (providers of 111 in Great Yarmouth and Waveney) (IC24)
- Norwich Clinical Commissioning Group (NCCG)
- South Norfolk Clinical Commissioning Group (SNCCG)
- North Norfolk Clinical Commissioning Group (NNCCG)
- West Norfolk Clinical Commissioning Group (WNCCG)
- Gt Yarmouth and Waveney Clinical Commissioning Group (GYWCCG)
- Anglia Commissioning Support Unit (CSU)
- NHS England Local Area Team (commissioners of specialist services and primary care services) (NHSE)

The purpose of the contact was to gain information about the processes and procedures each organisation has in place for complaints handling.

4.2 Phase 2

The second phase of the project was to ask for feedback directly from complainants. Each provider was asked to send out questionnaires to a randomly selected number of people who had made a complaint within the past 6 months and where the complaint had been closed. A freepost address was made available for return of the questionnaires and there was also the facility to complete the questionnaire on line.

At the time of writing this report a total of 330 questionnaires have been sent out by the NHS organisations who were the subject of the complaint and to date 52 completed questionnaires have been received by HWN.

Initial analysis of the questionnaires indicates that the information provided by the organisations as to how they handle complaints and the experience of those who actually made a complaint is not always the same.

In addition, the analysis illustrated a varied approach by the same organisation to different complainants. This apparent inconsistent approach may have been due to the complainant's recollection of the process or it may be due to inconsistency in complaints handling by one organisation. It is difficult to conclude whether this is due to the number of different complaint handlers or changes in staff. However what it does indicate is that clear communication is paramount to effective complaints handling.

The quotations below are taken directly from the questionnaires and illustrate the level of dissatisfaction and frustration experienced by patients and their families who have made a complaint:

'The letter I received got details of my complaint totally wrong'

'I felt the complaints process was 'set up' to achieve the outcome desired by the hospital'

'The NHS needs to have an independent complaints process rather than one that has working relationships with services that you are complaining about'

'A long winded process in order to deter'

'Process was atrocious, more understanding should be show@

However on a positive note, a respondent provided the following quote

' They were very helpful and kept me informed all the way through'

5. Results

As the report is yet to be finalised and the draft report is to be presented to HWN internal Quality Control Panel later this month, it is not possible to provide full details of the results. In addition HWN is currently collating the completed questionnaires from complainants in order to complete the report.

However in the meantime, the initial findings of this project indicate the following:

- All organisations have a written complaints policy
- The information available to the public via the internet is variable in format and detail
- All organisations advised HWN of the importance of an effective complaints handling policy within their organisation
- All organisations made reference to the complaints advocacy service provision in Norfolk (POhWER)
- Variability in the accessibility, amount and type of complaints information presented to Boards

To date HWN has identified the following specific examples of good practice.

Examples of Good Practice

- Easy read version of complaints leaflet
- Form sent to complainant at the beginning of the complaint handling process requesting clarification of the complaint and desired outcome (East Coast Community Healthcare)
- Guidance document on format of complaint response letters

6. Recommendations

HWN will be making a number of recommendations about improvement to the complaints handling process, specifically around the publication of the outcome of complaints to evidence the changes that have been made. A 'you said, we did' approach to publishing this information would make it easily accessible to all members of the public.

We will also be recommending that good practice and training resources for complaints handlers could be shared via a county wide forum for Complaints Managers.

Whilst we accept that some of the recommendations in this report will impact on the resources currently available within the complaints handling teams, we believe that much can be done to improve the processes by sharing good practice. By the implementation of a robust checklist of information to be exchanged between complainant and complaint handler at the beginning of the process, this should reduce subsequent protracted and difficult exchanges. As a final comment, HWN believe that by clearly publishing what improvements and changes are made as a result of complaints, all involved are more likely to view the complaints handling process as positive and worthwhile.

The findings of the final report will be shared with all stakeholders involved and HWN will monitor the implementation of the recommendations.

HWN will be pleased to bring a report back to HOSC in the future detailing progress on implementation of the recommendations contained in the report.

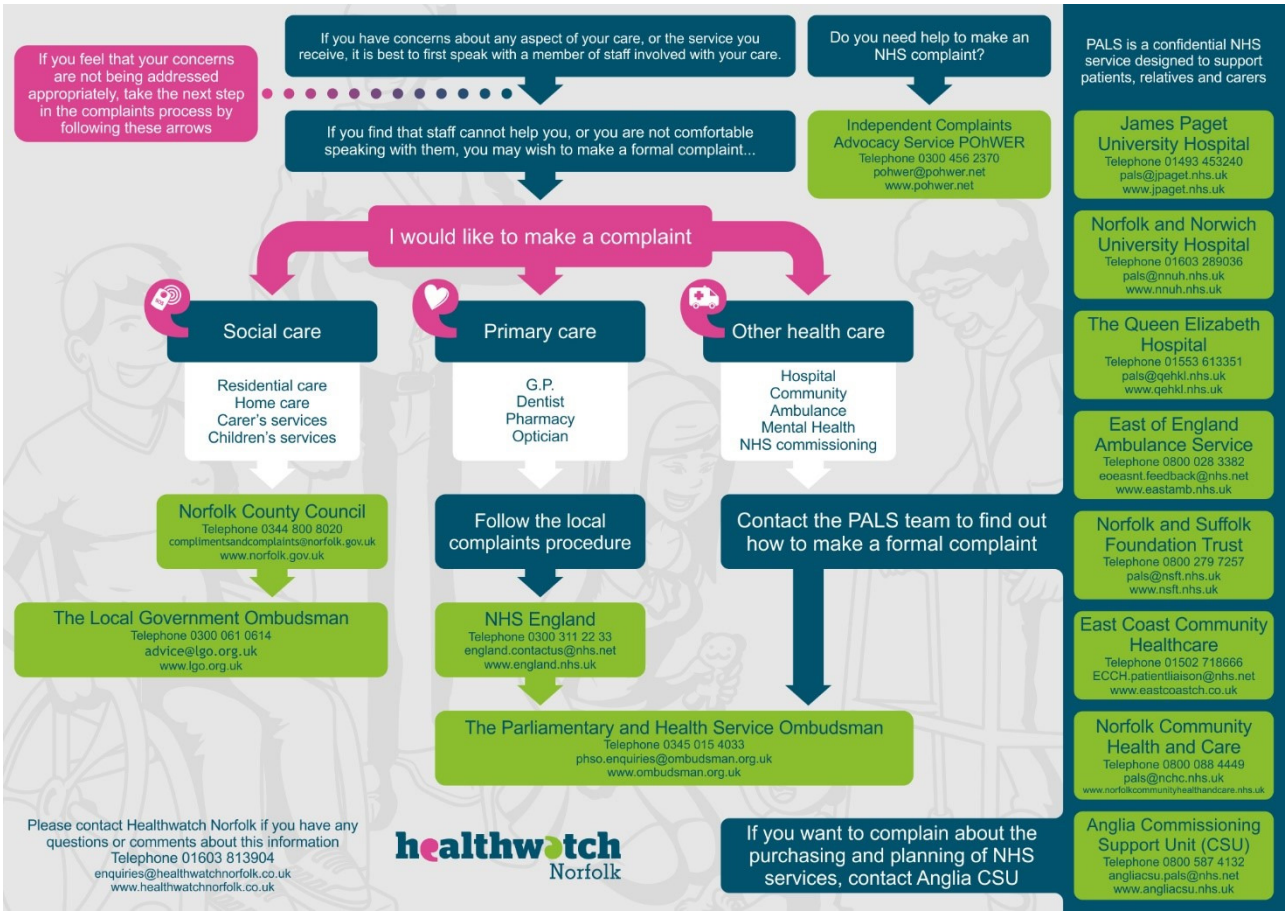
Appendix 1

Recent regulations and reports published about NHS complaints handling

- Complaints Regulations local authority social services and National Health Service complaints (England) regulations 20009
- The Health and Social Care Act 2012
- The NHS Constitution
- Care Quality Commission Essential Standards outcome 17
- **Identifying Good Practice**
- The Health Committee Sixth Report on Complaints and Litigation August 2013
- The Francis Report: One Year On (published February 2014 published by The Nuffield Trust) - http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140206_the_francis_inquiry.pdf
- A Review of the NHS Hospital Complaints System -Putting Patients Back in the Picture – Rt Hon Ann Clwyd MP and Prof Tricia Hart October 2013 - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf
- House of Commons Health Committee – After Francis, making a difference – published in September 2013 - http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/657/657.pdf
- Designing Good Together – transforming hospital complaints handling published by PHSO August 2013 - http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/22013/Designing_good_together_transforming_hospital_complaints_handling.pdf
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report – by Prof Sir Bruce Keogh KBE – July 2013
- The NHS Governance of Complaints Handling published by PHSO June 2013 - http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/20897/PHSO-IFF-Governance-of-Complaints-Handling-research-UNDER-EMBARGO-5-JUNE-0001.pdf
- The NHS Hospital Complaints System published by PHSO April 2013 - http://www.ombudsman.org.uk/__data/assets/pdf_file/0018/20682/The-NHS-hospital-complaints-system.-A-case-for-urgent-treatment-report_FINAL.pdf
- Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry – Executive Summary (published in February 2013) - http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Appendix 2

Diagram produced by Healthwatch Norfolk illustrating the complexity of which organisation to contact if you wish to make a complaint. The version of the diagram on our website will help people to locate the correct contact details to make a complaint.



End of life care in Norfolk's hospitals

Suggested approach from Maureen Orr, Scrutiny Support Manager

A report on how end of life practices in Norfolk's hospitals have changed in response to the decision to phase out use of the Liverpool Care Pathway for the dying in the NHS.

1.0 Background

1.1 On 11 April 2013 Norfolk Health Overview and Scrutiny Committee received a report about use of the Liverpool Care Pathway (LCP) in Norfolk's acute and community hospitals. The LCP was developed in the late 1990s at the Royal Liverpool University Hospital in conjunction with the Marie Curie Palliative Care Institute. It was intended as a way of providing the best quality care possible for dying patients in the last hours and days of life, whether they were in hospital, at home or in a care home. It was widely seen as a way of transferring the model of excellent care provided in hospices to other healthcare settings in which terminally ill patients may find themselves when they are close to the end of life.

1.2 The LCP was introduced because, during the 1990s, there was an increasing consensus in the UK medical community that standards of end-of-life care were patchy. In particular, concerns were expressed about issues such as:

- patients being subjected to invasive testing and treatment that offered no chance of preventing death
- causing unnecessary pain and suffering by needlessly prolonging life.

1.3 The LCP had recommended as a model of best practice by the Department of Health and had been adopted in many UK hospitals and other healthcare settings, including those in Norfolk.

1.4 In April 2013 NHOSC heard of concerns about the LCP, raised nationally, where some relatives had claimed that their loved ones were put on the pathway without their consent and some said it had hastened death in relatives who were not dying imminently.

1.5 A review of the LCP by Baroness Julia Neuberger, Senior Rabbi at the West London Synagogue and former Chief Executive of the King's Fund, was underway to examine:

- the experience and opinions of patients and families
- the experience and opinions of health professionals
- hospital complaints
- local payments made to hospitals in respect of the LCP
- the literature about benefits and limitations of the Liverpool Care Pathway.
-

1.6 The report of the review, entitled 'More Care, Less Pathway' was published in July 2013. It can be viewed on the Gov.UK website via the link below:- https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients

The recommendations included:

- phasing out the LCP and replacing it with an individual end of life care plan
- a general principle that a patient should only be placed on the LCP or a similar approach by a senior responsible clinician in consultation with the healthcare team
- unless there is a very good reason, a decision to withdraw or not to start a life-prolonging treatment should not be taken during any 'out of hours' period
- an urgent call for the Nursing and Midwifery Council to issue guidance on end of life care
- an end to incentive payments for use of the LCP and similar approaches
- a new system-wide approach to improving the quality of care for the dying

1.6 The government's response was to announce its intention to phase out the LCP in the NHS over the next 6 – 12 months in favour of an individual approach to end of life care for each patient, with a personalised care plan backed up by condition-specific good practice guidance and a named senior clinician responsible for its implementation.

1.7 The Boards of all acute NHS Trusts were also asked to put into effect the following actions immediately:-

• undertake a clinical review, led by a senior clinician, of each patient who is currently being cared for using the LCP or a similar pathway for the final days and hours of life, to ensure that the care they are receiving is appropriate and that the patient, where possible, and their family is involved in decisions about end of life care; and

• assure themselves that a senior clinician is assigned as the responsible clinician to be accountable for the care of every patient in the dying phase, now and in the future.

4.0 Purpose of today's meeting

4.1 NHOSC agreed to look at the subject of end of life care again primarily to hear

how local services are phasing out the Liverpool Care Pathway and to examine the new practices that have taken its place.

4.2 Representatives from the acute and community hospitals have been invited to provide information and to attend today's meeting to answer members' questions. Their reports are attached at:-

Appendix A – Norfolk and Norwich University Hospitals NHS Foundation Trust
Appendix B – The Queen Elizabeth Hospital NHS Foundation Trust
Appendix C – Norfolk Community Health and Care NHS Trust

The representative from the James Paget University Hospitals NHS Foundation Trust will give a verbal report at today's meeting.

5.0 Suggested approach

5.1 After the hospital representatives have presented their reports, you may wish to explore the following areas with each of them:-

(a) Have they stopped using the Liverpool Care Pathway?

(b) After the Neuberger report came out, did the hospitals ensure that there was a clinical review led by a senior clinician of each patient who was being cared for using the LCP or a similar pathway to ensure that they were being appropriately cared for?

(c) Can the hospitals give an assurance that a senior clinician is assigned as the responsible clinician to be accountable for the care of every patient in the dying phase?

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Report to Health Overview and Scrutiny Committee

Report from:	**Jo Segasby, Director Women, Children and Cancer Services**
Subject:	**End of life Care**
Purpose:	**For information**
Date:	**Tuesday, 27th May 2014**

1. Introduction

End of life care was previously discussed at HOSC in 2012, following negative press reports regarding care of patients and the use of the Liverpool Care Pathway (LCP). Since then an independent review has been undertaken by Baroness Neuberger regarding the use of the LCP. Results of the review were published in July 2013 with the following recommendations

- phasing out the LCP and replacing it with an individual end of life care plan
- a general principle that a patient should only be placed on the LCP or a similar approach by a senior responsible clinician in consultation with the healthcare team
- unless there is a very good reason, a decision to withdraw or not to start a life-prolonging treatment should not be taken during any 'out of hours' period
- an urgent call for the Nursing and Midwifery Council to issue guidance on end of life care
- an end to incentive payments for use of the LCP and similar approaches
- a new system-wide approach to improving the quality of care for the dying

2. NNUH immediate response to recommendation

- Use of the LCP was phased out and it is no longer used in the hospital
- All staff were issued with guidance regarding senior review of patients identified as being at the end of life
- Palliative care rounding document implemented to ensure robust documentation of end of life care (appendix 1)
- All reference to Liverpool Care Pathway removed from documentation and patient information
- Collaborative working with the Norfolk and Suffolk Palliative Care Academy to implement the Department of Health's e-learning project for End of Life Care (e-ELCA)

3. **Ongoing development of local End of Life Strategy**

In March 2014 NHS England supported and published statements produced by the Leadership Alliance for the Care of the Dying People identifying 5 main areas. The End of Life Steering Group have adopted these as the basis of end of life care at the hospital:

- Dying is recognised and communicated clearly with all decisions and actions taken in accordance with the person's needs and wishes, and that these decisions and actions are reviewed and revised regularly according to need.
- All communication between staff and patients and those important to the patient is sensitive.
- The dying person and those important to them are involved in all decisions about care and treatment to the extent the dying person wants.
- The needs of the family are actively explored, respected and met as far as is possible.
- An individual care plan is agreed to include – food and drink, symptom control, psychological, social and spiritual support – and is co-ordinated and delivered with compassion.

As a result a clinical guideline 'Caring for the people in the last days and hours of life' has been implemented. Patient information regarding anticipatory medication and information for the dying has been drafted.

All patients in hospital have a named Consultant and therefore a Senior Clinician is accountable for the care of every dying patient.

APPENDIX1 **Palliative Care Rounding**

Please use this as a prompt for holistic care whilst ensuring all communications, assessment summaries and clinical decisions are fully documented and care plans are followed as appropriate for patients who are end of life and wish to stay in the Norfolk & Norwich NHS Trust for their end of life care.

Date …… Patient Name……. Hospital No……. Ward…….....

Key: Y/N = Yes/No NA = Not applicable O = Medication/care offered G = Medication/care given

	4 HOURLY CHECKS ARE ADVISED Time:										
	Symptom Control										
1	Does the patient have any pain or signs of pain? If yes offer analgesia										
2	Does the patient have any nausea or vomiting? If yes offer anti-emetics										
3	Is the patient restless/agitated? If yes, offer medication.										
4	Is the patient short of breath? If so, please offer medication or appropriate intervention.										
	Comfort Measures										
1	Oral fluid offered and given as appropriate (documented)										
2	Food offered and given as appropriate (documented)										
3	Does the patient require additional hydration?										
4	Elimination needs checked: • Bowels open? • Pads changed? • SRC? • Help to the toilet?										
5	Has oral care been given? Document daily oral assessment & care plan										
6	Skin integrity – has this been documented and care plan followed										
7	Regular medication given as appropriate/syringe driver checked? PRN medication given if required. Ensure medication safety										
8	Have hygiene needs have been met?										
	Carers/Family address need on each shift										
1	Communication has occurred with family? Document in notes										
2	Family aware of facilities available for them & their well being ensured including drinks, food, toilet, open visiting & car parking facilities										
	Spiritual Needs assess need on each shift										
1	Patients and families spiritual needs addressed e.g. Chaplain offered? Document in notes										
	Psychological Needs assess needs at least once per shift										
1	Patients and families psychological needs addressed? Document in notes all input										
	Signature & Designation										

The Queen Elizabeth Hospital, King's Lynn

End of life care

Queen Elizabeth Hospital approach

1. **Immediate Actions:**

Initial Response communicated to all staff on Wednesday 17th July as follows:

No more patients were to be started on the LCP
Patients who were on the LCP were reviewed urgently by a senior clinican to ensure that the management plans were appropriate. If felt to be clinically appropriate the patients could continue on the LCP.

Further communication sent to all staff Friday 19th July as follows:

Clarifying the major principles of good palliative care; regular assessment and management of symptom control and comfort measures, effective communication with patients and their families, and provision of psychological, social and spiritual support.
Further discussion and consultation, led by NHS England and other key stakeholders, will take place about how best to ensure that people in the last days of life, and their families, receive the best possible quality of care. In the meantime, doctors and nurses should take heed of the following advice:

For patients who are currently on the LCP, doctors and nurses should:

- Continue to reassess the patient regularly and frequently.
- Ensure a consultant review of the decision for the patient to remain on the LCP, ideally by the consultant and team who best know the patient.
- Ensure that the patient's family is aware that the patient is on the LCP, understands the reason and purpose of this, and agrees with this decision.
- Communicate with the patient (wherever possible) and family/carers regularly to address questions or concerns about any aspect of care, or the LCP itself.
- If a patient remains on the LCP, continue to implement it properly. This includes regular assessments, symptom control and comfort measures (including offering oral fluids and good mouth care), communication with the patient and family/carers, and provision of psychological, social and spiritual care.
- If a patient comes off the LCP, continue to pay attention to, and address, symptom control, comfort measures, and psychological, social and spiritual care, alongside any other treatment.
- Reassess the patient regularly and frequently so that the care plan can be adjusted, taking into account the patient's wishes (where known) and family's views, especially their knowledge of the patient's wishes.

For patients who are not currently on the LCP but who is likely to die within the next few days, doctors and nurses should:

- Assess the patient regularly and frequently so that an end of life care plan can be made or adjusted, taking into account the patient's wishes (where known) and families' views.
- Communicate with the patient (wherever possible) and family/carers regularly to address questions or concerns about any aspect of care. In particular, families need to be warned if the patient is likely to die in the next few days or hours, so that they have time to begin preparing themselves.
- Ensure that any decision to put any patient on the LCP is made only by a consultant who best knows the patient following a face to face assessment, in consultation with the patient (wherever possible) and family/carers, and other members of the multi-professional team.
- Continue to pay attention to, and address, symptom control and comfort measures (including offering oral fluids and good mouth care), and provision of psychological, social and spiritual care

A paper was provided to the Trust Board on July 23rd 2013 by Dr Mark Blunt to advise on the actions taken.
The Board supported the plan for transition away from the LCP.
An executive, Dr Beverly Watson, was appointed to act as a responsible member for end of life complaints.
An independent review of complaints related to the LCP which have not been resolved satisfactorily.

2. **Current Status:**

Best Supportive Care and Individualised End of Life Care Plans were implemented in September 2013 part of mandatory training for all clinical staff within the trust.
Currently 55% of staff have attended training sessions.

End of life care is taught on the FY1/FY2 core medical training program delivered within the hospital.

A pilot has been conducted using "ceiling of treatment" in MAU – work is ongoing to role this out across the Trust.

The Macmillan team/Shouldham ward provide a 24 hour palliative care telephone access advice line, with support across Norfolk from Specialist Palliative Care Consultants.

The Trust has been actively engaged in the development of individualised care planning "yellow folders" which can be used both in the community and in the acute trust to support patients and families in meeting both their needs and wishes at end of life. We are awaiting a finalized version which we will pilot in the Haematology department.

The Trust has driven the use of the Airedale Project in three nursing homes across King's Lynn to help deliver new models of care to nursing home residents, with the aim to avoid admissions to the acute hospital where community care pathways can be accessed. The project uses telemedicine to help select treatment pathways in nursing home residents.

3. **Future Plans:**

The Trust awaits the final outcome of the work of the National Leadership Alliance for the Care of Dying People (LACDP) with regard to best practice guidance.

The Trust continues to engage actively with West Norfolk CCG regarding the development of a streamlined palliative care service across the community and acute trust.

The Trust participates annually in the National RCP/Marie Curie Care of the Dying audit. Results for 2013/14 are awaited.

4. **Audit:**

A review of the management of a sample of patients admitted with a non curable malignancy who subsequently died in hospital was carried out in July/August 2013 .This confirmed the following:
1)Patients were well managed with 7/ 10 receiving a NCEPOD Grade 1 and 3 receiving a Grade 2. Of the Grade 2 events 2 were deemed to have had an unnecessary escalation of treatment and 1 the family voiced dissatifacction although there were no clear failings identified.
2)Palliation using anticipatory prescribing on analgesia and symptomatic relief continued despite the withdrawal of the LCP

5. **Complaints:**

1 complaint was received regarding the LCP in 2012 which was closed with a satisfactory outcome.

Norfolk Community Health and Care NHS Trust

Norfolk Health Overview and Scrutiny Committee – End of Life care in Norfolk hospitals, May 2014

The Liverpool Care Pathway (LCP) was recommended as a model of best practice by the Department of Health and had been adopted in many UK hospitals and other healthcare settings, including those in Norfolk. Within NCHC, the LCP was embedded within our End of Life Care Policy. National concerns about elements of the LCP led to a review by Baroness Julia Neuberger.

The report of the review entitled 'More Care, Less Pathway' was published in July 2013 (https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients). This report included the recommendation that the LCP should be phased out and its use discontinued by 14 July 2014.

NCHC response to the report

1. Immediate actions taken July 2013

- a clinical review took place of each patient currently being cared for within NCHC using the LCP, to ensure that the care they were receiving was appropriate and that the patient, where possible, and their family was involved in decisions about end of life care;
- the trust issued a statement to all staff (16.7.13) to ensure that, whilst interim guidance was being developed, patients were only be placed on the LCP by a senior responsible clinician in consultation with the healthcare team. Staff were reminded of the need to formally review patients on the LCP daily and to always involve patients and those important to them in any decisions about their care. In addition, staff were advised that decisions to withdraw or not to start life-prolonging treatments should not be taken during any 'out of hours' period. All our teams were reminded of the 24/7 Specialist Palliative Care Adviceline which is available for support and guidance to all professionals.
- assurance that a senior clinician was already always assigned as the responsible clinician to be accountable for the care of every patient in the dying phase and that this would continue;
- confirmation that the trust were not receiving any incentive payments (e.g. under the CQUIN payment framework) for use of the LCP;
- a review of complaints concerning End of Life and the LCP was undertaken.

A paper was presented to the trust board on 28.8.13 reviewing the situation and addressing the Ministerial requirements for review as detailed above. The board agreed to nominate a Non-Executive (Vivienne Clifford-Jackson) and Executive Director (Dr Rosalyn Proops, Medical Director) for End of Life Care.

2. Interim guidance

NCHC interim guidance for care of people in the last days and hours of life has been written following NHS England's published statements from the Leadership Alliance for the Care of the Dying People (LACDP, NHS England, 20th March 2014). The LACDP are committed to ensuring high quality care for those people in their last days and hours of life and those important to them which is delivered with compassion and competence. It is clear that there will be no national care pathway to replace the LCP. Instead, care should focus on 5 main areas:

- dying is recognised and communicated clearly with all decisions and actions taken in accordance with the person's needs and wishes, and that these decisions and actions are reviewed and revised regularly according to need
- all communication between staff and patients and those important to the patient is sensitive

- they dying person and those important to them are involved in all decisions about care and treatment to the extent the dying person wants
- the needs of the family are actively explored, respected and met as far as is possible
- an individual care plan is agreed which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion

From 1 June 2014 we will no longer be using the LCP within NCHC. Whilst awaiting the final LACDP report, new trust 'Individual End of Life Care Guidance' has been launched. This includes 'guiding principles' for managing patients in the last days and hours of life as well as symptom control guidelines, a care rounding document and a Shared Communication Sheet to be used at the bedside.

3. Future plans

As a trust, we recognise the need to demonstrate that we are maintaining standards of care for dying patients. We have consistently taken a proactive approach to palliative and end of life care and already have an active education programme in place for our staff which we will continue to develop. Our End of Life Policy is currently being reviewed and will be updated once the final LACDP recommendations are published. Standards of care will be stipulated by the LACDP and these will be audited trust-wide annually.

Norfolk Community Health and Care NHS Trust

ENCLOSURE:

Date of Trust Board	28 August 2013
Title of Report	**Liverpool Care Pathway (LCP):** **NCH&C's response to national independent review**
Purpose of Report	For information
Abstract	The LCP was developed as a model of End of Life care. Recent concerns have resulted in an independent review which has concluded that the LCP should be phased out and an individual approach to End of Life care for each patient be introduced, with a personalised care plan backed up by condition-specific and practice guidance, and a named senior clinician responsible for its implementation. The Minister has set out certain actions for all (Acute) NHS Trusts to be put into effect immediately. This paper addresses those actions for NCH&C.
Risks and benefits of proposed action	Ministerial requirement to follow letter of 15 July 2013 with subsequent risks of sanctions should actions fail to be taken.
Strategic Objective and/or Annual Plan Objective and/or Quality Goal	To provide high quality compassionate End of Life care.
Recommendation	The Board is asked to approve actions
Presented by	Rosalyn Proops – Medical Director, NCH&C
Previous consideration by Board Committee or EDT	
Appendices	**Appendix 1:** More Care, Less Pathway: A Review of the Liverpool Care Pathway" – Published July 2013 **Appendix 2**: NCH&C Communication to Staff 16.7.13

In completing this report, I confirm the following matters have been considered:

a) Implications for the NHS Constitution
b) Implications for CQC registration
c) Equalities Impact
d) Environmental impact

Any material considerations arising from the above are reported below.

1. SUMMARY

An independent review of the Liverpool Care Pathway (LCP) entitled "More Care, Less Pathway: A Review of the Liverpool Care Pathway" was published on 15 July 2013 and distributed at the same time as a letter from the Minister, Norman Lamb and followed by advice from the Department of Health (Appendix 1 attached).

The review states that, *"it would seem that when the LCP is operated by well trained, well resourced and sensitive clinical teams, it works well."*

"However it is clear to us, from written evidence we have received and what we have heard at relatives' and carers' events, that there have been repeated instances of patients dying on the LCP being treated with less than the respect that they deserve."

It is for this reason that the Minister required all Trusts to review current practice. This is described in the paper.

2. BACKGROUND

The LCP was developed from a model of care successfully used in hospices. It provides for a generic approach to care for the dying, intended to ensure that uniformly good care is given to everyone thought to be dying within hours or within two or three days, whether they are in hospitals, nursing homes or in their own homes.

The pathway requires scrupulous attention to clinical detail and to documentation.

The pathway requires patients consent or decisions to be taken in the patient's best interests. As the review notes, *"in some cases, relatives and carers incorrectly consider they are entitled to decide whatever treatments their relatives receive, and in others clinicians fail to seek consent from a patient or consult the relatives and carers in a best interest assessment when treatment is being changed"*.

The review notes that the LCP documentation is deficient in making distinct and clear where the need for consent and explanation exist.

It is the application of the LCP which is critically important, both in its decision-making, communication, decisions about hydration, nutrition, sedation, pain management and accountability. The overriding principle must be one of care with compassion.

The Minister requires the following reviews to have taken place:

2.1 "To undertake a clinical review led by a senior clinician of each patient who is currently being cared for using the LCP or similar pathway for the final days and hours of life, to ensure that the care they are receiving is appropriate and that the patient, where possible, and their family is involved in decisions about End of Life care, and

2.2 Assure themselves that a senior clinician is assigned as a responsible clinician to be accountable for the care of every patient in the dying phase, now and in the future.

2.3 There needs to be a review of complaints concerning End of Life and the LCP with the requirement that should complaints take place, then Department of Health approved list of independent experts will be available. An expectation to re-examine past complaints.

2.4 Each Trust Board appoints a member with responsibility for overseeing any complaints about End of Life care and for reviewing how End of Life care is provided."

3. ACTIONS TAKEN

3.1 On receipt of the Minister's letter and report, a communiqué was sent to all staff (Appendix 2 attached).

3.2 Information has been collected and will be collated regularly on the number of LCPs initiated in each of NCH&C's inpatient units and in the community.

Data is available on the number of patients:

- for whom an LCP is considered but die before the LCP is commenced
- who have an LCP in place at the time of death
- who have an LCP in place in Community Teams
- who have an LCP in place in all In-patient Units.

Data relating to the last two months is presented below:

June/July 2013	36	patients died on the LCP in the community teams over a six week period.
June 2013	11	patients died on the LCP in in-patient units, the majority at Priscilla Bacon Lodge.
July 2013	6	patients died on LCP at Priscilla Bacon Lodge.

The data will be collated monthly unit by unit, including Priscilla Bacon Lodge.

3.3 An audit of the LCP with particular reference to the concerns highlighted in the review is underway. This will use the national standards plus appropriate additions.

This audit will be conducted speedily and reported to the Board in November 2013.

3.4 A review of complaints, backdated to 2012 concerning End of Life and/or LCP has been completed. Three complaints have been identified which will be reviewed by the Medical Director and Director

of Nursing, Quality & Operations and reported to the Board in November 2013.

3.5 The monthly mortality review panel will receive monthly data on numbers of LCPs in each of the units and the community. This will include numbers of LCPs initiated and numbers of patients dying for whom an LCP was in place.

3.6 It is proposed that the nominated Non-Executive Director for End of Life is Vivienne Clifford-Jackson, and the Executive Director is Dr Rosalyn Proops, Medical Director.

Terms of reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee

Report from Maureen Orr, Scrutiny Support Manager

The Committee is asked to approve revised terms of reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee.

1.0 Revised terms of reference

1.1 The terms of reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee are agreed between Norfolk Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee (HSC). In June 2013 NHOSC considered a suggestion from Suffolk for changes to the membership of the joint committee.

1.2 NHOSC did not support the proposed revisions to the terms of reference at that stage but proposed that NHOSC and Suffolk HSC should look at the terms of reference again in late 2013 or early 2014.

1.3 The Chairmen of NHOSC and Suffolk HSC met on 24 April 2014 and agreed to put forward revised draft terms of reference (Appendix A) for both committees to consider. Suffolk HSC will receive the revised draft terms of reference (ToRs) on 2 July 2014.

1.4 Today NHOSC is asked to agree the revised draft ToRs. On 17 July 2014 NHOSC will be asked to nominate three Members to the Joint Committee, subject to both Norfolk and Suffolk HSC having agreed the revised draft ToRs by then.

2. Action

2.1 NHOSC is asked to agree the revised draft terms of reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or 0344 800 8011 (Textphone) and we will do our best to help.

The revised sections are shown in italics at paragraph 1.1, 1.2 and 1.3.

Great Yarmouth and Waveney Joint Health Scrutiny Committee Structure and Terms of Reference

1. Structure of the Committee

1.1 The committee to be composed of ***six*** members.

1.2 Both authorities to appoint ***three*** members to the committee.

1.3 ***The membership to be drawn from members of Norfolk Health Overview and Scrutiny Committee (NHOSC) and Suffolk Health Scrutiny Committee (SHSC) including the Great Yarmouth Borough Council member of NHOSC, the Waveney District Council member of SHSC. The other two members from NHOSC and SHSC respectively may be appointed from adjoining districts to Great Yarmouth and Waveney where a proportion of their residents look in the first instance to the James Paget University Hospital NHS Foundation Trust for acute services.***

1.4 There is no requirement for the appointments to the joint committee to be in line with the political balance on Norfolk County Council or Suffolk County Council.

1.5 To be quorate the committee requires three committee members to be present.

1.6 Each authority is allowed to substitute for the committee members.

1.7 The resourcing and costs of the committee will be shared between the two authorities.

2. Terms of Reference

2.1 The Joint Scrutiny Committee will meet for scrutiny of the health service in the Great Yarmouth and Waveney locality, as deemed necessary by the Chairmen of either Norfolk Health Overview and Scrutiny Committee and the Suffolk Health Scrutiny Committees.

2.2 General health service issues within the Great Yarmouth and Waveney area will be scrutinised either by Great Yarmouth and Waveney Joint Health Scrutiny Committee or by Norfolk Health Overview and Scrutiny Committee and / or Suffolk Health Scrutiny Committee as deemed necessary by the Chairman of either Norfolk Health Overview and Scrutiny Committee and / or Suffolk Health Scrutiny Committee.

2.3 In carrying out review and scrutiny of a particular matter the Committee shall have regard to any guidance issued by the Secretary of State; invite interested parties to comment on the matter; and take account of relevant information available to it.

2.4 Norfolk County Council and Suffolk County Council have arranged for the Joint Health Scrutiny Committee to have the power to make referrals to the Secretary of State in response to 'substantial variation' in respect of health services within the Great Yarmouth and Waveney area. The Joint Health Scrutiny Committee must notify Norfolk County Council and Suffolk County Council of its intention to make such a referral before the referral is made.

2.5 Where the Joint Health Scrutiny Committee makes such reports and recommendations the report will be consensual and shall include:
• An explanation of the matter reviewed or scrutinised;
• A summary of the evidence considered;
• A list of participants involved in the review or scrutiny;
• Any recommendations on the matter reviewed or scrutinised.

2.6 The Joint Health Scrutiny Committee does not have the power to call in Cabinet decisions of either Suffolk County Council or Norfolk County Council.

February 2014

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2014

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
17 July 2014	Stroke services in Norfolk – report of the task and finish group. Access to dentistry in Norfolk – an update report on action following the new oral health needs assessment. Delayed Discharge from Hospital in Norfolk – report of the joint NHOSC & Community Services OSP scrutiny task & finish group.	
4 Sept 2014	System-wide review of health services in west Norfolk – an update from West Norfolk CCG. Health and Wellbeing Strategy 2014-17 – a progress update from the Health and Wellbeing Board. Policing and mental health – a briefing by Mr Stephen Bett, Police and Crime Commissioner for Norfolk.	
16 Oct 2014	Availability in the local NHS of NICE recommended treatments and drugs	

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for reports to the Committee 2014

Date to be confirmed - Changes to Mental Health Services in West Norfolk – consultation by the CCG and Norfolk and Suffolk NHS Foundation Trust on potential closure of inpatient facilities

Date to be confirmed - Changes to mental health services in central Norfolk – an update on the implementation of the Norfolk and Suffolk NHS Foundation Trust Service Strategy 2012-16 in the central Norfolk locality.

NHOSC Scrutiny Task and Finish Groups

Task & finish group	**Membership**	**Progress**
Stroke Services in Norfolk	Cllr John Bracey Cllr Michael Chenery of Horsbrugh Cllr Nigel Legg Cllr Margaret Somerville (Chairman) Cllr Tony Wright Alex Stewart – Healthwatch Norfolk	The Group is on schedule to report back to NHOSC in July 2014.
Delayed discharge from hospital in Norfolk (joint task & finish group with Community Services OSP)	From NHOSC:- Cllr Michael Chenery of Horsbrugh Cllr Alexandra Kemp* Cllr Nigel Legg Cllr Tony Wright From Community Services OSP:- Cllr Shelagh Gurney Cllr Brian Hannah Cllr Harry Humphrey Cllr Margaret Somerville	The Group is on schedule to report back to NHOSC in July 2014

* Cllr Kemp ceased to be a member of NHOSC on 27 February 2014, but by agreement will continue to serve with the Delayed Discharge Task & Finish Group until it finishes its work.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	Mr J Bracey
South Norfolk	-	Dr N Legg (substitute Mr R Kybird)
Gt Yarmouth and Waveney	-	Mrs M Fairhead
West Norfolk	-	M Chenery of Horsbrugh
Norwich	-	Mr D Bradford (substitute Mrs M Somerville)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mrs A Claussen Reynolds
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg Mrs M Somerville
James Paget University Hospitals NHS Foundation Trust	-	Mrs M Fairhead Mr C Aldred
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Somerville)

Norfolk Health Overview and Scrutiny Committee 29 May 2014

Glossary of Terms and Abbreviations

A&E	Accident and Emergency
BMA	British Medical Association
BoD	Board of Directors
BP	Blood pressure
CLIP	Complaints, Litigation Incidents and PALS
C&LS	Complaints and Legal Services
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CTG	Cardiotocography
Datix	A leading supplier of patient safety incidents healthcare software
DNR	Do not resuscitate
eELCA	Department of Health's e-learning project for end of life care
ECG	Electrocardiogram
ED	Emergency Department
EDIS	Emergency Department Information System
EEG	Electroencephalogram
FY	Foundation year
GMC	General Medical Council
GMS	General Medical Services
GPhC	General Pharmaceutical Council
HCHS	Hospital and Community Health Services
HOSC (OSC)	Health Overview and Scrutiny Committee
HR	Human Resources
IRMER	Ionising Radiation (Medical Exposure) Regulations 2000
LACDP	Leadership Alliance for the Care of Dying People
LCFS	Local Counter Fraud Specialist
LCP	Liverpool Care Pathway
MAU	Medical Assessment Unit
NAO	National Audit Office
NCEPOD	National confidential Enquiry into Patient Outcomes and Death
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS LA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System

OED	Oxford English Dictionary
PAC	Public Accounts Committee
PALS	Patient Advice and Liaison Service
PCaW	Public Concern at Work
PDN	Practice Development Nurse
PHSO	Parliamentary Health Service Ombudsman
QEH	Queen Elizabeth Hospital, King's Lynn
RCA	Root cause analysis
RCN	Royal College of Nursing
RIDDOR	Reporting of Injuries Disease and Dangerous Occurences
SAU	Surgical Assessment Unit
SI	Serious Incident
TEC	Trust Executive Committee
UEA	University of East Anglia
YTD	Year to date