Board Paper 2020/21/41

Shetland NHS Board

Meeting:	Shetland NHS Board		
Paper Title:	Quality Report – Update on Progress		
Date:	15th December 2020		
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Decision / Action required by meeting:

The Board is asked to note the progress made to date with the delivery of the action plan and other associated work which focuses on effectiveness, patient safety and service standards/care quality.

High Level Summary:

The report includes:

- A summary of the work undertaken to date in response to the 'quality ambitions' described in the Strategy;
- Our performance against a range of quality indicators (locally determined, national collaborative and national patient safety measures)
- When available, feedback gathered from patients and carers – along with improvement plans

Key Issues for attention of meeting:

- Noting the good performance as shown in the report

Corporate Priorities and Strategic Aims:

The quality standards and clinical/care governance arrangements are most closely aligned to our corporate objectives to improve and protect the health of the people of Shetland and to provide high quality, effective and safe services.

Implications : *Identify any issues or aspects of the report that have implications under the following headings*

Service Users, Patients and Communities:	The focus of the quality scorecard is on evidencing safe practice and providing assurance to service users, patients and communities that services are safe and effective
Human Resources and Organisational Development:	The focus of this report is on evidencing effective training and role development to deliver care, professionalism and behaviours which support person centred care
Equality, Diversity and Human Rights:	EQIA is not required.
Partnership Working	Quality standards and assessment of impact applies in all NHS settings.
Legal:	
Finance:	Quality standards and the delivery of them is part of the standard budgeting process and are funded via our general financial allocation.
Assets and Property:	Nil

Environmental:	A Strategic Environmental Impact Assessment is not required or has been completed.	
Risk Management:	The quality agenda focuses on reducing risks associated with the delivery of health and care services. The adverse event policy also applies to HAI related events.	
Policy and Delegated Authority:	Delegated authority for the governance arrangements that underpin quality and safety measures sit with the Clinical, Care and Professional Governance Committee (and the associated governance structure)	
Previously considered by:	Data in this report is also shared with the Joint Governance Group which met in November 2020	

"Exempt / private" item	*Public document*

PROGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION
PROGRESS ON THE DEVELOPMENT OF A PATIENT EXPERIENCE FRAMEWORK

The Board supported a formal proposal to develop an approach (or framework) that would enable us to bring together the various systems that are in place to gather patient experiences and feedback so that we can demonstrate clearly how feedback is being used to improve patient care.

Progress continues and since December 2020 the following actions have been taken:

- There continues to be regular interactions via social media and with the local media during the pandemic to make sure that people in our wider community and patients know how to access our services and know how services have changed in order to meet new requirements as a result of COVID 19. This has included films, radio interviews, podcasts, articles in local news media and live streaming information sessions on social media, facilitated by the Chief Executive.

- A project has commenced to undertake a review of the clinical strategy and the methodology includes bringing together a very broad set of perspectives. Patients, community leaders, members of the public and third sector organisations will be invited to participate in every stage of the strategy development between now and March 2021. Some of the early engagement includes invitations to participate in semi structured interviews to help design the initial workshop and involvement in the workshops held in October and December 2020. A webpage has been developed to hold all of the key resources which can be found at: https://www.shb.scot.nhs.uk/board/clinicalstrategy/index.asp

- Edna Watson, Chief Nurse (Community) is leading a community engagement project to review and develop sustainable options for community nursing, including in the most remote parts of Shetland. This project is at the early stages and the focus has been on listening to groups and individuals to understand community nursing needs and provision.

DELIVERING QUALITY CARE AND SUPPORTING STAFF DURING THE PANDEMIC

Excellence in Care Celebration Event

On October 16th 2020, we hosted an Excellence in Care celebration event, where individuals and teams presented a broad range of improvement work undertaken during 2020. Five projects were selected for awards and recognition and included improvement to patient care in: Audiology, Bereavement Care, introducing a Medical Termination Pathway, Diabetes and Asthma Care.

Several presenters also shared their work through interviews with the local media and social media to highlight and showcase the work widely across Shetland.

POGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION FOR INFORMATION AND NOTING

Our focus over the last ten months has been to ensure that we maintain safe and effective care in all settings during the initial phase of the pandemic and through into more recent months where we have remobilised services.

Some care assurance improvement work has been paused during the pandemic, as shown in Appendix A which sets out the quality dashboard. However, service improvement work, including the Excellence in Care programme have now resumed. Throughout the pandemic we have maintained key care assurance work such as strategies to reduce patient falls whilst in hospital, tissue viability and safeguarding children and adults. The Tissue Viability Group and the Falls Group have taken a lead on improvement work to reduce falls with harm and patients developing avoidable pressure ulcer. Since the last quality scorecard was published in October 2020, we have not had any patients with a fall with harm or a pressure ulcer reported and hope that trend continues with greater awareness of the lessons learnt leading to harm reduction.

We have also been encouraging teams to undertake debriefs following adverse events to share learning and opportunities for improvement. The high level lessons learnt from this work is shown in Appendix B and there is a correlation between the adverse events e.g. falls and the identification of lessons learnt/actions for improvement. Work is also underway to review risk registers i.e. corporate, departmental and pandemic related to ensure that we have robust systems in place to identify and mitigate risks across the organisation.

Appendix C includes a summary of feedback, concerns and complaints from Q2 2020-21.

In terms of remobilisation, plans continue to be implemented in order to re-establish or increase service provision across the organisation – whilst at the same time, considering how best to manage a potential further COVID outbreak. Since October 2020, we have been developing plans to manage winter pressures alongside the pandemic/service remobilisation requirements and a draft plan will be submitted to the Board in December 2020 and IJB in January 2021. The plan includes some procedures unique to this winter; which set out infection control pathways for patient placement and outbreak management. Heads of Service have also considered the risk of Brexit in the review of business continuity plans. As always, the plan has been developed in partnership and includes all services that provide an input to the delivery of care in all settings.

Considerable work has been undertaken by NHS Shetland and the Health and Social Care Partnership to provide enhanced support in community settings during the pandemic. This includes input from multi-disciplinary teams to provide care

assurance in Care Home settings and more recently, environmental audits in Health Centres to enhance infection control measures and ensure that requirements for physical distancing are implemented. The care assurance data has been shared with the Joint Governance Group (JGG) along with a review of our experiences to date, managing the pandemic in the community setting.

In October and December 2020, the first two of three workshops were held as part of the ongoing work to review the clinical and care strategy for Shetland. The events included a broad range of participants including patients, members of the community and partner organisations. The next phase of the strategy refresh will focus on active community engagement and a toolkit is being developed to enable people to get involved, share their thoughts and experiences. The indicative plan is that we will build in the ideas from the community engagement exercise into the third and final workshop at the beginning of February 2021.

Following a recent review of large scale change projects that have been commissioned across partner organisations; it has been agreed that a Board will be established to lead a piece of work to identify key priorities for funding and support in Shetland. The Board will follow the model of that set out by the ANCHOR project and consider how best to implement community led support models for services across the age range. The intention is to develop a framework that sets out the priorities and a high level programme of work by February 2021.

Quality Report - Board

Generated on: 26 November 2020

Health Improvement

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HI-01 Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter)	Not measured for Months			63.5%	63.7%	64.5%		58%	Exceeding national target of 50% and local target of 58%. National data for 2018-19 shows us at 59.7% - the 2nd best performing Board in Scotland and well above the national average (43.5%).
PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	8	11	12	80	1	11		129	The number of ABI screenings undertaken is high, but patients asked do not tend to meet the threshold for a full ABI. This could be interpreted as positive in that it means people are not drinking at hazardous or harmful levels, or it may mean that the screenings are being targeted at the wrong people. The ABI Delivery Improvement plan was disrupted due to COVID-19; a revised timescale for delivery of training modules is under development.

Patient Experience Outcome Measures

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-01 % who say they had a positive care experience overall (aggregated)	94.1%	100%	100%	100%		100%		90%	

	Months			Quarters			Icon	Target	
Code & Description	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated)	93.75%	95.24%	100%	100%		95.24%		90%	
NA-HC-14 What matters to you - % of people who say we took account of the things that were important to them whilst they were in hospital (aggregated)	100%	100%	100%	100%		100%		90%	
NA-HC-17 What matters to you % of people who say we took account of the people who were important to them and how much they wanted to be involved in care/treatment (aggregated)	87.5%	85.71%	85.71%	100%		85.71%		90%	
NA-HC-20 What matters to you % of people who say that they have all the information they needed to help them make decisions about their care/treatment (aggregated)	95.59%	97.62%	100%	100%		97.62%		90%	
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	93.33%	97.5%	100%	100%		97.5%		90%	
NA-HC-26 % of people who say they were involved as much as they wanted to be in communication, transitions, handovers about them (aggregated)	94.12%	89.47%	100%	100%		89.47%		90%	

Patient Safety Programme - Maternity & Children Workstream

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-CF-07 Days between stillbirths	1,098	1,128	1,159	945	1,036	1,128		300	
NA-CF-09 Rate of neonatal deaths (per 1,000 live births)	0	0	0	0	0	0		2.21	
NA-CF-15 Rate of stillbirths (per 1,000 births)	0	0	0	0	0	0		4	
NA-CF-16 % of women satisfied with the care they received									Currently reviewing the questionnaire and collation process.

Service & Quality Improvement Programmes - Measurement & Performance

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
MD-HC-05 SEPSIS Six - actions performed < 1 hour (Sepsis is a complication of an infection when the body's immune defences attacks the body's own organs and tissues)									Ward 3 are undertaking the Sepsis audit as part of their ongoing Clinical Governance work. There will be a review of the anaesthetic team job plans to help identify an individual to also partake in the audit.
NA-HC-08 Days between Cardiac Arrests				559	13	44		300	See Appendix 1 of the August 2020 Board Quality Report
NA-HC-09 All Falls rate (per 1000 occupied bed days)	10.77	8.85		2.83	7.54	8.85		7	Senior charge nurses, along with Occupational Therapy and Physiotherapy staff have explored ways in which the environment of the wards could be improved with regard to patient safety and experience. In addition, a multi-disciplinary Falls Group is being set up to review all falls reported on Datix to see what lessons can be learnt and how they may be prevented in future.

	Months			Quarters			Icon	Target	
Code & Description	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	1.35	0	0	1.42	0	0		0.5	
NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4)	52	82	113	36	16	82		300	The Tissue Viability Group has been re-established and will resume evaluation of pressure ulcer reporting. They will also review the contributing factors towards occurrence of pressure ulcers in both hospital and community, as well as actions for improvement and training needs. The most recent pressure sores have been on vulnerable patients who were at high risk, and all showed improvement with appropriate nursing care.
NA-HC-54 Pressure Ulcer Rate (grades 2-4)	0	0	0	0	1.51	0		0	
NA-HC-59 % of patients discharged from acute care without any of the combined specified harms				96	98.6	98.9		95	
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered	100	90		100		90		75	
NA-HC-75 % of total observations calculated accurately on the NEWS 2 charts – Ward 1	94.26%	89.68%	78.41%			92.22%			
NA-HC-76 % of NEWS 2 observation charts fully compliant (Accuracy) – Ward 1	55%	30%	40%			43.33%			Consistency in achieving compliance across the entire observation chart has been discussed at the Ward team meeting and it is intended to carry out spot checks of News charts and also provide additional training to staff.
NA-HC-77 % of total observations calculated accurately on the NEWS 2 charts – Ward 3	89.85%	95.62%	97.22%			93.44%			
NA-HC-78 % of NEWS 2 observation charts fully compliant (Accuracy) – Ward 3	30%	55.56%	70%			46.55%			

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Not measured for Months								The format of the Patient Safety Conversations was reviewed and agreed by the Joint Governance Group. The new approach was to be tested in a few departments, the first being in Ward 3 on 17th March. Unfortunately, this had to be cancelled due the COVID-19 lockdown. The Medical Director plans to recommence as soon as it is safe to do so.
NA-IC-23 Percentage of cases where an infection is identified post Caesarean section	Not measured for Months			0%	0%	0%		0%	Note: Surgical Site Infection Surveillance suspended due to COVID-19.
NA-IC-24 Percentage of cases developing an infection post hip fracture	Not measured for Months			0%	0%	0%		0%	Note: Surgical Site Infection Surveillance suspended due to COVID-19.
NA-IC-25 Percentage of cases where an infection is identified post Large Bowel operation	Not measured for Months			0%	0%	0%		0%	Note: Surgical Site Infection Surveillance suspended due to COVID-19.
NA-IC-30 Surgical Site Infection Surveillance (Caesarean section, hip fracture & large bowel procedures)	Not measured for Months			0%	0%	0%		0%	Note: Surgical Site Infection Surveillance suspended due to COVID-19.

Treatment

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
CH-MH-03 All people newly diagnosed with dementia will be offered a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan	100%	100%	100%	100%	100%	100%		100%	This is not currently being measured as a target at national level. We *offer* the link worker to everyone newly diagnosed and therefore we meet the target (understandably, not everyone wants to take up the offer). See CH-MH-04 for details of our balancing measure.
CH-MH-04 People with diagnosed dementia who take up the offer of post diagnostic support (ie have an active Post	Not measured for Months			38.6%	40%	41.9%		50%	Note: this is a local measure showing the number of people with an active PDS Status as a percentage of those diagnosed with dementia who take up the offer of

Code & Description	Months			Quarters			Icon	Target	Latest Note
	August 2020	September 2020	October 2020	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q2 2020/21	Q2 2020/21	
	Value	Value	Value	Value	Value	Value	Status	Target	
Diagnosis Support status)									post diagnostic support. 54 of 129 cases. This measure was revised for year 2019-20.
MD-HC-01 Quarterly Hospital Standardised Mortality Ratios (HSMR)	Not measured for Months			1.19	1.09				Latest available provisional national data. Rate remains consistently well within expected levels. Next data due Feb 21.

Appendix B - Adverse Event Data

Month	Number of Adverse Events	Number of Category 1	Number of Debriefs Completed	Thematic Learning
September 20	68	0	4	• **Communication** – discussion of event with stores team and adjustment of stock levels • **Patient Safety** o improvement to the ward environment by raising sinks and bathroom furniture o Purchasing new chair and bed sensors o Increasing the number of pressure pads available and use of monitoring equipment in place for patients with confusion
October 20	53	0	5	• **Communication** - to ensure communications regarding site visits are followed up and clear communication is maintained throughout the process. Review how to manage future visits and have one person to co-ordinate on the day. Include in the plan movement of stock to the other monitored fridge. Staff to undertake training on how to install new temporary probes • **Patient Safety –** ensure reviewed Patient Group Directive (PGD) and checked vaccine before going out on visits. The vaccine can also be checked with colleague if available. Attendance at flu training updates • **Staff Safety** o Make updates to home visiting policy and ensure staff familiarise themselves with the policy. Ensure reporting of any variances to senior management and risk assess each situation dynamically o Risk assessment is a continuous process and should be updated on a regular basis and post incident x2 o Multi agency risk management was in situ and should continue to ensure robust safety plans for staff
Total	**121**	**0**	**9**	**-**

NHS Shetland Feedback Monitoring Report 2020_21 Q2

Since April 2017 all NHS Boards in Scotland have been required to further monitor patient feedback and to report performance against a suite of high level indicators determined by the Scottish Public Services Ombudsman (SPSO). This report outlines NHS Shetland's performance against these indicators for the period July to September 2020_21 (Q2).

Further detail, including the actions taken as a result of each Stage 2 complaint from 1 April 2020 is provided (this allows an overview of types of complaints in year and also for any open complaints at the point of reporting to be completed at a subsequent iteration of the report). All Stage 2 complaint learning from 2019/20 was included in the Feedback and Complaints Annual Report presented to the Board in August 2020.

A summary of cases taken to the Scottish Public Services Ombudsman from April 2019 onwards is included at the end of this report, allowing oversight of the number and progress of these and also the compliance with any learning outcomes that are recommended following SPSO investigation.

Summary

- Corporate Services recorded 38 pieces of feedback in Quarter 2 of 2020_21 (1 July 2020 – 30 September 2020):

	01.07.20 – 30.09.20		01.04.20 – 30.06.20 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	4	10	2	17
Concerns	17	45	3	25
Complaints	17	45	7	58
Totals:	**38**		**12**	

- The 17 complaints received related to the following areas:

	01.07.20 – 30.09.20		01.04.20 – 30.06.20 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	5	29.4	2	28.5
Directorate of Community Health and Social Care	9	52.9	3	42.9
Acute and community	2	11.8	1	14.3
Corporate	1	5.9	-	-
Other	-	-	1	14.3
Withdrawn	-	-	-	-
Totals:	**17**		**7**	

Key highlights

- Complaint numbers are increasing to more typical levels, and in particular there is increased feedback regarding waiting times for non-urgent, but significantly life improving operations. This is not unique to Shetland.
- We received official notification of one further case referred to the SPSO during the reporting period but we have not yet heard if this will be investigated. We closed one SPSO set of recommendations in August 2020.
- ISD no longer collates complaint performance data on a quarterly basis. As NHS Bodies already publish annual reports covering complaints, we are asked instead to include complaints information covering nine Key Performance Indicators (KPIs).

  A standardised reporting template regarding the key performance indicators has been agreed with complaints officers and the Scottish Government.
- Quarterly complaint data received for Family Health Service providers has not been included in this report. Compliance with returns remains low and for those areas that do submit the numbers are negligible. This will continue to be picked up through professional leads.
- Complainant experience in relation to the complaints service provided for Stage 1 and Stage 2 complaints will be included on an annual basis given the low numbers involved.

Complaints Performance

Definitions:
Stage One – complaints closed at Stage One Frontline Resolution;
Stage Two (direct) – complaints that by-passed Stage One and went directly to Stage Two Investigation (e.g. complex complaints);
Stage Two Escalated – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)

1 Complaints closed *(responded to)* at Stage One and Stage Two as a percentage of all complaints closed.

Description	01.07.20 – 30.09.20	01.04.20 – 30.06.20 (previous quarter)
Number of complaints closed at Stage One as % of all complaints	56% (9 of 16)	71.4% (5 of 7)
Number of complaints closed at Stage Two as % of all complaints	44% (7 of 16)	28.6% (2 of 7)
Number of complaints closed at Stage Two after escalation as % of all complaints	0% (0 of 16)	0% (0 of 7)
NB One Stage 2 complaint remains open so is not included in these figures		

2 The number of complaints upheld/partially upheld/not upheld at each stage as a percentage of complaints closed *(responded to)* in full at each stage.

Upheld

Description	01.07.20 – 30.09.20	01.04.20 – 30.06.20 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	22% (2 of 9)	20% (1 of 5)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	43% (3 of 7)	50% (1 of 2)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	-	-

Partially Upheld

Description	01.07.20 – 30.09.20	01.04.20 – 30.06.20 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	67% (6 of 9)	20% (1 of 5)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	43% (3 of 7)	50% (1 of 2)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	-	-

Not Upheld

Description	01.07.20 – 30.09.20	01.04.20 – 30.06.20 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	11% (1 of 9)	60% (3 of 5)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	14% (1 of 7)	0% (0 of 2)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	-	-

3 The average time in working days for a full response to complaints at each stage			
Description	**01.07.20 – 30.09.20**	**01.04.20 – 30.06.20 (previous quarter)**	**Target**
Average time in working days to respond to complaints at Stage One	5.7	5.6	5 wkg days
Average time in working days to respond to complaints at Stage Two	38.3	19	20 wkg days
Average time in working days to respond to complaints after escalation	-	-	20 wkg days

*Response times for Stage 2 complaints remain significantly impacted upon by capacity due to the Covid-19 Pandemic.

4 The number and percentage of complaints at each stage which were closed *(responded to)* in full within the set timescales of 5 and 20 working days			
Description	**01.07.20 – 30.09.20**	**01.04.20 – 30.06.20 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	56% (5 of 9)	40% (2 of 5)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	29% (2 of 7)	100% (2 of 2)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	-	-	80%

5 The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description	**01.07.20 – 30.09.20**	**01.04.20 – 30.06.20 (previous quarter)**
% of complaints at Stage One where extension was authorised	44%	60%
% of complaints at Stage Two where extension was authorised	71%	0%
% of escalated complaints where extension was authorised	-	-

Learning from complaints

For Quarter 2 there are no particular complaint trends to highlight although restrictions resulting from the Covid-19 Pandemic have contributed to concerns being raised about potential waiting times for life changing procedures. We have also seen an increase in mental health complaints.

Staff Awareness and Training

Staff are provided with key information on feedback and complaint handling at each induction session. Staff attending mandatory refresher training are given an update sheet on feedback and complaints. The Feedback and Complaints Officer is continuing to speak with departments to try and empower more people to feel confident to handle a Stage 1 complaint or signpost effectively to the appropriate support. Reminders have been put in staff briefings.

A management bundle on feedback and complaints has been developed for delivery by the Feedback and Complaints Officer through 2020. Work will be done to consider how best to deliver this virtually in 2021.Staff are also able to access excellent national e-learning resources regarding feedback and complaint handling, including investigation skills, through TURAS Learn.

Stage 2 complaints received 1 April 2020 to 30 September 2020

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Actions
1	Complainant felt there could have been an earlier diagnosis of cancer	Consultant/GP	Yes		Part upheld	• No evidence to suggest outcome would have been different with an earlier diagnosis. Decision making at each stage found to be understandable in the circumstances. • Review of systems to ensure a safe process for the review and communication of results.
2	Availability of results and potential harm in delay	Medical Records/A&E	Yes		Upheld	• Longer term looking at an electronic ordering system. Until then a daily histology report from Aberdeen has been put in place to avoid issues with postal delays.
3	Late diagnosis and not informed directly	Consultant	N	Delay in investigation due to leave	Upheld	• Patient offered consultation with consultant to discuss concerns raised and also to identify any ongoing clinical issues and has confirmed they are satisfied with the outcome.
4	Significant delay in diagnosing rare disease	Consultant	N	Input from a number of clinicians including out with NHSS	Upheld	• Full apology given and meeting offered to discuss pathway to diagnosis. • Medical training session organised with specialist consultant to raise awareness of distinct, but rare symptoms.
5	Staff attitude	Consultant	N	Delay in investigation due to leave and capacity in department	Part upheld	• Acceptance that manner may have been brusque and apologies given for causing distress, however the message was seen to have been professionally necessary to impart.
6	Poor experience of appointment, including staff attitude	Consultant	N	Capacity to conclude investigation	Upheld	• Full apology given for patient's perception of appointment which was recognised to be rushed, despite best intentions.

7	Treatment and staff attitude	GP	Y		Part upheld	• No evidence to support concern about staff attitude, however learning points identified regarding process. Education session put in place.
8	Data protection concerns	GP/Admin			Open	
9	Concerns about physical and mental health issues	Acute and community	N	Complexity across multiple health disciplines and capacity to conclude investigation	Part upheld	• Despite delay to final written sign off, the complaint was handled immediately on receipt due to impact on care being provided, including prescribing plans. • Process reviewed regarding follow up for patient.
10	Concern about discharge and care at home	Acute and community	Y		Not upheld	• Discharge process found to be in line with best practice in terms of NoK contact.

Cases escalated to the Scottish Public Services Ombudsman from 1 April 2019 to 29 November 2020

Date notified with SPSO	Our complaint ref	SPSO ref	Area of complaint	Date of SPSO outcome	SPSO outcome	SPSO recommendations	Action update	Board/SPSO status
2019/20								
21.10.19	2018_19_24	201902265	Unreasonable attempt to continue procedure and should have been stopped sooner	09.06.20	Upheld	1. letter of apology for the failings identified by 10.08.20 2. Evidence that this matter has been fed back to relevant medical staff in a supportive manner that encourages learning by 09.10.20 3. Evidence that the junior doctor included this case in their appraisal by 10.08.20	File submitted 07.11.19 Letter of apology sent to family Evidence sent to SPSO for all three actions 10.08.20	Considered closed by SPSO
09.01.20	2019_20_16	201908764	GP attitude during consultation	09.01.20	Will not take forward	None		Closed
12.08.20	2018_19_18	201907983	Complication following surgical procedure		Under review		Additional information submitted for consideration	Open

Key:
Grey – no investigation undertaken nor recommendations requested by SPSO
Green – completed response and actions
Amber – completed response but further action to be taken at the point of update
No colour – open case