

## Council of Governors Item 10.3

**Subject:** Q2 Complaints Report 2023/24  
**Date of meeting:** 5<sup>th</sup> December 2023  
**Prepared by:** Laura Allwood Patient & Family Support Manager  
**Presented by:** Sue Pemberton Director of Nursing and Quality

### 1. Executive Summary

The purpose of this report is to provide an update on the numbers of formal and informal concerns received into the Trust. The report will provide an overview of contacts made to the patient and family support team for either advice or information.

Within quarter two (1<sup>st</sup> July- 30<sup>th</sup> September) the Trust received a total of:

- 11 formal complaints
- 116 contacts comprising of- 73 informal concerns - 43 requests for information or advice.
- 29 compliments by letter or e-mail received (all shared with the appropriate teams)

The 11 formal complaints received in this quarter are all closed except 1, 6 were partly upheld, 3 not upheld and 1 upheld. Regular communication is had with the complainants to ensure they are kept up to date with progress being made. All complaints are managed as per the Trust Policy.

### 2. Contacts - Informal concerns, Advice & Information

#### 73 Informal Concern Themes

- **Surgery-** 10 calls around chasing surgery and rescheduled dates. Waiting times, multiple cancellations and poor communication about the cancellations- one patient was advised whilst attending CNP (Clinical Nurse Practitioner) clinic that they were cancelled.
- 3 calls around awaiting TAVI (Transcatheter Aortic Valve Implantation).
- Valve availability- had to be secured from Aberdeen.
- **Appointments-** 13 contacts received. Cancelled appt due to strike. Chasing appointments.
- Chasing cardiology/genetic assessment. Respiratory appointment cancelled due to Industrial Action - rescheduled for 7 months. Chasing appointment for cardiology. Wants a further cardiology but been discharged- complex patient. Chasing appointment for Professor Lip clinic. Patient attended Outpatient Department- no letter or text and advised no appointment- patient very angry and rude to staff. Patients' wife very unhappy that first appointment cancelled due to Industrial Action, second appointment consultant on leave- admin error- 3<sup>rd</sup> appointment has been, and apology given. 2x awaiting telephone appt and had been cancelled.
- Chasing results and follow up appointment.
- **Chasing results-** 7 patient chasing different results- MRI (magnetic resonance imaging), echo result, ECG (echocardiogram) / CT (computerised tomography) scan.
- **Discharge-** given incorrect discharge info, attending walk in issues post thoracic surgery.
- **Referral-** 2 calls chasing referral.
- **Communication-** unhappy with the text service
- **Delays-** cardiology patient and needed emergency surgery.
- Target health lung- patient with disabilities has concerned before going for the lung scan.
- Accident in car park- daughter of the patient raised concern about safety.
- **Chasing follow up-** After angiogram awaiting follow up.

- **A deceased patient-** family were distressed that the tubes were left in.
- **ACHD-** Issues around consultation and letter. Appointment made in error for 2025.
- **Radiology-** Long wait for MRI scan as has a PPM (permanent pacemaker). Awaiting stress MRI and wanted to know waiting times.
- Further medical treatment- 3 letters had been sent to the consultant needing advice being patient could be considered for a transplant at another hospital.
- DVLA/Work letter- chasing with the consultant- delay due to doctors leave.
- Questions around medication and some symptoms post-surgery- appointment has been expedited.
- Being able to access the courtesy bus with a disability- escalated to Liverpool University Hospitals NHS Foundation Trust PALS (patient advice and liaison service).

#### **43 Advice & Information**

- Subjects include:
- Death notification x4
- Enquiry about the monitoring system
- Information request
- Symptom advice
- Appointment query x3 calls
- Admission information
- Volunteer enquiry x2 calls
- Chasing result letter
- Lost property
- Chasing appointment as cancelled appointment in May due to no registrar- on waiting list for next appointment.
- Chasing referral for PFO (patent foramen ovale) closure.
- Had stent procedure abandoned on discharge needed further explanation and support- consultant rang the patient.
- TAVI complication- family concerned about psychological impact on the patient. TAVI team resolved.
- Medical records- request.
- Inpatient- family rang wanted input with discharge plans x2.
- Awaiting surgery dates enquiries- x3
- Chasing appointment/referral- cardiology to cardiac surgeons.
- Ambulance advice.
- Chasing biopsies following thoracic procedure for a deceased patient.

#### **Administration related concerns**

- Chasing clinic letter.
- 3 calls about phoning the secretary and leaving messages with no response or return calls.

#### **Higher level informal concerns:**

- Met a patient and his wife in Outpatient Department with the cardiac surgeon who had taken over his care as consultant who operated has retired. Patient had rheumatoid arthritis and is on very specialised medication for this with a post operative wound infection and some complications medication could not be started. Wife felt that they are continually having to chase things up- Plan set for PET (positron emission tomography) scan and WCC (white cell count) in Manchester. Medication has now been started.  
**Closed**
- Request for further information following complications following a TAVI which led to open heart surgery. The patient sadly had a stroke and has been left with some disabilities. Letter sent to the patient but outcome of the RCA (Root cause analysis) and offer to meet. **Closed.**
- Issues noted around carelink and arriving for an appointment which was cancelled. Letter to follow.

- Patient raised concerns around how his cardiology care had been managed- as needed emergency heart surgery whilst visiting family. Letter sent to the patient. **Closed.**
- Cystic Fibrosis patient- ongoing communications issues with the patient and her mum. Professor Walshaw has requested several times to see the patient face 2 face but has been declined. Deputy Director of Nursing sent an email to cease communication as Professor Walshaw can't do the referral to another hospital without the review. **Closed.**
- Historical case- November 2020- questions raised by the wife of a deceased patient via an advocate- issues were around his health after a permanent pacemaker was fitted and conduct in outpatients. Letter sent to the advocate to share. **Closed.**

### 3. Complaints

**Table 2** below provides details of complaints per month via division year to date

Number of complaints per month/division				
Total/month in brackets	Surgery	Medicine	Corporate	Clinical Services
April 23	1	4	0	0
May 23	2	3	0	0
June 23	0	2	0	0
July 23	1	2	0	1
Aug 23	1	3	0	0
Sept 23	1*	2	1	0
Oct 23				
Nov 23				
Dec 23				
Jan 24				
Feb 24				
Mar 24				
<b>Total</b>	<b>6</b>	<b>16</b>	<b>1</b>	<b>1</b>

\*joint within LHCH

**Table 3-** below shows the complaints received in Q2 formal complaints and learning outcomes per division.

Q1 Complaints			
9	Medicine	Concerns raised about communication with the Cystic Fibrosis team. Waiting time for test results and problems arranging a blood test closer to home.	<b>Closed- Partly upheld</b>
12	Medicine-community	Unhappy with the consultation with cardiologist in the community cardiology clinic. He feels he was not looking at him and was typing on the computer. Also, unhappy that the monitor is unavailable at the clinic and had to be sent out after.	<b>Closed- Partly upheld</b>
Q2 Complaints			
13	Surgery	Cancelled and rescheduled surgery between September 22 and March 2023. Due to the delays the patient ended up becoming seriously ill and had a prolonged admission to ITU (Intensive Therapy Unit) at Liverpool University Hospitals NHS Foundation Trust.	<b>Closed- Partly upheld</b>

<b>14</b>	Clinical services	Referred in December 2022 for a cardiac MRI scan from the Isle of Man- stated as urgent. When the wife chased middle of January 23 advised it was down as non-urgent and next available. Patient passed away in February 2023.	<b>Closed- Partly upheld</b>
<b>15</b>	Medicine	Unhappy with a cardiology consultation.	<b>Closed- not upheld</b>
<b>16</b>	Medicine	Led by Warrington Hospital- information requested why a patient was transferred back to Warrington Hospital in January 2022	<b>Closed- not upheld</b>
<b>17</b>	Medicine	Concerns raised regarding the discharge from ACU (Acute Coronary Unit) being hurried, wound not examined properly on discharge and no district nurse referral sent. No follow up care plan given and the experience from the discharging nurse was poor.	<b>Closed- Partly upheld</b>
<b>18</b>	Surgery	Concerns raised about the named surgeon and the patient being told who would be doing the surgery, the operation note on EPR (electronic patient records) incorrect date of birth and case sheet number. Patient had surgical emphysema- patient and family not told. Took 7 weeks for the biopsy results to come back- advise that could be lost and is querying whether they were the correct biopsies.	<b>Closed- Partly upheld</b>
<b>19</b>	Medicine	Telephone consultation end of August 23 and advised needed to take a new medication and would be sent to the GP (general practitioner). Patient chased the letter and prescription for 8 days and feels this length of time was unacceptable.	<b>Closed- Partly upheld</b>
<b>20</b>	Medicine	Poor experience when had a procedure in catheter lab in April 2022.	<b>Closed- Partly upheld</b>
<b>21</b>	Corporate/surgery	Incident between a staff member and patient in the car park after a clinic appointment. Staff on Cedar ward- claimed to be rude and made him feel he shouldn't be coming to the ward for his appointments with the consultant.	<b>Under investigation</b>
<b>22</b>	Medicine- ACHD	Led by Salford- unhappy about the patient's discharge in March from Cherry ward. Patient had a learning disability. Readmitted to Salford Hospital 2 days later, transferred to LHCH and family not advised how ill the patient was. Patient sadly passed away on ACU.	<b>Closed- Upheld</b>
<b>23</b>	Medicine- PP	Price of the procedure and device has increased since the first estimation. Patient has paid all invoices prior to surgery. Has been sent invoice for outstanding charges- not advised separate cost for Maze procedure.	<b>Closed- Partly upheld</b>

**Key: Upheld** = complaints considered well founded – requiring action/learning **Partly upheld** = action may be required for part of the complaint **Not upheld** = following investigation no evidence found to substantiate complaint, but acknowledgement of disappointment given and apologies where necessary

### **3.1 Parliamentary Health Service Ombudsman (PHSO)**

1) Information request for a formal complaint that was dealt with in 2021 within the surgical division. Full medical records, complaint file and images all sent as requested. Await to hear from the Ombudsman on whether they will take the case on.

2) Final Report received, and trust agrees with the final recommendations made by the ombudsman. £500 has been rewarded to the complainant, apology letter alongside action plan has been sent also to the complainant and to the ombudsman. **Partly upheld- final outcome.**

### **3.2 Complaints Review Panel**

The Non-executive review panel meeting for Q2 took place on the 31<sup>st</sup> October 2023 and they were satisfied with the complaint process and responses.

### **3.3 Medical Examiner concerns raised.**

All deaths are scrutinised by the medical examiner and medical examiner officer, any that raise any concerns are highlighted to Dr Raph Perry (Medical Director) and Dr James Greenwood (Patient Safety Lead) along with the Deputy Director of Nursing.

In Q2, 4 deaths were highlighted to them for full mortality review group reviews to take place.

### **4. Recommendations**

The Council of Governors are requested to note the report and the content.