

Council of Governors Item 9.3

Subject: Patient and Family Support Team Q1 Report 2022/23
Date of meeting: 26th September 2022
Prepared by: Laura Allwood Patient & Family Support Manager
Presented by: Susan Pemberton Director of Nursing, Safety and Quality

1. Executive Summary

This report outlines the informal concerns and complaints captured in Q1, 1st April-30th June 2022. The Trust received a total of 9 formal complaints for Quarter 1. In addition, 77 contacts were made, 57 informal concerns and 20 requests for information or advice.

The Trust has received 13 compliment letters/emails in this quarter-all have been shared and feedback has been given to appropriate teams and directorates.

2. Contacts - Informal concerns, Advice & Information

The Table below provides a summary of the contact themes.

Quarter 1 Contacts -Overall Total = 77
57 Informal Concerns – themes <ul style="list-style-type: none"> • Surgery- long waiting time, cancelled complex surgery at short notice, Covid swab result query as surgery cancelled and cancelled surgery with no alternative date given. • Outpatient Department OPD- Experience in outpatients (OPD)- coffee shop no cash being taken, car park and courtesy bus issues. Letter received by a patient and was unaware of the contents from recent clinic appointment. • Referral- delay from last year and wanted appointment sooner and awaiting appointment from referral in January. • ACU-Acute Coronary Unit- hard to get information about a patient – prior to visiting • Administration: multiple concerns raised around being unable to get hold of secretaries and administration teams- messages not returned and calls ringing out- especially regarding the Inherited Cardiovascular Conditions (ICC) team. DVLA (Driver and Vehicle Licensing Agency) forms taking a while to be responded to and delay in clinic letters going to the general practitioner -GP • Post operative- Struggling with pain in sternum and worried about the options. Appointments on different days for scans and tests. • Pulmonary Function Team- attended on a Sunday, appointment unable to be completed as GP did not sign the referral. • ACHD Adult Congenital Heart Disease- Waiting times for surgery. • Waiting times- several chasing appointments after being referred to LHCH

- **Appointments-** Poor patient experience in cardiac diagnostics, mobile CT scanner, wrong appointment sent out regarding spirometry. A young ACHD patient arrived for appointment-cancelled and was sent away.
- **Inpatient-** poor patient experience in CT scan and lost property.

- 20 Advice & Information** - Subjects include:
- **Referral-** information request about referral
 - Medication queries
 - Received appointment and can't attend and unsure what it was for
 - ECG (electrocardiogram) results needed for GP
 - Advice about DA languages (new interpretation/translation company)
 - Information request from the coroners
 - Advice on patient being able to go on a flight
 - Deceased- what to do with the monitor
 - Calls to a secretary from a patient who had complex mental health issues
 - Chasing notification of change of medication to the GP
 - Patient had a fall on the ward and relative wanted to know more information
 - Alerting us to a patient who had additional needs

- Informal complaints- requiring more in-depth investigation included:**
- **Private patient-** administration issues and expectations of costs- call to family with the Programme manager and Patient and Family Support manager- follow up email sent.
 - Unhappy not being seen by the consultant as on leave refused to see the registrar- met with the consultant and Patient and Family Support Manager
 - **Rowan- Private patient-** ECG experience- ward manager call to the patient to discuss.
 - Patient had a cardiology procedure in December 20021 and had a rare complication- letter sent to the patient explaining what had happened and offered to meet to discuss further.

3. Complaints

The Table below provides details of complaints split by division for the year to date.

Number of complaints per month/division				
Total/month in brackets	Surgery	Medicine	Corporate	Clinical Services
April 22	0	2*	0	2*
May 22	2*	1*	0	0
June 22	1*	3*	0	0
July 22				
Aug 22				
Sept 22				
Oct 22				
Nov 22				
Dec 22				
Jan 23				
Feb 23				
Mar 23				
Total	3	6	0	2

*Joint within LHCH

The table below shows the formal complaints received and closed in Q1 and learning outcomes per division.

Ref:	Division	Summary of complaint	Outcome/Learning
Q1 22/23			
1	Clinical services/medicine	Was an inpatient on the 16 th Feb for a pacemaker. After discharge on the 25 th Feb got a call to say mix up with medication. Advised to stop taking usual medication and would be sent out in a taxi. Blood test beginning of march showed kidney failure- claim due to medication mix up.	Closed- upheld
2	Medicine	Potential negligent discharge from birch ward. Discharged on the 19 th Aug 2019 and became critically unwell after arriving home ad readmitted. Patient sadly died on the 11 th September.	Closed- partly upheld
3	Clinical services	Breach of confidentiality by a support worker on the post operative critical care unit towards the patient- family history related to the staff member.	Closed- not upheld
4	Medicine	Discharge- should the patient have received an inpatient MRI scan or when realised the results came through should the plan have changed. Cardiac rehab query, advice over work, covid swab result post discharge.	Closed- not upheld
5	Private Patient-surgery	Private patient- administration, communication and expectation concerns raised. Was not aware of all the costs, not aware of the ward he would go to and some hospitality issues. Issues around discharge- query too soon and trying to contact cedar ward.	Closed- upheld
6	Surgery	Poor experience on oak ward- could hear staff talking about her outside the room and was left feeling very uneasy- was moved to another ward.	Closed- partly upheld
7	Medicine	Misdiagnosis- had CT scan in Jan 21 result stated severe left atrial dilation and this was explained via a telephone appt. 12 months later had a further call with Dr Todd who listened to the concerns raised- then received a call from Dr Sristava about a mis diagnosis on the scan.	Closed Meeting held- formal letter completed- partly upheld
8	Surgery/medicine	Cardiac surgery in 2010 and has since been advised that has a valve mis match which has now caused health problems which needs aggressive treatment and is under the heart failure team.	Closed Meeting held- formal letter completed-Not upheld
9	Private Patient-medicine	Private patient experience- felt like was treated as an NHS patient, issues around privacy, availability of side room/TV and private chef. Feels the cost of the procedure does not reflect his experience.	Closed- partly upheld
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)

There was a formal complaint dealt with in January 2021 around why they were cancelled at a very late stage for an angiogram and the interpretation of an Xray. A second letter was then sent to the patient in March 2021 to formally close the complaint response and answer the few last queries the complainant had sent. The complaint file and patient records have been sent to the PHSO in May 2022.

3.2 Complaints Review Panel

Q1 review panel meeting to be held in September 2022.

3.3 Medical Examiner concerns raised

All deaths are scrutinised by the Medical Examiner / Medical Examiners Office, and any that raise any concerns are highlighted to the Medical Director, Dr Raph Perry and Deputy Medical Director, Dr Nigel Scawn along with Deputy Director of Nursing and Quality, Joan Matthews.

In Q1, 6 deaths were highlighted for full mortality review - group reviews to take place.

4.0 Recommendations

The Council of Governors are asked to receive the report and the content and be assured that the Trust has a robust complaints management process in place and all actions and learning from both informal and formal complaints are discussed at both divisional and organisational level.