

## Council of Governors Item 7.3

**Subject:** Patient & Family Support Team Annual Report 2019/20  
**Date of meeting:** Tuesday 2<sup>nd</sup> June 2020  
**Prepared by:** Laura Allwood, Patient & Family Support Manager  
**Presented by:** Sue Pemberton, Director of Nursing & Quality

### 1. Executive Summary

This report outlines the complaints, informal concerns and compliments received in Quarter 4, 1st January 2020 – 31<sup>st</sup> March 2020. The Trust received a total of 7 formal complaints for Q4 making a total of 36 YTD. Of the 7 formal complaints none were upheld meaning no actions or learning was identified and 3 were partially upheld and 2 awaiting final outcomes.

In addition, the Patient & Family Support Team received 90 contacts, of which 54 were informal concerns and 36 were requests for information or advice. All informal concerns were successfully resolved by liaising or escalating to appropriate manager/divisional team. 4 informal responses either via email or letter and several phone calls made to resolve all the issues.

Any learning and actions required were managed locally and included in the monthly divisional complaints reports. Consultants also copy the Patient & Family Support Manager into any letters to patients following action taken. All action plans were managed through the relevant Divisional Governance Committees.

During Q4, there were 12 written compliments via the CEO or Patient & Family Support Team commending the care, services and staff. This outweighed the number of complaints received.

### 2. Contacts(PALS)/Informal concerns/Requests for advice and information

**Table1**

<b>Quarter 4 Contacts - Total = 90</b>
<b>36 – Requests for advice and information-</b> Subjects include: <i>Request for information from other Trusts, change of details, parking queries and travel advice, how to make a complaint, appointment advice.</i>
<b>54 - Informal concerns</b> – Subjects include: <i>COVID related issues raised include- visiting issues, cancelled procedures, vulnerable patients wanting more information. Discharge process queries from the ward areas, ACHD surgical cancellations and expectations of rebooking. Parking issues and delay in discharge letters to GP. Bereavement follow ups awaiting reports.</i>

### 3. Complaints

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

Number of complaints per month/division				
Total/month in brackets	Surgery	Medicine	Corporate	Clinical Services
April 19	0	2	0	0
May 19	0	3	0	0
June 19	0	4*	1	0
July 19	0	2	0	0
August 19	2	0	1	0
September 19	0	4	0	1
October 19	2	3	1	2
November 19	0	2	0	0
December 19	0	0	0	0
January 20	1	3	0	0
February 20	2	0	0	0
March 20	1	0	0	0
<b>Total</b>	<b>8</b>	<b>23</b>	<b>3</b>	<b>3</b>

\*involved more than one division. Any action plans/learning is presented to the relevant committee as a separate agenda item by the divisional leads.

**Table 3** below shows the complaints received in Q4 and learning outcomes per division.

Ref:	Division	Q4 Summary of complaints	Outcome
30	Surgery	Joint complaint with Clatterbridge Hospital- <b>Diagnosis/Treatment</b> -Patient was diagnosed with Mesothelioma in 2015 and referred to oncology in Clatterbridge. Family are querying appropriate diagnosis and tests done to support the disease staging.	<b>Open- delayed due to Covid response</b>
31	Medicine	<b>Treatment and care as an inpatient TAVI</b> - issues regarding preoperative information being given, issues regarding post op care, heart monitoring, external pacemaker checks and care on Birch ward.	Closed- partially upheld.
32	ACHD	<b>Surgery Cancelled</b> - had 2 calls in a week to cancel surgery dates back to February, questions raised around the 2nd phone call why it was a ward clerk, who made the decision to put back the surgery was it MDT or individual.	Closed-Not upheld
33	Medicine	<b>Patient care</b> - Had a heart attack in 2015 was told that artery was completely blocked, health deteriorated whilst being medically managed. Referred to another Doctor had a procedure to unblock in July 2019. Is wondering if has been misdiagnosed by the original Doctor.	Closed- Not upheld
34	Surgery	Joint with Whiston Hospital- <b>Patient care</b> - Concerns around referral time from Whiston Hospital to LHCH, why he was discharged after 3 days and was discharged without stockings.	Closed- partially upheld
35	Surgery	<b>Clinical care</b> - Had an elective left lung biopsy VATS on 14/1/20, had issues with severe pain post op, the attitude of the Consultant and Nurse Practitioner, left without pain relief for some time. Expressed several times that she lives alone and had concerns but was discharged and admitted shortly after to Whiston Hospital.	Closed-partially upheld

36	Surgery	<b>Care received on surgical ward-</b> Several concerns raised around medication, insufficient washing facilities and communication with staff and patient.	<b>Open- delayed due to Covid response. Has requested a face to face meeting.</b>
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### 3.1 Parliamentary Health Service Ombudsman (PHSO)

One current complaint referred to the ombudsman from August 2019 (original complaint received by the Trust in October 2018 and dealt with by the complaints process) regarding the communication and care awaiting a TAVI. Patient was provided with TED stockings post operatively then developed necrotic toes following discharge. Patient was later diagnosed with Peripheral vascular disease. A response was sent to the ombudsman on 7/9/19 and we have now received a provisional recommendation in March 2020 from the PHSO which is awaiting review by the Trust. Has been delayed due to Covid response by the Trust.

### 3.2 Complaints Review Panel

In Q4 a panel was held and complaints including investigations, responses and action plans were reviewed from Q3 by one of the Non-Executive Directors. They were assured that the investigations were comprehensive and assured that complaints management was robust and did not request to review any of the complaints further.

### 3.3 Complaints Summary 2019-20

In 2019/20 the Trust received 36 formal complaints, all of which were investigated and responses provided. Apart from 2 in Q4 which were delayed due to the Covid response by the Trust they are now in the process of being completed. Both complainants made aware of the situation and reason for the delay as one required a face to face meeting and the other is joint complaint with another Trust.

This is the same as the previous year and a decrease of 26.5% compared to 2017-18 when 49 were investigated. This is due to proactive action at the earliest opportunity to review and resolve concerns that are raised through local resolution.

Of the 36 complaints investigated, 8 were fully upheld, 13 were partially upheld and 13 were not upheld (unfounded) and did not require action or learning. Of the 36 complaints, 24 were responded to within the negotiated timeframe and 10 complainants agreed extensions.

Two complaints are still outstanding from Q4, one of which is a joint complaint with another Trust. First initial response provided however, needs to go back to the other Trust for questions but due to covid response unable to do this. This has now started to be looked at again. The second complainant would like a face to face meeting locally in Wales and due to the covid response and national lockdown it has not been possible to complete a response.

No complaints received in 2019/20 were referred to the Parliamentary Health Service Ombudsman at the time of this report.

## 4. Recommendations

The Council of Governors are asked to receive the report and the receive assurance that the complaints process, management and procedure is robust and monitored for effectiveness and is based upon the Trust's Complaint Policy,