

Council of Governors (in Public)

Item 7.5

Subject: Q1 Complaints Report 2016/17
Date of meeting: 26th September 2016
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Presented by: Sue Pemberton, Director of Nursing & Quality

1. Background

The purpose of this paper is to provide the Council of Governors with the number of concerns and complaints, and the trends, outcomes and learning for quarter one (1st April – 31st June 2016). Also detailed within the paper is an update on the complaints referred to the Parliamentary Health Services Ombudsman (PHSO).

2. Concerns Raised

In quarter 1, 95 contacts were made which shows a slight decrease compared to Q1 2015/16 when 114 were received. Of the 95 contacts made, 47 requests were made for advice and information and 48 informal concerns were raised with the themes listed below:

- Waiting times for appointments for surgery
- Waiting times for surgery
- Referral enquiries
- Car parking charges

Reporting is through the monthly Divisional Governance meetings where identification of learning is identified and monitored.

All concerns were resolved and none escalated to a formal complaint.

3. Complaints

The table below demonstrates quarter on quarter, the numbers of complaints received, trends and grades for 2015/16 and 2016/17.

| Q1 2015/16 (April-June) | Q1 2016/2017 (April – June) |
|--|--|
| Total = 19 | Total = 17 |
| Clinical Care (16) No particular theme, operator or area | Clinical Care (12) No particular theme, operator or area |
| Communication (2) | Communication/Information – clinical (1) |
| Discharge process (1) | Waiting Time in outpatients (2) |
| | Waiting time - Referral Process (2) |
| Key: Upheld = complaints considered well founded – requiring action 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 | |

All complaints were investigated, acknowledged and answered in line with policy and

procedure.

4. Learning from complaints

At the time of producing this report 13 complaints from Q1 were considered upheld/partially upheld requiring action or improvement. All action plans were presented to the relevant governance committee. If immediate action was taken, no action plans were required but the detail of the complaint and learning was discussed at the committee.

All complaint responses either verbal or written were honest and open in line with the statutory Duty of Candour.

The learning from complaints in Q1 includes:

- Improved communication processes.
- Families to be informed of day/times of ward rounds and invited to attend.
- Ward staff to encourage patients and relatives on admission to highlight any concerns they have during their stay.
- Process of communicating the decision for patients referred for a TAVI reviewed and they will be informed via telephone and followed up with a letter.
- Improvements in record keeping
- All family members to be made aware of the Care Partner Programme and Report, escalate and talk during on admission.
- Staff to follow and adhere to the medicine management policy.
- Review the process for recording technical issues associated with blood cross matching from haematology database and how this links with EPR.
- Improve communication with patients whilst waiting areas for clinic/diagnostic tests.
- Review patient administration functions and referral processes.

5. Parliamentary and Health Service Ombudsman (PHSO)

In Q1 the Trust received the findings on two complaint investigations that had been referred to the 2nd stage of the complaints procedure. On completion of their investigations they took the decision, not to uphold either of the complaints as detailed below:

Complaint 1

Patient underwent an angiogram procedure via the wrist and complained they were left with permanent pain, swelling and other symptoms in the arm. The patient complaint that a hand surgeon at another Trust had misdiagnosed the symptoms without imaging.

The PHSO reviewed the Trust's complaints file and the patients' health records from both Trusts. They also sought the advice of a Cardiologist and an Orthopaedic Consultant. They did not uphold this complaint and their decision was based on the fact that there was no evidence that anything went wrong during or following the procedure. The symptoms described were not a recognised complication of the procedure and the hand surgeon reached a reasonable conclusion. **Outcome – Not upheld**

Complaint 2

Patient had an ICD (defibrillator device) implanted in 2014 and prior to discharge sustained a cardiac arrest and sadly died. The complainant, the patient's wife complained that LHCH did not consider patient's pre-existing conditions, relevant tests were not done, there was a delay in activating CPR (resuscitation) and discharge planning was inadequate.

The PHSO reviewed the Trust's complaints file and the patients' health records. During their independent review, they took advice from a Consultant Cardiologist. They found that the care and treatment provided for the patient was appropriate.

Outcome – Not upheld

There are four complaints awaiting investigation with the PSHO detailed below:

Complaint A

The wife of a deceased patient complains about a number of issues relating to the care and treatment of her late husband in 2014 who was transferred for treatment of a pleural effusion. The complainant believes that her husband died sooner than he would have done, had he received better treatment. The complainant also raised concerns how the complaint was handled but did not provide details regarding this.

As a result complainant is seeking acknowledgement of failings and financial remedy.

Complaint B:

The husband of a deceased patient complains about the care and treatment provided to his wife in 2014. The complainant states that his wife's cancer was treated as infection and a CT biopsy was cancelled and feels this contributed to his wife's death.

As a result the complainant wants an apology, service improvements, recognition of errors and financial remedy to be donated to a local hospice.

Complaint C:

The daughter of a deceased patient complains that the Trust did not notify her mother of all the risks associated with an angioplasty procedure. The patient sustained a complication during the procedure and had emergency surgery but sadly died.

As a result the complaint wants service improvements, for the Trust to acknowledge the failings regarding the patient's death and compensation.

Complaint D:

A patient complains about a 6 months wait for valve surgery having initially been referred when they were an inpatient in another Trust and the referral was not properly made by the referring Trust or processed by LHCH. The complainant is seeking an apology, service improvement and financial remedy.

Complaints A-C as detailed above received full investigations and responses by the Trust. Complainants were all invited to meet with staff with only complainant C doing this. Complaint D was initially made in relation to another Trust but after reviewing the issues complained there was involvement from LHCH with the PSHO deciding to include this episode of care within their investigation.

6.0 Recommendations

The Council of Governors is asked to receive the report and receive assurance that complaints management is proactive and robust.