

## Item 12.2

### Council of Governors

**Subject:** Q4 Complaints Report 2023/24  
**Date of meeting:** 4<sup>th</sup> June 2024  
**Prepared by:** Laura Allwood Patient & Family Support Manager  
**Presented by:** Joan Mathews 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 four (1<sup>st</sup> January– 31<sup>st</sup> March) the Trust received a total of:

- 6 formal complaints
- 125 contacts comprising of- 79 informal concerns - 46 requests for information or advice.
- 6 compliments by letter or e-mail received (all shared with the appropriate teams)

The 6 formal complaints received in this quarter are all closed except 1, 1 was partly upheld and 4 were not upheld. Regular communication is had with the complainant 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

##### 79 Informal Concern Themes

Subjects include:

- **Cardiac surgery** concerns x 28 calls/emails received around numerous cancellations/rescheduled/waiting times/effect having on mental health/family. 4 x inpatient call that was cancelled on the ward.
- **Lung cancer**- 4 contacts -Patient's concerned around longer waiting time and being advised to phone weekly.
- **Surgery**- Post surgery follow up appointment cancelled, requesting sick note for 2 months post-surgery and inpatient- low in mood patient awaiting Cardiac MRI.
- **Surgical patient**- has had wallet returned but money missing- query items had been given to the NOK.
- Surgery last year- post operative appointment has been cancelled several times x2.
- **Referral x4**- respiratory referral declined consultant agreed to see the patient as new information provided. Chasing referral regarding a mitral clip- referral letter from surgery to medicine hadn't been completed. Patient awaiting medical intervention- had to be referred from surgery- referral letter had not been done- now completed.
- **Patient not for surgery**- chasing local medical review.
- ACU/pharmacy issue- length of time awaiting TTO- staff expectations- letter provided to the family.
- **Appointments**- not called in for appt- was for a post cardioversion ECG- order was not on the system apology and reimbursement given. Referred to cardiology but no update on the referral and not had any appointment as yet. Post DCCV – patient attended for ECG letter stated would be seen by someone but was an error.

- Unhappy with cardiology appointment- felt not all questions were answered.
- Text service- received appointment for CT scan- thought was spam and couldn't get all the information up.
- **ACHD admin**- patient turned up and cancelled but patient unaware. **ACHD**- Chasing referral to the Royal, awaiting procedure date and waiting for surgery date had been previously cancelled.
- Results chasing PFT results.
- **Radiology**- patient attended for CT angio but should have had hydration prior- patient had to stop. learning for radiology and new clinical plan made with the patient.
- **CT department**- patient very anxious and unhappy with the experience.
- **Radiology**- Cancelled MRI scan and patient were unaware and turned up- appointment was the next day.
- **Cardiology**- Patient felt wrongly discharged, MRI scan results and waiting time for appointment, received results letter and wanted another appointment and letter received querying the anaesthetic cover as day case procedure was cancelled due to anaesthetist being out the previous night.
- **Medicine**- elderly, diabetic patient attended for EBUS concerns raised around consent and listing-being dealt with as an incident.
- **TAVI**- complications during procedure and patient advised to complain.
- **Transfers**- 2 calls from patients advised they had been awaiting transfer from LHCH to another hospital. Brother of a patient raising concerns around waiting for a stroke bed.
- **Communication**- poor experience for a family member in radiology.
- **Inpatient**- wife of a patient rang from CCU- delay in CT scan, relaying of the results and subsequent transfer to Walton- being dealt with as an incident.
- PP- patient had a CT scan privately and was still awaiting results 2 months later.

#### 46 Advice & Information

- Unsure of future medical plan- wanted clarification.
- Chasing referral into the hospital
- Request medical records.
- Pacemaker monitor enquiry
- Questions after surgery
- Chasing cardiac surgery date x5 calls
- Dropped step counter- advice needed.
- Wrong address
- Chasing results from monitor
- Appointment- advice, not received clinic letter
- Car pass enquiry
- Admin- Pain clinic referral chasing up
- Advice around getting support for a patient on discharge.
- Robert Owen enquiry
- Chasing angiogram from Dec 2023
- Radiology referral if has been received and wait enquires.
- Insurance enquiry
- Chasing district nurses post-surgery-IOM patient
- Chasing cardiac MRI and follow up.
- Appointment change but struggling to get through.

<ul style="list-style-type: none"> <li>• Patient engagement event- patient attended wanted face to face follow up appointment from surgery.</li> <li>• Historical deceased case- potential jewellery missing.</li> <li>• Chasing result from recent monitor</li> <li>• Chasing clinic letter post surgery.</li> <li>• Cancelled post operative appointment-enquiry new date.</li> <li>• Complaint- outcome enquiry (historical case)</li> <li>• Chasing referral for cardiac surgery</li> <li>• Complaint advice</li> <li>• Contact detail enquiry</li> <li>• Information request</li> <li>• Incident update</li> <li>• Attended wrong consultant clinic</li> </ul>
<b>Administration related concerns</b> <ul style="list-style-type: none"> <li>• <b>Admin-</b> Private patient- unhappy with the tone and advice given in the clinic letter. GP and patient – delay in receiving clinic letter. Patient turned up to outpatients- unhappy with trying to get information about the DVLA form.</li> <li>• Admin- not receiving clinic letters.</li> <li>• Not receiving correspondence from LHCH- result letters/consultant letters.</li> </ul>
<b>Higher level informal concerns:</b> <ul style="list-style-type: none"> <li>• <b>Cedar-</b> patient was transferred to another hospital and wife rang to raise issues around care and treatment- has had a conversation with the WM and an informal letter has been sent.</li> </ul>

**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	1	0	0	0
Nov 23	2	3	0	0
Dec 23	2	3	0	0
Jan 24	0	2	0	0
Feb 24	0	0	0	0
Mar 24	3	1	0	0
<b>Total</b>	<b>14</b>	<b>25</b>	<b>1</b>	<b>1</b>

\*joint within LHCH

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

<b>Q3 Complaints</b>			
<b>24</b>	Surgery	Unhappy with the after care and follow up after a Ross procedure in August 2022	<b>Closed- partly upheld</b>
<b>Q4</b>			
<b>35</b>	Medicine	Led by LUFT- 1- Appropriate advice given by the community nurse for a low pulse. Also, when transferred to LHCH it took 2 days.	<b>Closed-not upheld</b>
<b>36</b>	Medicine	Led by Whiston PALs- Virtual ward- equipment failed and have not picked this up as arranged, the consistency of calls as set out prior to discharge and lack of escalation and discharged. Patient was readmitted a few days later.	<b>Closed-not upheld</b>
<b>37</b>	Surgery	Patient cancelled for cardiac surgery three times, once over Christmas had arrived at the hospital. 2 further cancellations whilst an inpatient and on the day of surgery due to emergency events happening in theatre.	<b>Closed-partly upheld</b>
<b>38</b>	Surgery	Long wait for thoracic surgery for lung cancer.	<b>Closed-not upheld</b>
<b>39</b>	Medicine	Patient was referred to Clatterbridge after diagnostic tests and Lung MDT outcome October 2022 and a 2 <sup>nd</sup> MDT took place in April 2023. Patient then went on to get 2 <sup>nd</sup> opinion in another hospital and has since had surgery for her lung cancer. Concerns raised about the outcome and plan of care.	<b>Open- under investigation</b>
<b>40</b>	Surgery	Via Sefton Complaints Team- Delays in cancer diagnosis of lung cancer, getting biopsies and finding the liver cancer. Issues raised with Southport Hospital/GP and LHCH.	<b>Closed-not 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)

**Notification from the PHSO investigating a complaint-** Case from July 21, patient had a heart attack and went via the catheter lab and then had urgent cardiac surgery during the same admission. Sadly, the patient passed away following sudden deterioration on cedar ward. Several family meeting's took place, and a formal complaint process was undertaken. All medical records and complaints file sent to the PHSO in July 2023. Await outcome but likely to take time. A written letter from Dr Perry had to be sent to the family due to their aggression towards a member of the LHCH staff after one of the meetings. **Update Q4- awaiting provisional report.**

**March 24- Formal complaint dealt with and closed in December 2023.** Patient was on ACU and issues raised around discharge process, district nurse involvement and follow up plan. Full complaint folder and medical records sent in March 2023. **Await to hear if PHSO is taking the case on.**

### 3.2 Complaints Review Panel

The Non-executive review panel meeting for Q4 took place on the 16<sup>th</sup> April 2024 and they were satisfied with the complaint process and responses.

### 3.3 Medical Examiner concerns raised

Lead of the ME's has changed to Dr Damien Cullington for the next year, Dr Amy Hill has been recruited to the medical examiner team from 1<sup>st</sup> February 2024 with the retirement of Mr Williams.

All deaths are scrutinised by the ME/MEO, any that raise any concerns are highlighted to Mr Manoj Kuduvali and Dr James Greenwood along with the Joan Matthews DON.  
In Q4, 8 deaths were highlighted to them for full MRG's to take place.

#### **4.0 Recommendations**

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