MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Complaints and PALS – Annual Board Report 2016

Requested/ Required by: Trust Board
Clinical Governance Committee
The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

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Directorate: Corporate Services

Specialty: Quality and Governance

Complaints and PALS – Annual Board Report 2016

Requirement for document:	This report is a requirement of the The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This annual report and programme provides: • A review of the complaints and concerns received by the Trust in 2015-16. • A review of performance in responding to complaints in 2015-16. • A summary of the learning and action taken in response to complaints received 2015- 16.
Cross references:	This report is a requirement of the The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This report is supported by the Trust's key policies and procedures: • Managing Concerns and Complaints Policy and procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First annual Board report	June 2013
2.0	Second annual Board report	June 2014
3.0	Third annual Board report	May 2015
4.0	Fourth annual Board report	May 2016

Contents:

1. Executive Summary

The Trust has a statutory duty to investigate and respond to complaints in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the regulations). This statutory obligation is further supported by the Trust's values – PRIDE – which highlight the importance of being customer focused and striving for continuous improvement. While complaints are often considered to have a negative connotation, we recognise that they are also valued methods of feedback and can highlight shortfalls in current practice or policy. In this way, we can use complaints to improve our services and deliver a higher standard of customer service and improved patient experience.

The regulations require an annual report to be produced which:

- specifies the number of complaints received
- the number of complaints which were well founded (upheld)
- the number of complaints referred to the Health Service Ombudsman (PHSO)
- summarises the subject matter of the complaints received
- any matters of general importance arising from those complaints or the way in which the complaints were handled
- any matters where action has been or is to be taken to improve services as a consequence of those complaints.

In light of the report in February 2013 following the Francis Inquiry, increased emphasis has been placed on the need for Board members to be aware of not only the number of complaints, but the issues being raised to ensure executive level support for service improvement arising from complaints.

2. Introduction

The year 2015-16 has seen continued stability in both the Patient Advice and Liaison Service (PALS) and Complaints, with all staff posts filled. Nonetheless, periods of sickness within the PALS team revealed a lack of resilience in the service, which resulted in some difficult decisions being taken in relation to some of the innovations introduced during the previous year.

Compliance with performance in responding to complaints was the key focus for the service and positive steps were taken in this respect.

Changes were introduced by the Health and Social Care Information Centre as of 1 April 2015 to the frequency of data returns and the data being reported.

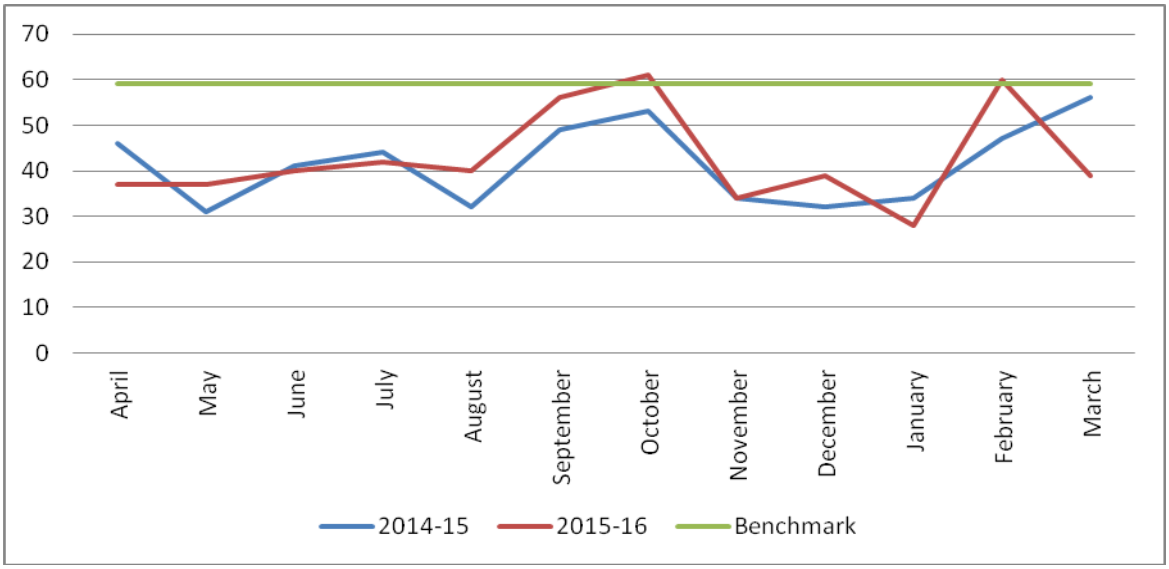
These key issues will be discussed in more detail further on in this report.

3. Complaints received

For the year 2015-16, the Trust received 513 formal complaints, an increase of 28 complaints from the previous year (485 complaints received 2014-15). This is the first increase in the number of complaints received during a financial year since 2011 and is to be expected in line with increasing activity levels across the Trust.

The graph below (3a) compares the number of complaints received in 2014-15 against the number of complaints received in 2015-16 and the current benchmark of approximately 59 complaints per month. The benchmark is based on the national mean of 6.26 complaints per 1000 inpatient episodes (excluding day cases). This shows that, depsite the increase in number of complaints received by the Trust, we broadly remain below the national mean.

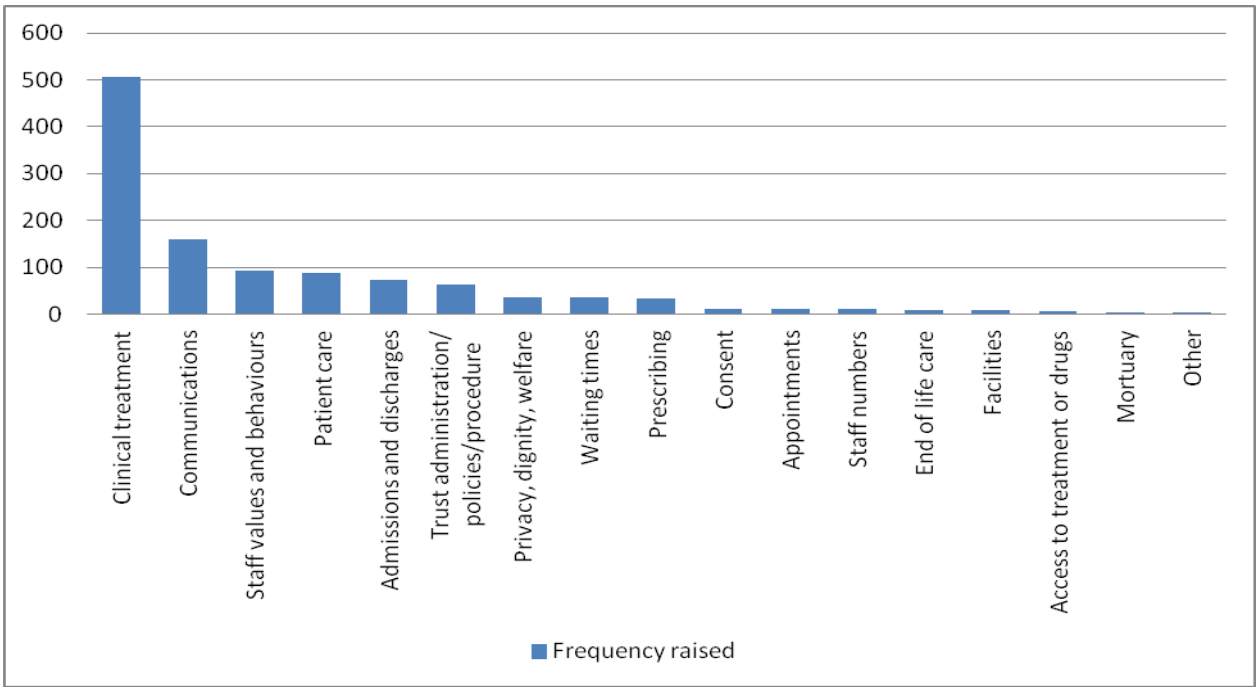
a) Number of whole complaints received



4. Subject of complaints

The subjects used to record the substance of the complaints received by the Trust are determined by the Health and Social Care Information Centre (HSCIC). In April 2015, the HSCIC launched a new methodology for collecting data relating to complaints. They increased the frequency of data collection from annually to quarterly, with the first data return completed in August for complaints received April to July 2015. Furthermore, they revised the subject codes. As a result, we are not able to draw direct comparisons between the subjects raised in complaints received 2015-16 and those received previously. Under the new reporting structure, each element of each complaint is counted seperately. This means that the total number of subjects reported each quarter can exceed the total number of complaints being made, in that one complaint can contain a number of subjects (eg, one whole complaint about communication, clinical treatment and waiting times would be reported as three subjects). For the year 2015-16, the Trust received complaints about 1186 subjects.

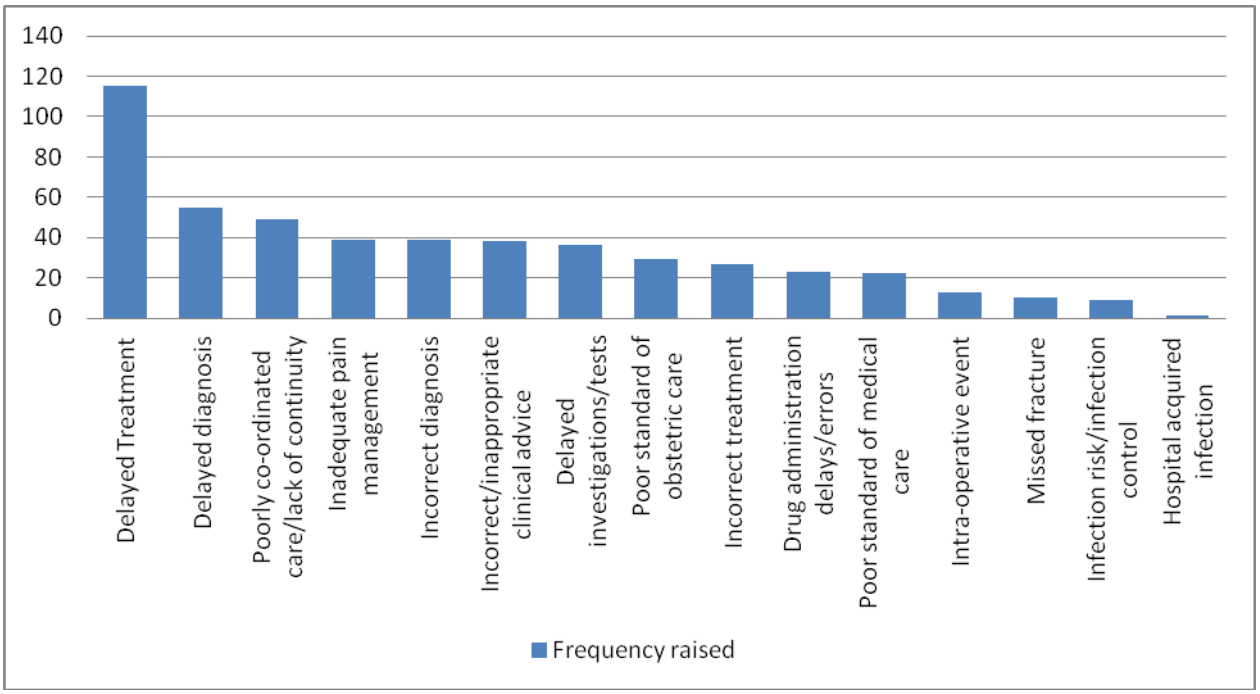
a) Number of subjects raised



This clearly illustrates that issues relating to clinical treatment were the most frequently raised in complaints received by the Trust in 2015-16, totalling 506. This far outweighs the other subjects. However, other issues commonly raised relate to: communications, staff values and behaviours and patient care.

Although direct comparison between subject codes is not possible, in order to enable some continuity, the subject codes defined by the HSCIC have locally determined sub-codes which have been maintained to enable some comparison to be made.

b) Complaints about clinical treatment by sub-subject



This identifies that the most frequently raised issue in complaints about clinical treatment relates to delayed treatment, followed by delayed diagnosis and poorly co-ordinated care/lack of continuity.

An example of a complaint about delayed treatment is illustrated by this patient story:

A child, E, was brought to the ED by his parents, having cut his head when he fell against some furniture at home one evening. He was promptly assessed on arrival and directed through to the play area. His head was bleeding profusely and continued to do so. The dressing was changed a number of times, but quickly soaked with blood. Staff attempted to stem the bleeding to no avail. His parents were informed that there were no staff who could stitch the wound and that they should attend the regional plastics centre the following day at 11.30am. At 2.00am, E was moved to majors and further attempts were made to close the wound with steristrips, even though these had not worked previously. Staff then used adrenaline soaked pads with some effect, but a small movement from E caused the bleeding to start again. Mention was made about placing a stitch to close the wound, but nothing was done. Shortly before 7.00am, unsuccessful attempts were made to take a blood sample. By now, E was pale and limp with reduced responsiveness. At 11.00am, intravenous access was achieved and E was transferred urgently to the plastics centre. E's parents complained that he was left bleeding in the ED for 15 hours, that staff had been unable to stem the bleeding, that intravenous access had not been obtained or blood samples taken earlier and there was a delay in a doctor seeing E.

Investigation of this complaint recognised that there had been delays in treating E and the complaint was therefore upheld. Advice had been obtained from the regional plastics centre,

which staff followed. ED staff do not routinely undertake suturing of head wounds, as this is usually undertaken by plastic surgeons. However, when the recommended treatment was not working, staff should have attempted to suture the wound as a temporary measure. As a result of this complaint, an ED Consultant delivered training on management of head wounds to the ED team. Intravenous access and fluids would not normally be required for a patient with a head wound, but given the amount of bleeding, the Matron agreed that intravenous access should have been considered. The Matron issued a reminder to all ED staff around this. The Matron also agreed that E was not adequately monitored by staff given the persistent bleeding and issued a reminder to the ED staff around the importance of regular observations. E's presentation was managed by and ENP and two ED doctors; it is not usual to refer children to the paediatricians unless sedation or an overnight admission is required. This case was discussed at the Acute and Emergency Medicine clinical governance meeting and discussion took place with colleagues at the regional plastics centre around improving management of prolonged bleeding and communication pathways between the Trusts.

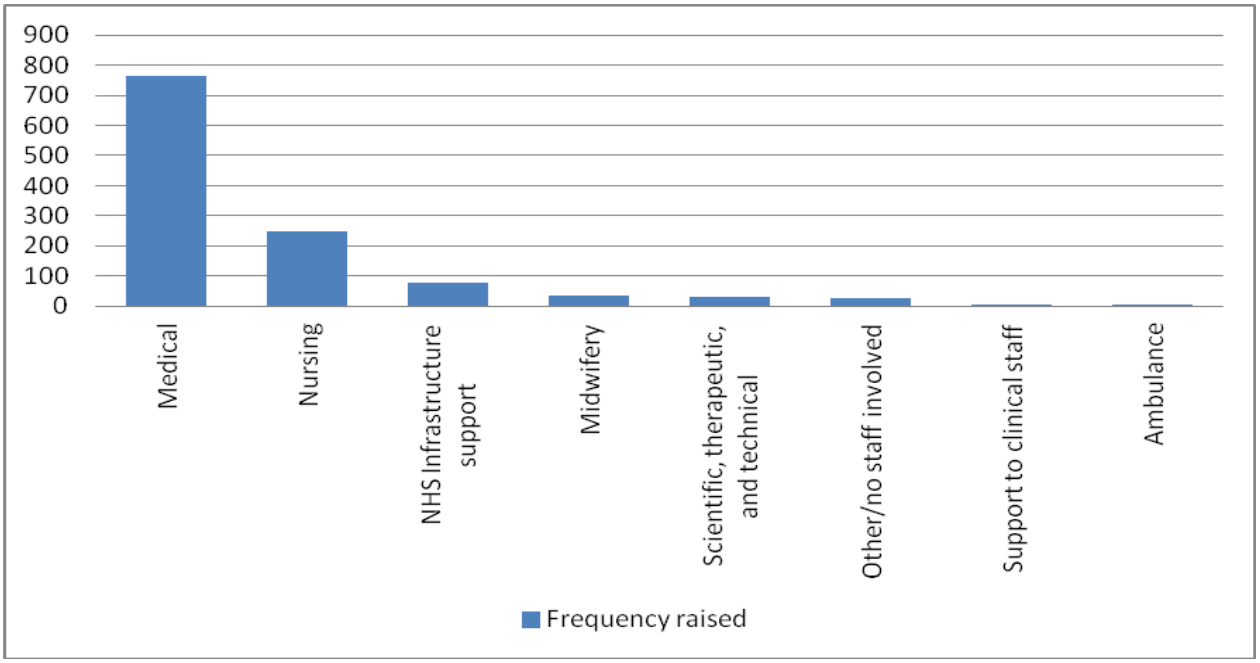
5. Staff groups identified in complaints

As part of the data the Trust is required to capture from formal complaints, we record the professional group involved. Again, changes were made to these categories by the HSCIC in April 2015 and data is now reported per subject, rather than as whole complaints.

To clarify, staff under NHS Infrastructure support would include hospital administrative staff, managers etc. Staff under support to clinical staff would include porters, catering staff, domestic staff etc.

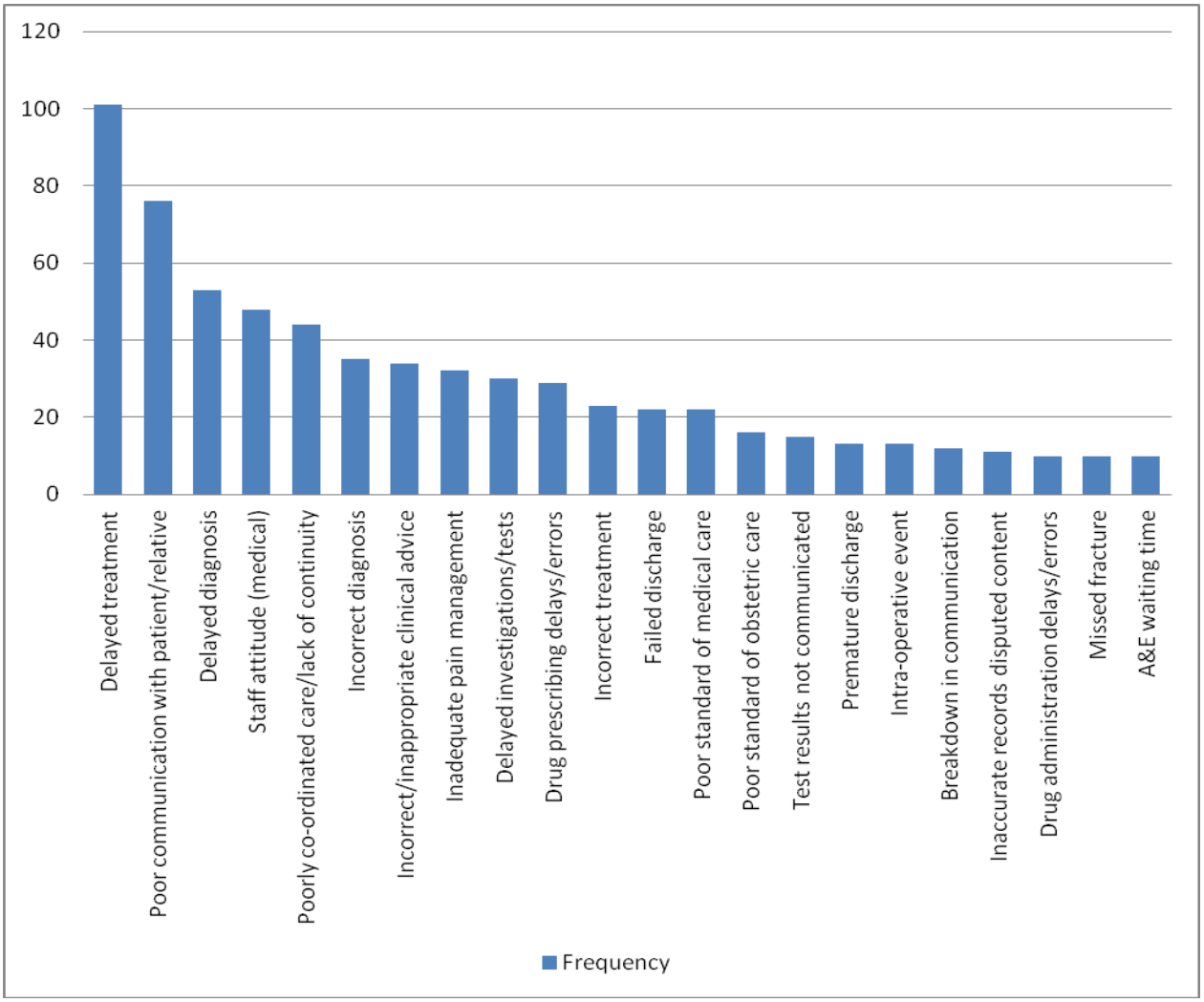
Chart 5c shows the number of subjects raised in complaints, by staff groups.

c) Complaints by staff group



As this shows, the group most frequently identified in complaints is medical staff. Looking at these in more detail, complaints about doctors is broken down in the following graph (5d).

d) Sub-subject of complaints about medical staff



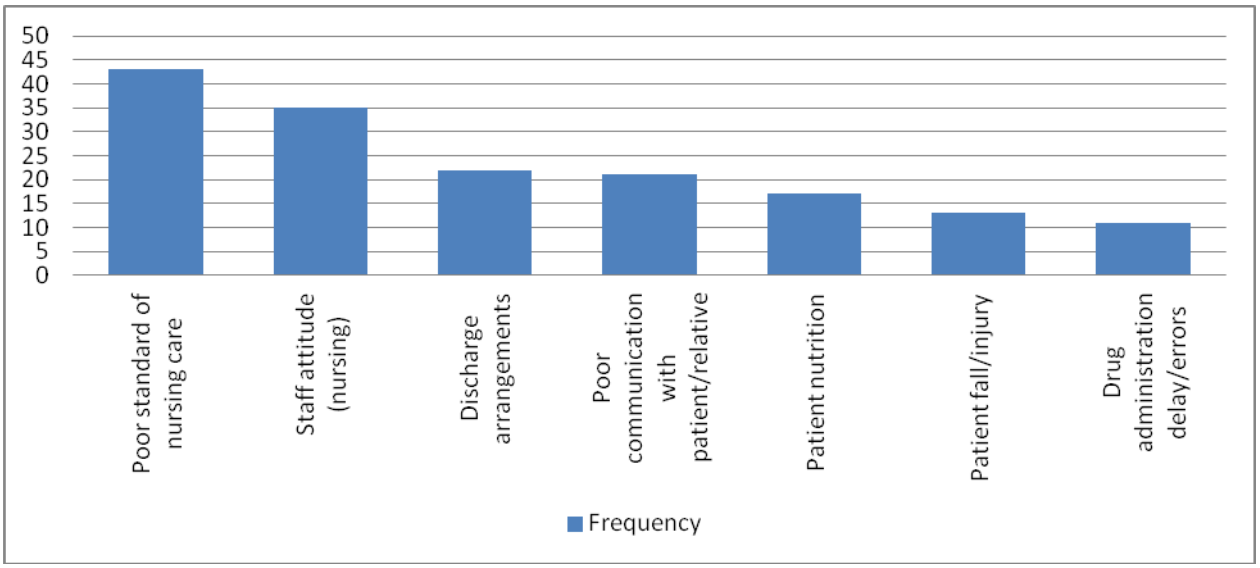
This graph focuses on those sub-subjects with over 10 incidences recorded, so while this does not account for all the complaints made against medical staff, it highlights those issues most frequently raised about them. Complaints about medical staff are considered during appraisals and as part of the re-validation process. All complaints relating to the manner and attitude of doctors are shared with the Trust's Medical Director.

The overall numbers of whole complaints primarily relating to doctors, nursing and midwifery staff have increased, but proportionally, have remained broadly the same when compared to the previous year. This is illustrated below:

	Medical (including surgeons)	Nursing, midwifery and health visiting
Number of complaints received 2011-12	444	204
Porportion of all complaints received	47%	22%
Number of complaints received 2012-13	403 ↓	120 ↓
Proportion of all complaints received	60%	19%
Number of complaints received 2013-14	354 ↓	93 ↓
Proportion of all complaints received	62%	16%
Number of complaints received 2014-15	328 ↓	95 ↑
Proportion of all complaints received	68%	20%
Number of complaints received 2015-16	346 ↑	103 ↑
Proportion of all complaints received	67%	20%

Although the number of issues raised in complaints about nursing staff is significantly lower, consideration should be given to these. Graph 5e offers more detail around this and again, contentrates on sub-subjects with over 10 incidences recorded.

e) Sub-subject of complaints about nursing staff



An example of a complaint about poor standard of nursing care is illustrated by this patient story:

Mr D was admitted to a medical ward and was terminally ill. His nephew, Mr C, raised concerns about poor quality nursing care provided over a weekend, impacting on Mr D's dignity. Mr C had visited on a Sunday afternoon and found Mr D on his bed, with the curtain pulled around him. Mr D was trying to remove a soiled pad from beneath him. As he was unable to do so, he was distressed. Mr C asked the one nurse present if she could offer some assistance, but Mr C was asked to wait as she was assisting another patient to slowly eat some ice cream, while two visitors watched. Mr C attempted to change the pad himself, but did not know where the supplies were. He calmed and comforted Mr D and then went to the next bay and found another nurse. This nurse said she was too busy and Mr D was not in her bay, but she would see if she could find someone to help. Mr C continued around the ward and found a third nurse who was also too busy to help. Mr C described that other patients were calling out for help. He assisted two patients by passing them urine bottles and another asked him to find a nurse as he was in discomfort. Mr C described alarms sounding and patients calling for help all around the ward, where there were only three nurses on duty. Mr C returned to Mr D's bedside and a nurse then attended. Mr D's dinner was left untouched and cold, but Mr C was able feed him a few mouthfuls of ice cream. Mr D was very thirsty, and once Mr C organised a cup of tea for him, he requested a second one straight away. The following day, Mr C was informed by staff that Mr D was dehydrated. Mr D was described as being at the mercy of staff as he was unable to operate the buzzer or his bed.

Investigation into this complaint revealed that there were four nurses and two clinical support workers (CSW) on duty at that time, but the senior nurse was taking her break. It was confirmed that staff do try to avoid taking breaks at mealtimes, but sometimes this is unavoidable. The staffing levels were in the process of being reviewed with a proposal to increase the number of staff on the late shift. The Lead Matron confirmed that when Mr C first asked for assistance, the CSW should have sought prompt support from a colleague. Apologies were offered for the understandable distress caused. The second nurse was dealing with a very upset patient and had intended to attend to Mr D as soon as the patient was settled. Apologies were offered that Mr C had found the nurse's response to be unhelpful and dismissive. Assurance was offered that all the staff on duty were engaged in other patient activity and had valid reasons for not being able to respond to his request immediately. Assurance was offered that staff were aware of Mr D's

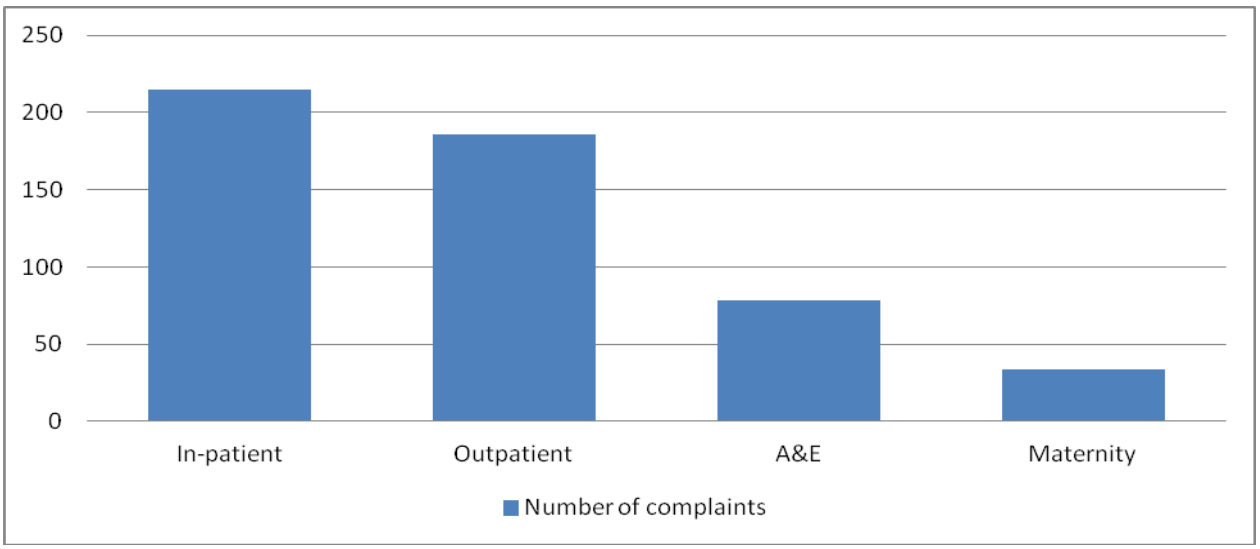
incontinence and made regular checks on him to maintain his comfort and dignity. Apologies were offered that Mr D's meal was found to be cold. Clarification was provided that the fluids given the following day were in response to a rectal bleed, not due to concerns of dehydration. The complaint was partly upheld.

Complaints relating to poor standards of nursing care and nursing staff attitude are routinely shared with the Chief Nurse on receipt.

6. Service areas identified in complaints

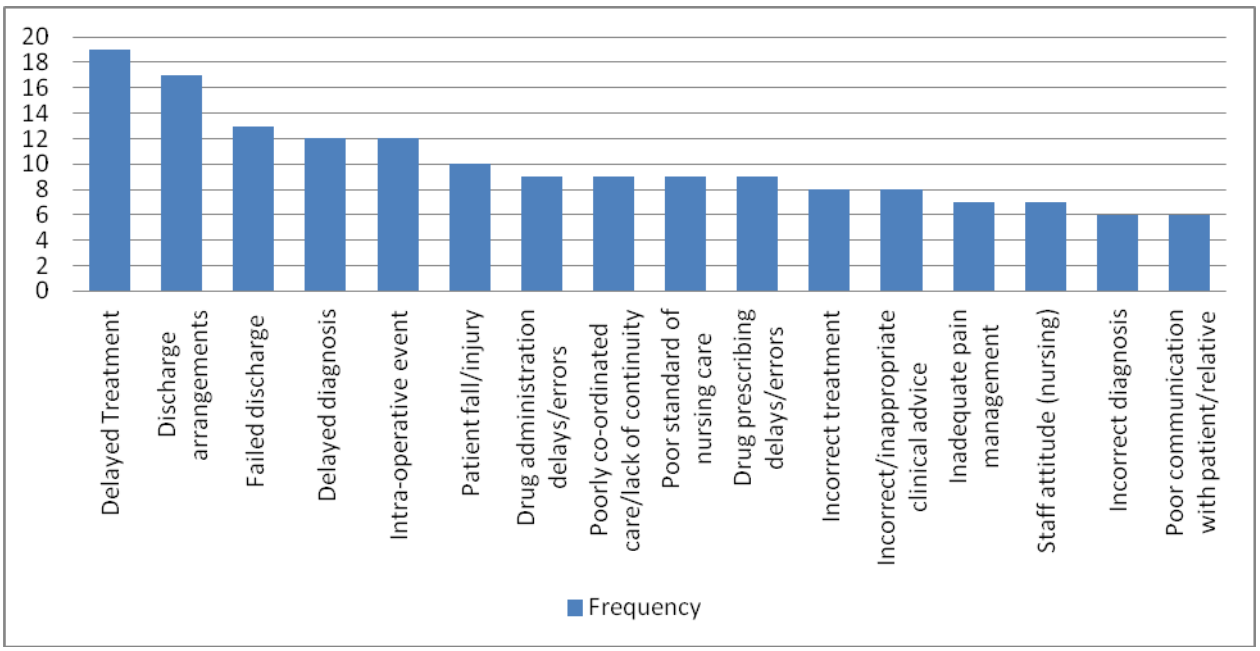
The distribution of complaints in relation to the service area involved is shown in graph 6f.

f) Complaints by service area



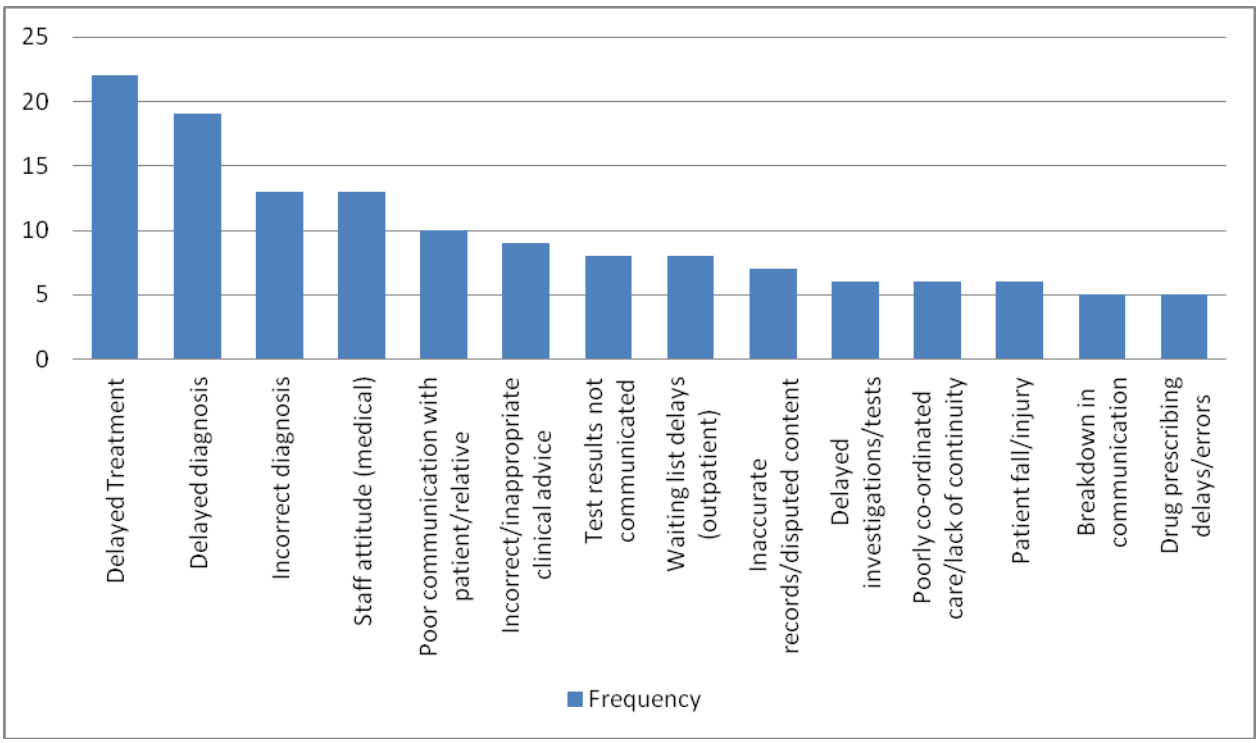
Of note, the number of concerns raised about inpatient and outpatient episodes are comparable. This is significant in that the Trust recorded 125,699 admissions and 467,320 outpatient episodes 2015-16, reflecting a higher proportion of complaints arising from inpatient services.

g) Primary sub-subjects raised in inpatient complaints



This graph identifies those issues with 5 or more incidences reported during 2015-16. This highlights that delayed treatment was the most frequently raised issue in complaints about inpatient care. However, it is worth noting that the Trust received a significant number of complaints relating to discharge arrangements.

h) Primary sub-subjects raised in outpatient complaints



This graph again highlights those issues with 5 or more incidences reported during 2015-16. Of note is the number of outpatient complaints about delayed treatment and delayed diagnosis.

7. Update on high profile complaint

In June 2014, the Trust was subject to media attention following audio recordings and photographs supplied to The Mail Online by the relative of a deceased patient. These were shared with the Trust at the same time and a formal complaint was recorded. Allegations included neglect of a terminally ill patient, inadequate pain management and poor staff response to requests for help. Given the serious nature of the concerns raised and the media coverage, the Trust took the step of commissioning an independent investigator to investigate the complaint. A safeguarding alert was also raised by the Trust and the investigator was asked to incorporate this into her investigation.

The findings of the investigation indicated that there was no evidence of neglect, however, recommendations were made regarding areas for improvement and appropriate action was taken in response to these.

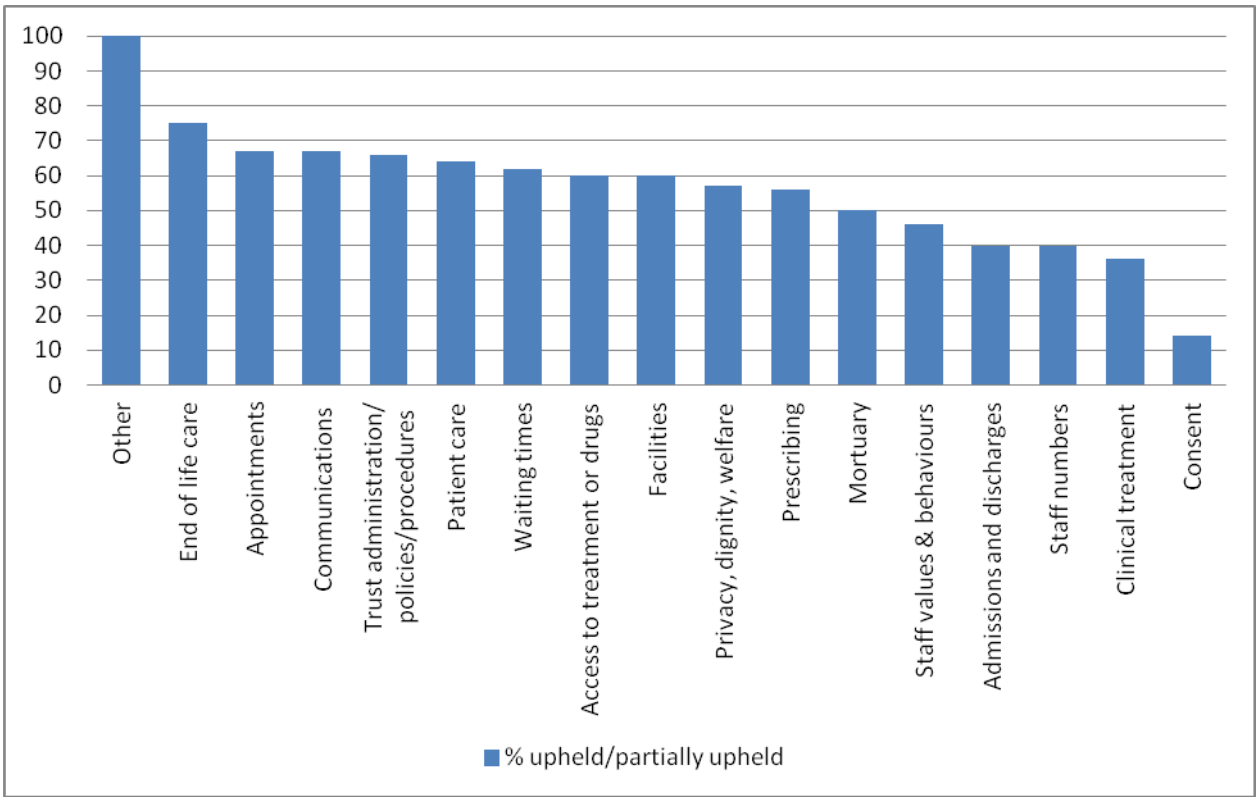
However, in October 2015, the Trust was informed that the complainant had referred the complaint to the Parliamentary and Health Service Ombudsman (PHSO) for review and they made the decision to investigate. They released their final report in December 2015 and did not uphold the complaint against the Trust. In the report, the PHSO commented that the Trust had demonstrated good practice by commissioning an independent review given the circumstances. The PHSO did not wholly agree with the findings from the independent review, but recognised that the Trust had accepted and acted on the recommendations made by the reviewer.

8. Upheld complaints

Where complaints are found to be justified, directorate staff will address the issues locally with individuals or teams as is appropriate and a record of actions arising from each complaint is held by the central complaints team and reported to the the Patient Experience Committee, with a summary of key Trustwide learning provided to the Clinical Governance Committee.

The Trust is asked to report on the overall outcome of complaints as part of the data return to the HSCIC. 270 complaints were reported as upheld or partially upheld, an increase from 2014-15 (162).

i) Percentage of complaints upheld by subject



Of note, only 1 complaint was received which was categorised as 'other' and related to lost property, for which financial redress was offered, as Trust policy and procedure for the management of the items was not correctly followed by staff. While the number of end of life complaints was small (4) it is disappointing to note that 3 of these were upheld or partially upheld.

Themes identifed from complaints relating to end of life care included:

- Lack of information provided to relatives/carers regarding patient's diagnosis, prognosis and care plan
- Pain control
- Lack of assistance with eating and drinking
- Staff not available to speak with relatives
- Delays at the point of discharge
- Appropriateness of personal care being delivered to patients in the last few hours of their life
- Ward enviornment affecting the amount of privacy afforded to dying patients and their relatives
- Lack of compassion shown by staff when relatives/carers seek help
- Lack of flexibility shown towards relatives/carers around visiting times
- Poor communication from staff towards patients

All complaints relating to end of life care are shared with the Chief Nurse and the Lead Nurse for Palliative Care and Associated Services on receipt. Individual actions have been identified from each of these upheld/partially upheld complaint to addres any shortfalls identified.

The lower proportion of upheld or partially upheld complaints about clinical treatment is influenced by the large number of complaints received. The Trust recorded 257 complaints about clinical treatment, of which 93 were upheld or partially upheld.

9. Learning from complaints

The central complaints team hold a record of the learning and service improvements identified from complaints. Due to changes in the Trust's governance structure during the course of the year, there has been some inconsistency in terms of where this is reported. We are currently providing a monthly summary of key Trustwide learning from complaints to the Clinical Governance Committee, with a quarterly report to the Patient Experience Committee including specific examples of actions taken as a result of complaints. Case studies and key messages from complaints are regularly included in the Trust's Governance Gazette.

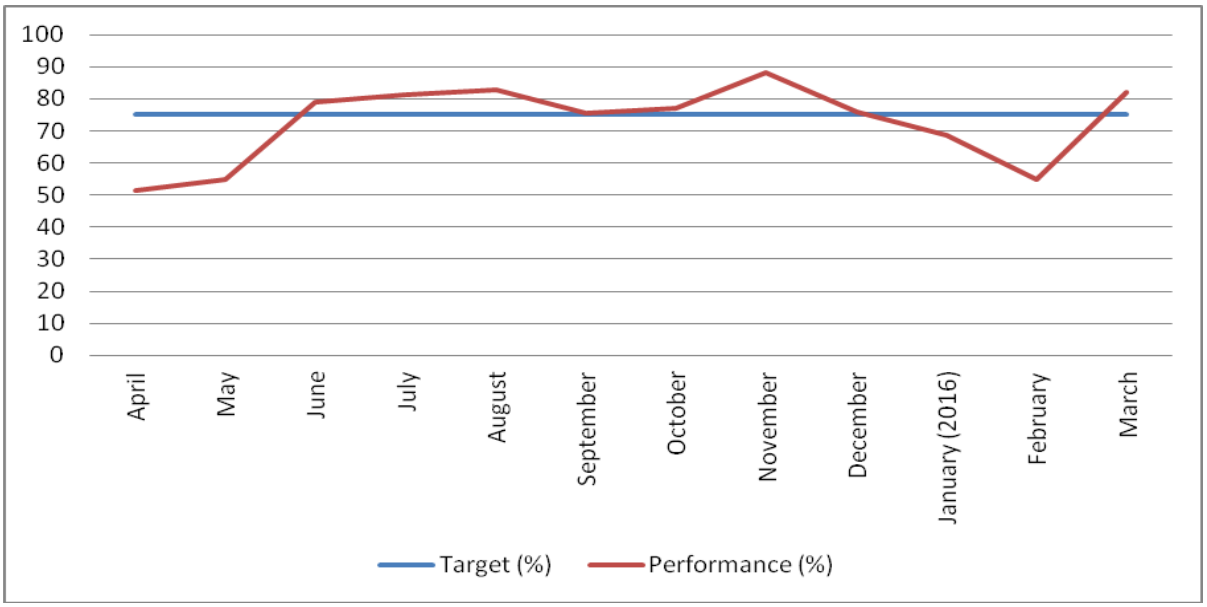
For every upheld or partially upheld complaint, the central team will ensure an action plan is initiated, with the responsibility for completion and provision of evidence resting with the individual directorates. In March 2016, the Trust's Datixweb (risk management database) was extended to provide modules for complaints and PALS. As part of this, the central governance team are exploring how this can be better used to capture and monitor actions arising from complaints and incidents.

The identified learning from upheld/partly upheld formal complaints responded to in 2015-16 can be found at Appendix A.

10. Directorate performance in responding to complaints

The directorates are measured on their compliance with responding to formal complaints within 25 working days (for low and moderate risk complaints) and 60 working days (for high risk complaints) of the Trust receiving the complaint. The Trust achieved 74.3% compliance for the year (66.5% 2014-15). Monthly compliance is shown in graph 10j.

j) Performance compliance 2015-16



As the above shows, compliance at the start of the year was challenging, which had been the case throughout the previous year. With the support of the Chief Nurse, changes were introduced to the management of complaints across the organisation and performance responded accordingly. Again, the target was missed in Janaury and February, but this was linked to exceptionally high levels of clinical activity during this period. The changes made to the management of complaints will be discussed in more detail later in this report. The table below breaks down percentage performance by directorate, by month.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Emergency Medical Services	57.1	87.5	84.2	90	90.9	69.2	73.3	94.1	78.6	70	50	87.5
Surgery, Urology, Gynaeonc, Head & Neck	30.8	40	76.9	37.5	71.4	87.5	66.7	70	85.7	66.7	66.7	60
Cancer & Haematology	N/A	0	100	100	0	0	75	100	75	50	50	100
Corporate Services	N/A	N/A	100	100	100	0	100	0	100	100	N/A	100
Women's & Sexual Health	100	25	75	85.7	100	66.7	88.9	92.3	50	100	80	66.7
Paediatrics	100	50	N/A	100	100	100	100	100	100	N/A	N/A	100
Trauma & Orthopaedics	50	66.7	0	75	66.7	75	100	100	100	66.7	25	100
Critical Care	N/A	N/A	100	100	100	100	N/A	100	0	N/A	N/A	100
Diagnostics, Therapies & Pharmacy	N/A	N/A	0	100	100	66.7	50	83.3	100	N/A	N/A	0

11. Satisfaction survey

In October 2014, the Trust introduced a new satisfaction survey being run in partnership between the Patients' Association and NHS Benchmarking Network. Response rates were disappointingly low and the feedback offered had very limited benefit. A decision was reached not to renew the Trust's participation in this scheme and a new survey was designed and launched in house, with the support of the survey team. A copy of the survey used since November 2015 can be found at Appendix B.

10 completed surveys were received between November 2015 and March 2016, a response rate of 5%. Key feedback from the survey has been:

- 80% of respondents found it easy or quite easy to make their complaint. Comments offered by the other 20% do not indicate that they actually had difficulty in making their complaint.
- The main sources of information on how to complain were PALS (36%) and the Trust website (36%)
- 80% of respondents felt that they were kept adequately informed of the progress of the investigation
- 60% of respondents had not been contacted by anyone investigating their complaint
- 62.5% of respondents found the response to their complaint easy to understand. Comments provided suggest that respondents felt that some issues of their complaint had not been covered in sufficient detail.
- 55% of respondents did not feel that the response to their complaint had addressed all their concerns.

- 27% of respondents felt that their complaint had been resolved. 54.5% of respondents did not feel that their complaint had been resolved and were planning to contact the Trust again.
- 90% of respondents felt that their complaint had been upheld or partly upheld.
- 56% of respondents felt that their complaint had made a difference.
- 50% of respondents scored the Trust 4 or 5 (5=excellent) for their overall experience of the Trust's handling of their complaint.

The key areas for improvement are therefore around making contact with the complainant to discuss their complaint and resolving complaints more effectively. Changes already made to how the Trust is managing complaints will hopefully support this; the changes are discussed in more detail later in this report.

12. Cases referred to the Parliamentary and Health Service Ombudsman

During 2015-16, 14 complaints were referred to the PHSO for review. The table below shows the outcome of the investigations.

	Upheld by the PHSO	Partly upheld by the PHSO	Not upheld by the PHSO	Outstanding
Number of cases	0	4	5	5

For every case upheld or partially upheld by the PHSO, the Trust has accepted their recommendations and provided evidence to the Ombudsman of our compliance with their recommendations. It is encouraging to note that the PHSO have not upheld any complaints against the Trust and that the majority of their investigations have been concluded as not upheld.

13. PALS contacts

For the year 2015-16, the Trust received 5221 PALS contacts an increase of 461 on the previous year (4760 received 2014-15). The increase in number of contacts received is a reflection of the accessibility of the service and the increasing clinical activity levels across the organisation. Data on emerging themes and trends captured by PALS is reported to the Trust's Clinical Governance Committee.

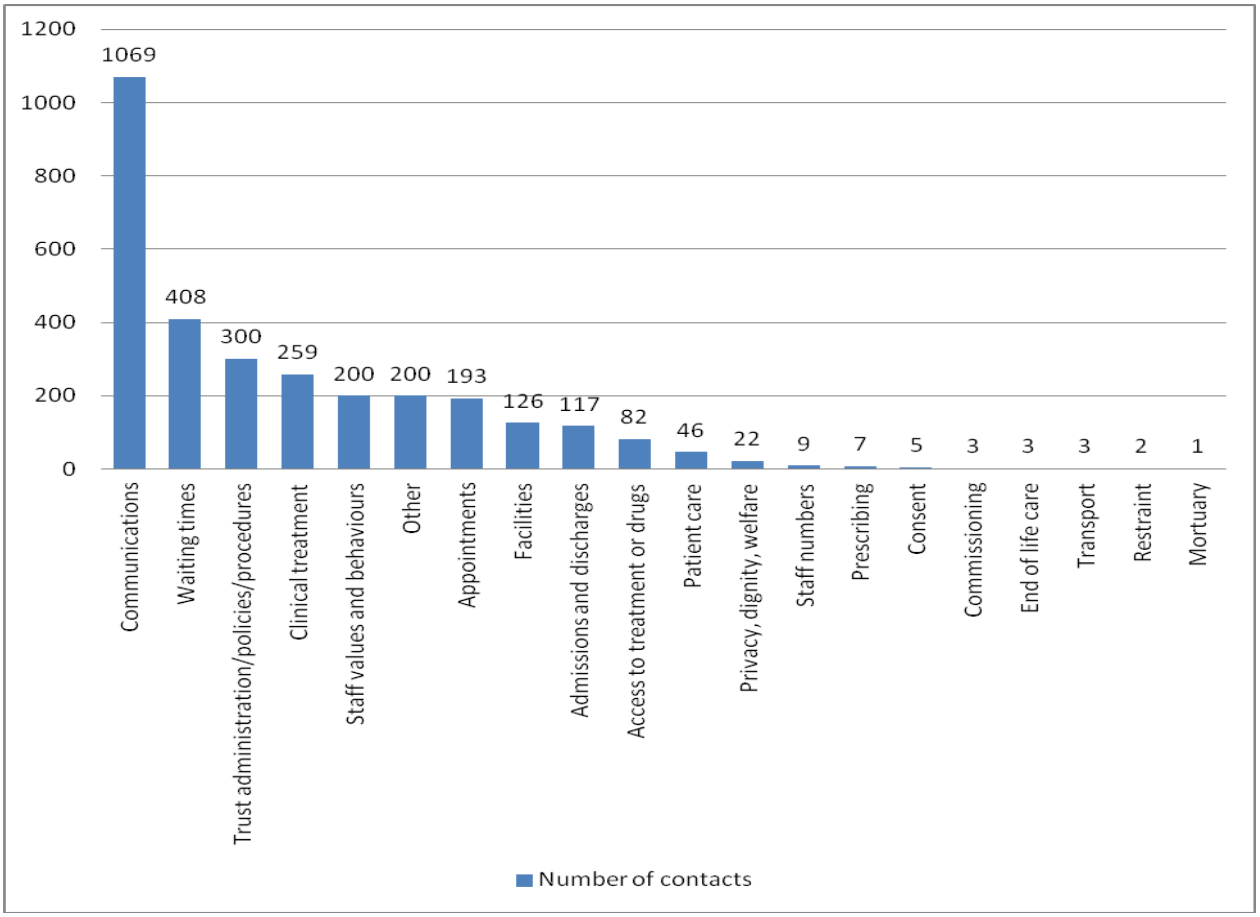
It is relevant to note that the contacts received by PALS vary in nature, ranging from requests for general information or advice which in many cases, PALS staff are able to respond to independently, to misdirected enquiries (ie people wishing to raise concerns or ask questions about their GP or the ambulance service), to problems and concerns about the services we provide as a Trust. To maximise the efficiency of the service, we do not always capture the same data for every contact, depending on the nature of the contact. However, the PALS team input as much data as is available, relevant and proportionate to every contact.

14. Subject of PALS contacts

The subjects and sub-subjects used by PALS to classify the nature of the concerns received by the service are the same as those used by the complaints team. This has allowed development of co-ordinated reporting on themes and trends across both services.

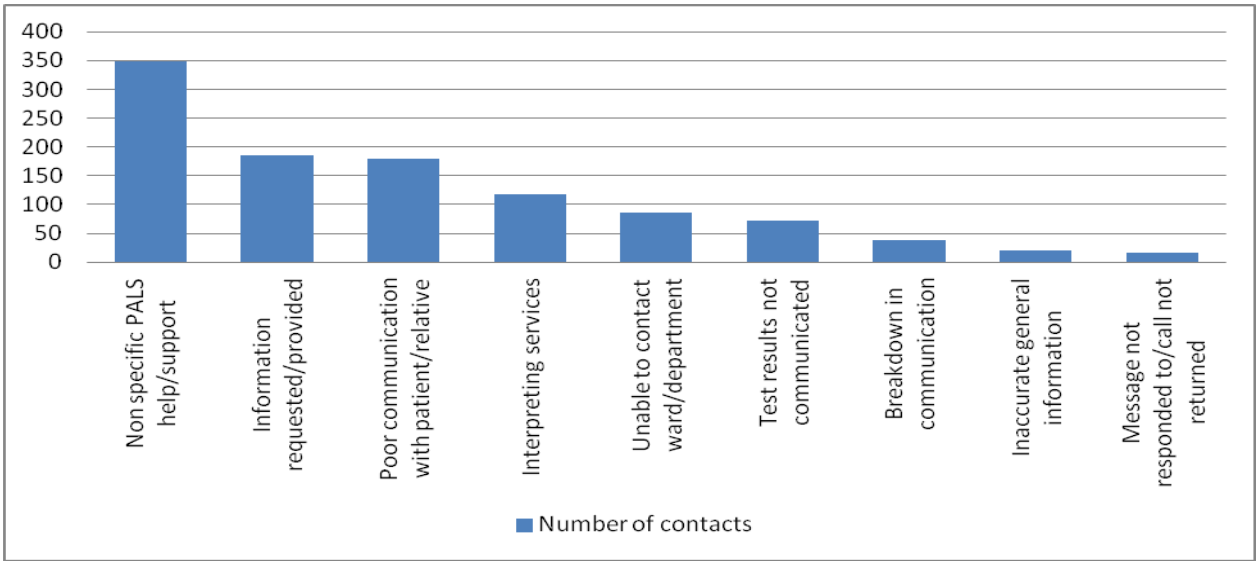
Chart 14k shows the frequency of PALS contacts by subject. This clearly illustrates that the main subject raised with PALS relates to communications. This is followed by waiting times and Trust administration/policies/procedures.

k) Subjects raised in PALS contacts



Taking into consideration that one of the functions of PALS is to act as an information point, it is probably unsurprising that communication features highly. However, it is helpful to look at this in more detail. A breakdown of contacts about communication is shown in graph 14l.

l) Contacts relating to communication

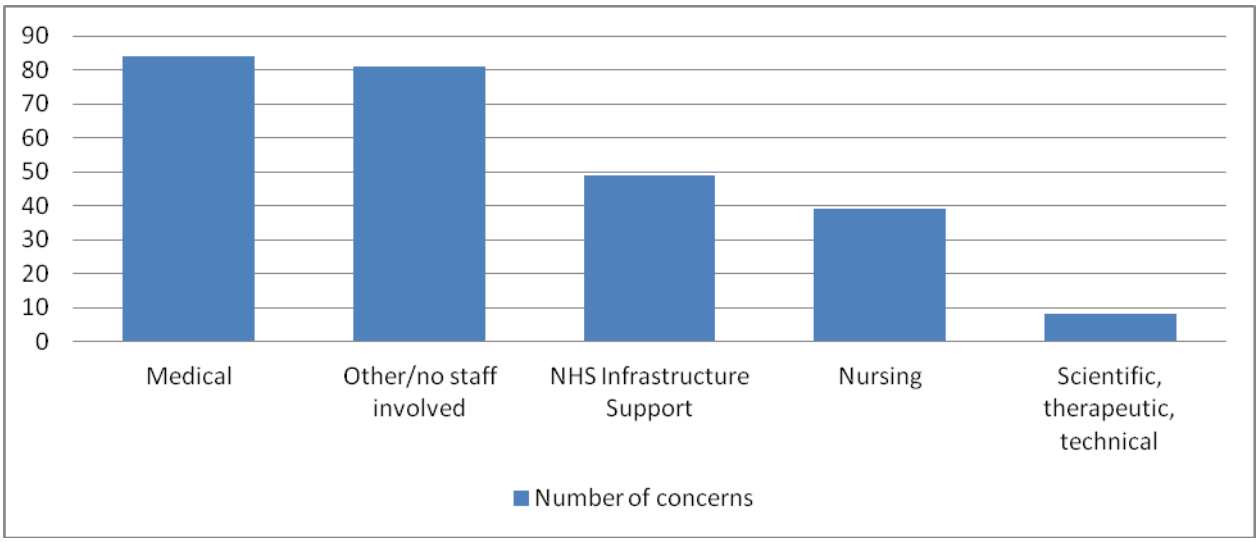


As outlined earlier, this shows that the highest use of PALS in relation to communication (349 contacts) is where there has been a direct request for help or support from PALS, which the PALS team would be able to respond to independently. However, it is significant that they have

recorded 180 concerns about poor communication from staff with patients and/or relatives (a slight reduction from 191 in 2014-15).

For 2014-15, 110 concerns were recorded about difficulty in contacting wards or departments. This has also reduced, with 86 concerns recorded 2015-16. A reduction in concerns about test results not being communicated is also noted, from 130 in 2014-15, to 72 in 2015-16.

m) Concerns raised about poor communication with patients and/or relatives



Examining the 191 concerns received about poor communication, we can see that the majority relate to communication from doctors (84). This is illustrated in graph 14m.

15. Innovations

As part of the revision of the Trust's clinical governance agenda, the Complaints, Litigation, Incidents and PALS (CLIP) Group was re-established. All new complaints are now reviewed by key governance staff to identify any emerging themes and trends and enables early identification of cases which may involve multiple governance areas. This provides an early warning system for the Trust and a summary report from CLIP is provided to the Trust's Clinical Governance Committee. Data captured through both complaints and PALS feeds into this process.

As described earlier in this report, a review took place as to how the central complaints team could better support directorate staff and improve the management of the complaints process. In response to this review and its recommendations, a pilot programme was launched in July 2015, which was evaluated very positively by staff and showed improvements in the timeliness of complaint responses. Following the success of the pilot, the programme was extended in January 2016 across the Trust to incorporate all Directorates, other than Emergency and Medical Services Directorate who joined in April. Due to the staffing structure in the Women's and Sexual Health and Paediatric Directorates, they continue to operate under the previous system. Key changes:

- The complaints team are making early contact with all complainants on receipt of their complaint to discuss their concerns and agree what outcome they are seeking. This offers a far more bespoke service to complainants and using this information, the complaints leads are able to be more focused in terms of what we need to investigate.
- Where it is clear which staff have been involved in the event being complained about, the complaints leads will contact individual staff directly to request comments or statements.
- Central directorate teams are made aware of the complaint throughout the process and are required to support their colleagues in providing any requested information in a timely fashion.

- The complaints leads will then draft a response to the complaint for approval by the directorate team, prior to being sent to the executive for final review and sign off.

In practice, this means that the time directorate staff invest in a complaint is being used more effectively and frees them up to address any actions arising from a complaint investigation.

This year has seen greater collaboration between the complaints team and clinical teams in terms of directorate clinical governance meetings. Complaints Leads have been peridoically invited to attend directorate clinical governance meetings to give focused input on emerging themes and trends at directorate level and to present feedback and lessons learned from complaints.

PALS have introduced new monthly directorate reports providing a summary of all concerns raised and hihglighting any that remain outstanding. Again, these have been well received by our directorate colleagues and are being used to support timely resolution of concerns raised through PALS.

The PALS staff have also embarked on a programme of workshadowing within the Trust. This has involved them identifying key services and departments and spending structured time with staff in those areas, improving their knowledge of service delivery and operation. The staff have found these opportunities very helpful in broadening their awareness, which in turn, supports the PALS staff to resolve more enquiries independently.

Patient information leaflets on both PALS and making a complaint have been updated following a thorough consultation. Furthermore, a new form is now available on the Trust's website to assist people wishing to make a complaint.

The PALS and complaints teams have identified their own set of key performance indicators (KPIs) to help focus on and support service improvements. These focus on maintaining pro-active communication with complainants where delays are anticipated; ensuring that action plans are initiated in a prompt fashion; improving the time taken to respond to PALS concerns; ensuring prompt response to all comments left via NHS Choices. KPIs are reported monthly and reviewed as a team for discussion and action.

In an effort to increase our transparency and invite opportunities for learning around our complaints service, two patient representatives, members of the Trust's Patient Experience Committee, were recruited to undertake an external review of a selection of complaints managed by the Trust during 2015-16. They selected 20 complaints at random and were given an oportunity to review the complaint files. They concluded that on the whole, complaints were investigated thoroughly, although not always responded to in a timely fashion. Communication was identified as a key theme and the reviewers felt that improving communication with patients and relatives would avoid complaints being made. Delays in diagnostic investigations and getting results were also identified. The reviewers felt that more information should be provided in complaint responses about the action taken to prevent the same issue reoccurring. They also commented that they had found the review emotionally draining and were surprised that no support is in place for the complaints team to address the emotional impact of the work.

Progress against the action plan created following the gap analysis against the complaint handling guidance issued in November 2014 can be found at Appendix C. This shows completion of the vast majority of actions, with some more complex areas still requiring work.

Looking ahead to the year 2016-17, the Trust's Policy and Procedure for Management of Concerns and Complaints is due for revision in June 2016. This will reflect changes made to the management of complaints within the Trust. The Committee is also asked to approve the publication of this annual report on the Trust's public website, in order to support the organisation to be an open and transparent one.

Work is also underway to develop a sustainable method for providing a regular summary of learning and outcomes from complaints, which can be maintained on the Trust's inter- and intranet, to provide insight to patients and the public around the value of complaints and to assist staff in sharing learning.

A new facility will be launched on Datixweb to enable staff throughout the Trust to log compliments directly, via a link on the intranet homepage. This will help to balance the feedback collected via PALS and complaints and will allow reports to be produced by different fields.

Plans will be developed to introduced regular satisfaction surveys of people using PALS to gain feedback on the service.

16. Summary and conclusions

Overall, positive progress continued in the management of complaints and concerns during the year 2015-16. While the number of formal complaints increased, this was to be expected, given the significant reductions over the previous three years and the increased clinical activity within the Trust.

Changes to the management of complaints have reaped benefits for both complainants and directorate staff and we look to build on these new working relationships as we move forwards. Performance in responding to complaints has fluctuated but overall, reveals an improving picture.

Further work is required to ensure that the learning from complaints is effectively disseminated, shared, embedded into practice and the impact assessed, to offer the required assurance that improvement has been achieved as a result of complaints. This continues to pose the greatest present challenge to the Trust in terms of complaints management.

17. Objectives for 2016-15

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
To improve satisfaction in complaints service to 75% by the end of the year.	Reported quarterly to PEC.	Complaints & PALS Manager	Associate Director for Quality, Governance and Patient Safety	Progress will be monitored by lead and reported to the Patient Experience Committee.	Reported monthly to governance team leaders meeting.
Achieve 75% compliance with meeting response times Trustwide	Performance reported monthly.	Complaints & PALS Manager	Associate Director for Quality, Governance and Patient Safety; Directorate Leads	Progress will be monitored monthly as part of the Trust's Quality and Governance Dashboard	Trust target is to respond to 75% of all complaints within identified timeframe.
Develop current processes for capturing, monitoring, implementing and evaluating learning from complaints.	Action planning module on Datixweb under review by governance team leaders. Reviewed at monthly management meeting.	Complaints & PALS Manager	Associate Director for Quality, Governance and Patient Safety; Chief Nurse; Trust Board.	Progress will be monitored by lead and reported to Clinical Governance Committee and Patient Experience Committee.	To be developed in line with module.

APPENDIX A

Learning from upheld/partly upheld complaints closed 2015-16

ID	Grade	Directorate	Closed	Description	Outcome
17882	HIGH	SURGE	27/04/2015	Patient suffered a wound infection following surgery; family feel that there was a delay in diagnosing and treating this. Query regarding the need for surgery and if condition was appropriately investigated. Query regarding appropriateness of discharge from hospital whilst still suffering with infection. Manner and attitude of doctor. Cleanliness of room	Apology that patient experienced poor continuity of care and for the impact it had. Case has been discussed at clinical governance to allow shared learning
17835	HIGH	SPECME	06/07/2015	Pt seen in clinic September 2013 and advised to lose weight to improve symptoms. Consultant at Brompton subsequently diagnosed a mass constricting pt's windpipe. Pt underwent surgery and symptoms resolved.	Acknowledged that diagnosis was missed. Assurance that respiratory clinic has upgraded imaging review equipment and is planning a review of clinic timings to try to reduce the risk of this happening again.
18111	HIGH	DIATHP	21/09/2015	Concerns raised regarding a tourniquet being left on pt arm for 2 hours following blood test taken causing swelling.	Result of human error. Staff reminded of need to remove tourniquets via staff meeting. Staff competencies reviewed to ensure all phlebotomists up to date with training.
18006	HIGH	EMS	08/07/2015	Management of shoulder injury in A&E. Poor pain control during manipulation. Availability of orthopaedic staff to speak with patient on the ward.	Dr failed to read all x-ray images, it was evident in two of the three images that the pt did have a fracture. Dr has apologised and shared this experience with his colleagues.
18178	HIGH	EMS	11/12/2015	REDACTED (at complainant's request)	REDACTED (at complainant's request)
18141	HIGH	EMS	15/10/2015	Concerns raised regarding the level of treatment provided in the A&E department. Following discharge pt represented at Queen Victoria, East Grinstead where her injuries were reassessed as serious and she required surgery to repair tendon, nerve and artery damage.	Inadequate assessment and wound management identified. ENP's attitude has been discussed with her via Matron and an audit to ensure that there are no gaps in ENP's knowledge around hand injuries to be carried out with update training to be provided if required.
17968	HIGH	EMS	18/06/2015	Patient was given an insulin overdose. He normally has 8 and was given 60 units. Query regarding appropriateness of discharge. Manner of doctor and comments made.	Dr misheard the instruction to prescribe 16 units as 60 units. This incident has been discussed with the Dr who is undergoing additional safe insulin prescribing training.
18475	HIGH	TRAORT	24/03/2016	Repeated intraoperative events / surgical complications including incorrect prosthesis being inserted resulting in multiple surgical interventions. Patient believes that these were as a result of poor practice.	Acknowledged that patient suffered a fracture following initial surgery and then, during the corrective operation, the incorrect sized prosthetic was inserted. Apology offered. WHO checklist now includes info re: prosthetics. Theatres team ensure patient records are available in theatre. Consultants must refer to patient notes before commencing surgery.
18082	HIGH	SURGE	17/08/2015	Appointments delayed over a five month period. Patient feels that his condition has worsened as a result.	Apology offered for delayed appt. Acknowledged that vision had reduced in that time however, explanation that we cannot say with any certainty that this would not have happened in line with condition. Reception staff reminded of the importance of ensuring appt timeframe info is on electronic record (monitored monthly). CAU instructed not to reschedule patients if this info is not present, these cases should be escalated.
17843	HIGH	TRAORT	07/04/2015	Delayed diagnosis of hip fracture.	Imaging did not reveal clear evidence of fracture. Clinical examination did not indicate fracture. On review, there was a change in patient's condition (need to use walking frame and more pain). Not clear if this was escalated to the orthopaedic team. Missed opportunity to carry out further investigations. Case discussed at directorate clinical governance.

ID	Grade	Directorate	Closed	Description	Outcome
18004	HIGH	TRAORT	17/07/2015	Patient was admitted to hospital following a fall with a badly broken hip. Following extensive surgery and whilst still in hospital, she suffered a further fall breaking the same leg lower down. The family were informed that an investigation would be undertaken however despite chasing, they have not been informed of the outcome.	Apology that appropriate updates were not provided during SI investigation. Communication discussed with relevant team.
17846	HIGH	DIATHP		Concerns raised that dilation procedure was carried out incorrectly causing a bowel perforation.	Confirmed that patient was consented for treatment albeit the consent form was not correctly completed. Case discussed at clinical governance. Acknowledge that with benefit of hindsight, tear was likely present on completion of treatment. Apologies offered.
18306	HIGH	EMS	07/01/2016	Concerns raised regarding a possible missed diagnosis of a type 2 odontoid fracture which had substantially displaced by the time it was identified.	Apology given that we did not identify the patients condition when presenting to TWH. Dr has reflected on his management of the case and also reviewed the literature available. He concluded that it was probably a case of spinal cord concussion and that in future he would have a lower threshold for imaging in the context of such a history, despite the normal clinical findings in the ED.
18206	HIGH	EMS	17/11/2015	Patient has raised concerns regarding the missed diagnosis following the incorrect interpretation of CT scan of his head.	The CT scan was misinterpreted by the Dr, an audit of his interpretation of scans and xrays has been done. The patients treatment was not compromised by the misdiagnosis and would not have been any different if his fracture had been diagnosed on first presentation
17977	HIGH	SURGE	11/06/2015	Delay in investigation results being communicated resulting in a delay in confirming cancer diagnosis	Apologies offered for delay in acting on results, explanation offered that non-urgent typing was delayed. Assurance offered that additional support is now in place to avoid such issues in the future.
18253	HIGH	SURGE	08/12/2015	Patient does not believe that she was appropriately consented for procedure rather she was given incorrect clinical advice regarding pain and likelihood of returning to work. Poor pain control during procedure. Lack of empathy.	Apology for distress caused. Explanation of treatment plan and that unfortunately, the fact she went off of the standard pathway, this delayed treatment. Case to be discussed at directorate clinical governance. Importance of following correct pathway discussed with nursing team.
18304	HIGH	EMS	17/03/2016	Concerns raised around delay in diagnosis, resulting in patient's death.	Actions identified as per serious incident investigation action plan. Training on bowel obstruction to be provided. Case discussed at clinical governance.
18110	HIGH	TRAORT	26/08/2015	Parents have raised concerns about their son's care following a fall, came to TW A&E x-ray taken and advised no break/fracture, parents were still concerned and returned to A&E the following morning, another x-ray taken again told no fracture. 10 days later child had a trip at nursery and seemed in pain, child taken to Medway A&E where he was diagnosed with break in the collar bone. Dr at Medway showed parents x-ray from TW and said that he could see the fracture on the xray.	Acknowledged that diagnosis was missed. Apology offered. Unfortunately fracture was very subtle. To be discussed at clinical governance meeting
17678	HIGH	AANDEM	13/04/2015	Pt's daughter wished to raise a complaint that pt's fractured neck was missed by staff at TWells. Daughter also concerned that doctor at TWells stopped pt's medication and these have not been reintroduced.	Acknowledgement that correct processes were not following resulting in the fracture not being identified sooner. ACTION: case discussed with SECAMB; need for elderly patients with neck pain to be immobilised discussed with triage nurses and added to existing teaching; existing c-spine rules updated, simplified and on display in triage for easy reference; jr doctors reminded of c-spine protocol; individual doctor's supervisor made aware of case to support development; improvements made to radiology alerting system for abnormal results.

ID	Grade	Directorate	Closed	Description	Outcome
17883	HIGH	AANDEM	15/04/2015	Missed dislocation of jaw. Child bought to A&E after a fall with extreme jaw pain, no pain relief was administered as patient could not open mouth and despite jaw being visibly out of place, patient was discharged. Represented the following day when the dislocation was identified and the patient transferred to East Grinstead to have it reset	Apologies given for delayed diagnosis. Events to be discussed with nursing/triage staff re pain control and analgesia. The case to be presented in the monthly clinical governance meeting for emergency medicine.
17844	HIGH	SPECME	24/04/2015	Concerns raised about standards of nursing care, lack of dignity, lack of compassion. Pt's bed marked as though pt has dementia - pt does not have a formal diagnosis of dementia. Family repeatedly having to inform staff that pt does not have dementia. Lack of diagnosis and effective treatment of symptoms over a prolonged admission. Relatives experiencing difficulty in obtaining information on pt's condition. Repeated ward moves exacerbating confusion. Pt fell and there was a subsequent delay in diagnosing a hip fracture.	Apologies given for the lack of dignity. Formal diagnosis of dementia was never given, however the pt's confusion was complex and the forget me not badge was used to aid staff, staff now been made aware that the badge should not be used unless a formal diagnosis has been made. Fall was unavoidable, however complainant should have been informed of fall. Concerns around patient dignity and communication discussed with ward team.
17947	HIGH	AANDEM	28/09/2015	Patient attended A&E, X- ray of lumbar spine taken. Patient was discharged then contacted to return to A&E as X-ray had been reviewed. On return MRI performed report showed acute fracture.	There was a delay in diagnosis, however this did not impact on the treatment pathway or plan. Dr mis-interpreted the x-ray. He will seek senior input in future and had undertaken further education and support and completed a case presentation to assist in his own professional development. Case also presented at directorate clinical governance committee.
17983	HIGH	SURGE	15/06/2015	Concerns raised regarding how the patient's anti-veg appointment was undertaken. The doctor was rude and the procedure hurt, which it has never done before. The patient was left with bruising to her eye. The family are querying if the doctor was suitably trained and would like assurance that she will not have to see the doctor again.	Explanation of why the patient was laid flatter than normal, assurance that breathing was monitored - reinforced that rationale should always be communicated to patients. Apology that procedure was painful and caused bruising, explanation of possibilities provided. Apology that patient found manner and attitude of doctor to be poor. Case discussed at directorate clinical governance.
18016	HIGH	EMS	20/07/2015	Patient attended A&E for a head wound, x-ray taken. Dr applied steri strips and referred patient to East Grinstead for stitching. East Grinstead ordered a CT scan the result was that the patient had a fractured skull with a piece of bone appeared to be on his brain. He was sent to KCH where he underwent a 6 hour operation.	Assurance offered that the treatment offered was in line with appropriate guidance. However, acknowledged that facial fractures were not identified on x-ray prior to referral to East Grinstead. Case to be discussed at A&E governance meeting
17779	HIGH	DIATHP	07/04/2015	Patient attended A&E following bike accident, diagnosed with dislocated shoulder. This was repositioned in A&E however during subsequent x-ray, the shoulder was dislocated again during the positioning for the image.	Errors did occur with the positioning for the x-ray. Radiographer undergoing additional training. Team asked to confirm their familiarity with all x-ray protocols.
18161	HIGH	SURGE	09/05/2016	Patient received incorrect clinical advice regarding her condition, prognosis and treatment options which caused significant distress. Poor standard of nursing care. Manner and attitude of doctor. Delayed treatment. Poor communication with family.	Unreserved apologies offered for patients for experience. Issues re: ward to be discussed with clinical and ward team to ensure learning. Additional training to be delivered re: NG tubes. Manner of consultant discussed with clinical and medical directors - consideration of mentoring undertaken. Consultant attended managing difficult interactions course. Need for consideration of MDT discussions for complex patients reiterated to surgical team.
15947	HIGH	SPECME	09/07/2015	Missed diagnosis, Cause of pain not investigated. Patient advised pain classified as muscular. Five nodes were discovered in right lung and one in left. Patient awaiting a date to have tumour removed and six nodes investigated.	Independent reviews commissioned into respiratory management and radiology reporting. Review showed that nodules were visible on initial CT scan and should have been reported. Report shared with radiologist, clinical & medical director. Case to be discussed at clinical governance.

ID	Grade	Directorate	Closed	Description	Outcome
17957	HIGH	EMS	25/06/2015	Patients daughter has raised concerns regarding the attitude and conduct of a specific nurse on the CDU at TW. Alleged rough handling of patient by member of nursing staff.	MTW will not book this nurse again. When bank/agency staff are working on CDU a senior member of staff will now work along side them when ever possible.
17978	HIGH	EMS	24/06/2015	Patient discharged from Stroke unit with another patient's medication. The patient had been taking this medication for 5 days and had to attend A&E to ensure she was unaffected by this. Dr later told family the medication was a vitamin supplement and patient had come to no harm.	Patient was in receipt of medication which was not prescribed to her. However the medication was a vitamin supplement and did not cause harm. Staff have been reminded to check all bags for medication.
18371	HIGH	CANHAE	22/02/2016	Patient fell in radiotherapy treatment room. No explanation offered to family about treatment given in respect of the fall. Pt informed family that he had hurt his arm and side. Patient died 8 days later.	Patient had had pre-therapy assessment and was deemed able to transfer from wheelchair to therapy couch. Unfortunately on the day even though both patient and son had confirmed his ability to transfer patient fell. Staff have been advised that they must ensure patients understanding of the procedure on the day and that they are fully aware of patients needs and abilities.
18265	HIGH	SURGE	06/04/2016	Pt presented to A&E with decreased vision. Concerns raised about a delay in making a diagnosis, primarily because there was no equipment available. Pt was subsequently kept in for observation. Concerns raised that patient's nutrition and hygiene needs were not met and that (in combination with drug therapy) caused her to develop renal failure, from which she died.	Apology offered for poor experience. Explanation provided that main diagnosis was not delayed and the lack of equipment did not have significant impact. Assurance offered that patient nutritional needs were supported. Acknowledged that medication was not reviewed appropriately and did impact on the patients renal function. Consideration is being given to how joint care arrangements and communication can be improved.
17970	HIGH	SURGE	10/06/2015	Test results following investigations in November only communicated in March 2015. Delayed diagnosis. Patient complaining regarding gross negligence against the hospital.	Apology offered for worry and distress caused. Scan results were acted on by radiology however they were sent to the incorrect MDT coordinator who then did not act on them. Issue has been discussed with the staff member and the MDT process is being reviewed.
18112	HIGH	EMS	28/10/2015	Patients mother has raised concerns following the failure to diagnose a dislocated elbow, this went undiagnosed for almost two weeks in which time the child had suffered a lot of discomfort and pain. Child required surgery which was carried out on 6 June.	Staff did not recognise that the radius bone was dislocated and did not identify the small fracture to the tip of the olecranon. Training sessions have been arranged for the ED department and the case was presented at Clinical Governance and shared at Registrar meeting at the Deanery for Surrey and Sussex
18281	HIGH	EMS	11/01/2016	Concerns raised regarding delayed treatment following chest x-rays which showed a shadow on the lung.	Assurance offered that there was no obvious evidence of tumour on either chest x-ray. However, it was accepted that there was action required following second x-ray and this was not arranged. Chest x-rays undertaken in A&E will now be discussed at trauma meetings.
18025	MOD	EMS	16/06/2015	Concerns raised regarding possible medication error, diagnosis and staff manner and attitude.	Treatment and investigations were appropriate however, doctors have been spoken to about their manner and attitude.
18078	MOD	EMS	19/11/2015	Patient came to A&E with back pain and was made to feel that he was wasting NHS time and money, he had an MRI booked and his partner asked if this could be brought forward and was told by the nurse to ask herself which she did and following results he was transferred to KCH where he underwent 10 hours of surgery for a tumour on his spine. Pt has now been left incontinent of his bowel and needs to self catheterise.	Concerns raised regarding staff attitude have been discussed with staff. Treatment appropriate and although nursing staff said an MRI would not be given, medical staff would have made the final decision and may have made the referral.
18030	MOD	SURGE	08/09/2015	Repeated cancellations of patients admission for urology surgery. Latest cancellation was at short notice despite the family being informed that this was due to consultant leave.	Apologies offered for obvious distress caused. Review of practice around arranging admissions and clinical staff now to give 8 weeks notice of any leave.

ID	Grade	Directorate	Closed	Description	Outcome
18257	MOD	SURGE	22/10/2015	Inappropriate comments made by nurse, lack of sensitivity to circumstances.	Apologies offered. Issues reported to the agency and the nurse will not work with the Trust again
18200	MOD	DIATHP	02/10/2015	Concerns raised regarding the manner and attitude of a member of MRI staff.	Information given was incorrect, LRM held with the staff member present and personal apology and explanation given.
18179	MOD	EMS	21/09/2015	Concerns raised regarding 'missed' diagnosis of rib fractures in A&E. Why was a CT scan not done during initial attendance. Delay in A&E.	On review, rib fractures were visible on initial x-ray - apologies offered for delay in diagnosis, but management would not have changed. Discussed with doctor concerned, who was been advised to seek senior opinion in future. Apologies for delays in A&E - department experienced a surge of unwell patients. Pt should have been offered pain relief earlier - discussed with doctor concerned.
18064	MOD	EMS	11/08/2015	Family unhappy with the discharge arrangements and the interaction of social services.	There had been a breakdown in communication between the nursing home and ward (on the part of the nursing home). Staff on ward had not completed the day before discharge form correctly. These errors will be discussed at the next ward managers meeting.
18219	MOD	CANHAE	19/10/2015	Patient's appointment cancelled on the day as treatment had not been signed off by the doctor. When the patient queried this with consultant, the consultant was unaware of the issue. Patient seeking explanation for cancellation of treatment.	Apologies offered. Consultant's intention was to stop one of two drugs but written instructions on medication chart were ambiguous, resulting in both treatments being stopped. Consultant recognises the need for clearer communication. Alert added to the front of the drug chart for patients continuing on supportive therapy alone in the future.
18218	MOD	SURGE	30/09/2015	Patient believes that she has suffered a corneal abrasion as a result of treatment. This was then not checked in advance of further treatment.	Changes made to the consent process to make specific risks in relation to diabetic patients more explicit. Changes to administration practice to limit the amount of anaesthetic and iodine used/left in contact with the eye.
17837	MOD	AANDEM	09/04/2015	Pt attended GP and was transferred by ambulance to A&E with cardiac symptoms. Pt sent home the same day. Returned to A&E the following day. Was made to feel she was wasting people's time and shouldn't be there. Left overnight in uncomfortable environment. Pt subsequently admitted for 2 weeks and required surgery.	First attendance and discharge appropriate. On reflection, patient should have been accepted for admission on second occasion - addressed with registrar concerned. Changes have since been made to admission process when a patient is referred to medical team by ED. Reclining chairs have now been purchased to improve environment.
18051	MOD	EMS	15/06/2015	Patient has raised concerns regarding the care, hydration and nutrition provided.	Regular quality and comfort rounds carried out by the senior nurse. Staff have been reminded of the need to ensure that cannulas are assessed regularly and removed if pain and discomfort occurs. Clear guidelines have been issued to staff as to how to obtain additional blankets and pillows from the linen store if and when required. Staff reminded of the need to support patients with their personal care and to ensure respect and dignity is maintained at all times. All staff have been reminded that patients must have a call bell within reach and these must be answered in a timely manner. Regular audits are being undertaken to ensure this standard is being met. Staff have now been advised that they should not record pt weight on whiteboard.
17993	MOD	SURGE	01/06/2015	Query misdiagnosis - patient was listed for cataract surgery however on the day the procedure was cancelled as the doctor did not feel the diagnosis was accurate. Family are querying what assessment was undertaken initially. Query re: consideration of dementia diagnosis	Apologies offered for confusion and short notice cancellation. Best interest process was not followed initially but meeting arranged and now held. The ophthalmology service are reviewing best interests process.

ID	Grade	Directorate	Closed	Description	Outcome
18094	MOD	EMS	29/07/2015	Patient has raised concerns regarding presenting to A&E three times before she underwent test, admitted and then got a diagnosis. Pt was then transferred to KCH for surgery. She feels staff advice and treatment was inappropriate.	Assurance offered that patients initial presentation did not indicate condition and assessments undertaken were appropriate. Apologies that patient was not transferred on a trolley - to be discussed at next meeting with SECAMB. Apology offered regarding confusion over CRE testing - to be discussed with ward staff and best practice guidance distributed.
18347	MOD	CRITCA	23/02/2016	Poor pain control during surgery. Patient not reviewed in advance by anaesthetist despite assurance this would happen.	Apology offered for distressing experience. Case to be discussed at clinical governance meeting
18075	MOD	SURGE	23/07/2015	Patient feels that the diagnosis of his condition has been delayed, particularly as there was a mention of suspected cancer. There were referral issues with regard to an ultrasound request and his appointments have been delayed (wait in clinic).	Assurance offered that treatment and communication during consultation was appropriate. Apology for worry caused. Recognition that documentation from MDT was poor and led to confusion - to be discussed with MDT coordinator. Apologies offered for delays in clinic; clinic staff reminded of expectations with regards to keeping patients informed when there are delays.
18113	MOD	SURGE	06/11/2015	Concerns regarding patients transfer. Concerns raised about the end of life care provided to the patient. query regarding pain control, should PCA have been considered. Issues regarding fluids and cannula.	Assurance offered that patient was fit for transfer at time he left hospital. Apologies that pain control was not as it should have been. This has been discussed with the nursing team to ensure learning. Apology that contact was not made with ambulance crew at time of incident, this has been discussed with patient safety manager
17939	MOD	SURGE	02/06/2015	Patient underwent surgery for banding and anal tag however tag not removed. Further surgery planned and tag still not removed.	Apology offered that skin tag was not removed as discussed. Discussed with team. Surgery rescheduled and to be undertaken by consultant
18193	MOD	SURGE	24/09/2015	Delayed diagnosis. Patient does not believe that her concerns were taken into account.	Pt referred to urology. Review of urological management shows correct pathway followed. No record that pt was repeatedly raising concerns as described. However, review of CT scan shows evidence of a thickened uterus which was not captured on the report and could have resulted in earlier diagnosis. Case discussed with radiologists at clinical governance, along with need to review all visible organs.
18095	MOD	EMS	14/07/2015	Following his A&E attendance, patient is alleging a beach of pt confidentiality by his ex-wife who works with MTW.	Disciplinary action taken.
18456	MOD	TRAORT	21/03/2016	Poor pain control. Patient allegedly suffered an overdose of morphine. Patient was given penicillin medication despite being allergic. Poor communication with family.	Apology offered for patient overdose. Explanation provided that staff were attempting to get patient's pain under control and unfortunately, this was complicated. Prompt treatment for toxicity provided. Apology that patient was given penicillin. Case with be discussed at clinical governance meeting.
18275	MOD	EMS	05/11/2015	Following an emergency admission, concerns raised regarding delays in treatment, nutrition and monitoring of patients ongoing medical condition whilst in the A&E department.	Apologies given for delays in allocating suitable bay, due to unexpected level of activity within ED. Adequate checks were carried out with regards to glucose monitoring however, decision should have been made earlier regarding NBM. Apologies offered for poor communication and matron has discussed this with staff.
18399	MOD	TRAORT	09/02/2016	Concerns raised regarding poorly coordinated care and the inaccurate clinical information provided following the patient's fall from a horse.	Apology offered for confusion and lack of coordination of care. Directorate reviewing electronic handover system and piloting a new digital system to improve service. Case discussed at clinical governance. Consultant will in future personally review management advice provided by tertiary centre. Confusion around patient's requests for copies of imaging discussed with admin team.
18319	MOD	SURGE	18/11/2015	Rapid eye referral not acted on. Patient ultimately felt she had no choice but to go private.	Apology offered. Process for managing referrals in rapid eye service has been reviewed. Financial redress offered. (Cost of private treatment £307.70)

ID	Grade	Directorate	Closed	Description	Outcome
18183	MOD	CRITCA	18/08/2015	Manner and attitude of nursing staff. Lack of empathy shown regarding patient's worry. Lack of update / communication.	Apology offered. Matron to discuss with nursing team
18350	MOD	SURGE	15/12/2015	Delay whilst waiting for surgery. Issues with lack of lights in car park and barrier to car park.	Apology offered for delays when attending surgery. Financial redress (parking fee £6) agreed. Apology for accident with car park barrier. Surgical list, staffing and provision of information on short stay to be reviewed.
18370	MOD	SURGE	22/02/2016	Incorrect advice and delayed treatment in response to reduced vision following cataract surgery.	Apologies offered. Assurance that vision was appropriate and oedema was not evident at initial appt. However, communication was insufficient and the referral from optician was not acted on appropriately which delayed treatment. Case to be discussed at clinical governance meeting.
18384	MOD	EMS	07/01/2016	2 year old child brought into A&E with respiratory problems just before midnight. He waited 20mins for triage. Mother has raised concerns regarding diagnosis and also that they found a dirty bloodied needle in the child play area.	Explanation and apology given for time waiting to be triaged, this was due to a high influx of patients at that time. Both the diagnosis and treatment were appropriate. An incident has been raised regarding the needle being left in the play area, blood was taken from a child in this area as to make them feel more at ease however, the nurse neglected to dispose of the needle correctly. Staff have been reminded of the importance of safe disposal.
18481	MOD	CANHAE	15/03/2016	Following admission via A&E concerns raised regarding the delay in treatment as staff lacked the training around portacaths. Lack of an oncology assessment unit or day unit.	Complaint has identified a lack of training for staff to be able to manage portacaths and additional staff have been identified and other staff made aware of how to contact them. TW does have assessment unit facilities to have day procedures however Maidstone does not and a business case is underway to assist with this.
18450	MOD	TRAORT	11/03/2016	Lack of support with eating. Poor pain control. Poor communication on discharge regarding MRSA. Lack of consideration of patients dementia.	Apology offered for the lack of support with eating, poor discharge arrangements and lack of consideration of dementia status. Assurance that pain relief was appropriate. Case to be discussed at ward meeting, red tray system implemented.
18217	MOD	DIATHP	15/10/2015	Concerns raised regarding the delay in reporting of results to GP.	Pathology department were unable to read the requesting doctor's name and the location for the report to be returned to was not completed. Doctor has been reminded of need for accurate and full documentation when requesting investigations. Message shared via governance gazette.
18036	MOD	EMS	20/08/2015	Pt's son wants an explanation to why his father was discharged to a nursing home, but he had to be re-admitted a few hours later.	Patient was discharged before being physically reviewed. Nurse had telephone conversation with a member of medical team regarding discharge and was told patient could go home, however not all of the patient's test results had been read and he should not have been discharged. Consultant has now reiterated to his team that no patients will be discharged prior to receiving and reviewing test results. Nursing team to ensure all appropriate discharge check lists have been completed.
18259	MOD	SURGE	10/11/2015	Notes not available for clinic appt on multiple occasions.	Apology offered for poor experience. Assurance that work is ongoing to improve the availability of patient information.
17941	MOD	EMS	07/04/2015	Patient feels that there has been a delay in managing his ear problems which has led to a loss of hearing.	Assurance offered that patients initial A&E review was appropriate. Acknowledged that referral could have been made when he reattended. Case to be presented at a teaching session

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18115	MOD	EMS	25/08/2015	Patient attended A&E with concerns regarding his diagnosis of popliteal aneurysms, dr seemed to dismiss his concern and concentrated on possible DVT. Pt was discharged and later due to ongoing concerns sought a private consultation, he was diagnosed with a thrombosed artery in left leg and severely compromised artery in right leg. He would like the cost of his private consultation and treatment refunded.	Dr should have taken note of patients previous condition and requested an ultrasound, request for reimbursement (£995) has been agreed. Case to be discussed at clinical governance meeting.
18002	MOD	SURGE	27/05/2015	Poor / insufficient pain relief during gynae procedure. Manner and attitude of doctor. Inaccurate clinic letter.	Apologies offered for pain and distress caused. Issues discussed with doctor concerned and standard practice reiterated.
18067	MOD	EMS	22/07/2015	Complainant would like to meet with staff, she would like to know why a PM was not requested following her husbands death, how the Dr concluded the reasons for death as written on the death certificate and why when viewing her husbands body he had little flies around his mouth.	LRM held, staff to have further training in preparing a body following death. Mortuary drain cover has now been repaired.
18150	MOD	SURGE	07/09/2015	Patient's wife disputes that she was contacted by ward staff to advise that patient was discharged. Delay in patient receiving fragmin injections from the district nursing team.	Very poor documentation surrounding discharge. Apologies offered and expected standards reiterated to the team. Discharge lounge staff reminded of need to consider patients' overall condition before offering food. Apologies offered for delay in fragmin injections - action identified by community Trust.
18012	MOD	EMS	23/06/2015	Missed fracture - patient was told that there was no bony injury however three weeks later was informed that a fracture was visible. Patient has been referred to East Grinstead for onward treatment.	Dr had correctly diagnosed however, an incorrect report was sent to GP by radiology. A&E are to develop a process of intercepting inaccurate reports being sent to GP
18484	MOD	SURGE	15/03/2016	Concerns raised that following discharge after surgery. Patient reports that she felt faint after discharge and returned to A&E where she was transferred to ward and underwent surgery due to an internal bleed.	Assurance that there were no indications that the patient was not fit for discharge, her observations were stable and no concerns were raised. Apology offered that there was a suggestion that the patient would be discharged from A&E, acknowledged that this was not appropriate. This will be discussed with A&E team.
18140	MOD	DIATHP	01/09/2015	Patient's husband has raised concerns regarding the appropriates and prescribed dosage of medication provided to his wife whilst an inpatient on ward 22.	Treatment appropriate however, there was an error made when dispensing the Nomad medication box on discharge. In future, once a nomad box has been prepared it will be sealed and disposed of if subsequent changes are required.
18333	MOD	SURGE	30/11/2015	Incorrect information on discharge summary. Manner of doctors	Apology offered for manner of doctors. Will be used as an area of learning.
17838	MOD	AANDEM	17/04/2015	Pt fell from horse. X-rays taken in A&E revealed fractures on L2, 3, 4 & 5. Advice sought from King's and pt discharged home. Pt subsequently recalled as review of imaging showed additional fractures of T6, 7, 8 & 9. Concerned about missed fractures and lack of information provided on discharge re further review, time off of work etc.	Some of the injuries were subtle and difficult to accurately diagnose on patient's first attendance. However, patient should have been kept in overnight for pain control and observation. Complaint will be used with A&E team for learning.
18205	MOD	CRS	30/10/2015	Patient has raised concerns regarding the patient information displays at TW OP Clinic, staff attitude and that outside the A&E entrance at TW still has the same flooring which she complained about in 2012.	Feedback given to reception team regarding respecting patient dignity and privacy. Plans are underway for a totally separate waiting area for women who wish to use it. Patients do have the option to choose a different name to be used on the display screens. The entrance to ED is monitored and there have been no reported incidents for the past 12 months.
18262	MOD	OBSGS	29/10/2015	Poor communication with patient, incorrect results shared. Arrangements for admission mismanaged.	Apologies offered. Explanation offered - all issues to be discussed at governance meeting.

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17904	MOD	DIATHP	29/07/2015	Complainant has raised concerns regarding the lack of physiotherapy , failure to provide suitable equipment, communication and level of care provided.	Apology for miscommunication regard equipment required and delay this caused - physio team reminded of the need to discuss requirements with ward team as well as documenting in notes and to ensure that all relevant info is provided. Apology for delay in commencing bed exercises - physio team reminded of the need to consider and introduce bed exercises. Need for consideration of home visit reiterated to staff. Apology offered for poor communication - tvn's reminded of the need to file information appropriately. Issues relating to tissue viability and handover process to be discussed at next ward meeting.
18092	MOD	EMS	20/07/2015	Concerns raised regarding appropriateness of discharge from A&E, Dr attitude, delays in diagnosis and receiving test results.	Apologies offered that diagnosis was missed on two occasions- written instructions have been given to medical staff to ensure x-rays are subject to senior review. Case also used at a teaching session. Apology for the delay in scan report being produced and delay caused. Importance of effective communication discussed with surgical team.
17976	MOD	EMS	17/04/2015	Concerns raised regarding the length of time a diabetic patient was left Nil by Mouth following the cancellation of his procedure.	Breakdown in communication between medical and nursing staff regarding NBM. Staff have been reminded that any cancellation of procedure by medical team is relayed to nursing staff.
18185	MOD	SURGE	28/08/2015	Delay in biopsy results being typed resulted in a wait for a date for her surgery. The pt had biopsies in Oct/Nov 2014 but then did not undergo surgery until the end of April. Concerns re: manner of AGM. Delays in responding to patient's calls/messages due to lack of staff.	Explanation offered that the reason the results were delayed was because of shortage of staff within the admin team, which caused a delay in typing non urgent information. Assurance offered that team now back to strength. Database also introduced to enable monitoring of outstanding results. Apology that staff member who contacted the patient was found to be dismissive, assurance that this was not intentional.
18157	MOD	EMS	10/09/2015	Concerns raised regarding communication to GP following clinic appointments in particular around changes in medication which impacted on her son's condition.	Apology given for delays - during April and December 2014, there were significant administrative staffing problems within the neurology department. Delay in the GP receiving the clinic reports and changes in medication could have had a negative impact on patients seizure control apologies given for the distress this caused. Team now fully established and turnaround times much improved.
18302	MOD	EMS	12/11/2015	Concerns raised regarding care provided to a dementia patient, including support with drinking, communication with relatives, discharge arrangements, a fall and lack of appropriate nursing care.	Hydration and nutritional needs were not met, patient had removed anti-slip socks and continence product and dementia needs were not met. Action plan in place and since complaint the dementia care on this particular ward has been improved. Case to be discussed with ward staff and meeting offered with Chief Nurse.
18209	MOD	EMS	16/10/2015	Manner and attitude of nurse, patient had an accident and the nurse was aggressive. Patient felt vulnerable. Why were antibiotics not prescribed sooner?	Matron to remind staff to ensure they have the most up to date information prior to sharing this with patient/families. Pt was appropriately treated with the correct antibiotics at the correct time. Allegations of nurses aggressive behaviour have been escalated via the appropriate pathway.
18425	MOD	EMS	25/01/2016	Concerns raised regarding delays in diagnosis and treatment.	The urine result did show E-Coli, however this would not have been known at the time of presentation as it generally takes 38 hours for the results from a full culture urinalysis to be made available. Normal practice is for laboratory to notify GP to access results. Although at the time of presentation there was no evidence of a urinary tract infection it may have been prudent for us to have started treatment with some form of antibiotics due to prior surgery. To be discussed with medical team.

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18237	MOD	OBSGS	12/10/2015	Poor communication between staff regarding need to attend triage unit caused patient distress. Patient was made to feel like a time waster. Manner of doctor.	Apologies offered for obvious distress caused. This has been discussed with all involved. Apology offered regarding poor communication, this has been highlighted to the triage team.
18027	MOD	EMS	15/06/2015	Pt's nursing care poor over weekend, pt left in soiled bedding, shortage of nurses to assists, pt became dehydrated. Pt's relative feels that pt has been left with a lack of dignity. Relatives felt that ward was unsafe due to lack of staff.	Help should have been sought from other nursing staff sooner to assist with pt personal needs. This has been discussed with staff involved and at the ward meeting. Staffing levels on ward being reviewed.
17942	MOD	SURGE	28/05/2015	Delay in screening results being given to patient/sent to GP. Pt concerned that as a result of this delay, she may have undergone an unnecessary colonoscopy. In view of delay, can pending procedures be brought forwards?	Apology for delays encountered. Appointment bought forward. Process for reporting back blood test results being reviewed by team.
17851	MOD	AANDEM	19/05/2015	Concerns that pt injured leg during admission and relatives not informed. Lack of privacy offered when relative raised concerns with ward manager. Relative unhappy that injury hadn't been documented in the records. Unhappy with subsequent handling of concerns by Matron.	Patient caught her leg on bed controls, assurance offered that she was not mishandled . Incident form was completed, case was highlighted in ward newsletter reminding staff to be mindful of where the controls were and a governance alert also issued regarding positioning of bed controls went out.
18227	MOD	OBSGS	07/01/2016	Patient received a poor standard of obstetric care, she suffered significant complications following delivery of baby. Baby was born in poor condition and required transfer to Medway. Retained placenta.	Meeting held. Confirmation that care provided was appropriate however, there was a miscommunication re: placenta which informed staff decisions. Issues will be discussed at directorate clinical governance.
17789	MOD	SPECME	27/04/2015	Delayed diagnosis of foreign body in foot. On subsequent x-ray - no foreign body present. Complainant feels that if foreign body had been dealt with in April, patient would have been able to return to work. Delay in referring back to hospital. Request for compensation.	Acknowledged that patient had foreign body in his foot which, despite being seen on imaging, was not acted on. Onward surgical referral was not made, x-ray wasn't discussed with radiology (as per consultant's request). Case to be discussed at directorate clinical governance.
18398	MOD	EMS	14/01/2016	Concerns raised regarding the diagnosis and reporting of a communicable disease. Also regarding breach of confidentiality.	Dr to update knowledge of ENT conditions and communication skills
18226	MOD	OBSGS	19/10/2015	Repeated rescheduling of appointments. Patient has been told that patients are not 'bumped' more than twice, however she has had her appt moved five times. What is being done to improve this.	Apology offered for issues surrounding appointments. Acknowledged that policy needed review and this is underway.
18252	MOD	OBSGS	26/10/2015	Poor standard of obstetric care, patient felt that decisions were made for her rather than her being included. Staff hide behind policy which is interpreted differently by individuals.	Apologies offered for poor experience. Issues raised to be discussed with individual staff to reiterate expected practice
17940	MOD	EMS	24/07/2015	Pt's wife raising concerns about delay in pt's case being discussed at MDM, delay in stent being fitted, delay in chemotherapy being started, lack of information around pt's infection. Main issue is poor communication with family on day of pt's death.	Assurance offered that treatment pathway was appropriate. Apology offered for the distress caused by the discussion regarding end of life - discussed with doctor concerned.
18473	MOD	SURGE	09/03/2016	Pt unhappy with attitude of audiology staff.	Apology offered for poor experience and manner of staff. Discussed with those concerned and wider team to reiterate expected practice.
18497	MOD	EMS	18/03/2016	Concerns raised regarding incorrect diagnosis and treatment of a childs head wound and subsequent infection by A&E Dr.	Doctor involved has reflected on case and agrees he should have considered the presence of a deeper seated infection. Doctor has taken personal learning from complaint.

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18264	MOD	SURGE	14/12/2015	Insensitive communication by urology doctor regarding patients condition and likely prognosis. Disputed content of records re: communication with family.	Apologies offered for poor standard of communication. Need for compassionate communication and privacy and support when breaking bad news to be discussed at directorate clinical governance. Trustwide work ongoing around improving communication.
18338	MOD	TRAORT	30/11/2015	Manner and attitude of orthopaedic doctor. Lack of examination.	Apology offered. Doctor attending customer care course
18288	MOD	EMS	18/03/2016	Concerns raised regarding that not all surgical staples were removed from his wound, pt subsequently had to have further surgery.	This was human error and staff were spoken with at the time. An aseptic technique was used for the removal of the remaining clips and there were no visible signs of infection. Unlikely that the clips being left in resulted in the further surgery.
18038	MOD	OBSGS	16/06/2015	Patient is concerned about the poorly coordinated care and communication when attending the hospital with a suspected miscarriage. They received conflicting communication regarding the viability of the pregnancy which caused distress.	Apologies offered. As a result of the poor communication, guidelines have been simplified and a treatment plan flow chart has been produced. The concerns have also been discussed and used as teaching for the junior doctors.
18402	MOD	EMS	22/01/2016	Concerns raised regarding the manner and attitude, communication and unprofessional conduct of the nurse in the A&E department.	Communication between nurse, patient and patients family was extremely poor. Nurse has apologised and given his commitment to improve his communication and understanding of how to manage situations.
18170	MOD	CRITCA	02/09/2015	Patient did not receive appropriate advice regarding how to manage his medication prior to his colonoscopy. This meant that the patient did not feel able to safely proceed. Delay in clinic.	Explanation offered that the advice regarding which medication to stop taking written on the appointment letter was incorrect. Apology offered. Any advice given in such instance will now be documented in the patient records and the doctors name clearly written. Case discussed with endoscopy team to ensure they are aware of protocols.
17952	MOD	TRAORT	01/06/2015	Patient feels that advice / diagnosis given re: shoulder injury was incorrect. Subsequently obtained private opinion and was told surgery was required.	Apology offered for error made - very unusual presentation of condition. Reimbursement offered for private consultation (£200).
17963	MOD	EMS	16/06/2015	Patient raises concerns regarding the communication between specialties which he feels was poorly coordinated and has impacted on his care. He feels that investigations and ultimately his treatment has been delayed.	Change in type of scan requested between 2 consultants meant that it is possible that patient had PE when imaging first done. Assurance offered that prognosis would not have been different. Department have an action plan in place to address typing delays. Follow-up appts in rheumatology required within 6 weeks will be booked before patient leaves the department. Additional consultant recruited to help increase bronchoscopy service. Staff in pharmacy and discharge lounge made aware of error with take home medication.
18321	MOD	TRAORT	23/11/2015	Patient not prescribed anticoagulants on discharge despite having a history of clots. Patient subsequently suffered blood clots.	Apology offered. Acknowledged that patient should have received anti-coagulants on discharge. Assurance that case will be discussed at clinical governance
18400	MOD	SURGE	20/01/2016	Poor communication with family regarding procedure undertaken. Lack of continuity of care. Incorrect information on clinic letter.	Apologies offered for unacceptable miscommunication. Explanation provided that operative information was not available at time of OPA. Importance of effective communication and documentation will be reiterated at clinical governance meeting
18391	MOD	SURGE	11/01/2016	Delay in advising patient of outcome of investigation and distress caused.	Apology offered for delay in informing patient of results of investigations and for distress this caused. Assurance offered that directorate are reviewing how investigations are reviewed and fed back.
18318	MOD	EMS	23/11/2015	Concerns raised regarding failed discharge and arrangements, diagnosis and lack of pain relief.	Patient was discharged without adequate pain relief, consultant has discussed the need for analgesia with the doctor involved.

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18213	MOD	EMS	02/10/2015	Pt and his daughter raised concerns regarding being given iodine patches when he is allergic and injuring his leg when climbing on to the theatre trolley.	Patient's iodine allergy was missed by staff in cath lab despite pt wearing red wrist band. Checklist being revised to ensure any iodine allergy is specifically recorded. Apology for injury sustained. Apology that allergic reaction and treatment for this wasn't documented on the EDN - reminder issued to medical team.
18106	MOD	EMS	13/08/2015	Concerns raised regarding a missed fracture, the unprofessional attitude, manner and communication of CSW and nurse in A&E and CDU.	Apologies given if staff manner was perceived as unprofessional, however there is no evidence to support that. There was a subtle fracture which was undisplaced, apologies given for interpretation error and this will be fed back to Dr involved.
18273	MOD	CRS	16/11/2015	Relative of pt feel that lack of compassion and privacy was shown by staff on ward in pt's last hours. Poor communication from staff to relatives with regards to care package. Poor communication to relatives following death with regards to paperwork and abrupt response from dept.	Apologies offered. Confirmation that work is underway regarding end of life care and the possibility of a symbol being used to identify rooms where a patient is receiving end of life care. Assurance offered that work is underway with regard to staff uniform identification and within the bereavement office.
17729	MOD	SPECME	28/05/2015	Patient states the consultant was extremely rude to her during the consultation. This impacted on the patient mental health. Request that she be transferred to another consultant.	Consultant recognises that consultation was difficult and apologises for unprofessional behaviour. Care transferred.
18416	MOD	SURGE	04/02/2016	Concerns raised around inappropriate discharge; patient was readmitted at request of hospital due to serious infection. Following readmission, pt did not receive IV fluids or antibiotics.	Apologies offered that the patient was discharged inappropriately. This has been highlighted to the locum agency in order that it can be discussed with the doctor. Apology for the delay in commencing IV fluids, explanation offered that patient initially declined IV access.
17872	MOD	CANHAE	08/05/2015	Concerns raised about delays in pathway including starting chemotherapy, communication with Dr and GP, information regarding prescribed medication. Concerns also raised regarding staff attitude and not receiving test results.	Apology offered for the drug prescribing error and two day delay in chemo being commenced. Apology for distress and worry caused. All outpatient staff and consultants reminded of need to start medication on the day of the new patient appt.
18415	MOD	EMS	11/03/2016	Concerns raised around end of life and nursing care. Poor pain control, poor communication with family, DNAR decision, incorrect diagnoses, drug administration issues.	There was a clear breakdown in communication, poor documentation around drug administration especially when patient has refused to take medication. Actions: Matron and ward Sister will reiterate to all staff the importance of regular updates and communication with patients and family members and to document these discussions in the nursing notes. A ward leaflet is to be devised to include the current working practices on the ward, information such as visiting times and how to contact the Ward Manager. The concerns raised will be shared anonymously at the ward team meeting and cross site ward manager's meeting. Senior ward staff to role model good practice on the ward in relation to communication and individual treatment plans. Ward Manager to identify ward staff to attend communication training. Ward staff to be reminded that the forget-me-not flower symbol is only to be used for those with a confirmed diagnosis of dementia. Ward staff to be reminded of the correct procedure following the death of a patient.
17961	MOD	SURGE	28/05/2015	Patient has raised concerns regarding the nursing care received and his vulnerability prior to and following TEMS procedure.	Apologies offered that enema was too hot, staff member was agency and is no longer going to be employed by the Trust. Assurance that concerns discussed with staff
18498	MOD	TRAORT	23/02/2016	Complaint suggests patient received poor standard of nursing care and was left on bedpan for extended period. Buzzer was unanswered for long time. Query re: staffing levels.	Matron spoke with patient and contacted complainant to apologise for poor experience and offer assurance re: ongoing care needs

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17958	MOD	EMS	29/04/2015	Patient has raised concerns regarding the staff within the A&E department. She felt that she was left alone too long between initial triage, treatment and x-ray. She has said that staff did not appear busy and no one came to update her and her husband as to the results of her test or reassure her that these were being followed-up. The patient expressed a wish to her husband that she wanted to leave, her husband then asked a male nurse to remove her cannula (which he did) and they left the department and hospital without being challenged staff.	Apology offered that result of ECG was not shared - this has been discussed with staff. Acknowledgement that patient should have been reviewed by nursing staff - discussed with nursing staff. Staff reminded of need for professional conduct when working at nursing station. Drs reminded to notify nursing staff prior to removing cannulas at patient request.
18162	MOD	DIATHP	11/11/2015	Concerns raised regarding the reporting of a CT scan. It appears that in 2011 following an accident a CT was performed and the reporting failed to identify a mass in the patient's neck.	The mass was not identified in 2011, case shared as a point of learning at radiology clinical governance meeting.
18258	MOD	SURGE	29/10/2015	Delayed treatment as appointment was not arranged as suggested	Apologies offered for poor experience. Assurance that directorate are doing all they can to improve the situation, additional staff being recruited, extra clinics being arranged (inc nurse led), community pathway being established.
17787	MOD	AANDEM	03/03/2015	Concerns raised about end of life care - pt in distressed state, delay in setting up IV.	Clinical care provided was appropriate but communication from nursing staff regarding need for IV could have been better. Communication issues to be shared with nursing staff.
18254	MOD	EMS	12/11/2015	Concerns raised regarding the A&E attendance including the quality of the triage assessment, pain control, delayed investigations and staff attitude.	Apologies offered for overall experience. Delays in providing pain relief and starting IV fluids. Issues around appearance of triage nurse to be addressed direct with him. Communication issues to be highlighted with the A&E team. Chief Nurse to discuss management of concerns with the Matron.
18224	MOD	EMS	21/10/2015	Delay in A&E. Poor communication and manner of nurse. Nature of waiting area.	Wait was due to patient having to be assessed by psychiatric team and waiting for appropriate tests results. Apology given for not keeping the patient and family member updated - staff reminded to keep patients informed. Business case in place to increase staffing.
18211	MOD	EMS	16/11/2015	Concerns raised regarding care provided on ward and to how patient acquired a very deep bedsore	Records show pt did develop some pressure damage and care plan was initiated to manage this. However, there is poor documentation following this and no body map was completed prior to discharge so difficult to comment on condition of pressure areas at the point of discharge. Discussed with ward teams involved.
18220	MOD	EMS	01/10/2015	Incorrect diagnosis caused much distress. Suggested that significant surgical intervention was required however this was incorrect.	Apology given for incorrect information provided by Dr, this was due to his inexperience, however he did consult with senior colleague following appointment but a new treatment plan was not written and communicated. Management of case discussed with doctor concerned.
18221	MOD	EMS	01/10/2015	Patient had CT scan on 20/7/15 and has not received the results.	Apologies given for the breakdown in communication and explanation. CT scan results were faxed to wrong GP surgery due to error in data entry. Discussed with staff involved and will be reiterated at next team meeting.

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17881	MOD	TRAORT	27/05/2015	Patient is unhappy with the advice given regarding the management of her orthopaedic injury which she feels has been poor. Her plaster cast was applied poorly. Incorrect information given by A&E. Patient believes that her discharge was inappropriate and she has ultimately required surgery at another Trust.	Apologies offered for delays. Explanation provided that although the treatment was not incorrect , she was discharged slightly to soon and hence we missed the opportunity to identify the complications. A&E have updated their info on local MIU and walk-in centres. Specific concerns shared with MIU staff. Plaster room staff reminded of need for professional communication. Concerns about x-ray discussed with radiologists. Patient should have been offered physio - discussed with drs. case discussed at orthopaedic clinical governance meeting.
18470	MOD	TRAORT	11/03/2016	Delayed diagnosis of injury. Patient believes doctors decision making was based on her BMI. Delayed investigation. Failure of surgery.	Apology offered that injury was not diagnosed sooner. Confirmation provided that there was no fracture seen on original x-ray however, acknowledged that this should have been repeated. Apology that patient felt greater interest was given to weight, assurance that this was not the case offered. Case to be discussed at clinical governance.
18076	MOD	EMS	01/12/2015	Concerns raised regarding the discharge planning, it would appear that the patient was discharged without the appropriate care package in place and social services said that they had not had the referral..	Investigation confirms no district nurse referral made - departmental staff reminded of how and when to make a referral.
18403	MOD	EMS	04/02/2016	Concerns raised by the pt's mother regarding the delay in re-insertion of PEG tube caused delayed treatment.	There were delays in commencing the Kepra and fluids, however the reinsertion of patients cannula was difficult and this was not fully explained. Patient's mother's concerns were not listened to. Matron will liaise with care home and mother to put a care plan in place for patient as he is likely to reattend in future.
18255	MOD	EMS	24/11/2015	Concerns raised regarding the care provided including treatment and management of known skin condition and deterioration of this condition.	Steroids were not documented or prescribed and the telephone call from patients daughter highlighting need for steroids was not logged. Call log introduced on unit to maintain record of incoming calls. Advice was sought from TVN, dermatology and pain team to manage condition. Ward pharmacist did not give the pharmacy adequate information regarding quantity of dressing required - discussed with pharmacy team.
17962	MOD	EMS	11/05/2015	Concerns raised about the appropriateness of assessment and treatment when admitted to A&E in line with his complex neurological condition.	Patient was not holistically assessed therefore discharged too soon, a special plan of care has now been set up and an alert is raised at ED reception as soon as patient is booked in.
18466	MOD	SURGE	21/03/2016	Concerns regarding the appropriateness of surgical intervention undertaken and the pain and distress this caused. Poor continuity in terms of information given regarding need for drainage. Doctor raised their voice at patient and expressed frustration.	Apology offered for pain and distress caused. Explanation provided regarding the change in plan, indicating that the specialist surgical opinion was that drainage was required. Apology for upset caused. Case discussed at directorate clinical governance.
18286	MOD	EMS	18/12/2015	Pt's brother has raised concerns regarding the end of life care and provided to his late sister on ward.	Apologies offered for food and drink being left out of reach and for delay in responding to call bell. Senior ward team looking at ways of managing response times to call bells. Concerns about communication from the CHC team have been fed back to them. Discharge was slightly delayed due to problems in assembling package of care. Wait for collection by transport should have been explained. Given patient's condition, she should have travelled individually by ambulance - practice will be adopted in future. Apologies offered for the delay in PALS contacting enquirer - team asked to reflect on impact this had. All issues to be discussed at ward managers meeting.
18446	MOD	EMS	07/01/2016	REDACTED (at complainant's request)	REDACTED (at complainant's request)

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18087	MOD	OBSGS	03/05/2016	Incorrect GP details stored and used. Patient believes that this impacted on and delayed her treatment.	Acknowledge incorrect GP details noted in error, apology offered. Assurance offered that gynae treatment was timely and appropriate. Case to be discussed with admin staff to ensure learning.
18155	MOD	SURGE	07/09/2015	Patients treatment was delayed since her Alzheimer's was not taken into account. Best interests meeting still outstanding.	Acknowledge that the best interests process fell short of expectations. This is currently being reviewed. Apologies for the distress that this caused.
18119	MOD	CRS	24/07/2015	Concerns raised regarding disabled access to car parking payment machines.	Apology offered and assurance that work will commence wk of 3/8/15
18330	MOD	DIATHP	25/11/2015	Issues with medication, delayed administration of medication as it was unavailable and delayed dispensation of TTO's. Patient not called for MRI.	Apology offered that scan was not undertaken as promptly as expected. Was within requested timeframe. Apology offered for delay in providing medication, discussed with ward team.
17662	MOD	CANHAE	01/07/2015	Why was pt allowed to undergo radiotherapy treatment for 4 weeks although he was so ill, did anyone think of reviewing his condition?	Course of radiotherapy was appropriate. Pt was regularly reviewed by experienced staff but no clinic review during treatment. ACTION: bladder cancer patients undergoing radical radiotherapy will undergo routine clinic review. Also consider referring pts for discussion at MDM during radiotherapy course.
18044	MOD	SURGE	22/06/2015	Patient complains regarding poor discharge information. She believes that double packing was inserted in her ear. She encountered a less than helpful attitude when contacting the Trust regarding the problems / infection.	Apologies offered for poor experience. Explanation of pathway of care. Memo sent to all ENT staff and SSSU reiterating advice to be given to ENT patients experiencing post op difficulties. Booking team manager asked to ensure staff are aware of escalation process re: timeframes of appt. Surgeon to review post op info given to patients.
17897	MOD	SURGE	19/10/2015	Patient feels that he was not fully consented for the risk of procedure before the day of his surgery, particularly relating to the fact he could not drive or fly. He has also encountered some delay with regard to his outpatient appointment.	Apologies that consent information was insufficient. Information being reviewed.
18050	MOD	EMS	18/06/2015	Patient feels that the delay in Dr writing to his GP to advise on medication could have caused a stroke.	Apology given for delay in typing letters, however this delay would not have changed the outcome of events. Assurance offered that additional typing support in place.
18229	MOD	TRAORT	13/10/2015	Patient believes comprehensive treatment has been delayed. She believes that the suggestion that she undergo an arthroscopy was a 'delay tactic' to make figures look better. Wants a date for surgery.	Apologies offered for delays encountered. Pathway explained. Apology offered that surgery was suggested at a point that it when it was not clinically indicated. To be discussed at clinical governance meeting
18098	MOD	EMS	23/07/2015	Concerns raised about inaccurate record keeping in A&E resulting in patient being referred to a clinic inappropriately. Concerns also that full notes were not available for consultation. Previously, pt has had to wait a year for a 3-month follow-up appt.	Apology offered that incorrect appt etc was arranged following A&E attendance, where the wrong patient was discharged on the system. Staff have been advised to be diligent when discharging. Apology for delay in clinic letters and appointments in ENT, assurance offered that secretarial team is back to full compliment and issues resolved.
18015	MOD	EMS	28/05/2015	She feels that she is being discriminated against as a 'special case'. Patient raises concerns regarding care in A&E.	Patient was provided with appropriate care and offered analgesia, during the presentation to A&E patient became verbally and physically abusive. The special case file was added in error and has now been removed.
18410	MOD	SURGE	26/01/2016	Concerns raised regarding the delays in providing results and communication with departments	Apology offered for delays. Assurance that the process of how test results are reviewed and communicated is being reviewed to identify how improvements can be made.

ID	Grade	Directorate	Closed	Description	Outcome
18037	MOD	TRAORT	02/09/2015	Patient believes that there was a delay in diagnosing the injury to his lower thumb joint.	Acknowledged that fracture at base of the thumb was missed during initial presentation and this delayed treatment. Assurance that this was noted during subsequent appt and at this time, staff were aware of both injuries. Acknowledged that communication with physio could have been improved. Discussed at clinical governance.
18251	MOD	EMS	11/01/2016	Concerns raised regarding the manner and attitude of cardiology Dr during OP appointment also communication around medication and why she would not be suitable for a stenting procedure.	Behaviour described was not appropriate, patient received call from consultant who apologised and will discuss matter with dr in question when he returns from extended leave.
18109	MOD	PAEDIA	04/08/2015	Concerns regarding a delay in a child being reviewed by Paediatricians following emergency presentation. Miscommunication regarding expectations following transfer. Communication with nurse	Apology offered for conflicting and inaccurate information given, whilst it was intended to be reassuring, it was not appropriate. Risk manager to liaise with matron for A&E to remind staff not to offer misleading information. the need to ensure that honest advice is given has been reiterated to hedgehog ward staff
18214	MOD	PP	06/10/2015	Unhappy with charges associated with care (overseas patient). Patient states she was informed that she would not have to pay. Concerned that itemised bill is not available.	Apology if the patient was incorrectly told that she would not have to pay for her treatment; we are unable to clarify who said this however the issue has been raised with the medical director in order that accurate information can be cascaded via clinical directors. Confirmation that information sent is all that is available, however clarification given that a payment plan could be arranged and the overseas patient officer could speak with insurance company if this would help.
18289	MOD	OBSGS	05/11/2015	Concerns raised regarding maternity care provided, the use of forceps and the advice given regarding delaying subsequent pregnancy.	Apologies offered for obvious worry caused. Assurance that baby was never in danger and there is no reason why the patient needs to wait before having a baby. Complaint discussed at multi-professional meeting, with focus on accuracy of information and communication.
18493	MOD	EMS	17/03/2016	Concerns raised regarding delayed treatment in A&E for an eye condition, and delays in obtain an OPA within ophthalmology.	ENP did not use the correct equipment to enable her to examine the eye appropriately. Training to be provided.
18448	MOD	CRS	22/02/2016	Patient unhappy with lack of food choice on SAU, suggests that she was offered fish pie three days in a row. Lack of bathroom facilities on SAU. Extended stay on SAU. Feels that Maidstone hospital is being downgraded.	Apologies offered for poor experience. Issues have been discussed with ward team and highlighted to catering manager.
18079	MOD	EMS	10/07/2015	Pt/daughter raised concerns regarding the length of time taken to receive a diagnosis, followed by the delay in pt's referral being sent to St Thomas' (7 weeks) for open heart surgery. Pt also raised concerns regarding the attitude of the Cons' Sec, who was rude and very unprofessional towards pt.	Two month delay to angiogram due to bed pressures over the winter. Consultant delayed writing the referral - apologies offered. Apologies offered re manner of secretary - reminded of expected standards.
18431	MOD	SURGE	22/03/2016	Delayed definitive treatment for gallbladder problem. Confusion regarding medication. Query why patient was not admitted via A&E. Issues with administration of medication. Concerns regarding suggested discharge. Lack of continuity of care.	Apology offered for delay in providing definitive treatment; this was initially owing to the need to clear the patients acute condition and then related to the busy nature of the hospital. Explanation regarding the medications stopped and assurance that they did not need to be weaned. Case to be discussed at ward and clinical governance meeting.
18440	MOD	EMS	30/03/2016	Concerns raised regarding written communications and information recorded on health records	Apologies given for the wrong information being sent to GP, a copy of the pt self discharge is on her records. Advice given by secretary was appropriate. Need for attention to detail reinforced with CAU team.

ID	Grade	Directorate	Closed	Description	Outcome
18390	MOD	EMS	04/01/2016	Concerns raised regarding failure to diagnose a fractured collar bone.	Inadequate x-rays taken to be able to identify injury, clinical director has spoken with staff involved and advised that the whole of the area should be x-rayed rather than one or two joints.
18451	MOD	SURGE	22/02/2016	Patients surgery was repeatedly cancelled at short notice, including during an inpatient episode. Blood tests not taken at pre-operative appt.	Apology that patient has experienced multiple cancellations. Assurance offered that every effort is made to avoid this however, owing to capacity it is sometimes unavoidable. The issues re: blood tests and the patient being given breakfast have been highlighted to staff
18222	MOD	EMS	08/10/2015	Appointment not provided in timeframe expected.	Patient was added to the incorrect Consultants follow-up list in error. CAU Team leader to discuss case with staff to ensure patients are booked on to correct list.
18276	MOD	OBSGS	05/11/2015	Incorrect medication prescribed. Delay in clinic, patient not kept informed. Lack of feedback following query to pharmacy.	Apologies that patient was missed from clinic. This has been discussed with OP manager in order that she can identify how this occurred. Apology that incorrect medication was dispensed. Pharmacy have formally reported this and are investigating.
17954	MOD	EMS	20/04/2015	Patient felt consultation was rushed, the doctor was very vague with her information and did not listen. The patient also feels the timeframe from appointment to letter being sent to GP unprofessional. She feels that the information in this letter is incorrect and has been fabricated. The second part of her complaint relates to inaccurate information following a CT scan being passed to her GP regarding the sizing of her ovarian cyst.	Apologies given for clinic delays and the inaccurate account of pt's smoking and alcohol history. Option of patient submitting addendum offered. Dr has taken feedback on board.
18482	MOD	SURGE	17/03/2016	Delayed surgery. Patient decided to go privately and would like financial redress.	Apology offered for delay. Explanation offered that owing to busy nature of hospital, it was not possible to undertake her surgery sooner however, she was clinically assessed on both occasions. Financial redress offered in recognition of continued pain (£250).
18282	MOD	EMS	12/11/2015	Patient injured when her cannula was caught causing a skin tear.	Injury was accidental and due to pt's fragile skin the wound was difficult to close, further training to be implemented around closure of fragile skin wounds.
18223	MOD	OBSGS	08/10/2015	Manner and attitude of staff member. Lack of compassion re: nature of scan.	Apology offered for distress caused. This has been discussed with team to ensure learning.
18381	MOD	CRS	07/01/2016	Concerns raised regarding the moving and handling of a patient by a porter from bed to bed and inappropriate comments.	Member of staff has been spoken to regarding his inappropriate remarks and accepts that these were inappropriate and has apologised for the upset caused. Assurance offered that individual's manual handling training is up to date.
18277	MOD	EMS	21/12/2015	Concerns raised regarding delayed diagnosis, treatment and tests. Concerns also raised regarding ward environment and medication.	Concerns regarding communication were upheld. Doctor has reflected on his communication.
18034	MOD	EMS	12/06/2015	Pt raised concerns that following an admission to A&E via ambulance, having fallen off a horse, she had had x-rays and was discharged home the same day, having been informed everything was ok, she was contacted by phone one week later and informed she had multiple fractures to her back and ribs and fluid on her lungs.	Incorrect interpretation of x-rays. Following standard practice of x-rays being re-read pt was advised of fracture. Case to discussed at Clinical Governance.
17975	MOD	CRITCA	09/06/2015	Patient was admitted to ITU and following discharge suffered significant anxiety and took his own life. Several weeks later a letter was received from ITU indicating that patients often suffer emotional / mental health issues	Unreserved apology offered for distress caused by correspondence. Assurance offered that this has been reviewed and the process of advising patients of possible difficulties after discharge formalised.

ID	Grade	Directorate	Closed	Description	Outcome
				following such experiences.	
18192	MOD	TRAORT	16/09/2015	Medication administration delays. Pain control. Manner of nursing staff.	Apologies offered for distress caused. Discussed with staff - importance of clear communication reiterated. Concerns regarding manner of nurse discussed with specific nurse and wider team. With regard to issues re: PALS work to be undertaken re: timeliness and responsiveness
18216	MOD	EMS	27/11/2015	Concerns raised regarding treatment within the A&E department, however the main areas of concern are regarding MAU and the lack of pain control, communication and discharge.	There was a misunderstanding regarding analgesia, SN thought that patient had already taken some previous to attending A&E. SN will be more vigilant around pain control in future. Apology given by the Dr regarding his attitude - he will consider feedback in his future practice.
18199	MOD	CRITCA	02/09/2015	Painful cannula insertion caused distress. Anaesthetist allegedly swore during insertion when child moved. When he later visited the patients mother, she felt he tried to blame the ODP. Child has suffered nightmares.	Apology for outburst of anaesthetist reiterated. Assurance that the way in which the anaesthetic was administered was appropriate.
18309	MOD	DIATHP	09/12/2015	Concerns raised regarding his late mothers wedding ring, the ring returned after the she passed away was not his mothers.	Apologies for confusion over rings. Offer to reimburse to the value of £200.00. Improvements made to mortuary registration processes to ensure that discrepancies are highlighted.
18443	MOD	EMS	04/03/2016	Patient information sent to wrong address causing a breach of confidentiality	Incident has been raised regarding this breach, and patient whose confidentiality was breach has been advised.
18274	MOD	CANHAE	09/11/2015	Concerns raised regarding a misdiagnosis and that the chemotherapy had to be stopped and patient referred to a different oncology consultant.	Initial diagnosis of neuroendocrine cancer was based on histopathology results. Due to aggressive nature of diagnosed cancer, chemo was started urgently. Day after first treatment, a supplementary report was issued confirming pt actually had melanoma. Actions identified by pathology - they will broaden their analysis of poorly differentiated and undifferentiated tumours to routinely consider melanoma. Team are reinforcing their processes for reviewing slides prior to MDM to pick up any discrepancies.
18137	MOD	OBSGS	16/09/2015	Patient states that she received a poor standard of midwifery care and she was not listened to. This resulted her progressing into labour before her transfer to delivery suite. Her pain was not well managed. She also states that her notes are incorrect and her birth plan not taken into account.	Acknowledged that midwives should have listened to the patient and apologies that this did not occur. Explanation provided regarding why entonox is not available in ante-natal ward. Case to be discussed with all ward staff. Patient also asked to come in and speak about experience at a directorate meeting.
18435	MOD	OBSGS	29/02/2016	Concerns raised regarding lack of coordination and communication when attending the fertility clinic. Environment of clinic and manner of receptionist.	Apology offered for poor experience. Assurance offered that changes are being made to the clinic / waiting area. Explanation re: lack of notes provided. Case to be discussed at clinical governance meeting
18071	MOD	SURGE	08/10/2015	Patient suffered cellulitis and infection 12 hours post operatively. This resulted in a readmission to hospital (ITU). Patient queries if medical history and treatment undertaken the day before was taken into account.	Acknowledged that patients pre-existing condition was not fully taken into account and advice was not sought re: medication. This has been discussed at clinical governance meeting.
18047	MOD	CRITCA	26/05/2015	Appointment letter sent to deceased patient	Apologies offered for distress. Issue discussed with CAU and need for attention to detail reiterated

ID	Grade	Directorate	Closed	Description	Outcome
18460	MOD	SURGE	03/03/2016	Delay in undertaking referral for onward review and treatment.	Apology offered for delay in producing the referral. Discussed with CAU and key performance indicators to be monitored by general manager.
18061	MOD	SURGE	12/06/2015	Concerns raised regarding test results not being available which the family feel have delayed the patients treatment. They are also unhappy with the manner and attitude of the dr they saw in clinic	Apology offered for delays encountered and confusion regarding scan results. Issues to be discussed with the clinical team at clinical governance meeting. Confirmation that the unavailability of notes is a significant issue and it is hoped that the transition to e-notes will help with this
18369	MOD	SURGE	31/12/2015	Delay in appointment being provided for a fluorescein angiography. Lack of contact following PALS concern.	Apologies offered for delay in arranging appt. Appt system being reviewed and additional training provided to Medway staff. Explanation offered of action taken by PALS and contact made.
18180	MOD	EMS	15/10/2015	Patient underwent a procedure in A&E in which he feels caused nerve damage.	Unfortunately the procedure carries a small risk of nerve injury which did occur in this case. A session in local anaesthesia to be added to the middle grade doctors teaching program.
18249	MOD	SURGE	19/10/2015	Patient lost to follow up - 2/3 month review expected but not arranged. Vision has reduced significantly in this time.	Apologies offered that follow up appointment was not made as requested due to admin error. This has been discussed with the CAU team. Explanation that we cannot confirm if the patients glaucoma has caused deterioration until clinical assessment has been undertaken.
18085	MOD	EMS	13/08/2015	Poor standard of nursing care. Family do not feel that the patients symptoms were acted on appropriately which caused distress. End of life care.	medical care appropriate, however the communication between staff and family was lacking. Ward sisters have discussed with staff.
18124	MOD	EMS	17/08/2015	Patient has raised concerns regarding the treatment received when attending A&E as her cast had become tight and needed to be reapplied.	Apology offered for poor experience. Audit / review will be undertaken in Sept / Oct regarding triage process. Staff reminded of the need to ensure that the option of going home without review is discussed with appropriate staff and of the need for confidentiality
18396	MOD	CANHAE	12/02/2016	Concerns raised regarding the positioning of cannula which caused pain and possible cellulitis or phlebitis. The preparation for the chemotherapy treatment appeared to be disorganised and nurse manner and attitude caused upset.	Communication breakdown with patient as to why cannula inserted into underside of arm. Chemotherapy medication given as prescribed however again a breakdown in communication has been identified. The manner and attitude of the nurse has been reported to agency.
18084	MOD	EMS	10/07/2015	Patient raised concerns regarding the staff attitude and the way he was discharged from A&E.	Transport is available and should have been offered, food and drink should have been given. Case discussed with staff where they have been reminded of the need to offer patients transport and refreshments whilst in ED. Safeguarding Vulnerable Adults matron to deliver training to ED nursing team.
18458	MOD	CANHAE	07/03/2016	Concerns raised regarding conflicting information given by nursing staff if there is a requirement for blood test prior to venesection procedure. Patient would like to know what the local protocols are and has raised concerns regarding the manner of nursing staff.	There is a need for a clear policy regarding blood tests prior to venesection, a policy is under development
18190	MOD	CANHAE	06/10/2015	Concerns raised regarding the changes in treatment pathway and communication levels.	Patient had not been kept fully informed of treatment plan and changes, apologies were given. Staff involved advised to ensure that all changes are effectively communicated to patients in future.

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17991	MOD	SURGE	28/05/2015	Patients coeliac disease not recognised despite the family informing staff of this on several occasions. Concerns also raised regarding the care provided to dementia patients.	Apologies offered that information was not handed over fully on all occasions and that this resulted in the patient eating gluten. Handover check list updated to highlight existing conditions.
18353	MOD	EMS	21/12/2015	Pt's grandson raised concerns regarding discharge arrangements, communication and ward moves.	Communication around patient moves was poor with staff not following Trust protocol. Staff have been reminded of the importance of keeping patient and family members informed of ward moves.
18419	MOD	CANHAE	31/03/2016	Concerns regarding poor communication at clinic appointment, family do not believe that the patients hearing difficulties were taken into account resulting in a lack of understanding. Medication mentioned in subsequent clinic letter not prescribed. Patient believed all further appointments had been cancelled. Concerns regarding admission to ward including lost notes, lack of physio and poor communication.	There was miscommunication during patients stay and some shortfalls within the nursing care. All areas are to be discussed with ward staff and Sister will be carrying out spot checks.
18086	MOD	EMS	15/07/2015	Issues with medication. Lack of action to patient / family concerns.	There was a lack of communication between the Consultant and weekend team, documentation was inadequate and this is to discussed with team for learning. Assurance given that patient did not come to any harm due to this breakdown.
18313	MOD	TRAORT	18/11/2015	Delayed treatment, patient was referred in March 2012 however, an administrative error occurred and surgery was not ultimately undertaken in Feb 2014. Patient is still waiting for second stage treatment.	Apologies offered for delays in pathway. Discussed with CAU team to ensure learning.
18397	MOD	EMS	29/03/2016	Concerns raised that delays in providing an MRI scan has led to a delayed diagnosis and delayed treatment.	A CT scan should have been performed - case to be discussed at clinical governance meeting.
18284	MOD	SURGE	04/11/2015	Difficulties with appointment system. Patient called to reschedule appt however he then received a letter indicating he had been removed from the list. He does not believe that the appt's system is fit for purpose.	Apology that incorrect letter was received. This has been discussed with CAU team. Assurance offered that appt system is fit for purpose
18469	MOD	EMS	25/04/2016	Concerns raised regarding the head wound treatment provided. Family feel that this was not undertaken correctly. They also have concerns if the correct amount of sedative was administered and the manner and attitude of staff.	Family reassured that treatment was appropriate, and senior consultant will feed back to doctor regarding his manner and attitude
18326	MOD	EMS	19/01/2016	Concerns raised regarding changes/not giving medication, falls, discharge arrangements and lack of support provided by social services.	There was a delay in obtaining medication and staff were not proactive in obtaining the prescription and sourcing the medication. Means of accessing emergency drugs to be be discussed with ward team. Ward staff reminded to ensure that relatives are informed when patients move wards. Family had confirmed that they would support patient on discharge until care package was in place.
18467	MOD	EMS	10/03/2016	Concerns that patient was not seen once by a doctor between arriving in ED at 7am and self-discharging from ward at 12.30pm.	A Paediatric dr should have been contacted straight away on arrival at A&E and observation commenced half hourly. Correct pathway reinforced at joint ED/paediatric meeting.
17884	MOD	OBSGS	28/05/2015	Patient was unable to have procedure at Maidstone hospital due to being MRSA +ve and would need barrier nursing post procedure. Patient went to Tun Wells for procedure and was not barrier nursed she was put in recovery with 4 other patients who later went to wards. Patients discharge paperwork states that patient's MRSA status is Negative	Apologies that MRSA status was not recognised and acted on appropriately. Lack of understanding about difference between decolonisation and treatment for MRSA (on the part of the Theatres staff) has been identified and update sessions provided.

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18287	MOD	SURGE	04/11/2015	Poor pain management on discharge which her family feel was inappropriate. She was just told to buy paracetamol.	Apology offered. Assurance that issues will be discussed at clinical governance.
17945	MOD	OBSGS	13/04/2015	Pt feels her treatment has been delayed as in Oct 2013 pt was told she required an operation for a prolapsed womb.	Apologies offered that patient was not appropriately followed up. Process being reviewed in light of issues.
18136	MOD	EMS	20/08/2015	Pt raises concerns that following an A&E admission and discharge for severe abdominal pain he was taken to another hospital where a small bowel obstruction was diagnosed and laparotomy performed.	Apology offered for missed diagnosis. Discussed with the team and the doctor involved.
18380	MOD	SURGE	07/01/2016	Lack of coordinated care and explanation re: liver functions. Poor standard of nursing care. Lack of suitable diet. Poor communication. Concerns that patient was discharged prematurely.	Assurance that care provided was appropriate and liver function has not been an issue in the long term and nothing had been kept from the patient. Apology that communication had been confusing; will be discussed at clinical governance. Apology for lack of appropriate diet available; catering manager will liaise with wards to ensure update training is provided as required. Assurance that discharge was appropriate.
18335	MOD	EMS	01/12/2015	Concerns raised regarding potential stroke misdiagnosis.	Following investigation it became apparent that the scan was misread and it did indeed show signs of an Ischaemic area, this was very subtle and most reporters would have missed it. Case to be discussed at clinical governance. The diagnosis of a stroke was not considered due to patient age and should have been.
18429	MOD	EMS	23/02/2016	Concerns raised the patient was given an incorrect diagnosis.	Communication was poor, the patient should have been advised this was a radiological diagnosis therefore, not a definitive diagnosis. Dr to arrange a further clinic appointment to discuss patients condition and complete further tests to ensure a definitive diagnosis is made. Consultant will discuss need for effective communication with his team.
17875	MOD	TRAORT	08/05/2015	Pt unhappy with manipulation of wrist following severe break. Pt does not think she was given correct amount of pain relief and no anaesthetic was administered. Pt has also raised concerns regarding her follow-up treatment at fracture clinic.	Apology that insufficient pain relief was provided when wrist was reset. Audit being undertaken to review and standardise practice
18186	MOD	SURGE	14/10/2015	Patient states that that there has been a lack of continuity and conflicting information was given during consultation with two doctors. Lack of empathy shown by doctor. Patient was informed that her varicose veins do not cause pain despite her expressly stating that they do. Lack of treatment offered.	Discussed with clinical and medical director. Advice given regarding onward referral. To be discussed as part of doctor's annual appraisal.
18215	MOD	SURGE	16/12/2015	Traumatic catheter insertion caused pain and false passages. Catheter consistently leaked. Discharged with catheter not working.	Apologies offered. Acknowledged issues with catheter which will be discussed with ward team and at urology clinical governance meeting
17946	MOD	SURGE	06/05/2015	Complication after stent insertion, stent moved position causing pain. Patient believes his condition was incorrectly linked to alcohol intake. Failed discharge. Manner of doctor. Four specific questions about the cause and nature of patients condition.	Apology that patient was referred to as being an alcoholic, explanation provided of relationship between alcohol and patient's condition. Concerns discussed with consultant, reminded of need for accurate documentation and communication. Explanation of treatment pathway. Case to be presented at clinical governance meeting.
18056	MOD	SURGE	21/07/2015	Concerns raised regarding the appropriateness of discharge	Complaint discussed with ward staff; individual staff member underwent monitoring of practice.

ID	Grade	Directorate	Closed	Description	Outcome
17920	MOD	SURGE	02/04/2015	Poor nursing care on the ward, patient catheterised unnecessarily and lack of support with nutrition. Delayed investigation / treatment and confusion over care plan. Loss of documentation on the ward. Poorly coordinated care.	Explanation provided re: care pathway during first admission. Assurance that this was appropriate. Apologies for the confusion and inconvenience on second admission. Case to be discussed at clinical governance.
18046	MOD	SURGE	13/07/2015	Concerns raised regarding delays in the patients treatment and poor communication. There has been an inconsistent message between the hospital and the GP regarding the outcome following the biopsy.	Apologies offered for delay and manner of doctor. Secretariat up to full complement and new pathway test database in place. Issue of consultant to consultant referrals to be discussed at clinical governance meeting
17967	LOW	EMS	28/04/2015	Concerns raised about lack of compassion shown towards patient by a doctor during a ward round. Pt now reluctant to return to hospital.	Apology for manner of consultant - he will undertake personal reflection on his manner and communication
18018	LOW	EMS	02/06/2015	Patient feels that the information given to the obstetric consultant by the diabetes nurse was false. This information impacted on her care plan during her pregnancy.	Apologies offered. Assurance that the importance of clear and effective communication has been reiterated. Assurance that there is no evidence that the patient's blood sugars were consistently high and no insulin was required.
18233	LOW	EMS	15/10/2015	Concerns raised regarding triage assessment and staff attitude and manner.	Reception staff have been reminded of the expected standards. Nurse to attend customer service training.
18348	LOW	EMS	27/11/2015	Concerns raised regarding the discharge process and transport back to care home	Apology given for communication breakdown regarding discharge and inaccurate information given. Appropriate care given and transport arranged in a timely manner once staff were aware of the problems with the transport contractors. Patient was moved from the ward to discharge lounge at 5pm and left the hospital at 6.15 pm.
18401	LOW	SURGE	14/12/2015	Incorrect information included on EDN	Apology offered for errors in EDN. Letter sent to GP to provide clarification. Importance of accurate documentation and communication to be discussed at clinical governance.
18444	LOW	EMS	26/02/2016	Concerns raised regarding discharge; although family had supplied outdoor clothing pt was discharged in his night clothing. Also would like reimbursement for broken glasses.	Discharge was appropriate and patient had had adequate assessments to support a safe discharge. Apologies were given and staff reminded regarding appropriate outside clothing on discharge. Ward agreed to reimburse for lost glasses.
18405	LOW	TRAORT	13/01/2016	Patient will only see a particular consultant and is unhappy that he will not be seen within the 18 week timeframe	Apology offered that appointment with specific consultant could not initially be offered in expected timeframe. Explanation of difficulties faced regarding capacity and assurance offered that directorate team are reviewing this issue. Appointment arranged.
18147	LOW	EMS	25/08/2015	Patient had concerns regarding the information in a letter sent from CAU, he wrote back asking for facts to be clarified and never received a response.	Patients letter was never received and this cannot be accounted for and apology given. Work is in progress to update letter templates to include names of staff so that patients will know who to contact.
17832	LOW	SPECME	13/10/2015	Poor communication around discharge - wrong relative contacted, pt discharged to a different nursing home than identified.	Full explanation given as to why patient was transferred to different NH. Staff did try to contact both complainant and her brother but were unsuccessful. ACTION: feedback from complaint shared with discharge team; review and share guidance on temporary discharge placements; review/develop information for relatives; discuss learning around documentation and use of appropriate rooms for discharge meetings at WM meeting; audit availability of bedside discharge info; review complaints process with discharge SW.
18356	LOW	CRS	24/12/2015	Concerns raised regarding a breach of confidentiality.	Disciplinary action taken.

ID	Grade	Directorate	Closed	Description	Outcome
18325	LOW	SURGE	20/11/2015	Delayed ENT treatment. Cancelled appointments. Patient does not feel her personal circumstances as a teacher were taken into account.	Apology offered for difficulties encountered. Actions underway to reduce waiting times include: working with local private providers to undertake surgery, recruiting additional consultants; increasing nurse-led aural clinics to release appointments in consultant clinics, running extra weekend clinics, setting up a community pathway for patients to be managed by GPs.
17951	LOW	EMS	17/04/2015	When patient had ECG done at Maidstone Hospital she believes that the nurse that was in the room with her took photos of her whilst she was in a state of undress.	Assurance offered by staff member that no photos were taken. Immediate implementation of new departmental policy requiring staff performing diagnostic tests to leave their mobile telephones in their lockers.
18409	LOW	EMS	25/01/2016	Concerns raised regarding the manner and attitude of A&E reception staff	Receptionists were following correct protocols however, communication could have been better and this has been discussed with them. Alternative staffing arrangements are being explored.

APPENDIX B

Complaints Satisfaction Survey

Thank you for taking the time to contact the Trust to make a complaint. We value the feedback you have provided and we want to use this to make a difference. We have investigated your complaint and provided a response (enclosed) which we hope you will find helpful. However, in order to ensure that we have met your expectations, we would appreciate you taking the time to fill in this questionnaire and returning it in the prepaid envelope provided. We will use your comments to help us evaluate and improve our handling of complaints.

1. **We know that it can be difficult to make the decision to raise a complaint. Once you had decided to make a complaint, how easy did you find it?**

   Easy ☐ Quite Easy ☐ Difficult ☐

   If you answered difficult, please explain why:

2. **Where did you find information on how to make your complaint?**

Information leaflets in the hospital	☐
Contacted the Patient Advice and Liaison Service (PALS)	☐
Contacted the complaints office directly	☐
Trust website	☐
Asked a member of staff	☐
Contacted the Parliamentary and Health Service Ombudsman	☐
Contacted the Independent Complaints Advocacy Service (ICAS/SEAP)	☐
Didn't need any information	☐
Couldn't find any information	☐
Other (please state)	☐

3. **Once you had made your complaint, did you feel you were adequately kept informed of the progress of the investigation?**

   Yes ☐ No ☐

   If you answered no, please explain why:

4. **Did the person investigating your complaint contact you to discuss your complaint?**

   Yes ☐ No ☐

5. **Was the response to your complaint easy to understand?**

Yes ☐ No ☐

If you answered no, please tell us how we could have improved it.

6. **Even if you didn't agree with our response, did the response to your complaint answer all your concerns?**

Yes ☐ No ☐

7. **Do you feel that your complaint has been resolved?**

Yes ☐ Partly ☐ No, but I don't want to take it any further ☐

No; I will be contacting the Trust again ☐ No; I will be contacting the Ombudsman ☐

8. **If we agreed with your complaint, we would describe your complaint as upheld. Was your complaint upheld?**

Yes ☐ Some of it was ☐ No ☐ Don't know ☐

9. **Do you feel that your complaint has made a difference? Has the Trust learned from your experience or made any changes as a result of your complaint?**

Yes ☐ A bit ☐ No ☐

If you answered no, please tell us why.

10. **And finally, how would you score your overall experience in relation to our handling of your complaint?**

(Very poor) 1 2 3 4 5 (Excellent)

If you scored us **less than 4,** please tell us what we need to do to improve.

APPENDIX C

No.	Recommendation/ issue	Action	Success criteria	Lead	Start date	Estimated completion date	Progress	Completion date	Evidence	Date of audit	Monitoring committee
1.	Raise awareness of right to complain	Review and update website information on making a complaint.	Public are aware of right to complain	Complaints & PALS Manager/ Communi-cations team	Feb 2015	Feb 2015	Completed.	March 2015	Trust Website	Subject to regular review and update as required.	PEC
		Review and update complaints/PALS leaflets.	Public are aware of right to complain	Complaints & PALS Manager	Feb 2015	March 2015	Completed.	April 2016	Leaflet published on Q-Pulse	Review dates indicated on leaflets.	PEC
		Explore possibility of advertising right to complain on TV information screens.	Public are aware of right to complain	Complaints & PALS Manager/ Communi-cations team	March 2015	April 2016	Unable to determine ownership. Enquiries still underway.			N/A	PEC
		Develop an easy read leaflet on making a complaint.	Public are aware of right to complain	Complaints & PALS Manager/ Communic ations/SVA Matron	March 2015	June 2015	Large print leaflets available.			Review date will be indicated on leaflet.	PEC
2.	Raise awareness of how to complain	Review clinical correspondence templates to include standardised message about how to give feedback.	Public are routinely and regularly made aware of how to complain	Complaints & PALS Manager/ EPR team	Feb 2015	March 2016	Referred to EPR team for discussion.				QC
		Ensure all patient information leaflets are updated with	Public are routinely made aware of how to complain	PILG	April 2015	March 2018	In progress. New standard wording provided to	Ongoing until all leaflets updated.	Leaflets on Q-Pulse	To be reviewed as each leaflet is	PEC

		details of how to give feedback.					leaflet administrator and being incorporated as leaflets are created/ updated			renewed/ introduced.	
3.	Raise awareness of support available to make a complaint	Advertise ICAS across Trust via posters.	Public are aware of advocacy service	Complaints & PALS Manager	April 2015	June 2015	Pull up banners purchased to raise awareness. Requests made to ICAS for promotional material.	April 2015	Closed as ICAS are no longer producing promotional material. Leaflets on the service held in both PALS offices.	Consider building into existing Quality Roadmap audits.	PEC
4.	Need to assure complainants that care will not be compromised by making a complaint	Review local induction processes.	Staff aware of complaints policy requirements	Complaints & PALS Manager/ L&D team	March 2015	August 2015	Dealing with complaints/ concerns is part of local induction checklist. Updated corporate induction with section on customer service/ dealing with concerns.	April 2015	Recruitment/LD records. Corporate induction package.	As per workforce planning	Workfor ce
		Publish article in Glenn's Newsletter and Governance Gazette	Staff aware of complaints policy requirements	Complaints & PALS Manager	April 2015	April 2015	Article about complaints in Gazette August 2014 and November 2015.	Nov 2015	Gazette archive (available on Trust intranet)	N/A (but will be rerun periodically to maintain awareness)	PEC
		Update complaints leaflet	Patients are aware that care	Complaints & PALS	Feb 2015	March 2015	Completed.	June 2015	Leaflet on Q-Pulse. Trust	Review dates	QC PEC

		and website information to reassure patients.	will not be compromised by making a complaint.	Manager					Website.	indicated on leaflets.	
5.	Ensure complainants know who they can complain to	Undertake comprehensive site review to ensure there is information available in all clinical areas of who complainants can complain to, addressing any shortfalls	Patients aware of who they can complain to	PALS team/ Patient Experience Matrons/ Ward Managers/ GM/AGM	April 2015	June 2015	New poster layout agreed to highlight how to raise concerns/ complaints or make comments. Funding being agreed with communicatio ns.	May 2016	Poster with comms for distribution.	Consider building into existing Quality Roadmap audits. PALS will monitor compliance on wards annually via ward round programme	PEC
		Review bedside folders	Patients aware of who they can complain to	Complaints & PALS Manager/ Patient Experience Matrons	April 2015	August 2015	Bedside folders now inconsistent and not available in all areas.	January 2016.	Closed as unable to progress.	Review in line with expiry date.	PEC
6.	Need to make outcomes of previous complaints more accessible	Develop website to provide a regular summary of outcomes from complaints.	Public able to access details of outcomes of all complaints	Complaints & PALS Manager/ Communi-cations team	April 2015	March 2016	Quality Committee asked to agree publication of Complaints Annual Report on Trust website, which includes outcomes from all upheld/ partially upheld complaints.			Update weekly	QC
7.	Need to	Investigators will	Complainants	ADNs/	July	July	Management	April	Datix, master	Audit in line	PEC

	improve communication between investigators and complainants during investigation period	be required to contact complainants on receipt of complaint	will receive a more personal service and be assured that complaint is being taken seriously	ADOs/GMs /AGMs/ CDs/ Matrons/WMs	2015	2015	of complaints changed – complaints leads attempt phone contact with all complainants on receipt of complaint.	2016	complaint files.	with complaints annual report (to commence May 2016)	
		Review complaint documentation templates	All complainants will be given opportunity to speak directly with investigator	Complaints & PALS Manager	March 2015	July 2015	Action proforma amended to reflect this. Information sheets reviewed.	December 2015	Datix.	Templates subject to review and update as necessary	PEC
8.	Ensure location of PALS offices is well advertised across sites	Review and update signage	Complainants know where they can go to make a complaint	PALS Team Leaders/ Estates and Facilities team	Feb 2015	March 2016	Escalated to Facilities Manager to incorporate into their forward planning.	Ongoing as signage is updated/ amended	Visual inspection of information points around sites.	N/A	PEC
9.	Ensure that complainants are aware that a formal record of their complaint is kept.	Amend current acknowledgement letter template.	Complainants aware of record keeping.	Complaints & PALS Manager	March 2015	July 2015	Information sheet amended Feb 2015.	February 2015	Datix	Templates subject to review and update as necessary	PEC
		Update website information.	Complainants aware of record keeping	Complaints & PALS Manager/ Commuincations team	Feb 2015	Feb 2015	Updated June 2015. Next update due June 2016.	Ongoing as required	Trust website.	Subject to regular review and update as required.	PEC
10.	Review measurement/ monitoring of complaints performance	Review current timeframes for responding to complaints.	Ensure complaints are responded to in a timely manner	Complaints & PALS Manager/ Ass. Dir. of Quality,	March 2015	April 2015	New approach to managing complaints has provided better	March 2016	Quality and governance dashboards.	Updated monthly.	CGC

				Governance and Patient Safety			compliance with performance targets.				
		Consider the meaningfulness of complaints data currently reported on Trust dashboard	Assurance of quality of complaints service provided	Ass. Dir. of Quality, Governance and Patient Safety/ Chief Nurse	March 2015	April 2015	Fed into to external review of Trust's governance arrangements	April 2015	External governance review report.	N/A	CGC
11.	Need to offer complainants support in understanding the outcome of their complaint.	Ensure that the role of the identified contact is clarified in responses to include that they can help explain the outcome of the complaint.	Increased patient satisfaction.	Complaints Leads	Feb 2015	Continuous.	Clarity now provided in all complaint responses around who to contact for support in understanding outcome of complaint.	February 2015	Datix. Master complaint files.	N/A	PEC
12.	Need to develop a sustainable system for monitoring completion of and compliance with complaint action plans.	Review Datix functionality to improve tracking of open action plans	Trust able to demonstrate effective learning/ improvements from complaints	Complaints & PALS Manager	Jan 2015	April 2015	Last reviewed at Team Leaders meeting April 2016.			Audits are identified on individual action plans as appropriate	CGC
		Review capacity of complaints leads to oversee completion of action plans.	Trust able to demonstrate effective learning/ improvements from complaints	Complaints & PALS Manager	April 2015	March 2016	New approach to managing complaints will free up capacity within directorates to implement learning.	January 2016	Memo to directorate management December 2015.	Audits are identified on individual action plans as appropriate	QC
		Review role of Trust Board and Directors in	Trust able to demonstrate effective	Chief Nurse/CEO /COO/MD/	March 2015	March 2016	Mock CQC inspection programme	April 2016	Mock inspection records.	Programme of inspections	QC TME Trust

		testing compliance with action plans.	learning/ improvements from complaints	NEDs			launched April 2016.			held by central governance team.	Board